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Abbreviations and definitions

Black Africans:	We recognise that Africans are not a homogenous group; the term describes diverse populations with a range of social and cultural beliefs and norms. For the purposes of the survey we have used the term “African” to include all people who describe themselves as “black African”.
HIV	Human immune deficiency virus – a viral infection that can be passed during sex.
Missing	The number of respondents not represented, usually because they did not answer a particular question.
N=	The number of respondents represented.
NHS GG&C	National Health Service Greater Glasgow and Clyde
The outreach worker:	This term will be used to refer to the WC AHP community outreach worker, Kalonde Kasengele, who carried out the majority of the work.
STI	Sexually transmitted infection – infection acquired during sex (including HIV).
WC AHP	Waverley Care African Health Project

Executive Summary

Background and rationale for the study

This study sought to obtain baseline information against which it would be possible to measure increased knowledge, attitudes and confidence of Africans living in NHS GG&C. Specifically, the survey was developed to collect information from Africans living in Glasgow on:

- a) whether HIV was seen as personally important to them
- b) their knowledge and attitudes towards HIV testing and testing services (including whether they have ever tested before)
- c) how comfortable they were talking about sexual health and HIV
- d) their knowledge about where to access condoms/femidoms and barriers to accessing condoms/femidoms
- e) how much control they felt they had over their sexual health.

Methodology

A quantitative approach was taken using online and paper-based surveys. There were a total of 110 questionnaires included in the final sample of analyses, with almost equal proportions of men and women. Key learning from the methodology we used are also discussed here.

Results

- 🧑 The majority of the sample were aged between 21-40 years and self-identified as Black African (81%). A high proportion of Africans (71%) considered HIV to be an important issue for them personally.
- 🧑 64% had received an HIV test from a health profession, while 31% had not, and 5% were unsure. Of those who had tested, females (38%) were more likely to test than males (25%).
- 🧑 The most common reason offered by participants on why people might not test is that *they had no reason to think they had HIV*. This was a view held more strongly amongst those who had never tested (93%) than the sample as a whole (74%).

Males also tended to make a larger proportion of the respondents who agreed with the reasons for not testing, which suggests that interventions must prioritise work with men.

- ✎ The majority of those who had never tested were under 30 (52%), male (61%), and born in the UK (35%). This suggests that the younger generation of Africans, especially those born in the UK, may not consider HIV as an issue relevant for them.
- ✎ Although only 9% of the people who answered the question stated that they did know where to get tested, this question had the highest non-responses (missing=35) which may be indicative of people not knowing where to test.
- ✎ While a larger proportion (over 50%) stated that they were confident in talking to friends and sexual partners about safe sex, there were still significant numbers within the sample who were not confident on both these aspects, 22% and 24% respectively. Increasing people's confidence in discussing safe sex practices is an important intervention point and has been found to correlate to people's ability to use condoms with new sexual partners.
- ✎ 33% did not agree that they were in control of getting HIV and 24% did not agree about being in control of passing on HIV. This suggests a sense of powerlessness amongst some participants. This was especially the case amongst the older groups (i.e. over 40 years), which may be linked to cultural taboos in some in some African cultures about discussing sex openly.
- ✎ 34% disagreed with the statement that they knew where to get free condoms, with those under 20 years and over 40 years more likely to disagree with this statement. This suggests that interventions must also focus on these age groups because they are least likely to access condoms.
- ✎ 35% agreed that they had difficulties accessing condoms in general with females and those aged over 40 years more likely to agree. This indicates that interventions must not only sign post people to relevant places to access free

condoms but they should also actively make condoms more accessible in various community settings in order to target different age groups and genders.

Recommendations

While the findings presented in this report must be interpreted within the context of a small and biased sample, a number of recommendations can still be made:

- 🧑 African communities need culturally appropriate information about the relationship between HIV and sexual practices, relationships, and sexual negotiation in order to raise awareness about HIV being a relevant issue for them in Glasgow. This is crucial as people tend to view HIV as an issue that is relevant for 'others' but not 'themselves'.
- 🧑 There must be discussions about implications of seroconcordant/discordant sex and raising awareness about how to access Post Exposure Prophylaxis (PEP) if required. In doing so, this will allow Africans to make informed decisions about the levels of risk they are prepared to take.
- 🧑 There is a need to promote early and regular testing as well as raise awareness about the availability and accessibility of sexual health and HIV treatment services.
- 🧑 Interventions must provide African communities with easy access to free condoms/femidoms (and lubricants for anal sex). In particular, femidoms should be actively promoted to females as this may be one way to overcome gender inequalities that tend to make women more likely to feel powerless about acquiring HIV.
- 🧑 We need to continue to challenge HIV related stigma; African people living with HIV need support to deal with the stigma they confront within their respective communities. Fear of stigma prevents people from discussing HIV risks and HIV prevention strategies; accessing HIV and sexual health services; testing for HIV, knowing their status and notifying their partners about their HIV status.

1 Introduction

Waverley Care is commissioned by NHS Greater Glasgow and Clyde (NHS GG&C) to deliver an African Health Project (AHP) covering both HIV prevention and support to black Africans and black African communities in the NHS GG&C area. Prevention activities include: 1) raising awareness about HIV and delivering information about HIV transmission, prevention and testing and 2) identifying acceptable models of condom distribution including provision of information about sexual and reproductive health services and safer sex strategies.

As part of the evaluation of the community outreach work, a short focussed survey was undertaken in order to obtain baseline information against which it would be possible to measure increased knowledge, attitudes and confidence of Africans living in NHS GG&C. It was also hoped that this survey would help to identify unmet HIV prevention needs which would inform the outreach work of the AHP.

The following reports the findings from the baseline survey that was conducted by the AHP in June and October 2010. The survey was developed to collect information from Africans living in Glasgow on:

- f) whether HIV was seen as personally important to them
- g) their knowledge and attitudes towards HIV testing and testing services (including whether they have ever tested before)
- h) how comfortable they were talking about sexual health and HIV
- i) their knowledge about where to access condoms/femidoms and barriers to accessing condoms/femidoms
- j) how much control they felt they had over their sexual health.

Basic demographic information of respondents was collected to allow identification of any variation in these skills, knowledge and attitudes across key demographic groups.

The report begins by providing the background and rationale for the work, before outlining the methodology that was taken to carry out the study. This is followed by a description of the results and a discussion of how these findings will help inform that outreach work being carried out in NHS GG&C.

1.1 Background and rationale for the study

By the end of 2009 there were 2240 new diagnoses of HIV infection among black Africans, representing 34% of all new diagnoses in the UK and 63% of new heterosexual transmissions. Most (68%) had acquired their infection abroad, mainly in Sub-Saharan Africa (Health Protection Agency, 2010). In the same year, a total of 428 newly identified cases of HIV were reported to Health Protection Scotland – a similar number to that reported in 2008 (n=411) (Scotland's Sexual Health Information, 2010). This compares with annual reports of between 150 and 180 diagnoses during the 1990s, between 160 and 250 from 1998 to 2002, and between 250 and 450 from 2003 to 2007 (Health Protection Scotland, 2009). In a similar trend to UK data, black Africans were disproportionately infected and made up the majority of heterosexual transmissions; they were the largest single ethnic group diagnosed during 2009, accounting for about two thirds (60/90) of heterosexual transmissions in the NHS GG&C area (Public Health Protection Unit, 2010).

Late HIV diagnosis is a particular problem among black Africans and is one of the most important factors associated with HIV-related disease and death in the UK (Burns et al., 2001). Late diagnosis is defined as taking place after antiretroviral treatment would typically have begun, or when the person has an AIDS-defining illness at the time of diagnosis. Without an understanding of the availability of sexual health services and the effectiveness of treatment in Scotland, some African people may continue to believe that HIV infection inevitably leads to illness and death. Lacking knowledge of HIV treatments and therefore not perceiving the benefits of diagnosis and being very fearful of finding out their status, are two of the reasons why some Africans with HIV spend a long time undiagnosed, and have poorer health outcomes (Dodds et al., 2008a). Other reasons for late diagnosis include fear of the stigma surrounding HIV/AIDS, general misinformation about the infection and self-perceived low risk (Dodds et al., 2008a). Self-perceived low risk is a particular concern and has been found to be the most common reason for not testing amongst those who have never tested (Hickson et al., 2009).

It is self-evident that all sexual HIV transmissions occur during sex between a person who is HIV positive and a person who is HIV negative. Targeted HIV prevention initiatives therefore need to be developed that are able to work with both sides of the equation.

“The Knowledge, the Will and the Power” (Dodds et al., 2008a) identifies that people living with HIV have much more opportunity to have serodiscordant sexual relationships given that the overall numbers of people with HIV in the UK remain low. They suggest that people living with HIV should therefore be a priority group for HIV prevention.

Results from the “Bass Line 2008-09 survey”, a community-based research project involving 2580 African people living in England, provides an insight into the sexual behaviour of black Africans in England (Hickson et al., 2009). More than 75% of the sample reported having been sexually active in the previous year, with more than half having a regular sexual partner. Of those with a regular partner, 25% reported having had other sexual relationships outside the regular relationship. Of those who reported having had sex in the previous year, 10% reported definitely or probably having had sexual intercourse without a condom with someone of a different HIV status from theirs. The risk of serodiscordant unprotected intercourse increased with the number of sexual partners: 25% of respondents who had sex in the past year did not use a condom in that time. Among those who had used condoms, one third reported that they had experienced condom failure in the past year (Hickson et al., 2009).

Maintaining safer sexual practices for all people, irrespective of HIV status, is key to HIV prevention. The use of condoms remains the best means of ensuring that HIV transmission does not occur during penetrative sex. The “*BASS Line 2007 Survey*”, although confined to England, illustrates some of the issues surrounding condom use and accessibility for people from African communities. The survey states:

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 (Dodds et al., 2008b: 37).

The survey also indicates a high level of condom failure in Africans – one third of the sample had experienced condom failure in the past year – so it is apparent that interventions to promote condom use also need to address condom failure. There is also evidence that HIV remains heavily gendered in many communities with women significantly more at risk because of social factors as well as physiological factors

(UNAIDS, 2010). This is true for some African communities in the UK (Dodds et al., 2008a).

Findings from the SHIBAH research project looking at sexual health issues that affect African men and women who use HIV services in Lambeth, Southwark and Lewisham (Chinouya et al., 2003) found a low level of knowledge about sexual health. Nearly three quarters of the people who completed the questionnaire believed that they could tell if they had a sexually transmitted infection (STI). One third believed that they could not pass on HIV if they had an undetectable viral load.

Findings from a Scottish study - "It's good to go for a test" (Cree, 2007) supported evidence that Africans are less likely to use leaflets and flyers to obtain information, as oral tradition plays a more important role in African people's lives and culture. Information on HIV treatment and support is best delivered in a participatory community context. This is because for the African audiences, information is shared as part of a collective life experience. This is supported by three other research studies conducted in London and England; the *Padare* study (Chinouya & Davidson, 2003), the *Shibah* report (Chinouya et al., 2003) and the two *Mayisha* studies (Mayisha II Collaborative Group, 2005). In particular, faith is said to be one key avenue through which Africans get information:

Faith plays a key role in everyday life for many people from African communities. It is for them a form of identity, and for new migrants especially, one of the key ways of integrating into life in the UK. For some people, participation in the life of a faith community is vital for their well being and the basis from which relationships are formed. If faith communities can address the stigma and discrimination surrounding HIV and recognise that HIV exists in their respective communities, not only will this develop support for people living with HIV within their own communities, it could also assist with the implementation of prevention strategies at local levels and help raise awareness about HIV. (AHPN 2009).

HIV testing and treatment can help reduce transmission of the virus. People who find out they have HIV infection may change their sexual behaviour as a result of the diagnosis. For example, they may start using condoms with partners who are not HIV positive or whose HIV status is unknown. Testing also provides an opportunity to address 'unmet HIV prevention needs' for example, sexual negotiation skills and access to condoms (Dodds et

al., 2008a). In addition, people with an HIV diagnosis may choose to receive antiretroviral therapy, which suppresses the virus and can reduce further transmission. A negative HIV test provides an opportunity to offer preventive education and advice and may also lead to changes in behaviour. Increasing the frequency of testing may result in earlier detection of HIV, thereby providing greater opportunity to reduce transmission.

As most of the studies mentioned above looked at African communities in England, their findings are not necessarily transferable to a Glasgow context. It was therefore hoped that this Baseline Survey would provide knowledge about local communities and therefore ensure an appropriate local HIV prevention response.

2 Methods

The questionnaire was developed and refined several times with the help of representatives from NHS GG&C. It was piloted with a group of AHP service users and volunteers to test:

- ✎ Understanding of the questions
- ✎ Understanding of why we were asking them
- ✎ Logistics of the questionnaire
- ✎ Acceptability of the questions.

The final questionnaire can be seen in **Appendix 1**.

An initial data collection period during May-June 2010, which used solely online methods of questionnaire distribution and data collection, proved unsuccessful. This led to a second phase of data collection, during October 2010, which used a mixed approach of more proactive online distribution and community based distribution of paper versions of the questionnaire. The learning outcomes from both phases are described in more detail below.

2.1 Online questionnaires

During the initial data collection phase, May-June 2010, 8 key contacts working with African communities in Glasgow were asked to distribute the link to the online questionnaire via their mailing lists and networks. **Table 1** below illustrates that these 8 contacts included a variety of large organisations, local groups, and individuals who were considered community peer leaders.

Table 1: Key contacts for the online survey

Key contacts	June 2010	October 2010
Organisations	1) African Caribbean Network 2) British Red Cross 3) Scottish Refugee Council 4) KANAIS	1) African Caribbean Network 2) British Red Cross 3) Scottish Refugee Council 4) KANAIS 5) Central and West Integration Network 6) Radio Kilimanjaro
Peer leaders	4	8
Total	8	14

However this approach proved unsuccessful and on further enquiry a number of barriers were identified. Firstly, although each of the key contacts had agreed to forward the online questionnaire on, very few appeared to follow this through. It is clear that in the future contacts should be followed up to encourage distribution and to identify and address any barriers. This learning was taken forward for the second phase.

Secondly, several of the key contacts were national organisations, with a Scotland-wide remit. This meant it was difficult for these organisations to target the questionnaire at NHS GGC residents only. This also caused a further issue with the data collected. Although the questionnaire's introduction made it explicit that it was aimed at NHS GGC residents only, it is possible that some African's from other health boards received and completed the questionnaire.

Other possible causes of this lack of engagement with the project from these contacts could include a lack of prioritising this project over their own work commitments, a mismatch between national function of the organisations and the local geography of the survey, and/or the explicit mention of HIV may have acted as a barrier. However, it must be emphasised that these are merely speculations as none of the contacts advised these were barriers.

As mentioned, in recognition of the poor response, a second data collection phase was carried out in October 2010, which incorporated much of the learning from phase 1. To counter the belief that the previous circulation may have been halted because of immediate reference to HIV, the introductory email to key contacts rebranded the survey as a "health" rather than an "HIV" survey. It was hoped this might remove any possible stigma associated with HIV.

In addition to the eight contacts that were previously approached, a further six were asked to help distribute the online survey (see Table 1 above). This included Central and West Integration Network, which has a major database of organisations in Glasgow that are regularly sent updates of upcoming events, Radio Kilimanjaro and a further four community leaders. During this phase contacts were followed up by email or telephone

for feedback on whether they had distributed the survey. This 'gentle' reminder proved effective in reinforcing the importance of the research. However evidence from where participants received their questionnaire suggest that this process did not ensure full support, as only 6 of the 14 organisations and community leaders contacted appeared to have distributed the survey.

During the second phase the personal Facebook account of the AHP worker was utilised to target Africans and other key peer leaders and organisations. It proved fairly effective, accounting for 10 of the 17 total online responses. Facebook may prove a useful distribution tool in future projects, although an official AHP facebook page would be utilised rather than the personal account of the AHP worker.

2.2 Paper-based questionnaires

In recognition of the low response in June 2010, the paper questionnaire was used as the main approach in October 2010 because it was felt that this method would have a higher response rate. This was distributed with teams of AHP volunteers at a variety of community venues popular with Africans.

Ten volunteers were recruited from the pool of AHP volunteers to undertake this research. Volunteers were provided with training, which focused on techniques for approaching potential participants using an agreed script. Volunteers expressed anxiety about how they could target Africans without stigmatising them or causing offence, and about providing inaccurate information on HIV. Role plays were used to practice approaching participants and volunteers worked with the outreach worker to explore possible ways of dealing with difficult scenarios. There were several suggestions to most difficult situations which helped volunteers to understand that in most cases, unless it related to factual information regarding HIV which volunteers were advised not to provide information on anything they were unsure about, there were no right or wrong answers. The key was to be pleasant and friendly in order to minimise hostile reactions from potential respondents. Where offence was caused, volunteers were strictly advised not to enter into any arguments but be apologetic and refer people on to the AHP worker who was always available; this helped to ease some of the anxieties volunteers had.

We carefully considered the selection of the week, timings, and venues for the survey distribution. The last week of October was chosen because it incorporated a number of key celebrations, including Black History month events and Zambian Independence Day, and was a period when all the students had started back. Distribution at train stations for example was carried out mostly after people had finished work rather than early in the morning during rush hour when people had less time. Below describes the successes and challenges encountered.

2.2.1 What was successful?

As the African communities in Greater Glasgow and Clyde are geographically dispersed, community events that brought Africans together in one venue provided useful and effective opportunities to disseminate the questionnaire. The four community events that were targeted (Zambian Independence Day, Maryhill Cultural Event, AHP Black History Month Cultural Day, and Black History Month closing event) proved to be very fruitful because they were generally well attended (ranging from 50-150 people). As such, they were good for the volunteer's morale as more people were likely to complete questionnaires at community events. Whilst the majority of people at these events were black Africans, volunteers decided to offer questionnaires to everyone (including non-Africans) in order to counter the issue of people feeling stigmatised. This proved very effective in easing a lot of the concerns that volunteers had about not appearing to stigmatise Africans. Based on how participants answered questions on ethnicity and country of birth, relevant surveys were included in the sample if they fitted the inclusion criteria. People were generally receptive to filling out questionnaires in such relaxed environments where there was a positive atmosphere. However, it must be noted that this tended to be more successful when it was carried out at the start of the event when people were arriving than when it was busy, especially where people were drinking alcohol.

Irrespective of the venue setting, people were more likely to complete the questionnaire if it was introduced as a "health" survey rather than an "HIV" survey. Indeed, when it was introduced as the latter, typical responses included participants insisting that it was not relevant for them as they did not have HIV. In addition, key gatekeepers (e.g. event's organisers) were more receptive when it was introduced as a health survey. At one

particular event the organisers initially refused to distribute the questionnaire when they were told that it was about HIV. However when the rationale for the questionnaire was fully explained to the organisers, and they understood that it would benefit the health of African communities in Glasgow, they agreed to participate in the project.

In addition, recruitment of participants to complete the survey was successful when volunteers own social networks were utilised. For example, one volunteer managed to get several responses from a women's group that she volunteered for.

2.2.2 Challenges

There were a number of barriers to distribution of the paper surveys, including: volunteers' morale (mainly due to fear of stigmatising individuals); labelling the questionnaires as an HIV survey created a barrier for some individuals; gate keepers within organisations who denied access to their client group; and some settings proved unsuitable for engaging with people.

With regards to volunteer morale, whilst none of the people that were approached 'explicitly' raised any issues about feeling stigmatised or being wrongfully approached because of their skin colour, volunteers were nonetheless concerned about stigmatising people that, at times, it became a barrier to approaching people in community settings. Although these fears were particularly felt amongst the three White Scottish volunteers, the remaining seven Black African volunteers also raised concerns about offending people because of how they would personally feel if they were targeted to complete an HIV questionnaire. For example, on one outing with two volunteers, morale became low when only one individual out of ten contacts agreed to participate over a 4 hour period. By the time the team arrived at the final distributing point, the Mitchell Library, volunteers refused to approach people assuming that they would not receive a positive response. This emerging issue regarding volunteer anxieties in undertaking targeted work with African communities will require further development as it has wider implications for the AHP outreach work.

It appears that HIV as a topic also created barriers. For example, on one occasion a community organisation initially agreed to distribute questionnaires to one of their women's groups. However the organisation later decided that they did not feel

comfortable targeting the Africans in a mixed ethnicity group. The topic also proved a barrier at an individual level, with some people quickly disengaging from conversations with volunteers once the content of the questionnaire was revealed.

Some of the locations proved inappropriate for approaching potential participants due to their nature. For example, despite having a high traffic of Africans around 5pm, none of the people approached at Glasgow Queen Street Station were willing to complete the questionnaire, the common reason offered being that they did not have time to fill out the survey. Similarly, we had little success in approaching Africans that we saw in the street.

2.3 The sample

There were a total of 110 questionnaires included in the final sample for analysis. The paper-based questionnaire proved to be more successful, accounting for 93 of the total responses. The main inclusion criteria is that participants had to have identified themselves as black Africans and living in Glasgow at the time of completing the questionnaire. A summary of the total returns, exclusions and final sample is shown below in **Table 2** below.

Table 2: Summary of survey responses

Survey returns, exclusions and final sample	Online	Paper	All
Total returns	17	109	126
Total exclusions	0	16	16
Non-Africans	0	9	9
Duplicates	0	2	2
Incomplete (mostly blank)	0	5	5
Final sample for analysis	17	93	110

As shown above, there were nine responses that were excluded because participants identified themselves as non-African. This included five White British, two from Asia, one

from the Middle East and one from the West Indies. The fact that that seven of the respondents received the questionnaire from the AHP event and the other two from the Zambian Independence Day celebration suggests that this group of non-Africans was due to the recruitment method used by volunteers whereby everyone was given questionnaires irrespective of ethnicity.

There were five incomplete questionnaires where participants did not provide full demographic details and did not complete more than two of the questions relating to HIV. It was not possible to ascertain whether this was a trend at particular venue(s) as there was no information about where people got the questionnaire from. In addition, there were two duplicates from the paper survey. This was a result of two participants who completed the surveys at service user and volunteer meetings. Both notified the outreach worker of their error which made it easier to look out for the duplicates based on similarities in how they had answered the questionnaires.

The issue of bias in the sample must also be highlighted. Although there were numerous efforts taken to ensure as many people as possible took part, the final sample cannot be said to be representative of the African population in Glasgow. This is mainly because the paper surveys were only able to capture a 'snapshot' of the population at the events that were on during the week of the survey and the lack of responses from the on-street approaches. Non-response rates were not recorded but will be recorded next time that the survey is re-run.

2.4 Analysis

All the paper questionnaires were entered onto Survey Monkey so that data could be extracted as an Excel file; a member of staff of NHS GG&C then carried out all the analyses using SPSS. In reporting the analyses, valid percent is used meaning that missing data is excluded when calculating the percentage.

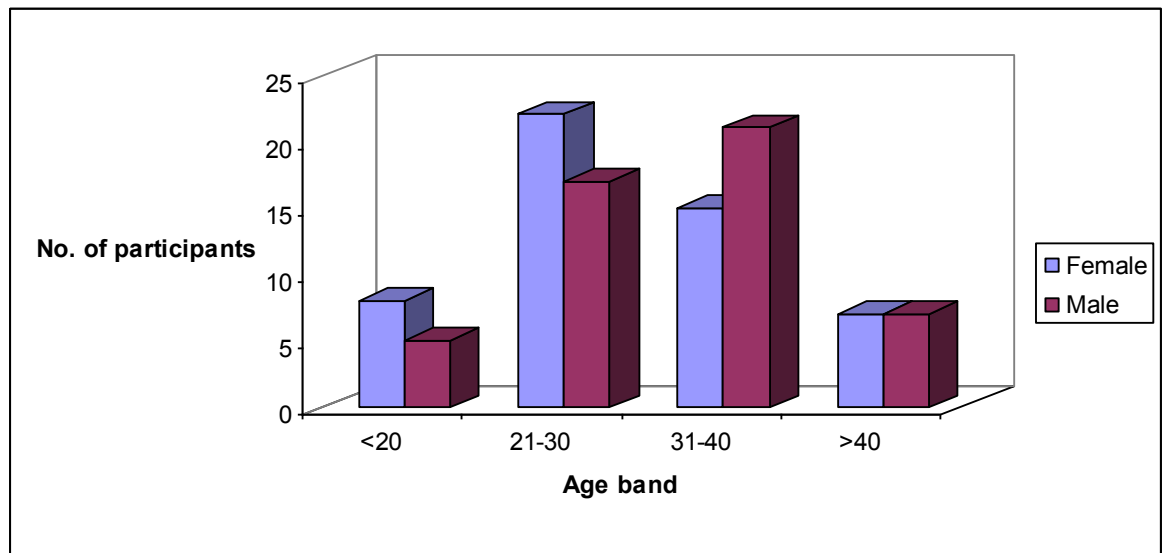
3 Results

3.1 Key demographics of sample

3.1.1 Gender and age

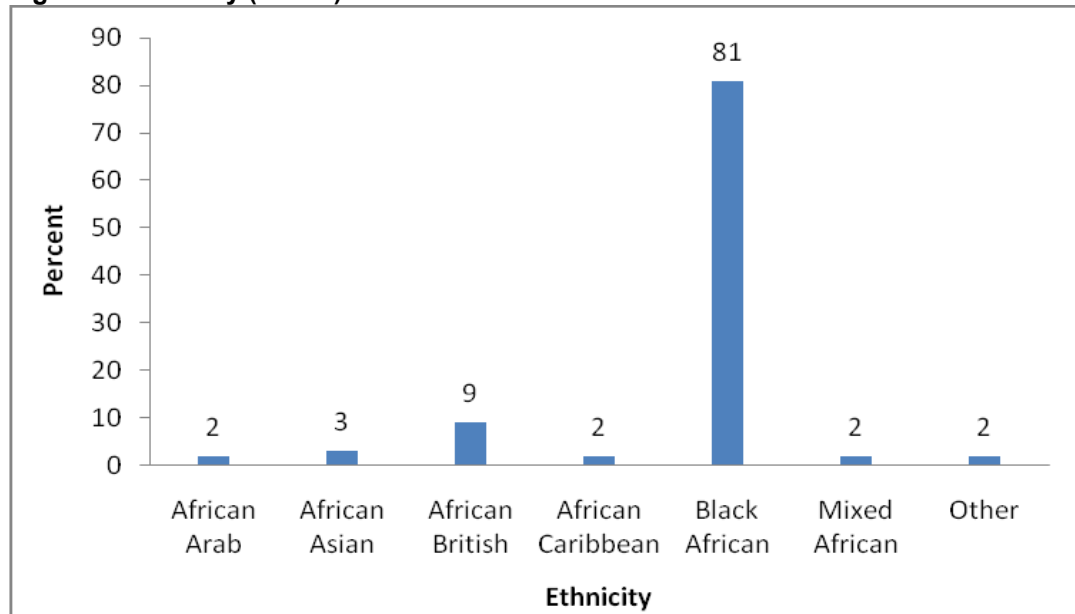
There were almost equal numbers of females (55) and males (54) in the sample. As demonstrated in **Figure 1** below, respondents' ages ranged from 16-60years, with the majority aged 21-40 years (73 %). There were no significant differences in age between males and females.

Figure 1: Participants age by gender (n=102)

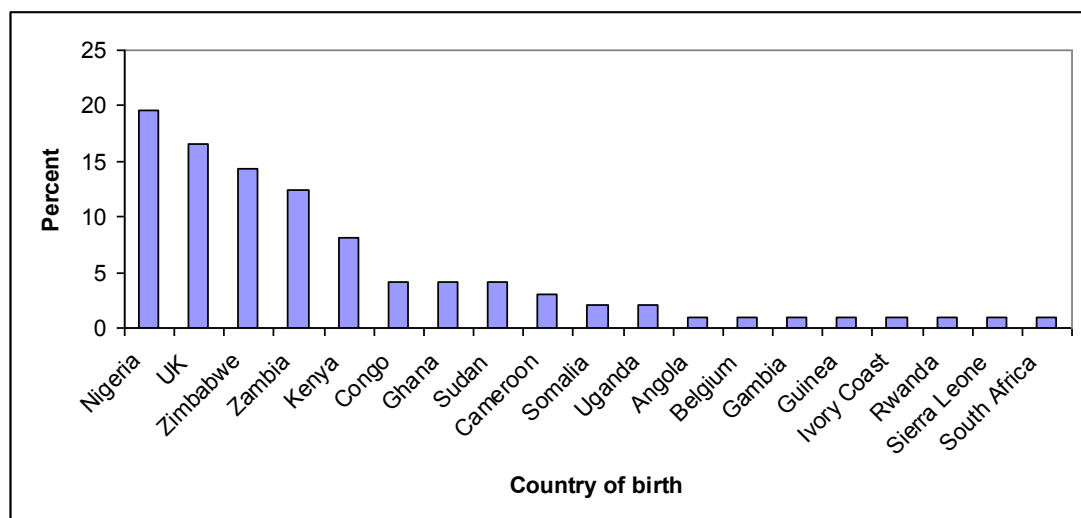


3.1.2 Ethnicity and country of birth

As expected, the largest proportion of participants identified themselves as black Africans when asked which ethnic group they belonged to (see **Figure 2**). There were no gender differences between likelihood of identifying as black African.

Figure 2: Ethnicity (n=103)

Respondents were also asked which country they were born. As can be seen in **Figure 3**, Nigeria, UK, Zimbabwe, Zambia and Kenya had the highest participants respectively. Moreover, data was analysed to ascertain whether there was any correlation between age and ethnicity between Africans born in the UK and the sample as a whole. Those born in the UK were likely to be younger, with 80% being under 30 years, and tended to mostly identify themselves as African British (33%) or Black African (40%). This was in contrast to the sample as a whole where the majority were aged between 21-40 years and self-identified as Black African (81%). However, the small sample size meant that this association could not be tested for significance.

Figure 3: Country of birth (n=96)

3.2 Knowledge and attitudes towards HIV

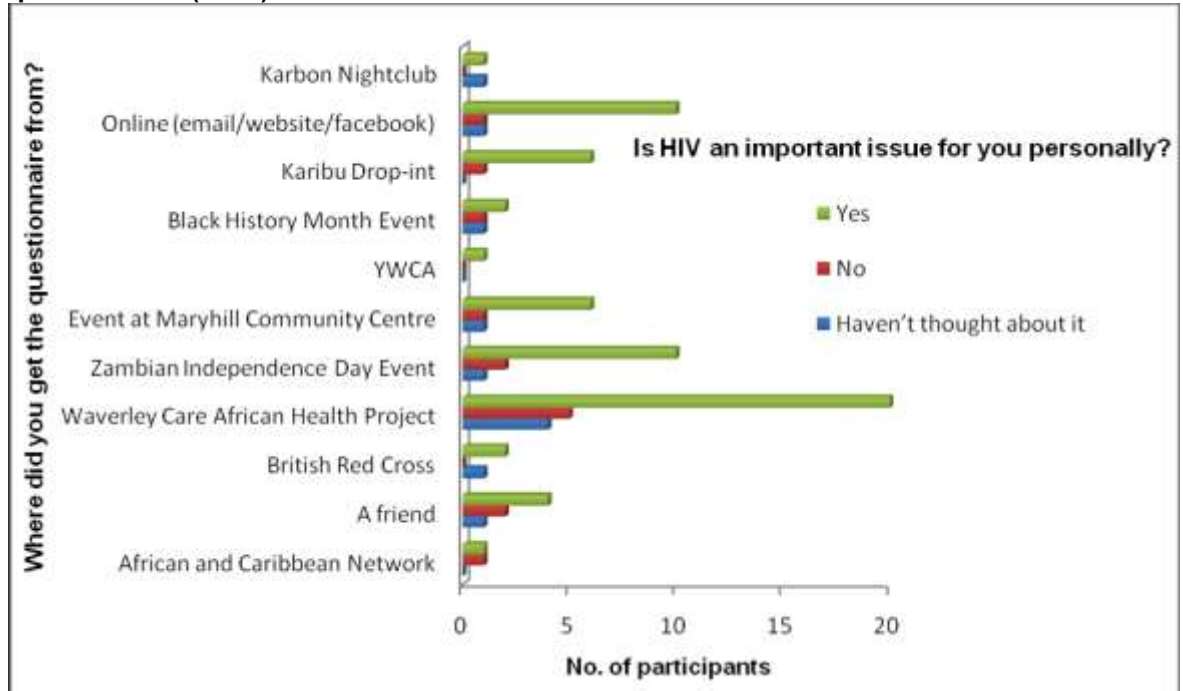
In investigating some of the reasons why Africans tend to test late and are at higher risk of contracting HIV, the following presents the findings relating to the questions that explored their knowledge and attitudes towards the importance of HIV, testing, condom use and how much in control they felt over their sexual health.

3.2.1 Personal importance of HIV

Participants were asked whether HIV was important to them personally and were given the options of a) Yes, b) No, and c) Haven't thought about it. The highest proportion (71%) believed it was important, with 17% stating it was not, while 12% were unsure.

However, it is possible that the high proportion asserting it was important was skewed by AHP service users and volunteers who were living with and/or affected by HIV. Evidence from **Figure 4** illustrating the cross tabulation of question 5 (where did you get the questionnaire from?) and question 6 (is HIV an important issue for you personally?) suggests that this may have been the case. Nevertheless, **Figure 4** also shows that, irrespective of where participants got the questionnaire, people were likely to consider HIV as being personally important to them. However, this association could not be tested for significance due to the small sample size.

Figure 4: Association between personal importance of HIV and where participants obtained questionnaire (n=88)



3.2.2 Testing

3.2.2.1 Sample as a whole

Respondents were asked whether they had ever received an HIV test from a health professional and given the options of a) Yes, b) No, and c) Not sure. 64% of respondents had received an HIV test, while 31% had not, and 5% were unsure. When these data were broken down by gender, females (38%) appeared to be more likely to test than males (25%) as shown in **Table 3**.

Table 3: Receiving an HIV test by gender

		Gender		Total
		Female (%)	Male (%)	
Have you ever received an HIV test result from a health professional?	No	13 (24.5)	20 (37.7)	33 (31.1)
	Not sure	2 (3.8)	3 (5.7)	5 (4.7)
	Yes	38 (71.7)	30 (56.6)	68 (64.2)
Total		53 (100)	53 (100)	106 (100)

However, although a difference was observed, this was not found to be statistically significant for this sample, although this could be explained by the low power of such a small sample. Moreover, when broken down by age, those below 20 years were least

likely to have tested. In fact, there were the only age group where a larger proportion of respondents had not tested (i.e. 8/13 or 62%).

Participants were then asked on the reasons why people may not test, with the option to make multiple selections. Overwhelmingly, the most common reason was that people felt that they *had no reason to think they had HIV* (74%). Some other interesting observations included *fear of having HIV* (23%), *fear of being treated differently if HIV positive* (29%), *not knowing where to test* (19%), fear that *having an HIV test would cause problems in their relationship* (25%), and a belief that they *did not need to test because they had tested already* (26%).

Differences by gender and age were also explored in the overall sample. Interestingly, males made up a larger proportion than females amongst the participants who agreed with the reasons for not testing. For example, of the 26% who agreed with the statement *I've already tested, I don't need to test again*, 19% were male. While this was the most noticeable difference, it was a common trend with the only exception relating to the statement *I don't trust the places I know where I could get a test* where more females agreed with this than males.

With regard to age, none of the respondents aged less than 20 years agreed with the statement that *people I know would not approve of HIV testing*. Similarly, none of the people aged below 30 years agreed with the affirmation that *it is not important to know my HIV status*. Moreover, those aged between 31-40 years were most likely to agree on most of the reasons for not testing. In fact, they were the only group where the majority in this age group (14/26 or 54%) agreed with the statement *I'm afraid of being treated differently if I have HIV*.

3.2.2.2 Never tested

Responses by the sample as a whole were also contrasted with those who had never tested (see **Table 4** below). As with the whole sample, the most common reason offered for not testing was that they had *no reason to think they had HIV*. In fact, this view was held more strongly amongst this group who had never tested (93%) than the whole sample (74%). Moreover, those who had never tested also selected fewer reasons for not

testing; the only other interesting observations being *not knowing where to test* (21%) and fear that *having an HIV test would cause problems in their relationship* (17%).

Table 4: Reasons for not testing amongst whole sample and those who had never tested

Reasons for not testing	Whole sample (n=84)	Never received a test (n=29)
I've no reason to think I have HIV	73.8	93.1
I'm too afraid I might have HIV	22.6	6.9
I'm afraid of being treated differently if I have HIV	28.6	10.3
I don't know where to get tested	19.0	20.7
People I know do not approve of HIV testing	15.5	6.9
It's not important to me to know my HIV status	8.3	6.9
I don't trust the places I know where I could get a test	16.7	10.3
Having an HIV test would cause problems in my relationship	25.0	17.2
I've already tested, I don't need to test again	26.2	3.4

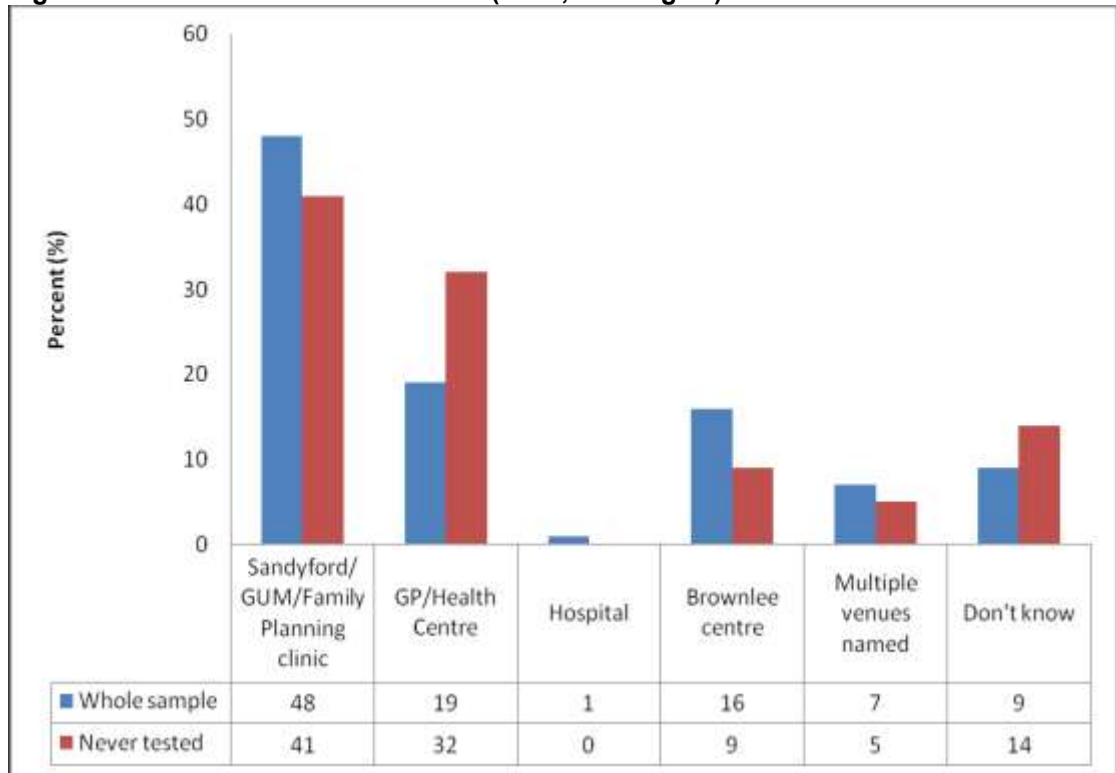
Interestingly, the majority of those who had never tested were under 30 (52%), male (61%), and born in the UK (35%). This suggests that the younger generation of Africans, especially those born in the UK, may not consider HIV as an issue relevant for them.

3.2.2.3 Accessing testing services

Participants were also asked an open-ended question on where they would go to take an HIV test in Glasgow if they (or someone they knew) wanted one. As shown in **Figure 5**, there was good diversity in knowledge levels of where people could test, with only 9% who did not know where to test. However, it is noteworthy that this question had the highest number of participants who did not answer it (missing=35).

Though not statistically significant, there were some notable differences between the whole sample and those who had never tested about knowledge of testing services. The former were more likely to suggest the Sandyford/GUM/Family planning clinics, the Brownlee Centre, and multiple venues. In contrast, it was only in reference to GP/health centres that those who had never tested had a higher percentage. Moreover, a slightly higher percentage indicated not knowing where to test amongst this group.

Figure 5: Where to access an HIV test (n=75, missing 35)



3.2.3 Key indicators of HIV prevention

The following presents data for the key indicators of HIV prevention that were explored, including confidence in communicating safe sex, motivation for avoiding contracting HIV or transmitting it to others, condom use, access to condoms, and faith and condom use.

3.2.3.1 Confidence in communication of safe sex and condom use

As presented below in **Table 5**, over 50% of participants were found to be generally confident in communicating about safe sex with both friends and sexual partner(s). Almost a quarter of respondents disagreed or strongly disagreed that they felt confident to discuss safer sex with friends or partners (22% and 24% respectively) with a smaller proportion answering that they were unsure (18% and 12%). Whilst there were no notable differences by gender, when broken down by age, almost equal numbers aged over 40 years disagreed with both statements about confidence in communicating about safe sex. In addition, over 60% strongly agreed that they could use condoms with a sexual partner, with males (37%) more likely to do so than females (27%). However, a fifth of the sample strongly disagreed with this statement.

Table 5: Confidence in safe sex communication and condom use

	% Strongly agree	% Agree	% Neither agree nor disagree	% Disagree	% Strongly disagree
I find it easy to talk about safer sex and HIV with friends (n=97)	54.6	6.2	17.5	6.2	15.5
I find it easy to talk about safer sex and HIV with sexual partners (n=93)	51.6	12.9	11.8	10.8	12.9
I can use condoms with a sexual partner if I want to (n=90)	62.2	7.8	5.6	4.4	20

3.2.3.2 Belief about control over avoiding HIV (re)infection and transmission

A key indicator of HIV prevention is people's motivation to avoid risk. Participants were asked how much in control they felt about getting HIV or transmitting it to others (see **Table 6**). Most respondents felt in control of whether or not they got HIV, however, as many as 33% did not agree, with a further 13% being unsure which represents an

important intervention point. Similarly, 24% disagreed about being in control of whether or not they could pass on HIV. There were no notable differences by gender. However, when focusing on age, those over 40 years equally agreed strongly and disagreed strongly with the statement about being in control of getting HIV.

Table 6: Belief about control over transmitting or contracting HIV

	% Strongly agree	% Agree	% Neither agree nor disagree	% Disagree	% Strongly disagree
I am in control of whether or not I get HIV (n=91)	45.1	8.8	13.2	14.3	18.7
I am in control of whether or not I pass HIV onto someone else (n=92)	58.7	9.8	7.6	6.5	17.4

3.2.3.3 Access to condoms

Access to condoms provides an important prevention method since the correct use of condoms is the most effective way of preventing the sexual spread of HIV (Sigma, 2008). As can be seen in **Table 7**, about a third of respondents disagreed with the statement ‘I know where to get free condoms/femidoms’ i.e. 34% did not know where to get free condom. Whilst there were no gender differences, those under 20 years and over 40 years more likely to disagree with this statement. Likewise, 35% of participants agreed that they had difficulties accessing condoms with females and those aged over 40 years more likely to strongly agree with this statement. These finding illustrates that this is an important intervention area.

Table 7: Access to condoms

	% Strongly agree	% Agree	% Neither agree nor disagree	% Disagree	% Strongly disagree
I know where to get free condoms/femidoms (n=93)	51.6	6.5	7.5	8.6	25.8
Sometimes I have a problem getting hold of condoms/femidoms (n=88)	20.5	14.8	12.5	9.1	43.2

3.2.3.4 Faith and condom use

Working with faith communities has been proposed as one important intervention strategy. Contrary to expectations, **Table 8** illustrates that faith did not come through as a barrier to condom use for the majority of respondents, although a sizable minority (22%) did assert that it went against their beliefs.

Table 8: Faith and condom use

	% Strongly agree	% Agree	% Neither agree nor disagree	% Disagree	% Strongly disagree
Using condoms goes against my faith/religion (n=90)	17.8	4.4	6.7	8.9	62.2

3.2.4 Tackling HIV in the community

The survey finished by asking respondents the following open-ended question: “Please use this space to tell us the **ONE** thing that you think should be done to help protect people from HIV in your community”. There were a total of 57 responses that included people involved with the AHP and the wider community. Some of the key themes that emerged include:

GP’s taking leadership on encouraging testing

“The GPs should inform their patients about HIV and the patient can then choose if they want to test or not. The GPs need to tell the patients where to go if they want a test. They should not wait for patients to ask first.”

Regular check-ups and testing when meeting new partners

“Having regular check-ups when meeting a new partner...teaching people how important it is to care for themselves and others or avoid completely...the whole thing”

Raising awareness in a culturally sensitive way

“Raise awareness through media, radio and Internet.”

“I think the material (Text and Imagery) available can be more culturally appropriate and stimulating.”

Working with Faith Leaders

“Strong awareness outreach programmes, especially in conjunction with the many African churches where the community is heavily involved but their leaders or elders are very hypocritical”

“Church leaders need to get on board and work together with the community and promote safety by allowing for condom use.”

Greater focus on young people

“Educating the youth on safe sex; making schools and colleges as a number one priority when promoting safe sex; encouraging parents to talk to their children about sex; showing them the effects of HIV and telling them that its okay to talk about HIV and that its not a taboo subject.”

4 Summary and discussion

This study sought to obtain baseline information against which it would be possible to measure increased knowledge, attitudes and confidence of Africans living in NHS GG&C. Specifically, the survey was developed to collect information from Africans living in Glasgow on: a) whether HIV was seen as personally important to them b) their knowledge and attitudes towards HIV testing and testing services (including whether they have ever tested before) c) how comfortable they found it to talk about sexual health and HIV d) their knowledge about where to access condoms/femidoms and barriers to accessing condoms/femidoms and e) how much they felt in control of their sexual health. We also wanted to know more about the demographics of those answering the questions, particularly age, gender and country of origin to identify any significant differences.

Before discussing the findings, it is important to discuss the key learning from the methodology we used. Firstly, we found that relying on an online approach is not ideal because of its numerous challenges. These included people being too busy and thus not prioritising the survey, a mismatch between national function of the organisations and the local geography the survey, and/or the explicit mention of HIV which can act as a barrier. As such, it is necessary to follow up organisations and community peer leaders to check if they have forwarded the information as it is not always a guarantee that they will do so. There was also evidence that it may be more fruitful to tap into social networking sites. Facebook in particular has a lot of potential as an effective online distributing method because of its popularity. Indeed, the largest proportion (i.e. 10/17) of online respondents was recruited via this method.

The poor response from the online surveys led to greater effort being placed on the paper-based surveys in the second run in October 2010 where we targeted environments that were popular with Africans. In particular, community events proved to be the most effective settings because African communities in Greater Glasgow and Clyde are geographically dispersed meaning that such events that bring Africans together in one venue provide useful and effective opportunities to obtain information. However, using paper surveys was considerably more effective than online distribution (i.e. 93/110), it still had its challenges. These barriers included volunteers' morale (mainly because of fear of stigmatising individuals), individuals who did not engage once HIV was mentioned,

organisations who acted as gate keepers and chose not to allow access to their client groups, and some settings were not suitable for engaging with people.

These challenges were countered in various ways. For example, the survey was rebranded as a “health” rather than an “HIV” survey. Interestingly, irrespective of the venue setting, people were more likely to complete the questionnaire if it was introduced as the former. In addition, to counter their own fears about stigmatising people based on their ethnicity, volunteers decided to offer questionnaires to everyone (including non-Africans) which greatly eased their concerns about offending people. This emerging issue regarding volunteer anxieties in undertaking targeted work with African communities will require further development as it has wider implications for our outreach work. In this respect, more training is required to make volunteers appreciate why it is necessary to target such communities, without implying that HIV is only an African issue.

There were a total of 110 questionnaires included in the final sample of analyses, with almost equal proportions of men and women. This is encouraging as it suggests that men can be reached if actively targeted to take part in interventions. For example, despite being a small sample, participants’ age distribution, ethnicity and country of birth were similar to the English Bass Line Survey 2009.

Comparisons were made between Africans born in the UK and the sample as a whole. Interestingly, those born in the UK were likely to be younger (i.e. under 30 years), and tended to mostly identify themselves as African British or Black African. This was in contrast to the sample as a whole where the majority were aged between 21-40 years and self-identified as Black African (81%). This suggests that not only should interventions be culturally sensitive, but they should also take into consideration that the younger generation are likely to be influenced by British lifestyle and attitudes to sexual health while the older generation are likely to adhere to African traditions. This may explain why those over 40 years appeared to be the least confident in communicating with friends and sexual partners about safe sex.

Results showed that 71% of Africans from this sample considered HIV to be an important issue for them personally. Whilst this may have been skewed by AHP service users and volunteers, more people tended to express that it was important to them irrespective of

where they got their questionnaire. Moreover, 64% had received an HIV test from a health profession, with females (38%) were more likely to test than males (25%). This difference could be due to the antenatal screening programme in place in the Health Board and also because women are more likely to engage with health services. However, almost a third of the sample had never received a test from a health professional which indicates that there is still a great need to encourage testing amongst African communities. In addition, the majority of those who had never tested were under 30 (52%), male (61%), and born in the UK (35%). This suggests that the younger generation of Africans, especially those born in the UK, may not consider HIV as an issue relevant for them.

The most common reason offered for why people might not test was that *they had no reason to believe they had HIV*. This was also the most common reason offered for not testing in both Bass Line Surveys. Indeed, self-perceived low risk is consistent with the literature that one of the main reasons people do not test is because they do not consider themselves to be at risk of contracting HIV (Cree, 2007). Males also tended to make a larger proportion of the respondents who agreed with the reasons for not testing. These findings suggest that interventions must prioritise work with men. This supports a key finding in the Bass Line survey which recommended that “interventions and programmes should prioritise encountering men over women if they wish to maximise their impact on HIV transmission” (Hickson, 2009: 45)

However, there must be caution in over-interpreting these findings as the question asked participants to tick the reasons they believed ‘people’ give for not testing. Thus, some participants may have been offering views of what ‘others’ believe are the common reasons rather than providing their own views.

In addition, while the Bass Line Survey 2009 found that 1 in 8 respondents did not know where to test, this study found that only 9% of the people who answered the question stated that they did know where to get tested. However, it must also be highlighted that this question had the highest non-responses (missing=35) which may be indicative of people not knowing where to test. This issue will need to be explored further during the community outreach work to ascertain people’s knowledge and confidence about using sexual health testing services.

Although a larger proportion (over 50%) stated that they were confident in talking to friends and sexual partners about safe sex, there were still significant numbers within the sample who were not confident on both these aspects, 22% and 24% respectively. Increasing people's confidence in discussing safe sex practices is an important intervention point and has been found to correlate to people's ability to use condoms with new sexual partners (Hickson et al., 2009). Moreover, the fact that 33% did not agree that they were in control of getting HIV and 24% did not agree about being in control of passing on HIV suggests a sense of powerlessness amongst some participants. In this regard, there is a need to increase people's confidence to take control of their sexual health. As mentioned above, findings from this study suggests this is likely to be amongst the older groups (i.e. over 40 years), which may be linked to cultural taboos in some in some African cultures about discussing sex openly (Dodds et al., 2008a).

Access to free condoms also emerged as an important issue. For example, 34% disagreed with the statement that they knew where to get free condoms, with those under 20 years and over 40 years more likely to disagree with this statement. This suggests that interventions must also focus on these age groups because they are least likely to access condoms. Indeed, they provide a particular risk group as they tend to be more likely to perceive themselves at low risk. In addition, 35% agreed that they had difficulties accessing condoms in general with females and those aged over 40 years more likely to agree. This indicates that interventions must not only sign post people to relevant places to access free condoms but they should also actively make condoms more accessible in various community settings in order to target different age groups and genders.

Although the current survey did not particularly indicate HIV stigma as a significant reason for not testing the responses to circulating an "HIV" survey or answering questions to an "HIV" survey, as well as the anxieties expressed by volunteers, demonstrate that this remains an issue.

5 Conclusion

While the findings presented in this report must be interpreted within the context of a small and biased sample, the above has shown that there are some similarities with other relevant studies, particularly the Bass Line surveys (Dodds et al., 2008b; Hickson et al., 2009). The study points to a number of key implications for the outreach work being conducted by the AHP.

Firstly, it suggests that African communities need culturally appropriate information about the relationship between HIV and sexual practices, relationships, and sexual negotiation in order to raise awareness about HIV being a relevant issue for them in Glasgow. This is crucial as people tend to view HIV as an issue that is relevant for 'others' but not 'themselves'. This is supported by the fact that the most common reason for not testing was the assertion that participants had no reason to think they had HIV. Embedded within this, there must be discussions about implications of seroconcordant/discordant sex and raising awareness about how to access Post Exposure Prophylaxis (PEP) if required. In doing so, this will allow Africans to make informed decisions about the levels of risk they are prepared to take.

Secondly, the findings point to a need to promote early and regular testing to counter the fact that Africans continue to test late in Scotland (Health Protection Scotland, 2009). In addition to raising awareness about free and confidential counselling and testing services, the findings suggest that interventions should take a targeted approach and promote the advantages of early testing. Central to this should be the promotion of the availability and accessibility of sexual health services and HIV treatment services. This is especially since there was evidence to suggest there may be a gap in knowledge relating to where to test.

Thirdly, though a larger proportion did not express problems accessing condoms, the fact that over a third stated they had difficulties indicates that interventions must provide African communities with easy access to free condoms/femidoms (and lubricants for anal sex). In particular, femidoms should be actively promoted to females as this may be one way to overcome gender inequalities that tend to make women more likely to feel powerless about acquiring HIV.

Finally, there was also evidence to suggest that we need to continue to challenge HIV related stigma; African people living with HIV need support to deal with the stigma they confront within their respective communities. Fear of stigma prevents people from discussing HIV risks and HIV prevention strategies; accessing HIV and sexual health services; testing for HIV, knowing their status and notifying their partners about their HIV status.

This work will be primarily carried out by the AHP outreach worker with support of volunteers, NHS GG&C and other relevant stakeholders by targeting Africans in their own community settings in order to maximise the effectiveness of interventions. Thus, focusing on these activities will help to achieve the ultimate goal of fewer HIV infections amongst Africans in the NHS GG&C area.

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Appendix 1: Sample of Baseline Survey



African Health Project Baseline Survey



Thank you for helping us with this important work.

If you would like further information or advice contact:

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Waverley Care's African Health Project is doing some work in NHS Greater Glasgow and Clyde to improve the health of Africans living in the area. The project aims to improve access to general healthcare, raise awareness of HIV, provide information and resources for communities; promote HIV testing and provide support to people around HIV if needed.

This questionnaire is a baseline survey designed to find out what African people living in Glasgow think about HIV.

This information will be help us shape our services to make sure that about HIV prevention and support services are developed and delivered in the most appropriate and beneficial way, and with the involvement of Africans living in Greater Glasgow and Clyde.

This questionnaire is completely confidential. The findings will be used collectively and no individuals will be identified.

ABOUT YOU

- 1) What age are you? _____ years
- 2) Are you: Male Female
- 3) Which country were you born in? _____
- 4) What is your ethnicity? (please tick one box)
- Black African African British African Asian
 African Arab White African Mixed African
 Other (please describe) _____
- 5) Where did you get this questionnaire from? _____
- 6) Is HIV an important issue for you personally?
- Yes No Haven't thought about it
- 7) Have you ever received an HIV test result from a health professional?
- Yes No Not sure

WHAT YOU THINK

- 8) The following statements are some of the reasons people give for **not testing** for HIV. Please tick all of those that you agree with:
- a. I've no reason to think I have HIV
- b. I'm too afraid I might have HIV
- c. I'm afraid of being treated differently if I have HIV
- d. I don't know where to get tested
- e. People I know do not approve of HIV testing
- f. It's not important to me to know my HIV status
- g. I don't trust the places I know where I could get a test
- h. Having an HIV test would cause problems in my relationship
- i. I've already tested, I don't need to test again
- 9) Where would you go to take an HIV test in Glasgow if you or someone you know wanted one? (name of place)

10) Please tell us how strongly you **agree or disagree** with the following statements by circling **one** number. [1 = strongly agree, 5 = strongly disagree]

- a) I find it easy to talk about safer sex and HIV with friends
 ①..... ②..... ③..... ④..... ⑤
- b) I find it easy to talk about safer sex and HIV with sexual partners
 ①..... ②..... ③..... ④..... ⑤
- c) I know where to get free condoms/femidoms
 ①..... ②..... ③..... ④..... ⑤
- d) Sometimes I have a problem getting hold of condoms/femidoms
 ①..... ②..... ③..... ④..... ⑤
- e) Using condoms goes against my faith/religion
 ①..... ②..... ③..... ④..... ⑤
- f) I can use condoms with a sexual partner if I want to
 ①..... ②..... ③..... ④..... ⑤
- g) I am in control of whether or not I get HIV
 ①..... ②..... ③..... ④..... ⑤
- h) I am in control of whether or not I pass HIV onto someone else
 ①..... ②..... ③..... ④..... ⑤

Please use this space to tell us the **ONE** thing that you think should be done to help protect people from HIV in your community.

