BASS Line 2007 survey

Assessing the sexual HIV prevention needs of African people in England

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Original Research Report

Acknowledgments

Survey design and recruitment collaborators: An extraordinary amount of time, energy and dedication was committed by the 96 agencies who collaborated on BASS Line 2007, and for this we owe them a huge debt of thanks. They include agencies who suggested content for the survey, requested booklets for local distribution directly from Sigma or got their booklets from a third party (identified by agency stamps on completed booklets), and those that promoted the survey via their websites or email contacts, or distributed posters and cards promoting the survey in community settings. Website addresses are also given for agencies who promoted the survey online.

- Africa Advocacy Foundation <www.a-af.org>
- African Caribbean Resource Centre
- The African Child
- African Communities Team at Camden PCT
- African Community Involvement Association <www.acia-uk.org>
- African Community Partnership
- African Culture Promotions (ACP)
- African Families Support Service (AFSS)
- African Health Care and Counseling Service
- African Health for Empowerment and Development (AHEAD) <www.africanhealth.org.uk>
- African HIV Policy Network (AHPN) <www.ahpn.org> <www.nahip.org.uk>
- African Institute for Social Development
- African Refugee Community Health and Research (ARCHRO)
- African Support & Project Centre (ASPC)
- African Youth Organisation
- Africans Getting Involved (AGI)
- Barnet African Health Organisation
- Beresford Project
- Black Gay Men's Advisory Group <www.bgmag.org.uk>
- Black Health Agency <www.blackhealthagency.org.uk>
- Body Positive North West
- The Brunswick Centre
- The Cara Trust
- Catholic HIV / AIDS Ministry – Westminster Archdiocese (CATHAM)
- Central Liverpool PCT
- Centre for African Families Positive Health (CAFPH) <www.cafph.org>
- Centre For HIV and Sexual Health Sheffield
- Che Jama at NHS Norfolk
- Children With AIDS Charity (CWAC)
- College of Venereal Disease Prevention
- Community Health Action Trust (CHAT)
- Community of Congolese Refugees in Great Britain (CORECOG)
- Congolese Community Council
- Congolese Youth Association
- Crescent Support Group <www.thecrescent.org.uk>
- Croydon PCT
- DHIVERSE
- East London Somali Welfare Association
- Ethiopian Community Centre in the UK (ECCUK) <www.eccuk.org>
- Ethnic Health Foundation (EHF)
- French African Welfare Association (FAWA)
- George House Trust (GHT)

- Group Evangelists
- Health Action Charity Organisation (HACO) <www.healthaction.co.uk>
- Hope Gate (formerly HIV/AIDS Association of Zambia, HAAZ)
- Humanitarian Support Services
- International Gospel and Health Group
- Jesus Kingdom City
- The Junction
- Kenya Women's Association
- Lambeth PCT
- Leeds Skyline Service (formerly Leeds Support and Prevention Centre)
- Leicestershire AIDS Support Services (LASS)
- London Ecumenical AIDS Trust (LEAT) <www.leat.org.uk>
- Lusoginal
- MDC Training & Consultancy
- Milton Keynes PCT
- Morden CAB HIV / AIDS Project
- MS Development Corporation
- MyHealthnet
- National AIDS Trust <www.nat.org.uk>
- National Institute for African Studies (NIAS)
- National Union of Students (NUS) <www.nusonline.co.uk>
- Naz Project London (NPL) <www.naz.org.uk>
- North Staffordshire Afro-Caribbean Community Association (NORSACA)
- 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
- Sahara Communities Abroad (SACOMA)
- Sahir House
- Sexual Health Service – St Mary's Hospital
- Shaka Services
- Shea Project
- South London African Women's Organisation (SLAWO)
- Southern Africa Aids Foundation
- Staffordshire Buddies
- Terrence Higgins Trust (THT) <www.tht.org.uk>
- Together In Prosperity (TIP)
- Uganda Community Relief Association
- Uganda AIDS Action Fund (UAAF) <www.uaaf.org.uk>
- UK Coalition of People Living with HIV & AIDS (now closed)
- Wandsworth Interpreting Service
- Wandsworth PCT
- West African Health Initiative
- West African Networking Initiative (WANI)
- Wrap It First
- Yorkshire Mesmac <www.mesmac.co.uk>
- Youth Projects International
- Zenith Women's Association
- Zimbabwean Women's Network UK

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Online survey design: Designed by David Reid and Gary Hammond at Sigma Research using www.demographix.com. Thanks to Derek Cohen and Bobby Pickering at Demographix for all their help.

Online survey promotion: Co-ordination by Catherine Dodds and Kathie Jessup with support from Godwin Adegbite. Thanks to the 20 agencies that volunteered their websites to promote the survey free of charge (listed above) and various web-masters for making it happen.

We also advertised the survey on a range of commercial websites. Our thanks to those companies who reduced or waived their normal advertising rates because of the nature of the project.

AfrikaDating <www.afrikadating.com>, AfroSounds <www.afrosoundsfm.com>, All Africa <www.allafrica.com>, Arberry Pink <www.arberrypink.co.uk>, Black Britain <www.blackbritain.co.uk>, Mister Seed <www.kenyans.co.uk>, Sugar Media <www.sugarmedia.co.uk>, UK Version <www.ukversion.co.uk>, UK Zambians <www.ukzambians.co.uk>, The Voice <www.voice-online.co.uk>, The Zimbabwean <www.thezimbabwean.co.uk>

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empowering African communities affected by HIV

NAHIP

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www.sigmaresearch.org.uk/go.php/reports/report2008b

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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	An infectious agent acquired during sex
mean	The sum of all values divided by the number of cases (commonly referred to as an 'average')
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 of less than 5%	If we had done the survey many 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	Unprotected intercourse between a person infected with HIV and person who is uninfected
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. Tables that indicate significance in this way appear mostly in Part Two (Chapters 6-12) of this report.
standard deviation	A figure that represents how a set of results is distributed, and how far a group of results falls from the average
STI sexually transmitted infection	Infectious agents acquired during sex (including HIV)
UI unprotected intercourse	Penetrative anal or vaginal intercourse without a condom
<	Less than
>	More than

Contents

Part one

Part two

1 Introduction and methods

1.1 CONTENT OF THE REPORT

This research report outlines the main findings of BASS Line 2007, an HIV prevention needs assessment among Africans in England. Recruitment to the survey was carried out from June to September 2007 by Sigma Research in partnership with 96 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 in this report is about the sex that African men and women living in England have and their sexual HIV prevention needs. All sexually active people have specific needs that must be met in order for them to 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 this report includes people who plan, deliver, and commission HIV prevention programmes targeting African people in England. This survey has collected the largest set of data on the HIV prevention needs of Africans in England. It 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).

The report is divided into two parts. Part One has five chapters providing the background and methodology of the survey, and a simple overview of survey responses. Part Two includes further statistical analysis of the key topics reported in Part One, by offering a comparison of respondents' answers across a selection of demographic variables.

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 4,172 African men and women in England who completed the survey. 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.

Part Two of the report includes seven short chapters. Chapter 6 draws out the relationship between respondents' HIV testing histories and their answers to other key questions. Chapter 7 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 8), level of education (Chapter 9), country of birth (Chapter 10), length of residence in the UK (Chapter 11), and religion (Chapter 12) play a role in their HIV prevention needs.

1.2 BACKGROUND AND DEVELOPMENT OF THE BASS LINE 2007 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 March 2007 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. Twenty 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 African researcher undertook 20 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 2007 questionnaire and research methodology received approval from the Faculty of Humanities and Social Sciences Research Ethics Committee, University of Portsmouth.

1.3 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 of a French language version of the survey in booklet and online formats.

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.*).

1.3.1 Booklets

A list of 109 potential collaborators was developed with support from AHPN and other stakeholder agencies. A total of 33,900 English language booklets, and 4,120 French language booklets were requested by and sent out to 82 agencies delivering services to African people in England. Recruitment was open for a four month period (June to September 2007 inclusive). At the start of the recruitment period, a low number of overall returns (fewer than 400 by the end of July) indicated a need for supported survey promotion in community settings. Two health promotion trainees who were part of the Terrence Higgins Trust Future Leaders Project were mobilised to meet with managers, volunteers and staff in NAHIP partner agencies to resolve difficulties with recruitment. This intervention proved to be of great value to the overall project.

We do not know the exact number of booklets distributed by agencies. Overall, 5309 survey booklets marked as distributed by 70 different agencies were received by Sigma Research via Freepost return, representing a 14% 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%). The average (median) number of booklets returned per agency was 14 (mean 76, range 1-909). We received 20 or more valid booklets from 29 different agencies.

1.3.2 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 or French via designated websites. The online questionnaire contained the same 53 questions as the booklet.

The online questionnaire was prepared and hosted (in both English and French) 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 four months as the booklet version (June to September 2007). It was substantially promoted by 11 African commercial websites (see *Acknowledgments*) and by 20 community groups via their websites and / or via their email contact lists. Overall, we received 1012 (998 English and 14 French) online responses.

1.4 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 as the process of booklet preparation for data entry began, that booklets returned from some agencies were invalid. This issue became apparent where responses to open ended questions such as Q49 (*What local authority do you live in?*) and Q53 (*What one thing would most improve the quality of your life?*) were identical across large batches of booklets that had been distributed by the same agency. Further exploration into these batches revealed similarity in handwriting and patterns in missing data. Although allowances had been made for the likelihood of informal translation and support with questionnaire completion, indicated by Q51 *(Are you filling in this survey by yourself or is someone helping you to understand the questions?*), among the batches under examination, this question tended either to not be answered, or the response indicated that the individual was completing the survey alone. Therefore, we had no reasonable explanation for the similar answers or the handwriting similarities and could not rely on the validity of data in those batches of booklets. The process of entering the data into a database allowed further quality control to take place. Once the information from booklets was available for analysis, it was possible to test the data-set for anomalies and to exclude invalid data. In most cases, invalid returns were a small proportion of any one agency's total returns.

Further exclusions were also undertaken in relation to the basic 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 BASS Line survey.

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 (%) BOOKLET	number (%) WEB	number (%) ALL
TOTAL RETURNS	5309 (84.0)	1012 (16.0)	6321 (100.0)
Invalid returns	1518 (28.6)	8 (0.8)	1526 (24.1)
Under 16 years of age	4 (<0.1)	5 (0.5)	9 (0.1)
Not in England	72 (1.4)	232 (22.9)	304 (4.8)
Not African	95 (1.8)	35 (3.5)	130 (2.1)
Already completed the survey	106 (2.0)	37 (3.7)	143 (2.3)
Insufficient data (mostly blank)	36 (0.7)	1 (0.1)	37 (0.6)
TOTAL EXCLUSIONS	**1831 (34.5)**	**318 (31.4)**	**2149 (34.0)**
TOTAL SAMPLE FOR ANALYSIS	**3478 (65.5)**	**694 (68.6)**	**4172 (66.0)**

Overall, two thirds (66.0%) of the returns collected were included in the final analysis. A slightly higher proportion of internet returns (68.6%) were retained compared to booklets (65.5%). Internet exclusions tended to be based on respondents not being in England (22.9%), or respondents not being African-identified (3.5%), or because people had completed the survey more than once (3.7%). However, the majority of booklet returns excluded (28.0%) were a consequence of the data validity issues described above.

2 Description of the people who took part

The final sample was 4,172 adults recruited in England who considered themselves to be African. This chapter describes this group of people using the following characteristics: gender; sexual attraction and gender of sexual partners; age; ethnicity; length of residence in UK; area of residence; household composition; current economic activity; education; religion; regular and primary sexual partnerships; circumcision; and knowing someone with HIV.

2.1 GENDER

The final sample includes slightly more men (51.2%) than women (48.8%). However, the internet sub-sample includes slightly fewer men (47.0%) than women (53.0%). This is interesting as it is frequently presumed that women are less likely to encounter online interventions and service information. Gender runs through the rest of this report as a major consideration in designing and targeting interventions.

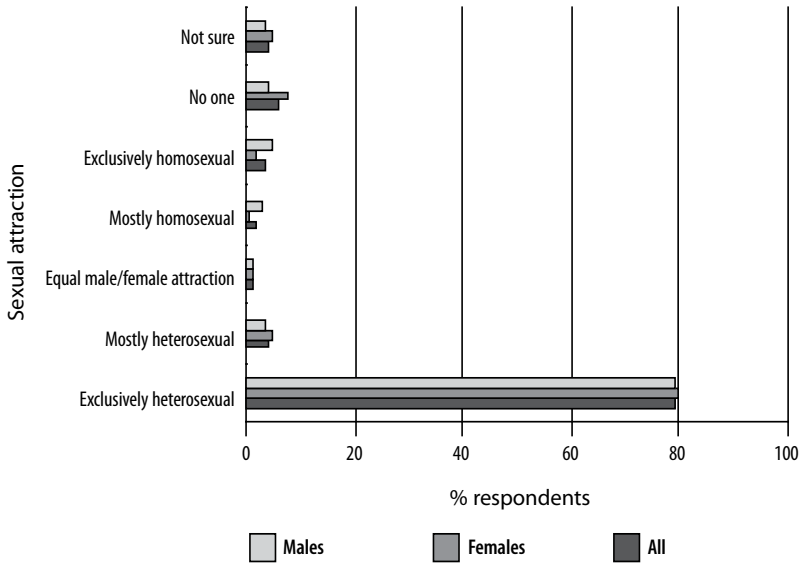
2.1.1 Sexual Attraction

All respondents were asked *Are you sexually attracted to men / boys or women / girls?* and were offered seven options. Overall, 6.1% said they were not sexually attracted to anybody, and this was more common for women (8.0%) than for men (4.3%). A further 4.2% were not sure whether they were attracted to men or women.

The majority of respondents (79.4%) identified that their sexual attraction was exclusively heterosexual (directed at the opposite sex only). Men and women were equally likely to report exclusive heterosexual attraction.

A substantial minority (10.2%) reported some homosexual attraction and this was more common for men (12.7%) than for women (7.8%).

Men were far more likely than women to report exclusive or predominantly homosexual attraction (7.6% of men and 2.2% of women).



Sexual attraction by gender (n=3862, missing 310)

2.1.2 Gender of sexual partners

Respondents were also asked *How many men / boys* and *How many women / girls* they had sexual intercourse with in the last 12 months. Chapter 4 reports on numbers of sexual partners. 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=2023)	% FEMALES (n=1917)	% ALL (n=3953)
No sexual partners	15.2	23.7	19.5
Opposite sex partners only	69.6	68.4	68.8
Both opposite and same sex partners	10.3	5.7	8.1
Same sex partners only	4.9	2.2	3.6

Two thirds of men (69.6%) reported that they had only had intercourse with women in the past year, while one in ten (10.3%) had sex with men and women, and one in twenty (4.9%) had sex only with men. Nearly a sixth (15.2%) of men said that they had not had sexual intercourse with anyone in the previous year.

One quarter of all female respondents (23.7%) reported not having had sexual intercourse with anyone in the past year – making them much more likely than men to report no partners. Similar to male respondents, women reporting exclusively heterosexual activity (in this case only intercourse with men) accounted for about two thirds (68.4%) of the responses. Sexual intercourse with women only and with both men and women was reported by a small proportion of women (2.2% and 5.7% respectively). Behavioural bisexuality was far less common among women than among men.

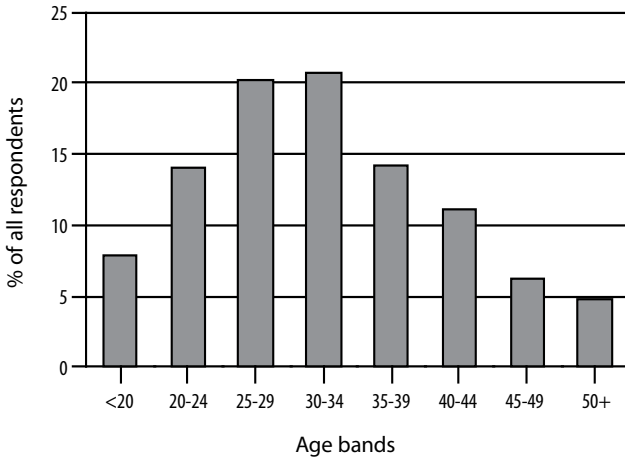
As we would expect there was a strong but imperfect association between sexual attraction and gender of sexual partners. A noteworthy finding was that more than half (57.8%) of men who had sex with both men and women in the previous 12 months said that they were only attracted to women. A smaller proportion who had sex with both men and women (7.5%) said that they were only attracted to males. One-in-eight men who reported only having intercourse with men in the past year (12.1%) said that they were only attracted to women.

When information about the gender of women's recent sexual intercourse partners was compared with their self-reported sexual attraction, there was a closer correlation between sexual behaviour and desire. However, the relationship between attraction and activity was not absolute. Despite the small numbers of women having sex with both men and women, just under half (43.4%) said that they were exclusively attracted to men, while a smaller proportion (8.4%) said that they were exclusively attracted to women. A third (32.4%) of women who reported having intercourse with only women in the last year reported only being attracted to men.

This demonstrates that sexual desire is not entirely predictive of sexual behaviour. These findings particularly highlight a tendency for men and women who engage in sexual intercourse with same sex *and* with opposite sex partners to only identify their desire as one that is heterosexual (opposite sex-oriented). We compare key indicators of HIV prevention need in Part Two (Chapter 7) using respondents' gender and the gender of their sexual partners.

2.2 AGE

The average (mean) age across the entire sample was 32 years (standard deviation 9.9, median 31, range 16-79). The fifth of respondents who completed the survey online were significantly older (mean 34.9 years, standard deviation 9.3, median 34, range 16-78) than those taking part through the booklet (mean 32.0 years, standard deviation 9.9, median 30, range 16-79). This may be because the news and social websites that were most successful in recruiting to the online survey attracted an older audience.



Age groups (n=4103, missing 159)

There was no relationship between age and gender, that is, the men and women in the sample were of broadly similar ages.

We present detailed age bands in the bar chart here, but simplify the age groups (under 20; 20s; 30s; 40s; 50 and older) when making comparisons by age in Part Two (Chapter 8).

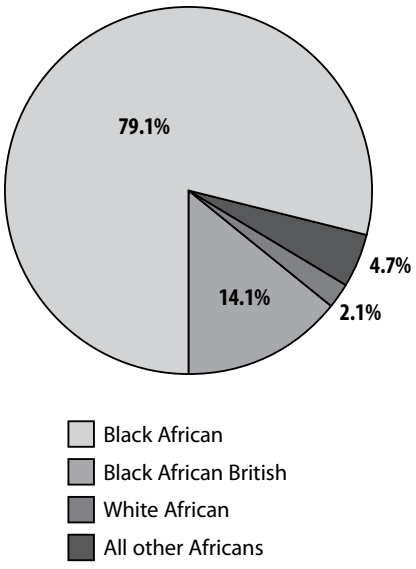
2.3 ETHNICITY

Self-identification as African was an inclusion criteria for participation in the study. Three other dimensions of ethnicity were also measured: self-nominated ethnic group, country of birth and first language.

2.3.1 Self-nominated ethnic group

The majority of respondents identified themselves as Black African when asked to choose from the following: Black African, African British, African Asian, African Arab, White African, Mixed African, and other.

There were no significant relationships between ethnicity and gender. Those identifying as Black African were, as a group, older (mean 33.0, standard deviation 9.6, median 32, range 16-79) than all other ethnicities.



Ethnicity (n=4150, missing 22)

2.3.2 Country of birth

Respondents were also asked the open ended question: *What country were you born in?* In total 86 different countries were represented. African countries accounted for 89.1% of responses, the UK for 8.4% and the rest of Europe, Asia, North America and South America together accounted for less than 2.4% of responses. The table below shows the 24 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=3913, missing 259)	% ALL	% that were male	Average age (median)	Age range
Zimbabwe	17.4	50.6	34	16-78
Nigeria	11.1	53.5	30	16-79
Uganda	9.8	39.9	32	16-68
United Kingdom	8.4	48.5	26	16-60
Kenya	7.8	44.7	32	16-54
Ghana	5.9	51.1	31.5	16-67
Zambia	3.9	43.1	36	17-65
Republic of South Africa	3.3	38.5	32	16-70
Republic of the Congo	3.2	56.8	30	17-70
Somalia	2.4	75.0	28	17-68
Sudan	2.3	80.9	32	17-54
Malawi	2.2	42.4	29	16-60
Cameroon	2.0	50.6	32	17-56
Democratic Republic of the Congo	1.8	71.4	34	16-63
Tanzania	1.8	48.5	30	16-63
Sierra Leone	1.6	64.5	30	18-69
Angola	1.4	58.8	29	16-60
Rwanda	1.3	47.9	35.5	17-53
Ethiopia	1.2	59.6	31	17-55
The Gambia	1.1	65.1	29.5	16-56
Eritrea	0.9	38.9	27	18-56
Cote d'Ivoire	0.9	55.9	29	19-46
Botswana	0.8	56.3	32.5	18-52
Burundi	0.8	40.0	30	17-49

Three countries, Zimbabwe, Nigeria and Uganda, accounted for over a third of all respondents (38.3%). The fourth most common country of birth was the UK. Overall, 8.4% of respondents were born in the UK, much lower than the 17.3% found among Black Africans aged 19-59 in the Labour Force Survey in 2002 (Lindley, Dale & Dex 2004). This suggests migrant Africans were more likely to take part in the survey than UK-born Africans (which would be because our research collaborators are more likely to serve migrants than UK-born Africans).

Males and females were represented in all country of birth sub-samples. The three country of birth sub-samples with the highest male-to-female ratio were Sudan, Somalia and the Democratic Republic of the Congo. The three country sub-samples with the lowest male-to-female ratio were the Republic of South Africa, Eritrea and Uganda.

All country of birth sub-samples showed a wide range of ages. The youngest country of birth sub-sample consisted of those born in the UK, among whom a quarter (25.8%) were under the age of twenty. The next youngest country of birth sub-samples were Eritrea, Somalia, Malawi and Cote d'Ivoire. The oldest groups according to country of birth were Zambia, Rwanda, Democratic Republic of the Congo and Zimbabwe.

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

2.3.3 Language

Respondents were also asked: *What is your first language?* There was a huge array of responses, with 331 different languages identified. Overall, 30.4% identified English as their first language.

The table below shows the 10 most common first languages in the sample, with the 321 remaining languages classed together as 'other', and accounting for less than a third (29.8%) of first languages. While these ten languages cannot be taken as representative of the first languages of all Africans in England, they do offer some indication of the languages spoken by those most likely to come into contact with NAHIP interventions.

First language among all respondents (n=3955, missing 217) Language descriptions from www.ethnologue.com	**% ALL**
English Spoken as a first and / or official language in many sub-Saharan countries.	30.4
Shona Mainly spoken in Zimbabwe and also in Botswana, Malawi and Zambia.	11.0
French Spoken as a first and / or official language across much of North Africa as well as in some Western and Central African countries.	6.4
Kiswahili /Swahili Spoken in East Africa (i.e. Tanzania, Kenya, and Uganda as well as Democratic Republic of the Congo, Burundi and Rwanda).	5.6
Luganda / Ganda Spoken mainly in southeastern Uganda, primarily in Buganda province.	4.3
IsiNdebele / Ndebele / Sindebele Spoken in Zimbabwe, South Africa and also in Botswana.	3.1
Arabic Spoken in standard and dialect forms in a range of North African and East African countries.	2.8
Yoruba Spoken in Nigeria. Also in Benin and Togo.	2.6
Lingala / Ngala Spoken in the Democratic Republic of the Congo, the Central African Republic and Republic of the Congo.	2.0
Somali Somali is the official language of Somalia. It is also spoken in Djibouti and parts of Ethiopia and Kenya.	1.8
Other	29.8

Men and women were equally likely to list English as their first language, but young people were more likely to list English than the older respondents: almost half (49.5%) of those under the age of 20 said English was their first language compared to only a quarter (25.7%) of those aged 50 or more. The first languages reported were closely related to respondents' country of birth in a predictable pattern.

Of those that completed the survey in French, 40.1% said it was their first language. Of the remaining respondents completing the survey in French 23.3% said their first language was Lingala, 7.5% Swahili/Kiswahili, 4.8% Kikongo and 4.4% Somali. No other first language was mentioned by more than 1% of people who completed the French language version of the survey (though 0.4% said their first language was English).

Respondents were not asked about their fluency in English, and it is highly likely that the survey's format and distribution mechanisms meant that the survey was more likely to attract confident readers of English (and to a limited extent, readers of French). In the final set of questions, all respondents were asked if they received any support to complete the survey. Of the final sample, 309 people (7.4%) reported some help completing the survey. Of these, 61 did not specify what language a third party had used to assist them. Of the remaining 248 respondents reporting assistance, 163 said they were being helped in English. While one reported they were sight impaired, it is assumed

that the majority of the others were being informally interviewed in another language. Among these 85 respondents, the most common languages used were Arabic (20 people); French (16 people); Swahili (9); Amheric (6); Shona (4); and Lingala (4). No other language was mentioned by more than 2 respondents answering this question about assisted completion.

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 lived in this country all their lives, and 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 68 years with an average (mean) of 8.4 years (median 6 years, standard deviation 7.7 years). There was no significant difference in the average length of time men and women had lived in the UK.

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=4018, missing 154)	**% ALL**	**Average age (median)**	**Age range**
less than 1 year	4.4	27	16-56
over 1 year – less than 3 years	13.3	28	16-69
over 3 years – less than 6 years	30.9	31	16-73
over 6 years – less than 10 years	23.3	33	16-73
10 years or more (migrants)	23.5	36	16-79
10 years or more (have ALWAYS lived in the UK)	4.6	22	16-57

The average (median) age of people who had lived in the UK for 12 months or less was 27 years, and increased as length of time living in the UK increased (as we would expect to be the case, apart from those who have lived in the UK their whole lives, who tended to be young).

In Chapter 11 we compare groups of respondents who have lived in the UK for different lengths of time using the following bands: up to one years (4.4% of the sample); between one and three years (13.3%); between three and six years (30.9%); between six and ten years (23.3%); and more than ten years (28.1%). 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 quarter did not answer this question (24.9%, n=1040). Those completing the online version were more likely to respond because they were not able to progress to the end of the survey until an answer to this question was given. One of the most likely explanations for this low response is that people may have feared that identifying their place of residence would impact on their anonymity.

The vast majority lived in England, with 0.1% living in Scotland, 0.1% in Wales and 0.1% from outside of the UK. No respondents indicated living in Northern Ireland. 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=4172)	Number of respondents	% ALL	% of those that answered
SHA not known	1040	24.9	–
London	1427	34.2	45.6
East Midlands	277	6.6	8.8
Yorkshire and the Humber	274	6.6	8.7
East of England	266	6.4	8.5
West Midlands	266	6.4	8.5
South Central	215	5.2	6.9
South East Coast	152	3.6	4.9
North West	150	3.6	4.8
North East	74	1.8	2.4
South West	18	0.4	0.6
Outside England	13	0.3	0.4

In the 2001 Census 78% of Black Africans living in England lived in London (Dobbs *et al.* 2006). In our survey only 46% of respondents living in England lived in London. This is likely to be a function of the geographic distribution of our research collaborators.

Separate data reports for each Strategic Health Authority (SHA), showing key findings by Primary Care Trust of residence, can be found on the Sigma Research website at www.sigmaresearch.org.uk/go.php/local/african/bl07

2.6 HOUSEHOLD COMPOSITION

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

Overall 29.8% lived alone. Men were more likely to live alone than women (34.1% compared to 25.3%). A third (32.9%) lived with a partner, including spouses. A partner was by far the most common co-inhabitant indicated. Men and women were equally likely to live with a partner.

A smaller proportion lived with parents or step-parents (9.5%) and the majority of these were below 25 years of age (although many younger respondents did not live with their parents). Females were more likely to live with parents than males (10.9% compared to 8.4%). Among those who said that they lived with other family members (4.9%) it was most common to live with siblings, uncles/aunts and cousins.

Only one respondent in seven (14.4%) lived with children for whom they were responsible. This was far more common among females (20.6%) than males (8.5%) 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, 43.2% also lived with a partner. This indicates that single-parenthood is not uncommon among those who live with dependant children, especially among women, which is likely to influence their access to clinical and behavioural interventions.

Some respondents (8.9%) lived with friends. This arrangement was slightly more likely among men (10.2%) than among women (7.4%). Some also shared with house-mates (7.6%). The likelihood of sharing with others decreased as length of time living in the UK increased, which may be explained 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=4090,missing 82)	**% ALL**
Employment (formal and informal)	
Full-time employment	33.7
Part-time employment	14.9
Casual / cash-in-hand employment	2.1
Carer / homemaker	3.3
Education / training	
Full-time education	26.6
Part-time education	12.8
On a training scheme / back-to-work activity	3.3
Unemployment / other	
Not in employment and registered for benefits	4.4
Not in employment and not registered for benefits	4.4
Unable to work (long-term illness / disability / medically retired)	2.6
Not allowed to work (immigration reasons)	9.2
Retired	0.8
Other	0.4

Most people were either involved in regular work (38.3%), or in education (29.9%), or both these activities (10.0%). A fifth (21.8%) were neither involved in regular work, or education or training. Immigration status may go some way toward helping to explain this figure, given that 9.2% of respondents identified that they were disallowed from work due to their immigration status. Very few of those who identified this barrier to legal work indicated that they had regular employment, and even fewer identified casual or cash-in-hand work as a means of income.

Men and women were equally likely to currently be in education or on a training scheme. They were also equally likely to be in part-time or casual employment or to be retired or unable to work because of illness or disability. However, men were significantly more likely to be in full-time employment than women (37.7% compared to 29.5%) and significantly less likely to be a full-time carer or homemaker (0.8% compared to 6.1%). Women were more likely than men to be not allowed to work because of their immigration status (10.6% compared to 7.9%) or to be unemployed (54.9% compared to 48.5%) whether they claimed benefits or not.

As we would expect, those in full-time or part-time education were younger on average, as were those on training schemes. Those that were in full-time employment were older on average, as were those unable to work because of illness or disability, and those who were unemployed or retired.

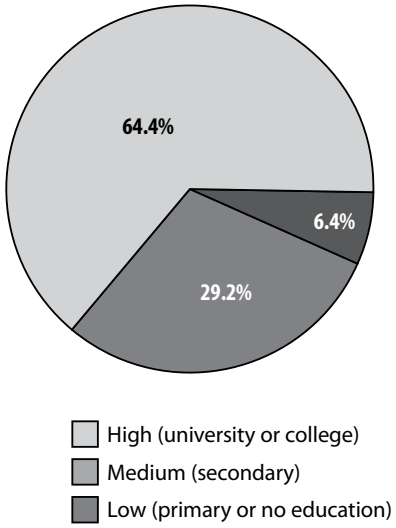
2.8 EDUCATIONAL ACHIEVEMENT

Respondents were asked *What is the highest level of education you have achieved?* and were offered the responses: *none; primary or elementary school; secondary or high school; university or college; other*. For ease of reporting, educational attainment was re-coded into the three categories appearing in the pie chart below.

Most respondents had a high level of education (64.4%) and only a small proportion reported low educational attainment (6.4%). Respondents recruited online were significantly more likely to have high educational achievement than those recruited using the booklet (84.4% versus 60.4%). There was no significant difference in education between men and women.

More than a third of those with low (33.6%) or medium (36.3%) education were currently engaged in some educational activity. This was especially common among the younger respondents (83.6% of under 20s were still in some form of education, and 52.1% of those aged 20-29).

People who had been in the UK for more than ten years were slightly more likely to have achieved a high level of educational attainment, compared to those that had been in the UK less time, a trend which is also demonstrated in analyses of national statistical data (Kyambi 2005). In Part Two (Chapter 9) these three education groups are used as a means of comparing sexual behaviour and HIV prevention need across the sample.



Education groups (n=4116, missing 56)

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.

Using respondents' answers it was possible to categorise more than half of the Christians as Roman Catholic, Orthodox or Protestant. 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 we have called 'Protestant unclassified', as well as those who indicated a denomination that can be identified as a sub-category of Protestantism.

Religion (n=4066, missing 106)	Number of respondents	% ALL
Christian	**2961**	**72.8**
Christian unclassified (no denomination given)	1228	30.2
Roman Catholic	596	14.7
Orthodox	33	0.8
All Protestants	1104	27.2
Protestant unclassified	*169*	*4.2*
Baptist	*40*	*1.0*
Church of England	*207*	*5.1*
Church of Scotland	*20*	*0.5*
Congregationalist	*12*	*0.3*
Jehovah's Witness	*23*	*0.6*
Methodist	*98*	*2.4*
Mormon	*5*	*0.1*
Pentecostal / Evangelical	*461*	*11.3*
Seventh Day Adventist	*69*	*1.7*
Islam	**717**	**17.6**
African traditional religion	**81**	**2.0**
Buddhism	**35**	**0.9**
Other religion	**26**	**0.6**
No religion	**246**	**6.1**

The majority of respondents indicated that they were Christian (72.8%). A substantial proportion of respondents indicated that they belonged to Islam (17.6%), while fewer belonged to an African traditional religion (2.0%), Buddhism (0.9%) or other religions (0.6%). Only three respondents identified themselves as Jewish.

Gender differences were noted in answers on religion. More men followed Islam (22.7%) compared to women (12.1%). Men were slightly more likely than women to indicate that they did not belong to any religion and slightly less likely to belong to a Pentecostal / Evangelical denomination. 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 ascribed as an aspect of femininity rather than masculinity, which offers some explanation for the finding that fewer women than men had no religion. For simplicity, the categories above have been condensed to four groups: Christian, Muslim, African traditional religion and no religion in the comparison of HIV prevention need across the sample by religion that is reported in Part Two (Chapter 12).

Spotlight on other research: Religion

The 2001 Census asked What is your religion? The categories and answers given were Christian (71.8%), Muslim (2.8%), Buddhist (0.3%), Hindu (1.0%), Sikh (0.6%), Jewish (0.5%), all other religions (0.3%), no religion (15.1%) and religion not stated (7.8%) .

The census identified that 68.8% of Black Africans were Christian, and that 20% were Muslim (Dobbs *et al.* 2006). These proportions are broadly similar to those found in our sample. Bearing in mind that the way in which people answer questions on religion is sensitive to the exact question wording, it appears that African people in England are probably more likely than other ethnicities to identify as belonging to a religion.

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.

Number and gender of regular sexual partners (n=3904, missing 268)	**% MALES** (n=1978)	**% FEMALES** (n=1894)	**% ALL**
No steady sexual partner at present	37.8	42.1	40.0
One FEMALE regular partner only	50.6	1.0	26.3
More than one FEMALE regular partner	5.5	0.3	2.9
One MALE regular partner only	4.7	54.6	29.0
More than one MALE regular partner	1.5	2.1	1.8

More than half (60.0%) indicated that they had (at least one) regular sexual partner. Women were more likely than men to report that they did not have a regular sexual partner, and were far less likely to report having more than one regular sexual partner.

2.10.1 Duration of longest relationship

All those who indicated at least one regular sexual partner were asked *How long have you been having sex with your steady partner? (If you have more than one, please give the length of the longest relationship)*. We refer to the relationships identified in response to this question as *primary relationships*. The average (median) duration of sexual relationships was three years (mean 5.5 years, standard deviation 6.1 years, range 1 month – 52 years). One quarter of all sexual relationships (24.7%) had lasted for eight years or more.

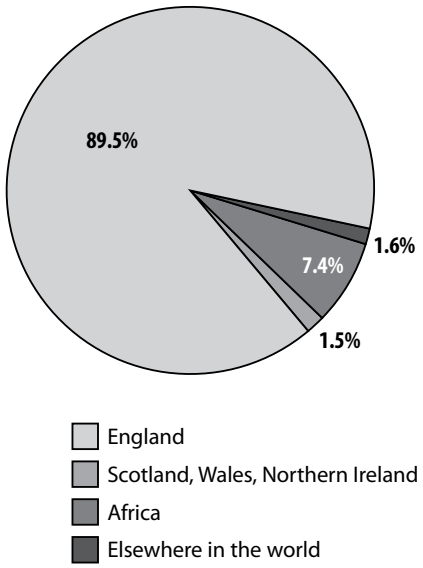
Shorter-term relationships were the norm for younger people, while people in their 40s and 50s were most likely to report being in a steady relationship lasting more than eight years. Also, those who lived in the UK for less than two years tended to report relatively short primary relationships (between 1 month and 3 years).

2.10.2 Regular sexual partner's location

Those in relationships were asked *Where does this partner live?* They were given four options, and were asked to choose one: *in England; in Scotland, Wales or Ireland; in Africa;* or *elsewhere* and given space to specify where.

The vast majority (89.5%) said their regular sexual partner lived in England. A small proportion (7.4%) said their partner lived in Africa. The remainder reported partners residing in either Scotland, Wales or Ireland (1.5%) or elsewhere in the world (1.6%).

Having a sexual partner who lived outside of England was most common among those who had lived in the UK for the shortest amount of time. Almost a third of those in relationships who had lived in England for less than two years reported a regular sexual partner who lived in Africa (26.5%) or elsewhere in the world (4.9%). As the number of years living in England increased, the proportion of those with partners living abroad decreased.



Steady partners' residence (n=2364, missing 83)

2.11 CIRCUMCISION

All respondents were asked *Have you been circumcised?* and were offered the responses: *No, Yes, Don't Know* (6.7% or 278 people did not answer). Overall, more than a third of respondents (37.1%) had been circumcised and another 4.1% said they *didn't know* if they had. Rates of circumcision varied substantially by gender as shown in the following table.

Circumcision by gender (n=3894, missing 278)	**% MALES** (n=2054)	**% FEMALES** (n=1840)
YES	60.6	10.9
NO	36.1	84.1
Don't know	3.3	4.9

Circumcision was far more common in men (60.6%) than in women (10.9%). When we excluded those that did not know if they had been circumcised or not, there was no relationship between being circumcised and age or length of residence in the UK. However, there were relationships 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 24 most common countries of birth are shown below in alphabetical order).

Circumcision by country of birth (n=3717, missing 455)	**% (n) MALE circumcised**	**% (n) FEMALE circumcised**
Angola	72.0 (18/25)	0.0 (0/10)
Botswana	43.8 (7/16)	15.4 (2/13)
Burundi	75.0 (9/12)	6.3 (1/16)
Cameroon	82.1 (32/39)	3.0 (1/33)
Democratic Republic of the Congo	93.8 (45/48)	0.0 (0/16)
Republic of the Congo	87.9 (58/66)	4.9 (2/41)
Cote d'Ivoire	89.5 (17/19)	0.0 (0/5)
Eritrea	84.6 (11/13)	50.0 (9/18)
Ethiopia	91.3 (21/23)	12.5 (2/16)
The Gambia	96.3 (26/27)	0.0 (0/14)
Ghana	79.6 (86/108)	14.7 (14/95)
Kenya	73.2 (93/127)	16.3 (25/153)
Malawi	28.6 (10/35)	6.4 (3/47)
Nigeria	90.5 (199/220)	33.5 (55/164)
Rwanda	43.5 (10/23)	0.0 (0/24)
Sierra Leone	94.9 (37/39)	47.6 (10/21)
Somalia	87.5 (56/64)	68.8 (11/16)
Republic of South Africa	48.9 (23/47)	4.2 (3/71)
Sudan	62.9 (39/62)	50.0 (8/16)
Tanzania	72.7 (24/33)	2.9 (1/34)
Uganda	39.1 (59/151)	0.9 (2/213)
United Kingdom	69.6 (103/148)	6.5 (10/154)
Zambia	37.5 (24/64)	3.8 (3/78)
Zimbabwe	22.4 (75/335)	1.3 (4/306)

Since we are only reporting circumcision prevalence for the countries where more than 20 respondents were born, these are not necessarily the only countries where circumcision is prevalent, though this data gives a clear indication of the rates of male and female circumcision among Africans coming into contact with NAHIP partners in England.

Male circumcision was *least* common among men born in Zimbabwe (22.4%), Malawi (28.6%), Zambia (37.5%) and Uganda (39.1%). Among women, circumcision (known as Female Genital Mutilation or FGM) was *most* common among those born in Somalia (68.8%), Sudan (50.0%), Eritrea (50.0%) and Sierra Leone (47.6%). It was also relatively common among women born in Kenya (16.4%), Ghana (14.7%), Botswana (15.4%) and Ethiopia (12.5%).

The implications of circumcision for HIV differ markedly for men and women. All other things being equal, men who are circumcised are less likely to acquire HIV than those who are circumcised (Weiss *et al.* 2000, Bailey *et al.* 2007, Gray *et al.* 2007). It is thought that the soft mucosal surface below the penile foreskin is vulnerable to abrasion; and that it provides a moist environment where pathogens are more likely to replicate, including other STIs that facilitate the transmission of HIV; and finally, that there are a high proportion of HIV target cells present in this mucosal surface (called Langerhans cells) that particularly facilitate the process of transmission and sero-conversion (Centers for Disease Control and Prevention 2008).

NAHIP partner agencies have not undertaken to increase the rate of circumcision among African men living in England (Dodds *et al.* 2008), and uncircumcised men are not a specific target for interventions among NAHIP partner agencies. It is possible, however, to consider how the needs of uncircumcised men may be incorporated in the planning of interventions, as they run a higher risk of acquiring HIV than men who are circumcised. One means of doing so would be to target interventions at men from countries where male circumcision is least prevalent.

For women, circumcision and other types of female genital mutilation (FGM) can lead to chronic problems with delayed healing, urinary tract infections, 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.

Spotlight on other research

Male Circumcision

International research (World Health Organisation 2007) suggests broad variations in the prevalence of male circumcision across Africa. It is reported to be 'almost universal' in North Africa and most of West Africa, whereas prevalence varies widely across much of southern Africa. For instance, Malawi, South Africa and Lesotho report male circumcision rates from 21-48%, while 80% of Angolan men are circumcised, and the average prevalence in Botswana, Namibia, Swaziland, Zambia, and Zimbabwe is approximately 15%. Similar variations exist across Central and Eastern Africa also. In Burundi and Rwanda, 15% of males are circumcised, while rates exceed 70% in Ethiopia, Kenya and Tanzania. In some settings, male circumcision is practiced routinely in infancy, whereas in others it is undertaken as a part of cultural rites among those in their late teens or early twenties.

Female Circumcision / Female Genital Mutilation (FGM)

FGM prevalence surveys demonstrate that more than 80% of women (aged 15-49) in Guinea, Egypt, Mali, Sudan, Eritrea, and Ethiopia have experienced the procedure, and rates for Burkina Faso (77%) and Mauritania (71%) are also high (UNICEF 2005). The same research indicates that FGM is predominantly practiced in North Eastern, Western and to a lesser extent South Eastern Africa. The practice can also be linked with different religious beliefs in different localities (that is, in some places FGM is more popular among Christians, in others, it is more so among Muslims).

2.12 KNOWING SOMEONE WITH HIV

All respondents were asked *Do you know somebody personally who has HIV (other than yourself if you have HIV)? Please do not include people who you know about through gossip.* Over two thirds (66.9%) said *yes*, including 44.7% that knew someone with HIV in Africa, 40.6% who knew someone in the UK, and 11.9% who knew someone elsewhere in the world (respondents could give more than one answer).

Women were more likely to know someone with HIV than were men (71.1% versus 62.7%), including knowing someone with HIV in Africa (47.4% versus 42.3%) and knowing someone in the UK (45.1% versus 36.2%).

Personally knowing someone with HIV increased with age, with 43.7% of the under 20s knowing someone, compared with 59.8% of those in their 20s and 74.7% of those aged 30 and over. However, it is notable that almost half of the teenagers in the sample personally knew someone with HIV.

Country of birth was also associated with knowing someone with HIV, with those born in Zambia (91.3% knew someone), Uganda (88.6%), Zimbabwe (85.3%) and Tanzania (83.3%) being most likely to know someone with HIV and those born in Somalia (31.7%), Eritrea (35.5%), Sudan (38.1%) or the UK (41.7%) being least likely to know someone with HIV. Again though, it is notable that, even in these groups, a substantial minority knew someone with an HIV diagnosis.

Knowing someone with HIV is likely to have a significant impact on individuals' perceptions of the illness, as well as their likelihood of testing for HIV and regarding themselves as being at risk of involvement in transmission. Increasing perceived proximity to HIV can help to improve the extent to which people without an HIV diagnosis manage the risk of transmission, and can also help to reduce stigma and isolation among those who are diagnosed with HIV.

2.13 SUMMARY & IMPLICATIONS FOR PLANNING

Men and women completing BASS Line exhibited equal access to the internet, which has implications for web-based approaches to HIV prevention

African men and women who are behaviourally bisexual or exclusively homosexual do not always identify their sexual attraction as same-sex oriented. More than half of men having sex with both men and women reported that they were only attracted to females. Homosexually active African men are unlikely to benefit from interventions targeted at gay men or bisexual men.

Three countries of birth were reported by more than a third of all respondents: Zimbabwe, Nigeria and Uganda, meaning that people from these countries are most likely to encounter NAHIP interventions.

Men and women were equally likely to report English as a first language, and it was less common for older people to do so.

- **Where decisions are taken about the production of materials in other languages, their tailoring and distribution should be biased toward those in older age groups.**

Just under one-third of all respondents had lived in the UK for four years or less, and this group was younger than those who lived in the UK for a longer period of time.

One third of respondents lived with a partner, and a slightly smaller proportion reported living on their own.

- **Confidential advice, support and testing services should be tailored to meet the needs of couples and of single people.**

A high proportion of respondents were single-parents (particularly women).

- **The planning of direct contact interventions should consider the provision of childcare, and outreach in locations likely to be accessed by single parents and families should be considered.**

A significant minority of respondents (one fifth) were not involved in any regular employment, training or education. Two thirds of respondents had university or college-level education, and the majority of remaining respondents had attended high school.

The vast majority of respondents were Christian, fewer than one fifth were Muslim, and only one-in-sixteen reported that they did not belong to any religion. Women were more likely than men to report belonging to an Evangelical or Pentecostal Christian denomination, while Muslim respondents were mainly male.

- **Religion clearly plays a part in the lives of most people in contact with NAHIP interventions, and planning needs to take account of the potential interaction between faith, religious doctrine, participation in a faith community and prevention activity.**

More than half of all respondents had at least one regular sexual partner. Women were less likely than men to report having a regular sexual partner. Having concurrent regular sexual partners was not the norm in this sample.

- **Where interventions target those with multiple regular partnerships, these should over-serve men, as they were twice as likely as women to report the practice.**

Among those with a regular sexual partner, the overwhelming majority reported that their primary sexual partner lived in England. Those most likely to report a primary partner living outside of England were people who had migrated to England most recently.

3 HIV testing and diagnosis needs

NAHIP partners want all African people who get HIV to have their infection diagnosed as quickly as possible, and agree the best way to do this is through HIV testing. We recognise a number of diverse needs related to having an HIV test, and seek to meet these needs to order to ensure people know about tests, want to use them and are able to do so (Dodds *et al.* 2008).

This chapter describes respondents' experience of testing for HIV. It describes experience of HIV testing, HIV prevalence, recency of testing and reasons for never testing among those that have not. It then compares respondents' current perceived HIV status with their HIV testing history before exploring experience of testing for sexually transmitted infections.

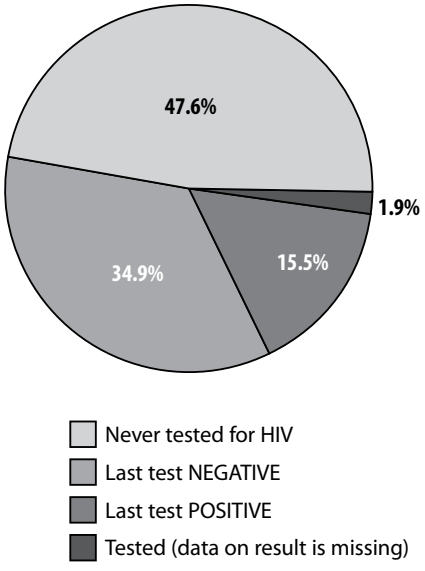
3.1 HIV TESTING HISTORY

Respondents were asked *Have you ever personally received an HIV test result from a health professional?* Just over half (52.4%) had received an HIV test result at some point and just under half (47.6%) had not. Exactly 50.0% of respondents completing the booklets had received an HIV test compared to 60.5% of those that had completed the survey online.

Of those who had ever received an HIV test result, 1.9% declined to say the result or gave contradictory answers. The pie chart shows the history of HIV testing among the entire sample.

Over a third (34.9%) of all respondents had tested HIV negative at some time before the survey. Half of those who had tested negative (49.5%) had done so in the last year, including 10.7% who had tested negative in the last month. Among the remainder of those tested negative, the majority (37.9%) had done so in the 2-5 years previously.

Overall, 15.5% of respondents had diagnosed HIV infection (or 30.7% of those that had tested and who disclosed their result). Since the respondents are best thought of as a snap-shot of the people who come into contact with NAHIP partner agencies and other providers of HIV prevention, treatment and care services, we should expect a higher proportion to be living with HIV than in the general African population of England, and this is the case. National surveillance systems estimate that 4% of the Black African population of England (aged 15-59) has diagnosed HIV (The UK Collaborative Group for HIV and STI Surveillance 2007).

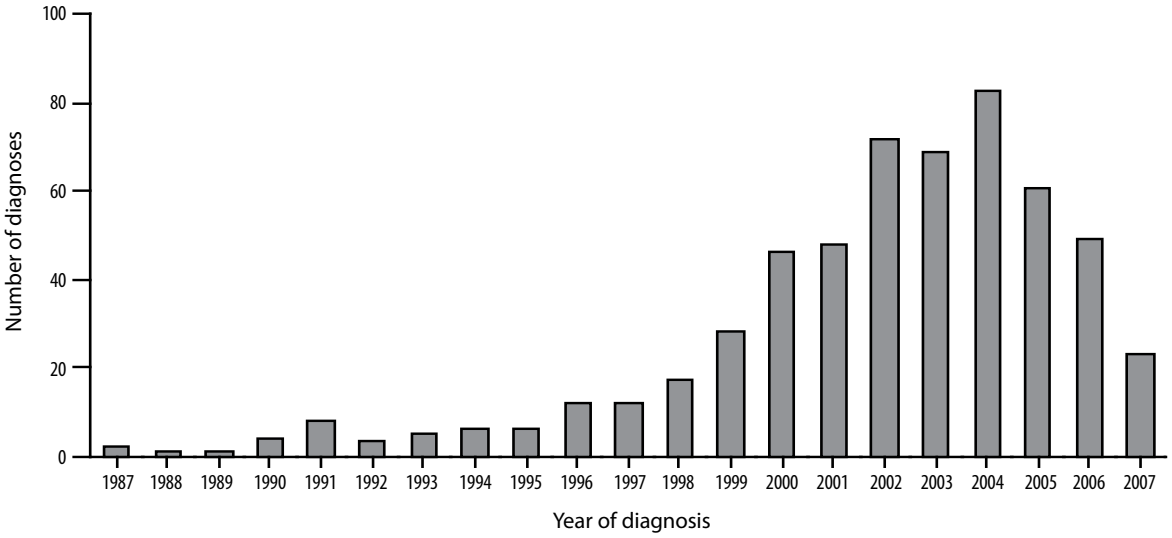


HIV testing history (n=4017, missing 155)

Having a large number of people with diagnosed HIV in the sample means we can 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 7 in Part Two).

There was great variety among the people in the survey who had diagnosed HIV. The length of time they had been diagnosed ranged from twenty years to one month. While a relatively small proportion

of the diagnosed positives had been diagnosed in the preceding year (estimated to be approximately 10% given the four month time span of the survey itself), half (51.2%) had been diagnosed in the last five years.



Year of diagnosis with HIV (n=628, missing 4)

3.2 HIV STATUS BELIEF

Before any questions about HIV testing, all respondents were asked *What do you think your current HIV status is (whether or not you've ever tested)?* and offered the five answers in the table below. Alongside HIV testing history, the answer to this question gives us 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 (37.7% of all respondents); and those who had previously tested negative and who thought they were still negative (33.4% of all respondents).

The following table shows the proportion of all respondents who gave each answer, and the proportion of those in each of the three testing history groups who gave each answer.

Current HIV status belief (n=4026, missing 146)	**% NEVER tested** (n=1902)	**% tested NEGATIVE** (n=1400)	**% tested POSITIVE** (n=622)	**% ALL**
definitely NEGATIVE	52.3	72.9	5.6	52.3
probably NEGATIVE	25.5	20.8	3.1	20.4
not sure / don't know	20.6	4.8	2.9	12.0
probably POSITIVE	0.9	0.6	7.4	1.8
definitely POSITIVE	0.8	0.9	81.0	13.5

Among those who had not had an HIV positive test result, the majority believed they were HIV negative: 93.7% of people whose last test was HIV negative thought they were currently negative (of whom three quarters thought they were definitely negative). Three quarters (77.8%) of those who had never tested also thought they were negative (of whom half thought they were definitely negative).

Of particular interest to HIV health promoters are the one-in-ten (11.6%) of people who had received a positive HIV diagnosis but thought they were HIV negative or were unsure of their status. In addition, there was a small group who believed they were HIV positive but had not been diagnosed (1.7% of those who had never tested and 1.5% of people whose last test was negative).

Of similar interest are the 12.0% of all respondents who were unsure, or did not know what they thought their status was. It is likely that these people will 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 people to 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.

People who had never tested were asked *Do you want to take an HIV test?* Those who had tested negative were asked *Would you like to take another HIV test?* Both groups were offered the answers: *No; Yes; Not sure*.

Overall, 32.9% of those who had not tested HIV positive said they wanted to take an HIV test. People who had previously had an HIV test were more likely to want to test again (47.1%), than those who had never tested at all (22.8%). Another 14.4% of people were unsure if they wanted to take a test or not, and being unsure was more common among the never tested (17.0%) than among those who had previously tested (10.9%).

Those that had tested negative for HIV more recently were more likely to want to test again. Half (52.1%) of those that had tested negative in the last year, wanted to test again, compared to 41.6% of those tested negative 1-5 years ago, and 36.2% of those tested negative more than five years ago.

3.3.2 Not knowing where to test

Among people who want to test for HIV, knowing where they can access a test will increase their chances of doing so. All respondents who had not tested HIV positive but 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?* Overall, 28.0% of the people who wanted to take a test or were unsure said *No*, they would not know where to go to get a test. This proportion did not differ between those who had said they did want to take a test, and those who said they were unsure.

As we would expect, people who had never tested were more likely to not know where to test (38.2%) than people who had previously tested negative (18.7%). Similarly, while 26.4% of those who thought they were HIV negative did not know where to test, this rose to 35.2% of those who were unsure of their status and 38.7% of those who thought they had HIV (but had not tested positive).

Overall, this meant 11.1% of the entire sample wanted to take an HIV test (or were unsure if they did or not) but did not know where to go to get a test. How this proportion varies across the other characteristics of the respondents is described in Part Two.

3.3.3 Reasons for never testing for HIV

Almost half of all respondents (47.6%) reported never having tested for HIV. All 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 an HIV test among those who have never tested (n=1800, missing 150)	**% of those who think they are NEGATIVE** (n=1385)	**% of those who are not sure of their status** (n=197)	**% of those who think they are POSITIVE** (n=28)	**% ALL**
I've no reason to think I have HIV	**73.3**	54.0	57.1	69.5
I am too afraid I might have HIV	9.3	20.8	**39.3**	12.0
I've never had intercourse	**10.5**	5.2	7.1	9.4
I am afraid of being treated differently if I have HIV	6.4	**14.8**	10.7	8.1
I don't know where to get tested	6.8	9.6	10.7	7.3
I am afraid of being treated differently if I take a test	6.2	**11.2**	7.1	7.2
People I know do not approve of HIV testing	5.9	**11.8**	3.6	7.0
It's not important to me to know my HIV status	6.1	**10.4**	3.6	6.8
I don't trust the places I know where I could test	5.8	6.6	7.1	6.0
It would cause problems in my relationship	4.8	**11.0**	0.0	5.9
I do not want to use'official' services	4.1	4.1	3.6	4.1
I didn't know the test existed	3.9	3.3	0.0	3.7
Other reasons	4.0	3.3	0.0	3.7

The most common reason people gave for never having tested (given by 69.5% of those who had never tested) was having *no reason to think they had HIV.* The only other reason given by more than one-in-ten people was being *too afraid they might have HIV,* given by 12.0%.

Most of the *other* reasons given re-iterated or confirmed prior answers. Many were further explanations as to why people had said *I've no reason to think I have HIV.* Some of these were more epidemiologically sound than others, and included reasons such as: monogamy; reliance on a partner's negative test; and a lack of recent sexual activity.

3.4 TESTING 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?* And in a separate question, *When, if ever, were you last diagnosed with a sexually transmitted disease, other than HIV?*

STI testing and diagnosis	**% Last time TESTED for any STI other than HIV** (n=4075)	**% Last time DIAGNOSED with STI other than HIV** (n=3994)
In the last month	9.0	3.0
In the last 12 months	22.5	7.1
1 to 5 years ago	20.1	8.4
More than 5 years ago	9.6	10.0
Never	34.3	66.3
Don't know	4.6	5.2

Almost a third (31.5%) had tested for STIs in the last year, including 9.0% that had tested in the last month. A similar proportion (29.7%) had tested for STIs more than a year ago, with two thirds having tested in the last 1 to 5 years. Finally, a third (34.3%) had never tested for STIs.

In response to the question about diagnosis, two thirds (66.3%) of all respondents had never been diagnosed with an STI, and another 5.2% said that they *did not know* whether they had received an STI diagnosis or not. Included in the remaining quarter (28.5%) that had ever been diagnosed with an STI, 10.1% had been diagnosed with an STI in the last year.

3.5 SUMMARY & IMPLICATIONS FOR PLANNING

Just under half of all respondents had never received an HIV test result. One third of all respondents had received a negative test result, half of whom had tested in the previous year.

A high proportion (15.5%) of respondents were diagnosed with HIV infection, half of whom had been diagnosed within the last five years. Given that the primary target group for NAHIP prevention activities are African people with diagnosed HIV (Dodds *et al.* 2008), their high degree of participation in this survey indicates a strong potential for engagement with this group.

- **In terms of unmet HIV testing need, we think the one-in-ten of all respondents who indicated they were unsure of their HIV status (most of whom had never tested), and the smaller proportions who either received a positive HIV test result but thought they were HIV negative, or thought they were positive but had not received a positive result, should be priorities for interventions intended to meet HIV testing needs.**

More than a quarter of those who wanted an HIV test said they would not know where to test (this represents more than one-in-ten of all respondents).

- **People who want to test are already motivated. They require information to help them access services.**

When those who had never tested were asked why not, their most common response was having *no reason to think they had HIV*.

- **In order to increase testing amongst those who have never tested, or tested negative in the past, it will be necessary to increase ambivalence about the likelihood that they could have HIV infection.**

4 Sexual risk and prevention behaviours

This chapter describes the specific HIV transmission and prevention behaviours that NAHIP partners are trying to influence (Dodds *et al.* 2008). These are: high numbers of sexual partners; unprotected intercourse with partners not known to be HIV sero-concordant; sex with others outside primary relationships; condom use and condom failure. While NAHIP partners do not currently seek to change the use of vaginal tightening agents prior to sex, estimates of the prevalence of this activity are also included.

4.1 NUMBER OF SEXUAL PARTNERS IN THE LAST YEAR

All 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 answers to both questions were merged to identify how many partners male or female respondents had.

Almost a fifth (19.3%) of all respondents reported no sexual intercourse partners in the last year. Just under a quarter (23.7%) of females had no sexual intercourse partners in the last year compared to 15.2% of men. Almost half (46.5%) of all respondents had one sexual intercourse partner in the last year. Again, females (51.6%) were more likely to report just one partner compared with men (41.7%). Hence, three quarters (75.3%) of females had either no partner or one partner in the last year compared to just over half (56.9%) of males. Men were more likely to have more than one partner in the last year. One-in-eight men (12.6%) had five or more partners in the last year, compared to one-in-eighteen (5.7%) women.

Numbers of sexual intercourse partners among MALES and FEMALES (n=3940, missing 232)	**% MALES** (n=2023)	**% FEMALES** (n=1917)	**% ALL** (n=3940)
None	15.2	23.7	19.3
One	41.7	51.6	46.5
Two	17.0	12.1	14.6
Three	8.7	4.9	6.8
Four	4.9	2.0	3.5
Five	3.7	3.0	3.3
6 to 12	5.2	1.7	3.5
13 or more	3.7	1.0	2.4

Variation in partner numbers was a function of the gender of respondents' partners as well as their own gender. As discussed in Chapter 2 (section 2.1.2), two thirds of women (68.4%) and men (69.6%) reported being exclusively heterosexual in the last year. However, men more likely than women to report they had sex with both men and women in the last year and were more likely than women to report they exclusively had sex with the same gender. So, exclusive homosexual activity was less common among women than men.

4.1.1 Number of sexual partners among men

Among men that had any sex in the last year, those that only had sex with women were more likely to have only one or two partners (74.3%) than those that had sex with men and women (42.8%) or those that had sex with men only (52.0% of which had one or two partners). Men who only had sex with women were less likely to have five or more partners (10.4%) than men who had sex with men and women (33.7% had 5 partners or more) or men who had sex with men only (38.0% had 5 partners or more).

Number of sexual partners in the last year, among MEN who had any sex (n=1716, missing 88)	**% only FEMALE partners** (n=1408)	**% both male & female partners** (n=208)	**% only MALE partners** (n=100)
One	57.1	–	39.0
Two	17.2	42.8	13.0
Three	10.7	9.6	4.0
Four	4.6	13.9	6.0
Five	3.7	6.3	9.0
6 to 12	4.0	17.8	13.0
13 or more	2.7	9.6	16.0

4.1.2 Number of sexual partners among women

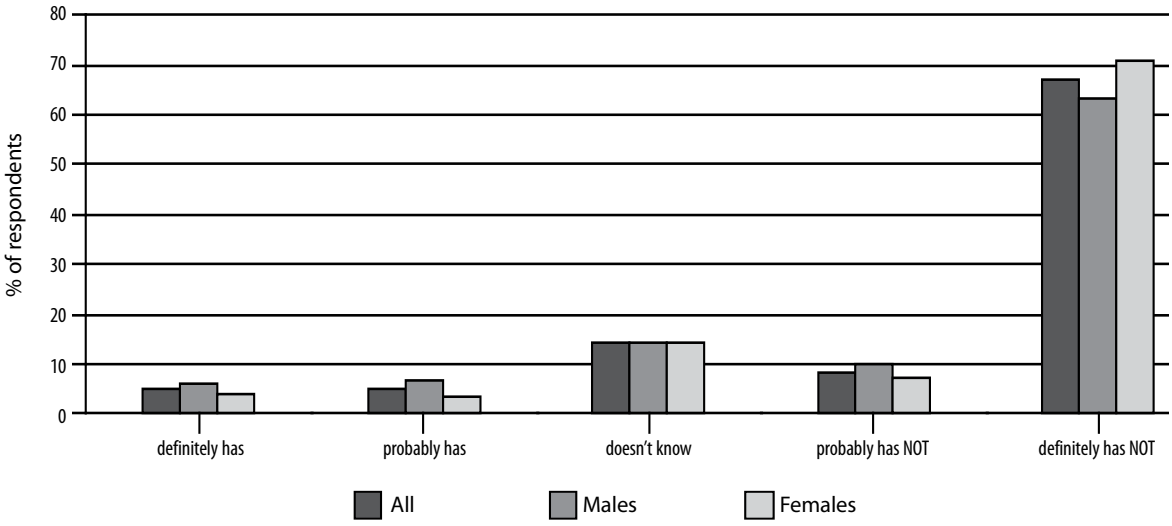
Among women that had any sex in the last year, those that only had sex with men were more likely to have one or two partners (86.5%) than those that had sex with men and women (56.0%) or those that had sex with women only (65.1% of which had one or two partners). Women that had sex with men only were less likely to have had five or more partners (5.4% did so) than those that had sex with men and women (28.4% had 5 partners or more) or those who had sex with women only (16.3% had 5 partners or more).

Number of sexual partners in the last year, among WOMEN who had any sex (n=1463, missing 93)	**% only MALE partners** (n=1311)	**% both male & female partners** (n=109)	**% only FEMALE partners** (n=43)
One	74.1	–	44.2
Two	12.4	56.0	20.9
Three	6.1	6.4	14.0
Four	2.0	9.2	4.7
Five	3.7	4.6	7.0
6 to 12	1.2	12.8	7.0
13 or more	0.5	11.0	2.3

4.2 LIKELIHOOD OF SERO-DISCORDANT UNPROTECTED INTERCOURSE

All 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?*

Two thirds (67.0%) of all respondents reported *definitely not* having had sero-discordant unprotected intercourse (sdUI) in the last year. A further one-in-eleven (8.6%) said they *probably* had not done so. However, one-in-ten (10.2%) reported *definitely* or *probably* having had sexual intercourse without a condom with someone who had a different HIV status to themselves in the last year.



Likelihood of sdUI in the last year (n=3686, missing 486)

Compared to men, women were less likely to report *definitely* (4.9% compared to 6.0%) or *probably* (3.6% compared to 6.6%) having had sdUI in the last year and more likely to report they definitely had not had sdUI (71.0% compared to 63.2%).

Women in a current regular sexual relationship were more likely to report sdUI than those who were not. Women who had a current regular partner were more likely to report *definitely* having sdUI in the last year (6.0% compared to 1.2%) and less likely to report *definitely not* doing so (66.9% compared to 76.3%). This relationship occurred among women but not men.

Likelihood of sexual intercourse without a condom with someone of a different HIV status increased with higher numbers of sexual partners in the last year. This relationship occurred among both men and women.

4.3 SEX WITH OTHERS OUTSIDE OF RELATIONSHIP

More than half (61.7%) of all respondents indicated that they currently had (at least one) regular sexual partner. Men were slightly more likely to report having any regular sexual partnership (64.4%) than women (58.8%).

All those in a current relationship were asked, *How many other people have you had sex with outside of this relationship?* More than two thirds (67.8%) said they had not had any other sexual partners during their primary relationship. Women were more likely to report monogamy (81.3%) than men (56.6%). However, this is not to say that sex with people other than their partner was a rarity amongst women (as one fifth said they had done so). The table below illustrates how many other sexual partners men and women had during their current primary relationship.

Number of other sexual partners during current primary relationship (n=2330, missing 120)	**% MALES** (n=1244)	**% FEMALES** (n=1072)	**% ALL who have a regular partner** (n=2330)
NONE	56.6	81.3	67.8
One	17.4	8.2	13.2
Two	8.7	6.0	7.5
Three	6.1	2.1	4.2
Four	3.3	1.0	2.3
Five	2.3	0.8	1.6
6 to 12	3.5	0.3	1.9
13 or more	2.2	0.3	1.3

Those living with a *partner / husband / wife / civil partner* were somewhat less likely to report sex outside of their primary relationship (27.2%) than those who were not co-habiting with their partner (36.5%). Living with dependant children reflected a similar pattern, as 23.3% of those living with children reported sex outside of the primary relationship, compared to 33.9% of those not living with children.

Those that had any sexual partners outside their primary relationship reported more sexual partners in the last year, and were more likely to report *definitely* (10.5% compared to 4.7%) or *probably* (9.7% compared to 2.9%) having had sexual intercourse without a condom with someone who had a different HIV status to themselves in the last year. Similarly, those that reported no sexual partners outside their primary relationship were more likely to report they definitely had not had sexual intercourse without a condom with someone who had a different HIV status to themselves (72.8% compared to 45.3%).

4.4 CONDOM USE AND FAILURE

All respondents were asked *Which of the following have you or a partner used (even if just once), during sexual intercourse IN THE LAST 12 MONTHS?* Three quarters (74.8%) of all respondents that had sex had used a condom and / or a Femidom (female condom) in the last year. Femidom use was far less common than condom use – 4.6% had used a Femidom compared to 73.5% using a condom (at least once).

Which of the following have you or a partner used during sexual intercourse in the last 12 months? (among those that had sexual intercourse in the last year) (n=3020, missing 183)	**% MALES** (n=1626)	**% FEMALES** (n=1373)	**% ALL** (n=3020)
Condoms ONLY	**72.5**	66.8	70.2
Femidoms (female condom) ONLY	1.0	**1.6**	1.3
Condoms and Femidoms	2.6	**4.6**	3.3
Neither condoms or Femidoms	23.9	**27.0**	25.2

A quarter (25.2%) of all respondents that had sexual intercourse in the last year had neither used a condom or a Femidom. Females were significantly less likely to have used a condom or Femidom in the last year than men.

People who had a current regular partner were more likely than those without a partner to report using neither condoms or Femidoms in the last year (27.8% of those in a relationship compared to 16.2% of those not in a relationship). This was true of women and men. However, among those in a regular relationship, those who were monogamous were less likely to use condoms than those who were not.

Similarly, using neither condoms or Femidoms was more common among those with fewer sexual intercourse partners in the last year, especially among those with only one partner. Conversely, use of condoms and / or Femidoms in the last year increased with higher numbers of sexual partners. This relationship occurred among both men and women.

4.4.1 Frequency of condom use in the last 12 months

All respondents were also asked *How often have you used condoms for intercourse IN THE LAST 12 MONTHS?* Among the entire sample, half were split between reporting either no sex in the last year (20.5%) or always using a condom for sex (29.9%). The other half reported sexual intercourse in the last year with intermittent (28.6%) or no condom use (21.2%).

Frequency of condom use for sexual intercourse among all respondents, in the last 12 months (n=3855, missing 317)	**% MALES** (n=1982)	**% FEMALES** (n=1873)	**% ALL** (n=3855)
Not had sexual intercourse in last year	15.9	**25.3**	20.5
Always	**32.5**	27.1	29.9
More than half the time	**11.6**	11.3	11.5
About half the time	**7.4**	5.4	6.5
Less than half the time	**11.9**	9.2	10.6
NO CONDOM USE in last year	20.7	**21.7**	21.2

Compared to men, women were more likely to have had no sexual intercourse in the last year (25.3% compared to 15.9%). However, men were more likely than women to always use a condom when they did have intercourse (32.5% compared to 27.1%).

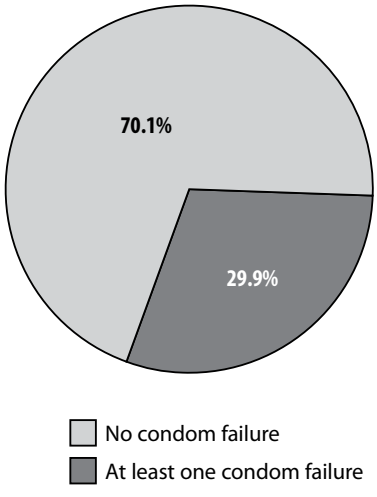
4.4.2 Experience of condom failure

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*? Just under one third (30.0%) of those that had used a condom in the last year had experienced a condom failure in that time.

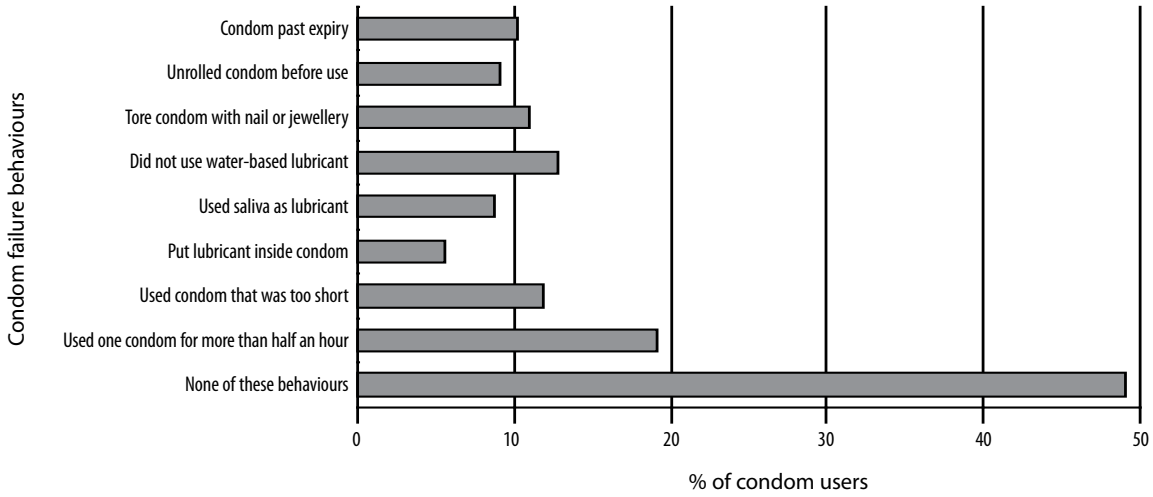
Condom failure was equally common among men and women, but more common among people with higher numbers of sexual partners. Among condom users, a fifth (20.8%) of those with only one sexual partner had experienced condom failure in the last year, compared with almost half (47.4%) of those with four or more partners.

Irrespective of their answer to this yes/ no question on experience of condom failure, all respondents were also told *All of the following make condoms more likely to break or come off. Which have you or a partner done IN THE LAST 12 MONTHS? (tick as many as apply).*

The chart on the next page identifies the list of behaviours that followed this question, but shows only those respondents that had sex and used a condom in the last year.



Condom failures among those using condoms last year (n=2216, missing 85)



Behaviours associated with condom failure last year (n=1720, missing 578)

The most common condom failure behaviours were use of a condom for more than half an hour and not using water-based lubricant. All but one of the eight condom-failure related behaviours in the chart above were significantly more common among those that had experienced a condom failure in the last year than among those that did not. The only behaviour not significantly associated with respondents' experience of condom failure was using a condom that was past it expiry date.

The only condom failure-related behaviour reported more commonly by men than women was the use of a condom that was too short for the penis (12.4% of men compared to 8.9% of women). None of the other condom failure-related behaviours varied by gender.

Spotlight on other research: condom failure

An extensive condom trial undertaken in the United States (Valappil *et al.* 2005) among women at high risk of acquiring STIs revealed a male condom failure rate (combined breakage and slippage) of 4.1%, and a female condom failure rate (combined breakage, slip out and slip in) of 5.6%.

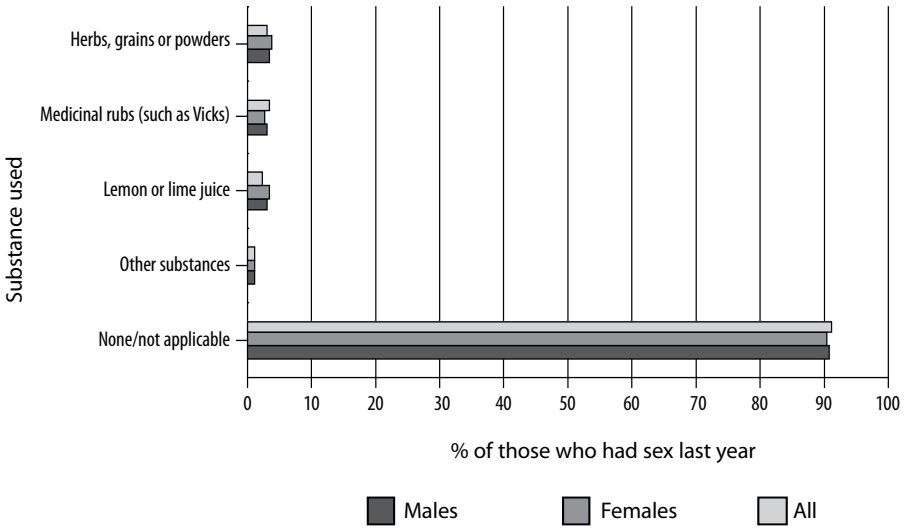
This same study found that failures declined as use of condoms increased, and that previous failure was the highest predictor of future failures. Thus, a small proportion of people taking part in the study were responsible for the highest numbers of reported failures. This indicates that having the skills required to use condoms effectively will be an important factor in reducing the likelihood of condom failure.

4.5 USE OF SUBSTANCES TO TIGHTEN / DRY THE VAGINA

Some methods for cleaning the vagina and the use of substances that tighten, dry or heat the vaginal area in preparation for sex can cause disruption of vaginal tissue and the loss of healthy bacteria (Hilber *et al.* 2007). NAHIP partners think there is too little evidence of harmful vaginal practices during or prior to HIV sero-discordant intercourse to make it worth introducing specific interventions to reduce their use (Fenton *et al.* 2002, Dodds *et al.* 2008). However, awareness of the prevalence of such practices will be of value to those providing support and advice to people involved in potentially sero-discordant sex.

All respondents were told: *using substances to tighten / dry the vagina might increase the chance of HIV being passed from one person to another.* They were then asked, *In the last 12 months have you and a partner used any of the following to tighten the vagina before or during intercourse?* They were allowed to tick as many as applied from the four items in the graph below.

Among all those that had any sexual intercourse in the last year, 9.3% had used any of these substances to tighten or dry the vagina. Among the possible answers, use of herbs, grains and powders (3.3%), was more common than medicinal rubs (2.9%) or lemon or lime juice (2.8%). Twenty nine people (1.1%) mentioned using other substances for similar reasons, though half of these did not say what they had used. Ice cubes were mentioned by four respondents, and cocaine (coke) by two. Other substances mentioned included alcohol, aloe vera gel, sandaliya (sandalwood) cream, sudan wood, tobacco leaves and Viagra.



Use of substances for vaginal drying / tightening (n=2835, missing 368)

4.6 SUMMARY & IMPLICATIONS FOR PLANNING

One-in-ten of all respondents said they probably or definitely had sexual intercourse without a condom with someone of a different HIV status (sdUI). Men and women who had higher numbers of sexual partners were more likely to have had sdUI.

- **Interventions to reduce sdUI should over-serve those with four or more sexual partners in the previous year.**

A quarter of all respondents that had sexual intercourse in the last year had neither used a male or female condom. Having fewer sexual partners, and being in a regular sexual relationship was associated with not using condoms in the last year. Men were more likely than women to always use a condom.

- **Women (particularly those in relationships) require interventions that will increase their ability and motivation to use condoms or to influence their partner to use them.**

One third of all those who had used a condom in the previous year had experienced condom failure.

- **Interventions to promote condom use (including condom distribution) should also aim to reduce the high incidence of condom failure amongst Africans in England. Such interventions should focus on discouraging the use of a condom for longer than half an hour and not using water-based lubricant.**

5 Indicators of HIV prevention need

HIV health promotion aims for people to be educated and informed about HIV and its prevention, and to exercise control over their own actions. The survey tried to establish how well-informed respondents were about HIV and its prevention and what degree of confidence respondents had in their own ability to avoid transmission. All of the respondents were asked a range of questions to assess their knowledge of HIV and AIDS, their confidence and control over HIV prevention, and to establish what topic areas they would want to know more about. Questions took three formats and were interspersed in small chunks throughout the questionnaire.

The data presented here compliments existing needs assessments and should contribute to an on-going picture of HIV prevention need among Africans in England. The indicators of need are fairly simple. As this is the first mapping of HIV prevention need among Africans in England on this scale, we wanted to establish broad patterns across different characteristics. For this reason we sought indicators of need that were meaningful both to our health promotion collaborators and to respondents. In this survey there were no gender-specific questions (to be answered either by only women or only men), nor were there any age, religion, country of origin or social class-specific questions. In terms of motivation to avoid HIV transmission, and control over doing so, people were asked different questions depending on whether they thought they had HIV or not.

Indicators of prevention need generally took one of two formats.

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 13 statements of fact. For each, respondents were asked to give one of 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 will 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 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

Three indicators about condoms and one indicator about sexual communication were asked of all respondents. All respondents were also asked about their motivation to avoid HIV transmission and

their control over it, with different questions for those who thought they had HIV and those who thought they did not.

A further fifteen items were offered as subjects respondents might want to know more about.

5.1 KNOWLEDGE ABOUT HIV/AIDS

A total of 13 knowledge items were offered in two separate sections of the survey. The first set of five were headed: *Some questions about HIV / AIDS and HIV testing...*, and appeared relatively early in the questionnaire. A further set of eight statements appeared later in the questionnaire headed: *Some questions about HIV / AIDS treatment and transmission....* All knowledge items are reproduced in the table below, which shows the overall proportions giving each response to each statement. Any answer given to these statements other than *I knew this before today* is taken as an indicator of need and the final column shows the overall proportion in need of this knowledge. 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
AIDS is caused by a virus called HIV. (n=4104)	93.0	3.4	2.6	1.0	7.0
A person with HIV can pass it to a partner during sexual intercourse. (n=3902)	92.8	3.4	2.2	1.7	7.2
HIV is never passed on through shaking hands or touching people. (n=3902)	91.5	3.2	3.4	1.9	8.5
There is no cure for HIV infection once someone has it. (n=3898)	89.5	3.9	4.1	2.6	10.5
There is a medical test that can show whether or not you have HIV. (n=4063)	88.1	5.3	4.6	1.9	11.9
People can have HIV without knowing it. (n=4041)	84.1	8.1	5.9	1.9	15.6
You cannot be sure that someone has NOT got HIV by looking at them. (n=4056)	83.5	8.8	5.5	2.2	16.5
There are HIV medicines that can help people with HIV to stay healthy. (n=3893)	80.9	8.3	8.4	2.4	19.1
Condoms are free from sexual health clinics, family planning clinics and some community organisations. (n=3883)	75.0	15.3	7.4	2.3	25.0
HIV medicines work better if people with HIV take them before they become ill. (n=3875)	61.3	22.8	10.3	5.6	38.7
Some people with HIV have been imprisoned in the UK for passing their infection to a sexual partner. (n=3865)	60.1	24.6	10.4	4.9	39.9
Africans are NOT deported from the UK solely because they have HIV. (n=4067)	57.9	16.2	20.7	5.2	42.1
At least 1-in-20 of all Africans living in England have HIV infection. (n=3884)	36.9	40.6	16.0	6.6	63.1

Relatively small proportions did not know very basic facts about HIV (such as: HIV is a virus, that it can be passed during sexual intercourse and that it 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 more complex HIV prevention needs.

There was also evidence of basic information need that could preclude people from testing for HIV. About one-in-ten people did not know that there is a medical test for HIV, one-in-five did not know of the existence of effective treatment for HIV, and more than one-in-three did not know that these treatments work better the earlier they are taken. Our collaborators felt that a major impediment to uptake of HIV testing was the false belief that Africans are deported from the UK if they are found to have HIV, which may be supported in part by the finding that 42% were not aware that this is *not*

the case. Where individuals know or think they have HIV, misinterpretations such as these are likely to affect their judgement about discussing HIV openly and accessing HIV-related services, including testing.

In terms of knowledge and skills to avoid HIV risk, 16% did not know it is possible to have HIV without knowing it and a similar proportion did not know that someone with HIV is not obviously positive simply by looking at them. Two people in three were unaware of the background prevalence of HIV infection among Africans in the UK and 40% were unaware of criminal prosecutions for the sexual transmission of HIV in the UK.

Accurate awareness of HIV prevalence among Africans in England helps to meet HIV prevention need. It can prompt individuals (who have tested negative or have never tested) to better consider any assumptions they hold about their own HIV status, as well as the HIV status of sexual partners. Accurate knowledge of HIV prevalence among Africans in England may also be an important means of supporting people in the management of their own HIV diagnosis.

One quarter of all respondents (25%) were unaware that condoms are freely available from sexual health clinics and other service providers. This is a noteworthy finding, given that the sample was largely recruited by agencies that undertake condom distribution.

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=3988, missing 184)	**% ALL**
Treatments for HIV infection	33.2
Immigration and HIV	33.0
HIV testing	30.8
Who is able to get free HIV treatment	27.5
Preventing discrimination against people with HIV	27.5
Safer sex and how to prevent HIV	25.9
The law and HIV transmission	25.9
Managing relationships	25.5
Living well with HIV	24.6
How to be more confident in sexual situations	22.7
Testing and treatment for other sexually transmitted diseases	21.5
Post-exposure prophylaxis (PEP)	20.9
How to stop condoms breaking or coming off	18.1
Where to find a boyfriend / girlfriend	15.0
What different kinds of condoms are available	14.9

One-in-six (15.7%, n=657) of all respondents did not want any further information about any of the fifteen topics listed and specified nothing else they wanted to know about. This suggests 84% of Africans in the UK want more knowledge about HIV and how to exercise control over its transmission.

The most commonly indicated topics were treatments, immigration and testing. These three topics are clearly interrelated (especially in light of the large number of people who may think testing HIV positive is a reason for deportation or who are unaware of the clinical benefits of early diagnosis). All other suggested topics also elicited the interest of a significant minority of respondents.

5.2 ACCESS TO CONDOMS

Condoms are not always required to prevent HIV transmission. People may decide to have no sex, or non-penetrative sex, or intercourse without a condom with someone they know has the same HIV status as themselves (this is sometimes referred to as *sero-sorting*). On those occasions when penetrative sex is not avoided, or when it is not clear that a sexual partner has the same HIV status, the use of condoms is the best means of ensuring that HIV transmission does not occur. In order to best manage the risk of transmission in such circumstances, individuals require easy access to condoms, and confidence about having condoms in their possession. The following table describes all respondents' level of agreement or disagreement when presented with the statements, *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=3769)	9.6	13.8	24.3	27.3	25.1
If I carried a condom I would worry about what people thought of me. (n=3797)	13.7	15.4	20.1	26.7	24.1

Any agreement with either statement was taken as the indicator of need. Overall 23.4% of respondents indicated sometimes having a problem getting hold of condoms. A larger proportion, 29.3%, indicated they would worry what people thought if they carried condoms. These two needs were positively associated in the same people: those who agreed they would worry what people thought if they carried condoms were much more likely to say they had a problem getting condoms. Overall, 38.5% indicated one or both needs not being met. Attitudes about the use of condoms have a substantial impact on HIV prevention need. It can be difficult to obtain and to use condoms in social and sexual settings where they are regarded with disapproval.

5.3 CONFIDENCE IN SEXUAL COMMUNICATION AND CONDOM USE

All respondents were also asked to agree or disagree with the statements, *I would find it easy to talk about safer sex and HIV with new sexual partners,* and *I can use condoms with a sexual partner if I want to.* These 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 is sometimes called self-efficacy.

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=3750)	35.8	27.3	22.6	9.1	5.1
I can use condoms with a sexual partner if I want to. (n=3745)	39.1	32.0	17.5	6.3	5.0

Two thirds (63.1%) agreed that they could easily talk about safer sex and HIV with new sexual partners. Just under a quarter (22.6%) chose *don't know / does not apply*. The remaining 14.2% disagreed with the statement, indicating a lack of confidence in their ability to initiate HIV preventive behaviours with new partners.

Nearly three quarters (71.2%) agreed they *could use a condom with a sexual partner* if they wanted to. However, 11.3% disagreed that they could use a condom if they wanted to, which indicates HIV prevention need.

5.4 MOTIVATION TO AVOID HIV (RE)INFECTION

In order for people to take action to reduce the risk of HIV transmission they need to want to not be involved in HIV transmission. People who thought they did not have HIV were asked to agree or disagree with *I do not want to get HIV (if I haven't already got it)*. Those who thought they did have HIV were asked to agree or disagree with *I do not want to get infected with another type of HIV (on top of the HIV I've already got)*. The following table shows the proportions giving each response grouped into those who have tested positive and those who have not.

Will to avoid HIV		% strongly agree	% agree	% don't know	% disagree	% strongly disagree
Not tested positive (n=3036)	I do not want to get HIV (if I haven't already got it).	80.6	10.9	4.7	1.5	2.3
Tested positive (n=525)	I do not want to get infected with another type of HIV (on top of the HIV I've already got).	83.6	9.5	3.8	1.1	1.9

Among people not diagnosed with HIV, 91.5% agreed that they did not want to get HIV. However, this meant that 8.5% did *not* agree, or were not sure.

Among those with diagnosed HIV, 93.1% indicated not wanting to get re-infected – a very similar proportion to those negative and untested respondents who wanted to avoid primary infection.

5.5 BELIEF IN CONTROL OVER HIV TRANSMISSION

The aim of HIV health promotion is that people have control over HIV in their everyday lives. In terms of HIV transmission, this means feeling in control of involvement in HIV transmission. People who thought they did not have HIV were asked to agree or disagree with *I am in control of whether or not I get HIV*. Those who thought they did have HIV were asked to agree or disagree with *I am in control of whether or not I pass my HIV to someone else*. The following table shows the proportions giving each response in the two groups.

Power to avoid HIV		% strongly agree	% agree	% don't know	% disagree	% strongly disagree
Not tested positive (n=3036)	I am in control of whether or not I get HIV.	38.6	23.7	23.6	7.8	6.4
Tested positive (n=513)	I am in control of whether or not I pass my HIV to someone else.	57.9	17.2	11.7	6.0	7.2

Among those who had not tested HIV positive, almost two thirds (62.3%) said they were in control of whether they get HIV or not. However, a quarter (23.6%) were unsure as to whether or not they were in control of getting HIV and 14.2% disagreed that they had control over infection. So overall, 37.8% of those who thought they were HIV negative indicated they did not feel in control of whether or not they got HIV.

Among those diagnosed with HIV, 75.1% *strongly agreed* or *agreed* that they were in control of whether they passed their infection to others. However, this means that the remaining quarter (24.9%) were either unsure or did not agree that they had control over transmission of their HIV infection to others. This suggests a significant proportion of African people with *diagnosed* HIV lack the knowledge, skills and the resources to ensure that their sexual partners do not acquire HIV from them.

5.6 SUMMARY & IMPLICATIONS FOR PLANNING

The vast majority of respondents knew that HIV is a virus that causes AIDS, and knew how the virus is and is not transmitted.

However, about one-in-ten people did not know that there is a medical test for HIV, one-in-five did not know effective treatment for HIV exists, and more than one-in-three did not know that these treatments work better the earlier they are taken. A further 42% did not know that people are *not* deported from the UK because they have HIV. Where individuals know or think they have HIV, such gaps in information will profoundly affect their judgement about discussing HIV openly and accessing HIV-related services, including testing.

A third of all respondents wanted to know about each of the following areas: HIV treatments, immigration and HIV, and HIV testing. This represents a significant opportunity for awareness and access interventions in these areas.

- **Interventions are required to address knowledge gaps regarding HIV testing, treatments and about how immigration policy interacts with HIV.**

Two thirds of those taking part did not know that one-in-twenty Africans living in England has HIV.

- **Interventions should aim to increase Africans' perceived proximity to the epidemic in England.**

There is evidence of significant de-motivation and powerlessness with regard to condom use, given that one-in-ten respondents lacked confidence in using condoms, one third were unsure or disagreed that they could talk about HIV or safer sex with new sexual partners, one quarter had a hard time getting condoms, and just under one third would worry about the social repercussions if it was known that they carried condoms.

- **Interventions to increase condom use should address confidence in negotiating their use and should aim to increase the social acceptability of carrying and using them.**

There is also evidence of de-motivation and powerlessness in relation to avoidance of participation in HIV transmission. Among those who were not diagnosed HIV positive, more than a third did not feel they were in control of whether or not they became infected. Furthermore, among those with diagnosed HIV, a quarter disagreed or were unsure that they had control over exposing sexual partners to the virus.

- **Interventions to increase confidence and skills to avoid sero-discordant unprotected intercourse are required.**

6 Variation by HIV testing history

Over a third of respondents (34.9%, n=1414) had tested HIV negative some time before the survey, 15.5% (n=632) had diagnosed HIV infection, and just under half (47.6%, n=1932) had never had an HIV test. This chapter provides an comparison of key risk behaviours and indicators of HIV prevention need across these three groups. A full description of testing history in the sample is given in Chapter 3 (Section 3.1).

6.1 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 among all respondents	% NEVER tested	% tested NEGATIVE	% tested POSITIVE
Two or more sexual intercourse partners in the last year	34.5	34.4	32.9
Four or more sexual intercourse partners in the last year	12.2	13.5	11.9
Any sexual partners outside their current regular relationship	19.2	19.3	20.4
Any unprotected sexual intercourse in the last year	48.3	**59.6**	32.1
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	9.9	8.2	**15.2**
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	**16.7**	12.9	10.4
Any experience of condom failure in the last year	14.8	19.8	**25.0**

No significant relationship was found between HIV testing history and the number of sexual partners people had in the last year, or their likelihood of having sexual partners outside of a current regular relationship. However, significant variations were found across other sexual behaviours that carry an increased risk of HIV transmission.

Compared with those who had never tested, or those tested negative, people with diagnosed HIV were significantly less likely to report any unprotected intercourse in the last year, but were more likely to report that they definitely or probably had engaged in sero-discordant unprotected intercourse (sdUI) in the same time period. Also people with diagnosed HIV were most likely to have experienced condom failure in the last year, which has significant implications for planning interventions to improve condom use skills.

Those who had never tested were most likely to say that they were unsure of their participation in sdUI in the last year, while people with diagnosed HIV were the least likely to express such uncertainty.

6.2 HIV TESTING HISTORY AND HIV PREVENTION NEEDS

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

Unmet HIV prevention need by HIV testing history	% NEVER tested	% tested NEGATIVE	% tested POSITIVE
PEOPLE WHO HAD NOT TESTED HIV POSITIVE			
DISAGREES OR IS NOT SURE: I do not want to get HIV (if I haven't already got it).	**10.8**	5.4	–
DISAGREES OR IS NOT SURE: I am in control of whether or not I get HIV.	**42.2**	31.8	–
PEOPLE WHO HAD TESTED HIV POSITIVE			
DISAGREES OR IS NOT SURE: I do not want to get infected with another type of HIV (on top of the HIV I've already got).	–	–	6.9
DISAGREES OR IS NOT SURE: I am in control of whether or not I pass my HIV to someone else.	–	–	25.0
ALL RESPONDENTS			
AGREES: I sometimes have a problem getting hold of condoms.	**26.9**	19.1	21.9
AGREES: If I carried a condom I would worry about what people thought of me.	**31.3**	27.2	26.5
DISAGREES: I can use condoms with a sexual partner if I want to.	12.0	8.5	**14.6**
DISAGREES: I would find it easy to talk about safer sex and HIV with new sexual partners.	15.8	9.7	**20.7**
Mean number of knowledge items NOT known (median)	**3.58** (3)	2.22 (2)	2.31 (2)

There were significant differences in need, but no single testing history group showed greatest need on all indicators.

In terms of knowledge, people who had never tested were in greater need than those who had tested HIV positive suggesting all basic HIV education interventions should over-serve people with little experience of HIV. As with knowledge, lack of access to condoms and concern about what others might think about carrying them, were most common among those who had never tested.

Not being sure about wanting to avoid HIV and not feeling in control of whether they got HIV was most common among people who had never tested rather than those who had tested negative. This may be because the act of testing and finding out one's HIV status may increase one's sense of control over the virus, or it may be that testing services also include interventions that increase knowledge and motivation.

However, the confidence to talk about safer sex and use condoms when they wanted to was least common among people with diagnosed HIV, and most common among those tested negative.

6.3 SUMMARY & IMPLICATIONS FOR PLANNING

Compared with the other testing history groups, people with diagnosed HIV were least likely to have had any unprotected intercourse in the last year, but most likely to have definitely or probably had serodiscordant unprotected intercourse in the same time period. They were also most likely to have experienced condom failure in the last year. Confidence in getting what you want from a sexual encounter, including using condoms and having safer sex was also least common among people with diagnosed HIV.

- **Interventions to increase interpersonal skills and confidence in risk reduction should over-serve people with diagnosed HIV.**

People who had never tested for HIV had more difficulty accessing condoms and were more likely to worry about what others would think of them if they carried condoms than those who had ever tested. They also had the lowest levels of knowledge about HIV in general.

- **Interventions for people who have never tested should prioritise their basic HIV information needs, including where to get tested and why.**
- **Interventions that seek to make condoms more easily accessible and acceptable should over-serve those who have never tested.**

7 Variation by gender

There were slightly more men (51.2%, n=2111) than women (48.8%, n=2010) taking part in the survey.

Two thirds of men (69.6%) reported that they had only had intercourse with women in the past year, while one in ten (10.3%) had sex with men and women, and one in twenty (4.9%) had sex only with men. Nearly a sixth (15.2%) of men said that they had not had sexual intercourse with anyone in the previous year.

One quarter of all female respondents (23.7%) reported not having had sexual intercourse with anyone in the past year. Women reporting exclusively heterosexual activity accounted for about two thirds (68.4%) of the responses. Sexual intercourse with women only and with both men and women was reported by a small proportion of women (2.2% and 5.7% respectively).

This chapter compares key risk behaviours and indicators of HIV prevention need by gender and also by the gender of sexual partners reported by respondents. A full analysis of gender and gender of sexual partners is reported in Chapter 2 (Section 2.1).

7.1 GENDER AND TESTING BEHAVIOURS

7.1.1 Gender of respondents and testing behaviours

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

Testing behaviour by gender among all respondents	% MALES	% FEMALES
Never HIV tested	**54.8**	42.9
Tested HIV positive	11.5	**19.9**
Wants test but does not know where to get one	**12.5**	9.2
Diagnosed with STI in last year	8.6	**11.3**

Men were significantly more likely than women to have never had an HIV test. This is not surprising given women's increased likelihood of accessing most health care services, as well as the possibility they encounter HIV testing in ante-natal settings. Compared to women, men were more likely to want to take an HIV test but not know where to go to get one.

Among *only* those who had ever tested, women were also more likely to have received a positive HIV test result than men (35.7% versus 26.1%). These two differences – women being more likely to have tested and, if they had, being more likely to have received a positive result – meant the women were considerably more likely to be living with diagnosed HIV than men (19.9% versus 11.5%). Women were also more likely to report being diagnosed with an STI (apart from HIV) in the last year.

7.1.2 Gender of partners and testing behaviours

The following table shows how the measures of HIV and STI testing varied among women and among men, by the gender of their sexual partners in the last year. The significant differences are *within* the group of men and *within* the group of women, and not between men and women as groups. The preceding table shows overall differences between men and women.

Testing behaviour by gender of partners in the last year among all respondents	% 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	**68.1**	50.5	55.9	39.4	**53.4**	37.5	40.6	52.4
Tested HIV positive	12.0	11.3	12.1	**18.4**	20.0	20.5	23.8	20.0
Wants test but does not know where to get one	15.5	12.2	10.6	13.4	6.2	10.2	10.1	9.8
Diagnosed with STI in last year	7.0	6.4	18.1	**21.1**	7.4	11.5	17.8	**18.6**

Among men, ever having tested was associated with gender of sexual intercourse partners in the last year, those not having had sex being least likely to have ever tested, those who had sex with men only being most likely to have done so. Ever having tested was also associated with gender of sex partners among women, being most common in women who had sex with men only, and least common in women who had no sex in the last year.

Among the women, having diagnosed HIV was not associated with gender of sexual partners in the last year. Among men however, those who had sex with men only in the last year were more likely to have diagnosed HIV than all other men. Among men, those that had sex with men only in the last year were also most likely to have had a diagnosed STI in the same time period. Similarly, among women, those that had sex with women only in the last year were most likely to have had a diagnosed STI in the same time period.

7.2 GENDER AND SEXUAL BEHAVIOUR

7.2.1 Gender of respondents and sexual behaviour

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

Sexual behaviour by gender among all respondents	% MALE	% FEMALE
Two or more sexual intercourse partners in the last year	**43.2**	24.7
Four or more sexual intercourse partners in the last year	**17.5**	7.7
Any sexual partners outside their current regular relationship	**27.5**	10.8
Any unprotected intercourse in the last year	**51.5**	47.5
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	**12.6**	7.6
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	14.4	14.2
Any experience of condom failure in the last year	18.9	17.3

On most measures men were more likely than women to have participated in behaviours with a risk of HIV transmission. Men were more likely to report having two or more, or four or more sexual partners in the last year, compared to women, and were significantly more likely to report sexual partners outside their current regular relationship. Men were also more likely than women to report having had any unprotected intercourse in the previous year, and were more likely to believe that at some point in the previous year they had unprotected intercourse with someone who had a different HIV status to them.

7.2.2 Gender of sexual partners and sexual behaviour

The following table shows the sexual behaviour measures by the gender of sexual partners for men and women separately. 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	42.9	**100**	61.0	25.9	**100**	55.8
Four or more sexual intercourse partners in the last year	15.0	**47.6**	44.0	7.5	**37.6**	20.9
Any sexual partners outside their current regular relationship	30.8	**42.4**	31.9	13.1	**24.3**	14.6
Any unprotected intercourse in the last year	**62.4**	60.2	47.8	63.1	64.0	53.7
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	13.7	**23.3**	15.9	9.0	**22.1**	17.1
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	15.4	25.4	**28.4**	18.9	17.4	22.9
Any experience of condom failure in the last year	20.9	**32.5**	24.7	22.0	**35.6**	20.5

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 15.0% of exclusively heterosexual men.

Behaviourally bisexual men were also much more likely than exclusively heterosexual or exclusively homosexual men to have sexual partners outside of their current regular relationship. Behaviourally bisexual men were also the most likely to report experiencing condom failure in the last year.

Among women, those who had sex with both men and women were the most likely to report most of the sexual behaviours that increase the risk of HIV transmission. More than one-in-three behaviourally bisexual women had more than four sexual intercourse partners in the previous year, compared to one-in-five exclusively homosexual women, and one-in-thirteen exclusively heterosexual women. Behaviourally bisexual women were also more likely than other women to report definitely or probably participating in sdUI in the last year.

7.3 GENDER AND HIV PREVENTION NEEDS

7.3.1 Gender of respondents 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
PEOPLE WHO HAD NOT TESTED POSITIVE		
DISAGREES OR IS NOT SURE: I do not want to get HIV (if I haven't already got it).	**9.7**	6.9
DISAGREES OR IS NOT SURE: I am in control of whether or not I get HIV.	38.2	37.4
PEOPLE WHO HAD TESTED POSITIVE		
DISAGREES OR IS NOT SURE: I do not want to get infected with another type of HIV (on top of the HIV I've already got).	**10.8**	4.6
DISAGREES OR IS NOT SURE: I am in control of whether or not I pass my HIV to someone else.	29.3	21.9
ALL RESPONDENTS		
AGREES: I sometimes have a problem getting hold of condoms.	**27.7**	18.8
AGREES: If I carried a condom I would worry about what people thought of me.	29.5	29.0
DISAGREES: I can use condoms with a sexual partner if I want to.	12.0	10.5
DISAGREES: I would find it easy to talk about safer sex and HIV with new sexual partners.	14.5	14.0
Mean number of knowledge items NOT known (median)	3.01 (2)	2.87 (2)

Only a few of the indicators of HIV prevention need showed an overall difference between men and women and these showed greater need among men than women.

Among respondents that had not tested positive, men were less likely than women to be motivated to avoid HIV infection. Similarly, among those tested HIV positive, men were less likely than women to agree that they wanted to avoid HIV re-infection.

Men were also significantly more likely than women to say they sometimes had a problem getting hold of condoms. However, concern about carrying condoms and confidence in using them did not vary by gender.

7.3.2 Gender of sexual partners and HIV prevention needs

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. The preceding table shows the overall differences between men and 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
PEOPLE WHO HAD NOT TESTED HIV POSITIVE								
DISAGREES OR IS NOT SURE: I do not want to get HIV (if I haven't already got it).	13.9	7.9	**14.9**	13.0	6.3	7.0	7.2	6.9
DISAGREES OR IS NOT SURE: I am in control of whether or not I get HIV.	42.2	36.5	44.9	38.0	33.0	38.4	**51.5**	25.0
PEOPLE WHO HAD TESTED HIV POSITIVE								
DISAGREES OR IS NOT SURE: I do not want to get infected with another type of HIV (on top of the HIV I've already got).	3.7	8.1	**33.3**	21.0	1.3	5.0	10.5	0.0
DISAGREES OR IS NOT SURE: I am in control of whether or not I pass my HIV to someone else.	36.0	25.2	52.9	31.0	10.0	25.4	26.3	**33.3**
ALL RESPONDENTS								
AGREES: I sometimes have a problem getting hold of condoms.	17.5	27.9	**44.3**	25.0	13.0	19.9	23.8	**33.3**
AGREES: If I carried a condom I would worry about what people thought of me.	21.9	30.2	**40.1**	21.0	28.0	29.6	32.0	18.9
DISAGREES: I can use condoms with a sexual partner if I want to.	14.6	11.1	13.5	14.0	8.8	10.3	15.3	10.8
DISAGREES: I would find it easy to talk about safer sex and HIV with new sexual partners.	14.8	14.1	17.4	16.0	13.0	14.1	22.7	8.1
Mean number of knowledge items NOT known (median)	3.76 (3)	2.74 (2)	**4.01** (3)	2.79 (2)	2.83 (2)	2.83 (2)	3.47 (3)	3.23 (3)

Among men, all knowledge items showed differences by gender of sexual partners and half of the other indicators also did. Where differences occurred it was men who had sex with both men and women who were most commonly in need.

Among women, there were fewer differences by gender of sexual partners in the last year. Behaviorally bisexual women were most likely to indicate they did not feel in control of whether they got HIV (if they did not already have it). Two of the other indicators showed unmet need to be most common among women who had sex with women only.

7.4 SUMMARY & IMPLICATIONS FOR PLANNING

Men were less likely than women to know where to get an HIV test, and less likely to have ever had one.

- **Interventions promoting HIV testing and diagnosis among Africans should over-serve men rather than women.**

Behaviourally bisexual men had the lowest levels of basic knowledge about HIV among men.

- **Interventions aiming to increase HIV-related knowledge among African men should over-serve behaviourally bisexual men.**

Women were more likely than men to report no sexual partners in the previous year, and men had more sexual partners in the previous year than women.

- **Interventions to reduce partner numbers among Africans should over-serve men.**

Homosexually active men (exclusively homosexual as well as behaviourally bisexual men) were substantially more likely to have had five or more sexual partners in the previous year.

- **Interventions to reduce partner numbers among African men should over-serve men that have sex with only men, and men that have sex with men and women.**

Men were more likely than women to report sdUI.

- **Interventions designed to reduce sdUI should over-serve men.**

Behaviourally bisexual men were significantly more likely than other men to have had sexual partners outside of their regular partnership, to have experienced condom failure and to think that they have participated in sero-discordant unprotected intercourse.

- **Interventions to influence the sexual behaviours of African men to reduce the risk of HIV transmission should benefit behaviourally bisexual men more than other men.**

Just under half of behaviourally bisexual men said they had problems getting hold of condoms, and two fifths worried what others would think if they were known to carry them.

- **Interventions to increase condom access and acceptability among African men should over-serve homosexually active men especially those who have sex with both men and women.**

Women with a regular sexual partner were more likely to report sdUI than those without a regular sexual partner, and this relationship did not occur among men.

- **Where interventions to reduce sdUI do target women, those in relationships should be prioritised.**

Behaviourally bisexual women were more likely than other women to report higher sexual partner numbers, to have participated in sdUI, and to have experienced condom failure in the previous year.

- **Interventions for African women should over-serve women who have sex with both men and women.**

- **Interventions to increase confidence in using condoms and to increase HIV knowledge among African women should equally serve women irrespective of who they have sex with.**

8 Variation by age

Fewer than one-in-ten respondents were under the age of 20 (7.8%, n=317). One third were in their 20s (34.3%, n=1391), and a further third were in their 30s (34.9%, n=1415). Those in their 40s accounted for less than a fifth of the sample (17.3%, n=703), and about one-in-twenty were aged 50 or older (5.6%, n=226).

This chapter compares key risk behaviours and indicators of HIV prevention need across five age groups. A detailed analysis of respondents' ages is reported in Chapter 2 (Section 2.2).

8.1 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 among all respondents	% <20	% 20s	% 30s	% 40s	% 50+
Never HIV tested	**79.3**	52.6	38.7	39.9	52.0
Tested HIV positive	3.9	7.9	19.0	**29.3**	22.0
Wants test but does not know where to get one	13.5	**14.2**	11.7	4.8	5.2
Diagnosed with STI in last year	6.6	**13.8**	11.1	4.2	5.6

Ever having had an HIV test was least common among those under 20, increased among those in their 20s and again in their 30s, leveled out among those in their 40s and declined slightly among those over 50. Having diagnosed HIV showed a similar pattern, being highest among people in their 40s.

People in their 20s were most likely to report wanting an HIV test and not knowing where to get one, though this was somewhat elevated for all respondents under 40. People in their 20s (and 30s) were most likely to report having an STI diagnosed in the last year.

8.2 AGE AND SEXUAL BEHAVIOUR

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

Sexual behaviour by age groups among all respondents	% <20	% 20s	% 30s	% 40s	% 50+
Two or more sexual intercourse partners in the last year	35.1	**41.7**	34.7	26.5	13.9
Four or more sexual intercourse partners in the last year	**16.1**	15.9	12.8	8.1	4.6
Any sexual partners outside their current regular relationship	14.8	17.8	**23.1**	20.2	14.6
Any unprotected intercourse in the last year	27.4	49.4	**54.9**	52.4	41.9
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	10.4	10.8	10.6	9.6	5.7
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	14.9	**17.4**	15.5	8.9	7.1
Any experience of condom failure in the last year	16.4	**21.8**	20.2	13.4	5.6

When examining sexual behaviour across age groups, respondents under 40 emerged as at highest risk. While people under 20 were most likely to report having had four or more sexual partners in the previous year, they were least likely to report any unprotected intercourse, or to report any sex outside their current relationships.

People in their 20s were most likely to report two or more partners in the last year, and were almost as likely to report 4 or more partners as the under 20s. They were also most likely to report not knowing if they had sdUI in the last year and were most likely to report any condom failure.

People in their 30s were less likely to report 4 or more partners than those under 30 but were most likely to report any partners outside their regular relationship, and any unprotected intercourse in the last year.

8.3 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+
PEOPLE WHO HAD NOT TESTED POSITIVE					
DISAGREES OR IS NOT SURE: I do not want to get HIV (if I haven't already got it).	10.0	7.7	9.1	8.9	4.0
DISAGREES OR IS NOT SURE: I am in control of whether or not I get HIV.	**45.3**	39.5	36.3	35.6	28.4
PEOPLE WHO HAD TESTED POSITIVE					
DISAGREES OR IS NOT SURE: I do not want to get infected with another type of HIV (on top of the HIV I've already got).	**33.3**	16.5	4.7	4.6	0.0
DISAGREES OR IS NOT SURE: I am in control of whether or not I pass my HIV to someone else.	**55.6**	31.7	23.1	23.5	13.2
ALL RESPONDENTS					
AGREES: I sometimes have a problem getting hold of condoms.	**27.5**	25.9	22.8	19.4	16.0
AGREES: If I carried a condom I would worry about what people thought of me.	27.8	32.2	28.2	27.7	27.6
DISAGREES: I can use condoms with a sexual partner if I want to.	9.5	9.2	12.5	**13.3**	12.5
DISAGREES: I would find it easy to talk about safer sex and HIV with new sexual partners.	15.7	14.8	14.6	13.7	9.4
Mean number of knowledge items NOT known (median)	**4.06** (3)	3.18 (2)	2.70 (2)	2.65 (2)	2.55 (2)

Most indicators of need varied by age and the majority showed greatest unmet need among the youngest group, the under 20s. Four needs indicators showed greatest need in the youngest group: problems getting condoms; not feeling in control of HIV transmission (for those tested positive and for those not tested positive); and motivation to avoid reinfection among young people with diagnosed HIV. Confidence in condom use showed the greatest level of need among people in their 40s, with younger people being more confident about their ability to use condoms with sexual partners.

8.4 SUMMARY & IMPLICATIONS FOR PLANNING

HIV prevention need is most acute among younger people. While under 20s have the greatest needs in relation to knowledge and confidence, those who are in their 20s (and 30s) are most likely to participate in sexual behaviour that risks HIV transmission.

- **In order to have the greatest impact on unmet prevention need, interventions targeting Africans should over-serve younger people, especially those under twenty.**
- **Key needs areas for interventions among younger people should include: increasing control over behaviours that can lead to HIV transmission; access to HIV testing services, and; reducing the extent of condom failure.**

9 Variation by education

Respondents reporting no formal education, or primary school level education only, were in the minority in this sample (6.4%, n=263), and are categorised as having low educational attainment. Those who attended secondary school level only (medium attainment) accounted for more than one quarter of all respondents (29.2%, n=1202), while two-thirds of respondents had attended university or college (64.4%, n=2651), and were categorised as having high educational attainment.

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

9.1 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 among all respondents	% LOW education	% MEDIUM education	% HIGH education
Never HIV tested	**60.2**	51.8	45.4
Tested HIV positive	16.2	**19.8**	14.0
Wants test but does not know where to get one	9.6	**14.5**	9.6
Diagnosed with STI in last year	**21.8**	14.4	7.1

All of the measures varied by education group. When considering the sample as a whole, those with a lower level of education were least likely to have ever tested and those with medium education were most likely to have diagnosed HIV. However, among those people who had tested, 40.7% of those with low education had tested positive, compared with 41.1% of those with medium education and 25.6% of those with high education.

One-in-five people who had not progressed beyond primary school education were diagnosed with an STI (other than HIV) in the previous year, compared to one-in-seven of those with medium education and one-in-fourteen of those with a college or university education.

9.2 EDUCATION AND SEXUAL BEHAVIOUR

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

Sexual behaviour by education among all respondents	% LOW education	% MEDIUM education	% HIGH education
Two or more sexual intercourse partners in the last year	**40.1**	38.3	31.9
Four or more sexual intercourse partners in the last year	**17.1**	16.6	10.6
Any sexual partners outside their current regular relationship	23.8	19.9	18.7
Any unprotected intercourse in the last year	**53.5**	44.0	51.7
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	**18.3**	12.6	8.3
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	**24.0**	19.8	11.3
Any experience of condom failure in the last year	16.9	**20.7**	17.2

Respondents who proceeded no further than primary or secondary school were significantly more likely to report most of the sexual behaviours carrying an increased risk of HIV transmission.

Respondents in the low (primary school) and medium (secondary school) educational groups were more likely than those who had attended college or university to report having had two or more, as well as four or more sexual intercourse partners in the previous year.

Compared with the medium and high education groups, those with low educational attainment were more likely to report: any unprotected intercourse in the last year; that their likelihood of participating in sdUI in the previous year was definite or probable; and that they were unsure if they had sdUI in the previous year.

9.3 EDUCATION AND HIV PREVENTION NEEDS

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

Unmet HIV prevention need by education groups	% LOW education	% MEDIUM education	% HIGH education
PEOPLE WHO HAD NOT TESTED POSITIVE			
DISAGREES OR IS NOT SURE: I do not want to get HIV (if I haven't already got it).	**17.1**	9.9	7.3
DISAGREES OR IS NOT SURE: I am in control of whether or not I get HIV.	**46.2**	42.7	34.9
PEOPLE WHO HAD TESTED POSITIVE			
DISAGREES OR IS NOT SURE: I do not want to get infected with another type of HIV (on top of the HIV I've already got).	13.8	5.3	6.9
DISAGREES OR IS NOT SURE: I am in control of whether or not I pass my HIV to someone else.	**48.3**	28.5	20.5
ALL RESPONDENTS			
AGREES: I sometimes have a problem getting hold of condoms.	**34.5**	30.4	19.1
AGREES: If I carried a condom I would worry about what people thought of me.	**39.9**	31.6	27.0
DISAGREES: I can use condoms with a sexual partner if I want to.	**16.1**	12.7	10.1
DISAGREES: I would find it easy to talk about safer sex and HIV with new sexual partners.	**24.9**	16.7	12.1
Mean number of knowledge items NOT known (median)	**5.39** (5)	3.49 (3)	2.50 (2)

Almost all the indicators showed greater need among people with the lowest levels of formal education. Among those without an HIV positive diagnosis, people with low education were most likely to be in need of motivation to avoid HIV and most likely to indicate they lacked control over whether or not they got HIV. Among those with diagnosed HIV, people with low education were most likely to feel they lacked control over whether or not they passed their infection to someone else.

Respondents' levels of education were also associated with their knowledge of HIV. People with the lowest level of educational attainment were clearly in the greatest need of knowledge and some attention will be required to ensure that interventions to meet this need are readily accessible by those with limited literacy (in English as well as in any other first language). People with low education were also most likely to express a lack of confidence about accessing, carrying and using condoms. They were also much more likely than people with high education to say they would find it difficult to discuss safer sex and HIV with new partners.

9.4 SUMMARY & IMPLICATIONS FOR PLANNING

Across the whole sample, people with lower levels of formal education (no more than primary school) were most likely to indicate low levels of knowledge about HIV, lack of control over participating in HIV transmission, poor access to, and ability to use condoms successfully.

- **HIV prevention interventions for Africans should always over-serve people with lower levels of formal education.**

10 Variation by country of birth

Three countries of birth, Zimbabwe (n=682), Nigeria (n=433) and Uganda (n=385), accounted for over a third of all respondents (38.3%). The fourth most common country of birth was the UK. Overall, 8.4% (n=329) of respondents were born in the UK. In addition to these four, the following countries of birth make up the ten most common responses in the sample: Republic of the Congo (3.2%, n=127), Ghana (5.9%, n=231), Kenya (7.8%, n=307), Republic of South Africa (3.3%, n=130), Somalia (2.4%, n=92) and Zambia (3.9%, n=154).

This chapter compares key risk behaviours and indicators of HIV prevention need by the ten most common countries of birth reported by respondents. A full analysis of ethnicity, including respondents' country of birth is reported in Chapter 2 (Section 2.3).

10.1 COUNTRY OF BIRTH AND TESTING BEHAVIOURS

The following table shows how the measures of HIV/ STI testing and unmet diagnosis needs varied by country of birth for the ten most common countries of birth.

Testing behaviour by country of birth	% R. Congo	% Ghana	% Kenya	% Nigeria	% R. South Africa	% Somalia	% Uganda	% UK	% Zambia	% Zimbabwe
Never HIV tested	42.6	**65.0**	42.2	54.8	34.9	**65.9**	33.8	63.5	35.8	36.6
Tested HIV positive	13.9	7.4	17.5	6.6	27.9	4.6	26.1	3.1	**28.2**	**28.5**
Wants test but does not know where to get one	14.2	9.0	7.8	10.8	5.8	8.1	8.5	9.5	6.2	8.3
Diagnosed with STI in last year	10.8	6.7	**11.3**	8.1	8.1	8.0	**13.9**	5.6	8.7	5.1

Ever having taken an HIV test varied strongly by country of birth with the groups of respondents from Uganda, South Africa, Zambia and Zimbabwe (where two thirds had tested) being much more likely to have tested than those from Ghana or Somalia or the UK (where only one third had 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 2006). There was no relationship between country of birth and the proportion of those who wanted an HIV test and did not know where to get one. Respondents from Uganda were most likely to have been diagnosed with an STI in the past year.

10.2 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	% R. Congo	% Ghana	% Kenya	% Nigeria	% R. South Africa	% Somalia	% Uganda	% UK	% Zambia	% Zimbabwe
Two or more sexual intercourse partners in the last year	35.5	32.9	**44.0**	34.5	33.1	37.5	31.1	**43.5**	33.3	28.1
Four or more sexual intercourse partners in the last year	10.7	12.5	12.3	13.9	13.2	**15.9**	9.7	**19.6**	10.7	8.8
Any sexual partners outside their current regular relationship	24.6	14.7	23.3	20.6	16.4	15.5	20.8	18.4	24.1	18.4
Any unprotected intercourse in the last year	50.0	49.3	**59.0**	**54.2**	48.4	48.3	45.4	44.2	51.4	48.9
DEFINITELY or PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	9.6	7.3	8.6	8.5	10.6	10.3	6.6	9.1	16.3	11.1
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	18.3	17.9	14.0	11.6	14.2	8.0	12.4	12.0	12.1	12.3
Any condom failure in the last year	13.6	13.5	18.9	16.7	20.8	7.1	**22.9**	16.2	**21.9**	18.7

A number of sexual behaviours that carry an increased risk of HIV transmission were not significantly associated with respondents' country of birth. Those behaviours that did demonstrate such a relationship were having two or more, or four or more sexual intercourse partners in the last year, having any unprotected intercourse and experience of condom failure.

Respondents born in the UK were most likely to report four or more sexual intercourse partners in the previous year, and second most likely to report two or more partners in the last year.

Respondents born in Kenya were most likely to report two or more partners in the last year and most likely to report any unprotected intercourse in the last year.

People born in Uganda were most likely to have experienced condom failure in the previous year closely followed by those born in Zambia.

10.3 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. Since there were less that ten people with diagnosed HIV who were born in either Somalia or the UK, these two countries are excluded from the comparison of people with diagnosed HIV (marked with a #).

Unmet HIV prevention need by country of birth	% R. Congo	% Ghana	% Kenya	% Nigeria	% R. South Africa	% Somalia	% Uganda	% UK	% Zambia	% Zimbabwe
PEOPLE WHO HAD NOT TESTED POSITIVE										
DISAGREES OR IS NOT SURE: I do not want to get HIV (if I haven't already got it).	12.5	10.5	9.1	5.6	5.0	9.9	6.4	7.9	5.9	5.9
DISAGREES OR IS NOT SURE: I am in control of whether or not I get HIV.	**48.9**	35.8	41.2	31.2	36.7	31.7	41.7	32.9	35.3	32.3
PEOPLE WHO HAD TESTED POSITIVE										
DISAGREES OR IS NOT SURE: I do not want to get infected with another type of HIV (on top of the HIV I've already got).	41.7	0	4.3	10.5	11.5	#	0.0	#	5.6	5.6
DISAGREES OR IS NOT SURE: I am in control of whether or not I pass my HIV to someone else.	66.7	14.3	23.4	36.8	34.6	#	20.3	#	26.5	17.8
ALL RESPONDENTS										
AGREES: I sometimes have a problem getting hold of condoms.	25.5	24.0	22.1	18.7	14.9	27.4	21.3	19.1	26.1	17.9
AGREES: If I carried a condom I would worry about what people thought of me.	27.3	23.0	30.6	29.4	14.5	**40.5**	26.8	23.2	26.5	28.5
DISAGREES: I can use condoms with a sexual partner if I want to.	**28.7**	11.1	10.0	7.2	12.4	13.1	12.0	4.5	9.9	12.2
DISAGREES: I would find it easy to talk about safer sex and HIV with new sexual partners.	20.0	8.9	14.8	10.8	22.2	**25.3**	10.5	14.1	13.1	12.6
Mean number of knowledge items NOT known (median)	3.26 (2)	3.56 (3)	3.19 (2)	2.51 (2)	2.58 (2)	**4.15** (3)	2.36 (2)	2.81 (2)	2.41 (1)	2.01 (1)

All the indicators varied by country of birth group except problems accessing condoms and motivation to avoid primary infection.

People from Somalia were most often in need of HIV-related knowledge, followed by people from Ghana. Somalis were also most likely to be concerned about carrying condoms and were least likely to feel confident about their ability to use condoms. Low levels of HIV-related knowledge among respondents from Somalia is worthy of note, but should be interpreted with some caution, given that it is the African country included in this comparison that has the lowest estimated HIV prevalence – probably not greater than 2.3% based on ante-natal clinic testing (UNAIDS & World Health Organisation 2007). In addition to a low-to-moderate prevalence in the country of origin, it is also likely that other key features such as cultural and religious norms combine with experiences of conflict to shape Somalis' high levels of information need when compared to those born in other countries.

Among people with diagnosed HIV, people from Republic of the Congo were also least likely to feel in control of HIV transmission. With regard to the indicators of motivation and power, the group of people from Republic of the Congo showed high need on four of the indicators, for example, they were more than twice as likely than people from all other countries to express a lack of confidence in their ability to use condoms. This suggests this group may also warrant being prioritised in HIV prevention programmes for Africans.

10.4 SUMMARY & IMPLICATIONS FOR PLANNING

Although there were differences in behaviours carrying an increased risk of HIV transmission and HIV prevention need among those from different countries of birth, no particular country group emerged as being in the greatest degree of overall need.

- **Interventions to reduce the risk of participating in behaviours that carry an increased risk of HIV transmission should aim to serve Africans from all countries of origin.**
- **Interventions to promote HIV testing that are concerned with equality of access across countries of birth should over-serve people from Somalia. However, given prevalence rates in that country and low to medium rates of participation in sexual behaviours that carry a risk of HIV transmission, such targeting may be unlikely to have significant impact on HIV incidence.**
- **If a choice has to be made between targeting national groups for interventions to increase HIV knowledge, condom failure and sexual negotiation skills, Somalis should be prioritised in order to gain equality across groups. On the other hand, it is likely that over-serving people born in the Republic of the Congo with such interventions would have greater impact on reducing HIV incidence.**
- **Given the high likelihood of HIV positive diagnoses amongst Zimbabweans, HIV testing interventions should over-serve people from this national group.**

11 Variation by length of residence in the UK

The length of time that respondents have resided in the UK is reported in five time bands. Those living in the UK for less than one year account for less than one-in-twenty respondents (4.4%, n=176). 13.3% of respondents (n=533) lived here for more than a year, but less than three years, while nearly one third (30.9%, n=1241) had done so for more than three years, and less than six. Nearly one quarter of all respondents (23.3%, n=938) had lived in the UK for more than six years, and less than ten, and a further quarter (28.1%, n=1130) had lived in the UK for more than ten years.

This chapter compares key risk behaviours and indicators of HIV prevention need by these five UK residence time bands. Responses regarding length of residence in the UK are described in detail in Chapter 2 (Section 2.4).

11.1 LENGTH OF RESIDENCE IN THE UK AND TESTING BEHAVIOURS

The following table shows how the measures of HIV / 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 years up to 6 years	% from 6 years up to 10 years	% 10 years or more (incl. non-migrants)
Never HIV tested	**55.6**	51.1	44.7	44.9	54.3
Tested HIV positive	5.3	15.1	16.6	**20.3**	14.8
Wants test but does not know where to get one	**17.3**	14.2	12.1	7.1	8.8
Diagnosed with STI in last year	8.3	9.6	11.0	9.3	8.7

Although significant differences were found by length of residence in the UK no one group stands out in these findings. Although recent migrants were least likely to have ever had an HIV test, they were also least likely to have received an HIV positive diagnosis.

The one variable that does consistently demonstrate a decline in need across time spent in the UK, is knowing where to get an HIV test among those who want one. Almost one-in-six respondents who had lived in the UK for less than a year wanted a test, but did not know where to get one, this proportion declines steadily the longer respondents lived in the UK.

11.2 LENGTH OF RESIDENCE IN THE UK 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 years up to 6 years	% from 6 years up to 10 years	% 10 years or more (incl. non-migrants)
Two or more sexual intercourse partners in the last year	29.1	35.2	35.1	33.3	33.4
Four or more sexual intercourse partners in the last year	**16.9**	10.4	11.6	11.2	14.2
Any sexual partners outside their current regular relationship	12.9	21.9	19.4	19.5	19.7
Any unprotected intercourse in the last year	42.7	44.2	49.7	49.1	**53.1**
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	7.2	10.5	9.1	10.8	9.7
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	9.6	16.9	14.9	15.0	12.4
Any experience of condom failure in the last year	18.6	14.4	19.5	**20.0**	16.2

Few significant differences emerged when examining sexual behaviour by respondents' length of residence in the UK, and there is no obvious pattern where differences exist. People who had lived in the UK for less than a year were most likely to report having four or more partners in the last year, but they were least likely to report any unprotected intercourse in the same time period. Those that had been in the UK more than ten years were most likely to report any unprotected intercourse in the last year.

11.3 LENGTH OF RESIDENCE IN THE UK AND HIV PREVENTION NEEDS

The following table shows the indicators of need by the time people had lived in the UK. Due to the very small number of people with diagnosed HIV who had lived in the UK for less than one year, these are excluded in the table below (marked with a #).

Unmet HIV prevention need by length of time in UK	% less than 1 year	% from 1 year up to 3 years	% from 3 years up to 6 years	% from 6 years up to 10 years	% 10 years or more (incl. non-migrants)
PEOPLE WHO HAD NOT TESTED POSITIVE					
DISAGREES OR IS NOT SURE: I do not want to get HIV (if I haven't already got it).	7.5	7.2	9.2	9.2	7.5
DISAGREES OR IS NOT SURE: I am in control of whether or not I get HIV.	35.9	44.3	37.7	35.9	36.7
PEOPLE WHO HAD TESTED POSITIVE					
DISAGREES OR IS NOT SURE: I do not want to get infected with another type of HIV (on top of the HIV I've already got).	#	7.9	8.8	5.0	4.7
DISAGREES OR IS NOT SURE: I am in control of whether or not I pass my HIV to someone else.	#	31.7	22.6	20.0	27.2
ALL RESPONDENTS					
AGREES: I sometimes have a problem getting hold of condoms.	26.3	**27.8**	24.6	20.9	21.3
AGREES: If I carried a condom I would worry about what people thought of me.	29.8	32.7	28.6	28.5	28.1
DISAGREES: I can use condoms with a sexual partner if I want to.	11.3	12.7	10.9	10.3	11.7
DISAGREES: I would find it easy to talk about safer sex and HIV with new sexual partners.	10.4	**18.5**	15.7	13.5	12.5
Mean number of knowledge items NOT known (median)	3.09 (2)	**3.34** (3)	2.87 (2)	2.70 (2)	2.86 (2)

Less than half the indicators of need showed a difference by length of time living in the UK, and those that did suggested greater need among those that had lived in the UK from 1-3 years. Although levels of need usually declined as years in the UK increased, this positive relationship was not universal. This is mostly likely to be a function of age as well as migration history.

11.4 SUMMARY & IMPLICATIONS FOR PLANNING

Those living in the UK for less than a year were most likely to have never tested for HIV and to want an HIV test and not know where to get one.

- **Interventions to increase access to HIV testing services should over-serve relatively recent migrants to the UK.**
- **As there is little relationship between length of UK residence and sexual behaviour, interventions aiming to influence behaviours that contribute to HIV incidence should serve all migrants equally.**
- **Interventions to increase motivation and control over HIV transmission risk, and those to increase basic HIV knowledge, should over-serve migrants who arrived in the UK in the last three years.**

12 Variation by religion

The vast majority of all respondents identified themselves in one of the following four religion categories: Christian (72.8%, n=2961), Muslim (17.6%, n=717), African traditional religion (2.0%, n=81), or having no religion (6.1%, n=246).

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

12.1 RELIGION AND TESTING BEHAVIOURS

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

Testing behaviour by religion among all respondents	% Christian	% Muslim	% African traditional	% NO religion
Never HIV tested	43.5	**61.9**	55.1	52.2
Tested HIV positive	**17.3**	11.1	12.8	10.6
Wants test but does not know where to get one	10.6	13.1	12.0	9.9
Diagnosed with STI in last year	9.8	10.2	19.2	9.5

Only two of the testing behaviour measures varied by religion. Christians were most likely to have ever had an HIV test, and also most likely to have received an HIV diagnosis. Muslim respondents were least likely to have ever had an HIV test. This should be contextualised by the findings below that indicate that Muslim respondents were often the least likely to participate in sexual behaviours that carry increased risk of HIV transmission.

12.2 RELIGION AND SEXUAL BEHAVIOUR

The following table shows that sexual behaviour carrying an increased risk of HIV transmission was significantly related to respondents' religion, and the pattern of relationships was consistent.

Sexual behaviour by religion groups among all respondents	% Christian	% Muslim	% African traditional	% NO religion
Two or more sexual intercourse partners in the last year	31.6	36.0	**54.1**	53.8
Four or more sexual intercourse partners in the last year	11.0	12.4	18.9	**27.3**
Any sexual partners outside their current regular relationship	19.1	18.6	29.6	23.6
Any unprotected intercourse in the last year	50.0	45.4	**59.5**	50.8
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	9.1	8.8	**31.9**	14.0
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	13.6	16.7	**26.4**	14.5
Any experience of condom failure in the last year	18.9	14.6	**30.1**	16.1

Respondents adhering to African traditional religions (of whom there were only 81 in the sample) were most likely to engage in sexual behaviours that carried an elevated risk of HIV transmission. They were more likely than those in other religious groups to report any unprotected intercourse in the previous year, and were also most likely to report definitely or probably participating in sero-

discordant unprotected intercourse, and not knowing whether they had sdUI. Followers of African traditional religions were also most likely to have experienced condom failure in the previous year.

Respondents following no religion were significantly more likely than those in all other groups to have four or more sexual partners in the previous year. Christians were least likely to report having two or more or four or more sexual intercourse partners in the previous year.

12.3 RELIGION AND HIV PREVENTION NEEDS

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

Unmet HIV prevention need by religion	% Christian	% Muslim	% African traditional	% NO religion
PEOPLE WHO HAD NOT TESTED POSITIVE				
DISAGREES OR IS NOT SURE: I do not want to get HIV (if I haven't already got it).	7.7	10.7	**16.9**	7.0
DISAGREES OR IS NOT SURE: I am in control of whether or not I get HIV.	36.5	41.3	**55.9**	34.5
PEOPLE WHO HAD TESTED POSITIVE				
DISAGREES OR IS NOT SURE: I do not want to get infected with another type of HIV (on top of the HIV I've already got).	6.1	6.5	0.0	**21.7**
DISAGREES OR IS NOT SURE: I am in control of whether or not I pass my HIV to someone else.	23.9	21.3	**55.6**	40.9
ALL RESPONDENTS				
AGREES: I sometimes have a problem getting hold of condoms.	20.8	29.3	**42.5**	23.9
AGREES: If I carried a condom I would worry about what people thought of me.	28.3	31.3	**45.1**	26.0
DISAGREES: I can use condoms with a sexual partner if I want to.	11.3	10.0	13.7	10.8
DISAGREES: I would find it easy to talk about safer sex and HIV with new sexual partners.	12.5	**19.1**	11.4	18.5
Mean number of knowledge items NOT known median)	2.61 (2)	4.09 (4)	4.50 (4)	2.71 (2)

All but two indicators of prevention need showed differences across religious groups, with those respondents following African traditional religions being most often in need. This group were most likely to lack a sense of control over getting or passing on HIV. They were most likely to report having difficulty getting hold of condoms and were most likely to worry about what others would think if they were known to carry condoms.

On only one item, Muslims emerged as in greatest need. One-in-five Muslims said they would not find it easy to talk about safer sex with new partner, contrasted with just over one-in-nine followers of an African traditional religion.

12.4 SUMMARY & IMPLICATIONS FOR PLANNING

Christian and Muslim respondents were least likely to have participated in behaviours with an increased risk of HIV transmission in the previous year.

- **HIV prevention activity intended to influence HIV risk behaviour should seek to over-serve African people beyond these two main religious groups.**

Although followers of African traditional religions were in highest HIV prevention need, the relatively small number in this group suggests a significant number of interventions to meet their needs would not be efficient. However, awareness of increased need among people in this group is vital.

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