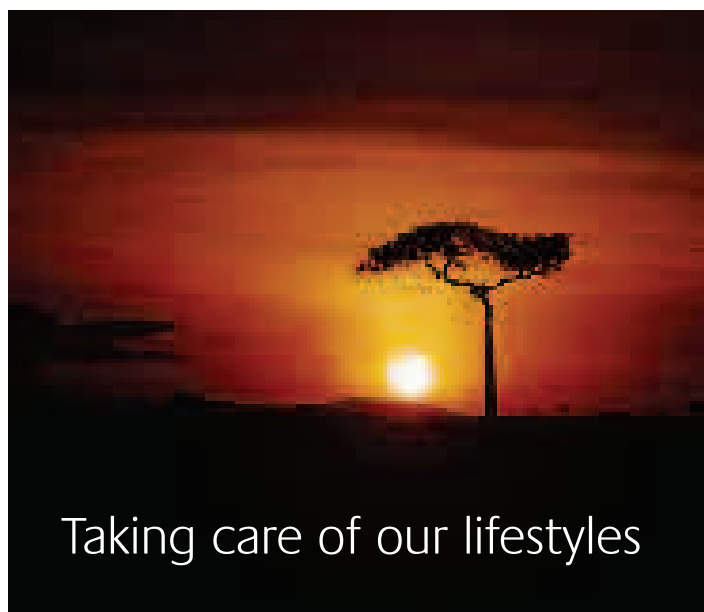
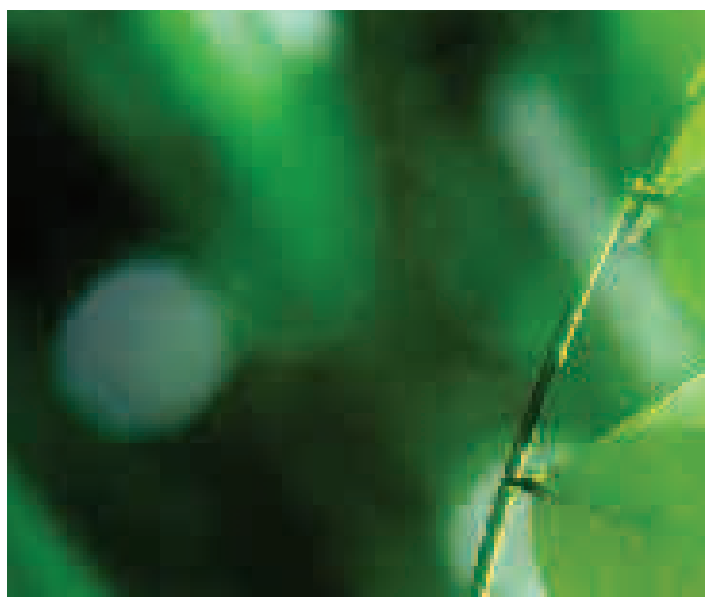


Mayisha II main study report

Assessing the feasibility and acceptability of community based prevalence surveys of HIV among black Africans in England. 2005.



Collaborators

STUDY INVESTIGATORS

Katharine Sadler (Project Co-ordinator),
Health Protection Agency (HPA) Centre for Infections
Dr Kevin Fenton (Project Lead), HPA Centre for Infections
Gillian Elam, HPA Centre for Infections
Christine McGarrigle, HPA Centre for Infections
Dr Danielle Mercey, Royal Free and University College
London Medical School
Dr Oliver Davidson, Camden Primary Care Trust (PCT)

STEERING COMMITTEE

Charles Aina, Health First, Lewisham PCT
Ibidun Fakoya, African HIV Research Forum
Walter Gillgower, Terrence Higgins Trust (THT) London
Juliet Lubega, Camden PCT
Dr Pat Nair, Bedfordshire Health Protection Unit
Lillian Ndawula, National African HIV Prevention
Programme
Melusi Ndebele, Luton PCT
Patrick Serugga, THT Wolverhampton
Winnie Ssanyu-Sseruma, Community Consultant
Spiwe Takura, THT Birmingham

QUALITATIVE INTERVIEWER

Gertrude Othieno, African Cultural Promotions

LOCAL SURVEY GROUPS

Joan Badcock, Enfield PCT
Paul Brotherton, Luton PCT
Diana Chituku, City & Hackney PCT
Dr Dzuzurai, Birmingham PCT
Alison Harbron, HIV Client Care Services, Luton
Jamie Kinniburgh, THT London
Maria Loizou, Health First, Lewisham PCT
Dr Edwin Lukongo, Coventry THT
Daisy Marara, ACA, Birmingham
Catherine Nelson, Luton PCT
Chinelo Nwajiobi, Enfield PCT
Stella Oryang, African Communities Project,
Hammersmith & Fulham PCT
Elias Phiri, THT London
Sarah Pulle, Newham PCT
Juliet Reid, Luton PCT
Fred Semugera, Croydon PCT
Morag Stewart, Luton PCT

FIELD WORKERS

Dorcas Adusei	Andrew Mapemba
Kennedy Aencha	Kundai Masona
Wondimagegne Alemayehu	Lilian Mbolonzi
Tafesse Fassika Amare	Annie Mouna-Njandjo
Alex Asiimwe	Thando Moyo
Hilina Asress	Joshua Muhindo
Felix Atse	Mukuka Mulenga
Ahmed Azeez	Edina Musekiwa
Oola Balam	Innocent Muza
Sarah Barigye	Harriet Namazzi
Waronah Bonny Chappy	Hope Nhete
Barney Chidavaenzi	Moono Nyambe
Shupi Chinaa	Rodgers Odhiambo
Nqobile Victoria Dondo	Abena Osei-Owusu
Amon Dzengew	Lawrencia Sarhene
Ben Effah	Bony Shamalo
Ibidun Fakoya	Kefilwe Sivako
Yodit Giday	Monica Sibindi
Mustafa Hassan	Eskinder Solomon
Blaise Kabongo	Bethel Tamiru
David Kakande	Kalister Tazarurwa
Catherine Kalanzi	Girly Thwala
Daudi Kiwanuka	Aminu Yakubu
Patrick Kwesiga	Stephen Zembe

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Executive summary

Background

- 1 In 2003, an estimated 16,200 Africans were living with HIV infection in the United Kingdom (UK), forming the second largest social group affected by HIV/AIDS.
- 2 To date the largest study of sexual attitudes and lifestyles among African communities has been the Mayisha (1999) study. Mayisha (1999) was a participatory community-based survey among five migrant African communities in inner London. This study demonstrated the feasibility of conducting community-based research studies among black Africans living in London and informed the development of local and national HIV prevention and intervention planning with African communities.

Study aims and methods

- 3 Mayisha II (2004) is a community-based survey of sexual attitudes and lifestyles among black African communities in England. The study was supported by grant funding from the Medical Research Council Sexual Health and HIV Research Strategy Committee. The aims were to:
 - Evaluate the feasibility and acceptability of providing unlinked anonymous oral fluid samples for HIV antibody testing as part of the community-based survey;
 - Measure diagnosed and undiagnosed HIV infection among the recruited sample and demographic and behavioural associations with HIV infection; and
 - Provide updated sexual behaviour and service use information to guide health promotion strategies and development of sexual health services and to guide direct and indirect estimates of HIV prevalence among African communities in England.
- 4 Mayisha II (2004) had three components:
 - A cross-sectional community-based survey (target 1500 respondents);
 - A nested qualitative study (target 40 respondents); and
 - Respondents were also given the option of providing an oral fluid sample using an Orasure™ device for anonymous testing for HIV antibodies.

- 5 The study's investigators were guided in their work by a community based collaborative group. Membership was selected to encompass a wealth of experience in sexual health and HIV research and in HIV prevention with African communities. Members included representatives from African HIV forums, Client Care Services, Directors of Public Health and African Health Promotion teams.
- 6 Community fieldworkers were responsible for recruiting respondents to the study. Potential fieldworkers from the local African community were identified through the community consultant, Local Survey Groups and through advertising in local venues and media.
- 7 A pilot study, undertaken prior to the main survey, demonstrated the feasibility and acceptability of undertaking unlinked anonymous HIV antibody testing as part of a community-based behavioural survey. In total, 114 black African men and women were recruited to the pilot study from a range of venues across London.

Results

- 8 In total, 1359 eligible black African respondents (872 from London, 252 from Luton and 235 from West Midlands) were recruited in Mayisha II.
- 9 Of the 1359 respondents, 51.9% (706) were men and 48.1% (653) were women. In general, among both men and women, fewer respondents in the older age groups were recruited than those in the younger age groups.
- 10 The sample was very diverse in terms of country of origin with 38 different countries of birth being reported by the sample. The majority of respondents were born in South Eastern and Eastern African (46.5% of women and 47.6% of men) with nearly a fifth born in Horn of Africa and 14.0% born in Western Africa. Region of birth did not vary significantly between men and women.
- 11 Levels of education were high among the respondents, with 76.9% of women and 81.1% of men attaining secondary school or university level education. Unemployment was also high, at 18.0% among the women and 15.4% among the men.

- 12 Marriage and fertility were important for respondents, a third of whom were married. Although half the sample had lived in the UK for over five years or were UK born, migration had an impact on relationships with around a quarter of married men and women having a partner that lived abroad (27.9% and 23.0% respectively).
- 13 Over half of respondents reported that they regularly attended a religious service, indicating the importance of religion for this sample.

Use of sexual health services and HIV testing in the Mayisha II community sample

- 14 Around two-fifths of both men and women (37.8% and 43.9% respectively) reported attending a genitourinary medicine (GUM) / sexually transmitted infections (STI) clinic, the majority of whom had done so in the last five years. Over three-quarters of all respondents had never had an STI diagnosis.
- 15 Of those who responded, just over half (50.9%) of the female respondents had ever had an HIV test compared to 42.9% of the male respondents. The vast majority of respondents who had ever tested, had done so in the past 5 years – 92.4% of women and 87.6% of men.
- 16 Reasons for testing, among the women, included fear of HIV infection due to mistrust of the husband or partner or following rape. Men cohabiting with partners tested following concurrent relationships and both men and women tested before entering new relationships or resuming interrupted long-term relationships. Among respondents that were not in relationships and had not tested for HIV there was a preference for having an HIV test with their partner before embarking on a new relationship.
- 17 Among both men and women, HIV awareness raising events and one-to-one outreach were key factors in motivating them to take an HIV test. Fear and anxiety about the test were present among those that tested for HIV.
- 18 Fear of stigmatisation, deportation and expectations of HIV as incurable or as a 'death sentence' continue to deter respondents from taking an HIV test. Men and women associated HIV transmission with promiscuity and inappropriate sexual behaviour and, partly due to their own fears regarding people living with HIV, expected to be stigmatised if they were diagnosed HIV

positive. Uncertainty about where to obtain a test or lack of time to attend a clinic were identified as additional barriers to testing.

- 19 There is evidence that some, including those with multiple partners, relied on their partners' to HIV test, and assumed that their partners' HIV negative result meant that they were also HIV negative. Others did not perceive themselves to be at risk of HIV because they were married or had been faithful to the same sexual partner for several years, trusted their partner, had low numbers of partners or regarded their partners as unlikely to pose a HIV risk.

Sexual behaviour in the Mayisha II community sample

- 20 Substantially more men than women reported two or more new sexual partners (20.0% compared to 7.9%) in the past year. Among married and cohabiting men and women, trust in the monogamous nature of their relationship and faithfulness to one partner were highlighted as key values, often underpinned by religious beliefs. However, both men and women's accounts included experiences of concurrent relationships, both their own and their partner's. Others described that they were separated from their partner, or had been unable to develop relationships, in part a consequence of the isolation they had experienced since migrating to the UK.
- 21 The majority of respondents reported that they in general had partners of the opposite sex (92.2% of women and 91.9% of men who responded). Same sex partners were reported by 8.0% of men and women.
- 22 Over half of the men and women that responded to the question regarding condom use at last sexual intercourse reported that they had used a condom, the majority of these using a condom to protect against both pregnancy and HIV/STIs. Among those that described consistent condom use, this was an issue that was discussed in the relationship, that both partners felt confident about and was regarded as a central tenet of safer sex practices.

- 23 Both those that consistently used condoms, and those that did not, agreed that condom use was not appropriate or necessary in long-term relationships - condom use implying a lack of trust. Among men and women not using condoms, dislike of condoms was widespread, although, within heterosexual relationships preferences of the man could be more influential in decisions to not use a condom. Inconsistent use of condoms in concurrent relationships was attributed to use of alternative contraception, lack of awareness of the possibility of STI transmission, and sexual desire.
- 24 Abstinence during the early stages of a relationship or prior to marriage was a strategy employed by some to avoid risk of STI / HIV infection, but also to avoid risk of involvement in untrustworthy partners or risk of emotional distress for themselves or children from earlier relationships. However, this was a strategy that respondents noted was not always sustainable, with accounts of respondents becoming 'carried away' or having sex sooner than they had planned to.

Oral fluid uptake in the Mayisha II community sample

- 25 Overall uptake of the oral fluid sample in the main study was 75.3% (1023/1359), with slightly more women (76.7%) giving an oral fluid sample than men (73.9%). Key motivational factors in oral fluid uptake were shared perceptions of the study benefits among respondents and trust in the fieldworker to maintain anonymity.
- 26 Uptake varied by area of recruitment; in London 81.7% (712/872), in Luton 65.1% (164/252) and in the West Midlands 62.6% (147/235) of respondents gave an oral fluid sample.
- 27 History of having previously had a voluntary HIV test had no impact on whether respondents gave an oral fluid sample - of those who reported they have never had a previous HIV test, 74.8% (537/718) gave a sample compared to 76.5% (482/630) of respondents who reported that they had a previous voluntary HIV test. Behavioural characteristics, such as number of sexual partners and condom use, had little impact on whether a respondent gave an oral fluid sample, but the venue or event that the respondent was recruited from did have an impact.

HIV positivity among the Mayisha II community sample

- 28 The following results are based on 493 women who gave a sample that could be analysed (representing 75.4% of the women recruited) and 513 men (representing 72.7% of the men recruited).
- 29 Of the 1006 respondents who gave an oral fluid sample that could be analysed, 141 were HIV antibody positive (14.0%). Community sample positivity was 15.0% among women and 13.1% among men. This is likely to be substantially higher than the prevalence of HIV in African communities in England, and represents the over sampling of HIV positive Africans, anticipated as part of our recruitment strategy. These HIV positivity data will provide further information on the factors associated with diagnosed and undiagnosed HIV infections among African communities. This will be the subject of future research publications.
- 30 In both men and women, community sample positivity was higher among respondents in the older age groups. For example, of men who were aged 40 to 44 years, 26.8% were HIV-infected and in women aged 35 to 39 years, 25.5% were HIV-infected. Community sample positivity was lowest among those aged under 25 years.
- 31 When comparing regions of birth, a higher proportion of women born in Southern Africa were HIV positive compared to women born in South Eastern and Eastern Africa (33.3% and 25.4% respectively), whilst the opposite was true of men (21.8% born in South Eastern and Eastern Africa compared to 18.2% born in Southern Africa). Community sample positivity in respondents born in Horn of Africa was lower at 4.2% in women and 2.7% in men (based on UN geographical regions).
- 32 In terms of relationship status, community sample positivity was higher among those reporting that they were widowed, separated or divorced (33.3% of women and 31.3% of men) and lower among women who were married (8.8%) and men or who were either single or in a relationship, but not living with their partner (9.1% and 8.6% respectively). Among women who reported either mainly same sex relationships or both male and female partners, community sample positivity was zero, compared to 17.4% of heterosexual women being HIV-infected. Among men, community sample positivity among those reporting same sex partners was 22.2% compared to 12.6% in heterosexual men.
- 33 Respondents who had attended a GUM/STI clinic in the past five years had a higher community sample positivity; 27.2% in women and 21.9% in men. Furthermore, community sample positivity in respondents who had ever had an STI diagnosis was significantly higher ($p = <0.001$) than in those respondents who had never had an STI diagnosis.
- 34 Of the 141 respondents (74 women and 67 men) that were HIV antibody positive, 63.1% (89) reported they had previously had a voluntary HIV test, of whom 53.9% (48/89) reported their last HIV test result to be positive. Qualitative data indicate that despite confidence in the Mayisha II confidentiality procedures and willingness to provide an oral fluid sample, HIV-related stigma and discrimination was sometimes a deterrent to respondents indicating if a HIV test had been taken elsewhere and revealing perceptions of their HIV status. Furthermore, despite history of having had a voluntary HIV test not having an impact on providing an oral fluid sample, respondents that had a previous positive diagnosis were less likely to give an oral fluid sample than those that had a previous negative test. Caution is therefore required when interpreting the proportions of diagnosed and undiagnosed HIV infection in this community sample.
- 35 Respondents made suggestions regarding interventions that would encourage HIV testing and knowledge of HIV status, both of which were regarded by these respondents as useful prevention strategies. A reduction in fear of discrimination, access to HIV testing in a wider range of health service settings and rapid testing or same day results were identified as key factors in improving take up of testing and knowledge of status. Respondents requested information about where to test, what happens at a test, testing and pregnancy, rapid testing, effectiveness of treatment, immigration and HIV testing and the difference between HIV and AIDS. Those that had taken an HIV test noted the importance of support and motivation from one-to-one outreach work and promotional events in their decisions to test. Improved access to free or inexpensive condoms was also identified as an important factor in reducing HIV transmission.

Conclusion

- 36 Mayisha II is now the largest study of sexual attitudes and lifestyles of African communities to be undertaken in England.
- 37 The success of overall recruitment and the uptake of the oral fluid HIV testing among respondents attests to the acceptability of using participatory methods for study design and implementation and the commitment of African communities to supporting studies of this nature and improving sexual health. The data derived from this study will provide updated behavioural estimates for the study partners to develop and evaluate culturally specific HIV health promotion interventions.

I. Introduction

1.1 Summary points

- In 2003, an estimated 16,200 Africans were living with HIV infection in the United Kingdom (UK), forming the second largest social group affected by HIV/AIDS.
- To date the largest study of sexual attitudes and lifestyles among African communities in England has been the Mayisha (1999) study.
- Mayisha II (2004) is a community-based survey of sexual attitudes and lifestyles among black African communities in England. The study was supported by grant funding from the Medical Research Council Sexual Health and HIV Research Strategy Committee. The aims were to:
 - Evaluate the feasibility and acceptability of providing unlinked anonymous oral fluid samples for HIV antibody testing as part of the community-based survey;
 - Measure diagnosed and undiagnosed HIV infection among the recruited sample and demographic and behavioural associations with HIV infection; and
 - Provide updated sexual behaviour and service use information to guide health promotion strategies and development of sexual health services and to inform direct and indirect estimates of HIV prevalence among African communities in England.
- A pilot study, undertaken prior to the main Mayisha II survey, demonstrated the feasibility and acceptability of undertaking unlinked anonymous HIV antibody testing as part of a community-based behavioural survey. In total, 114 black African men and women were recruited from a range of venues across London. The pilot recommended additional strategies that informed the main study's methodology, including:
 - Fieldworkers should be given details of when to recruit at pre-enrolled venues to ensure systematic sampling. They should work in groups of two to four, to ensure personal safety and to legitimise the study.
 - The plan for additional recruitment in the main study from churches, social events and universities was endorsed by suggestions from both pilot study respondents and fieldworkers.
 - Fieldworkers should aim to recruit more than one person at a time e.g. by approaching a group of potential respondents. Respondents will be less self-conscious if in a group.
 - Provide a sweet to counteract the salty taste of the OrasureTM oral fluid collection device.
 - Ensure that in-depth interviews are carried out at a venue that has a private area.

1.2 Rationale and background to study

In 2003, an estimated 16,200 Africans were living with HIV infection in the United Kingdom (UK), forming the second largest social group affected by HIV/AIDS (Brown et al 2004). In 2003, HIV infections acquired in Africa represented 72% (2,727/3,801) of all heterosexually acquired infections diagnosed in the UK and 90% of those acquired abroad. The proportion of HIV infections diagnosed in the UK among black Africans has increased from 24% (376 of 1598) in 1996 to 58% (3,323/5,732) of all newly reported HIV infections in the UK in 2003 (Health Protection Agency 2004).

The majority of these infections were acquired outside the UK. In recognition of the changing epidemiology, disproportionate burden of advanced HIV disease and death within this community, the Department of Health's Sexual Health and HIV Strategy identified HIV prevention with Africans as a priority area (Department of Health 2002).

An integral part of improving and supporting the delivery of evidence-based HIV prevention interventions is the ability to monitor levels of high-risk sexual behaviour in the community and their impact on diagnosed and undiagnosed HIV prevalence (National AIDS Trust 2001). Exploring this relationship has been made possible with the availability of oral fluid assays for HIV infection (Connell et al. 1993; Parry, Perry, and Mortimer 1987). The unlinked anonymous (UA) methodology has been used for many years to test sub-population samples available from clinical screening as a means of monitoring HIV prevalence, both diagnosed and undiagnosed. Such surveys have provided estimates of prevalence in sub-populations at higher-risk of HIV, genitourinary medicine clinic (GUM) attendees (Catchpole et al. 2000), (McGarrigle et al. 1998), injecting drug users attending services (Hope et al. 2001), and in lower risk pregnant women (Nicoll et al. 1998).

Furthermore, qualitative research, in combination with quantitative studies, has both informed the development of behavioural studies (Power 1998; Power 2002) and been used to explore the acceptability of collecting biological specimens from study participants in a sex survey undertaken in community settings (Fenton et al. 2001).

Despite being the second largest community affected by HIV in the UK, there are currently no established behavioural surveillance programmes for black Africans in the UK. To date the largest study of sexual attitudes and lifestyles among African communities has been the Mayisha study (Fenton et al. 2002) - a participatory community-based survey among five migrant African communities in inner London undertaken in 1999. This study demonstrated the feasibility of conducting community-based research studies among black Africans living in London and informed the development of local and national HIV prevention intervention planning with African communities. The feasibility and acceptability of collecting oral fluid samples in community venues for future HIV testing, linked to key sexual behavioural data has also been demonstrated for men who have sex with men (MSM) (Dodds et al. 2004). However, unlike MSM, there are currently no estimates of HIV prevalence linked to sexual behaviour in a community sample of Africans in the UK.

Mayisha II was carried out between August and December 2004. This was a community-based survey of sexual attitudes and lifestyles of black Africans, including the collection of unlinked anonymous samples tested for HIV and follow-up in-depth interviews. This report presents the key findings of the Mayisha II study. The report gives a summary of the pilot study conducted in February 2004, describes the methodology employed for the main study and presents the characteristics of the recruited sample and associations of HIV infection with socio-demographic and service use. A summary of the study results conducted in Luton and the West Midlands are provided separately in appendices I and II.

1.3 Study aims and objectives

The study aims were to:

1. Carry out a survey of sexual attitudes and lifestyles of 1500 black African men and women aged 16 years and over recruited from social and commercial venues in London, Luton and the West Midlands using a brief, validated, self-completion questionnaire;
2. Evaluate the feasibility and acceptability of providing unlinked anonymous oral fluid samples for HIV antibody testing as part of the community based survey;
3. Use the data generated from the survey to:
 - a. Update estimates of sexual behaviour and use of sexual health services among migrant African communities in England;
 - b. Measure diagnosed and undiagnosed HIV infection among the recruited sample and demographic and behavioural associations with HIV infection;
 - c. Provide updated data for the direct and indirect estimates of HIV prevalence among black African communities in England; and
 - d. Provide information to guide health promotion strategies and development of sexual health services.
4. Explore, using in-depth qualitative interviews, the cultural and psychosocial contexts in which sexual behaviour and sexual mixing within these communities are currently occurring.

Prior to embarking on the main survey, we undertook a pilot study, which enabled us to refine the venue-based recruitment procedures and also demonstrated the feasibility and acceptability of collecting oral fluid samples for anonymous HIV antibody testing in social venues. Section 1.4 summarises the methodology, results and conclusions of the pilot study.

1.4 Executive summary of Mayisha II pilot study 2004

Introduction

Mayisha II is a Medical Research Council funded study, co-ordinated with collaborators, by the Health Protection Agency Centre for Infections, London, in the Behavioural Surveillance and Research Unit. It is a community-based survey of sexual attitudes and lifestyles among black African communities in England.

Aims

1. To refine venue-based recruitment procedures to ensure optimum response rates;
2. To evaluate the feasibility and acceptability of providing unlinked anonymous oral fluid samples for HIV antibody testing as part of the community-based survey; and
3. To evaluate comprehension of questions in the questionnaire through in-depth cognitive interviews.

Methods

A cross-sectional quantitative survey and a nested qualitative in-depth interview study were carried out in February 2004 amongst black Africans over 16 years of age attending social and commercial venues in London. A short anonymous self-completion questionnaire, consisting of demographic, behavioural and attitudinal variables was administered. Respondents were also invited to provide an oral fluid sample, using the Orasure™ collection device, for unlinked anonymous HIV testing. The qualitative in-depth interview study targeted a sub-sample of respondents, to explore cognition of the questionnaire and to evaluate the acceptability of the study, survey methodology and instruments.

Sample characteristics

In total, 114 black African men and women were recruited from a range of venues across London. A large number of African countries were represented in the pilot indicating that a range of communities were recruited. We recruited people from both new migrant communities and established communities; 19% of respondents had lived in the UK for less than 2 years and 31% of respondents had lived in the UK for 10 years or more. The response rate to the oral fluid sample was 82% and all samples collected were of high enough quality to test.

Conclusions

- The pilot study demonstrated the feasibility and acceptability of undertaking unlinked anonymous HIV antibody testing as part of a community-based behavioural survey.
- From the quantitative and the qualitative pilot study, a set of recommendations have been produced to refine the survey methodology and instruments for the main study.
- Community engagement is essential for the success of the main study.

Recommendations from the Mayisha II pilot study

a. Developments to survey methodology

- A diverse group of fieldworkers (i.e. men and women from different countries and backgrounds) should be employed for Mayisha II to ensure inclusion of both established and newly migrant communities in the study.
- The fieldworker training programme should include comprehensive briefing to ensure that respondents receive clear explanations from fieldworkers about the aims and conduct of the study, for example: instruction on who the Health Protection Agency are, what they do, the aims of Mayisha II, the purpose of the oral fluid sample, the aims of the qualitative survey and what will happen to the results. These should be written as a set of clear and concise explanations. Experiences of the pilot study from the pilot fieldworkers should be drawn upon to develop the training.
- Fieldworkers should be given details of when to recruit at pre-enrolled venues to ensure systematic sampling. They should work in groups of two to four to ensure personal safety and to legitimise the study.
- A wide range of venues from which to recruit need to be identified, to ensure a diverse group of respondents participate in the study.
- The plan for additional recruitment in the main study from churches, social events and universities was endorsed by suggestions from both pilot study respondents and fieldworkers.
- Fieldworkers should aim to recruit more than one person at a time e.g. by approaching a group of potential respondents. Respondents will be less self-conscious if in a group.
- Provide a sweet to counteract the salty taste of the Orasure™ device.
- To reassure respondents about confidentiality, replace the “sealable brown envelope” with tamper-proof packaging for return of completed questionnaires and oral fluid samples.
- Ensure that in-depth interviews are carried out at a venue that has a private area.

b. Developments to questionnaire

Through cognitive analysis of the questionnaire we identified some questions that respondents had difficulty in answering. Questions 7, 9 and 13 should be amended to make them more relevant to respondents' relationship status and employment circumstances and more relevant to those receiving treatment for HIV. Questions 5 and 16, about migration and number of sexual partners, should be re-worded to reduce levels of sensitivity. Question 23 should be replaced with a simple and clear 'peer-norm' question. The questionnaire should also be re-formatted in places to enhance visual clarity of the questions and response options.



2 Methodology

2.1 Summary points

- Mayisha II has three components:
 - A cross-sectional community-based survey (target 1500 respondents) ;
 - A nested qualitative study (target 40 respondents); and
 - Respondents were also given the option of providing an oral fluid sample using an Orasure™ device for anonymous testing for HIV.
- The study population was black African men and women aged over 16 years, attending pre-identified social and commercial venues and events in London, Luton and the West Midlands.
- The study's investigators were guided in their work by a community based collaborative group. Membership was selected to encompass a wealth of experience in sexual health and HIV research and HIV prevention with African communities. Members included representatives from African HIV forums, Client Care Services, Directors of Public Health and African Health Promotion teams.
- Community fieldworkers were responsible for recruiting respondents to the study. Potential fieldworkers from the local African community were identified through the community consultant, Local Survey Groups and through advertising in local venues and media.
- The study was conducted from August to December 2004 in three study areas, London, Luton and the West Midlands, encompassing both established and newly migrant populations.

2.2 Study design

2.2.1 Type of study

Mayisha II has two components; a cross-sectional community-based survey of sexual attitudes and lifestyles, and a nested qualitative study. The cross-sectional survey comprised a short (24 closed questions) anonymous self-completion questionnaire that collected demographic, service use, behavioural and attitudinal variables (see Appendix 3 for an example of the questionnaire). Respondents were also given the option of providing an oral fluid sample using an Orasure™ device for anonymous testing for HIV. A subset of those respondents providing contacts details were then followed up for in-depth interviews, guided by a topic-guide, that explored sexual lifestyles and attitudes in more detail (see Appendix 3 for an example of the topic guide).

2.2.2 Study area

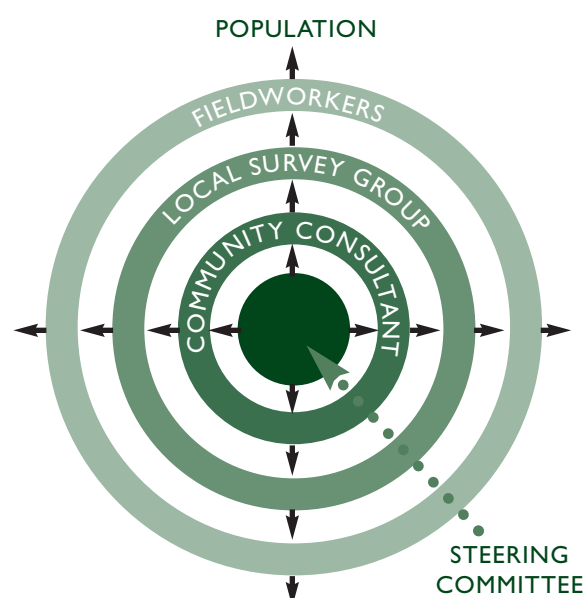
The study was conducted across London, Luton and the West Midlands and was designed to ensure recruitment of migrants from high-prevalence regions in Africa as well as the more established African communities in the UK. HIV surveillance data and census projections were used to determine which areas would be most suitable for recruitment. London has the largest number of diagnosed HIV cases in Britain (Rice *et al* AIDS 2004) and the largest population of African communities, so was therefore the primary recruitment site. Outside of London, we recruited in the West Midlands, which has an established community of Africans and Luton, which has a new community of migrants from Africa particularly the South Eastern region.

2.2.3 Study population and size

The study population was black African men and women aged over 16 years, attending pre-identified social and commercial venues in London, Luton and the West Midlands. We aimed to recruit 1000 people from London, 250 from Luton and 250 from the West Midlands. These target numbers were based on expected prevalence and behaviours known from existing surveys.

FIGURE 1

Structural overview of Mayisha II



2.2.4 Study duration

Recruitment to the venue-based survey took place over four months in London (September to December 2004), three months in the West Midlands (August to October) and three months (August to October) in Luton.

2.2.5 Ethics

Ethics approval was received from the Trent Multi-Centre Research Ethic Committee for both the pilot and main studies.

2.3 Establishing key partnerships

The study used a community participatory research approach developed for the first Mayisha study (Fenton et al. 2002), in which key African community organisations were involved in all stages of the study design, development and implementation (see Figure 1). A project Steering Committee was established with a diverse, multi-skilled membership including academic, policy, research and community representatives; the African HIV Policy Network (AHPN); the African HIV Research Forum (AHRF); the African Health Promotion Team at the Terrence Higgins Trust; and local African Health Promotion teams. Membership was selected to encompass a wealth of experience in sexual health and HIV research and HIV prevention with African communities.

In London, a Community Consultant with expertise in working with African communities in the UK worked with the study co-ordinator in setting up and managing the study over the recruitment period. In Luton and the West Midlands, this role was filled by an African Health Promotion Specialist. Specifically, they identified and trained a team of fieldworkers, enrolled suitable recruitment sites and managed the team of fieldworkers throughout the fieldwork.

In each area, Local Survey Groups (LSGs) were established to oversee and advise on the implementation and promotion of the study. Members included representatives from African HIV forums, Client Care Services, Directors of Public Health and African Health Promotion teams. A Memorandum of Understanding was agreed between the Local Survey Groups and the Mayisha II Research Team, outlining the aims of the study, identifying the agreed roles and responsibilities of team members, setting achievable goals within the time period and outlining the meeting schedule with planned outputs.

2.4 Enrolling and training fieldworkers

Community fieldworkers recruited respondents to both the quantitative and qualitative study. Potential fieldworkers from the local African community were identified through the community consultant, Local Survey Groups and through advertising in local venues and media. A short screening questionnaire was used to assess the suitability of all applicants and to also ensure that a diverse group of fieldworkers in terms of gender, age, country of origin, languages spoken and prior research experience worked on the study. The screening assessment also provided an opportunity to describe the work and the commitment required from the fieldworker and to answer any questions that they had.

Three teams of fieldworkers (one team in each area) were enrolled and trained: 20 in London; 13 in Luton; and 14 in the West Midlands. All fieldworkers completed a one-day training course on the survey background, objectives, methodology, key recruitment procedures and to learn the required administrative skills. Training included feedback from the pilot study, role play and practice in providing answers to questions likely to be encountered in the field and a detailed review of the survey procedures and materials.

Fieldwork started within two weeks of the training day, allowing sufficient time for fieldworkers to assimilate the survey methods, objectives, guidelines and materials, whilst providing enough time to ensure that details of the survey were retained. Fieldworkers were provided with all survey materials, a research diary and a recruitment bag for holding study packs. A set-up meeting with the project co-ordinator and the local co-ordinator (community consultant in London) was held on the first day of fieldwork.

During the fieldwork period, fieldworkers attended a bi-weekly meeting to de-brief with the local co-ordinator or community consultant and the study co-ordinator and to exchange completed study packs with new ones. Throughout the recruitment phase, fieldworkers were encouraged to record any observations of the recruitment venue or event, the recruitment process and their fieldwork experiences, in their research diary.

2.5 Fieldwork phase

The study adopted an opportunistic yet purposive sampling methodology. We identified different types of venues across the three areas to recruit from as many different African communities as possible. Venues and events were identified and enrolled by the local co-ordinator or Community Consultant, the Local Survey Groups and the fieldworkers. These included bars and nightclubs, hairdressers, shops, community centres, university's and colleges, churches, community events, football events and social gatherings. Upon agreement with the venue owner, a suitable time and day was identified for fieldworkers to conduct the research. In some venues, the research was advertised prior to the fieldworkers agreed recruitment time, either via a bulletin in a newsletter, or by putting posters that explained the survey up in the venue for clients to read. The sites from which the sample was recruited are summarised in Figure 2 with the proportion of respondents from each type of site that also gave an oral fluid sample.

Within each venue, fieldworkers approached eligible individuals and explained the two-component structure (questionnaire and oral fluid sample) of the study before inviting them to participate. They were given information sheets that outlined the anonymous and confidential nature of the study. Respondents were given the questionnaire to complete and asked to give an oral fluid sample. Overall, 75.3% of eligible respondents (1023/1359) gave an oral fluid sample (see Figure 3).

Respondents in the pilot study had reported that the swab had an unpleasant salty flavour, so all respondents were provided with a lollipop to take away the taste. The sample and the questionnaire were then put in a tamper-proof envelope, sealed and placed in the fieldworkers' collection bag. Respondents were reassured about confidentiality and were provided with contact details for the statutory and community based organisations available to discuss any HIV-related issues.

FIGURE 2

Recruitment locations for the Mayisha II sample *(% oral fluid uptake at each type of recruitment site)

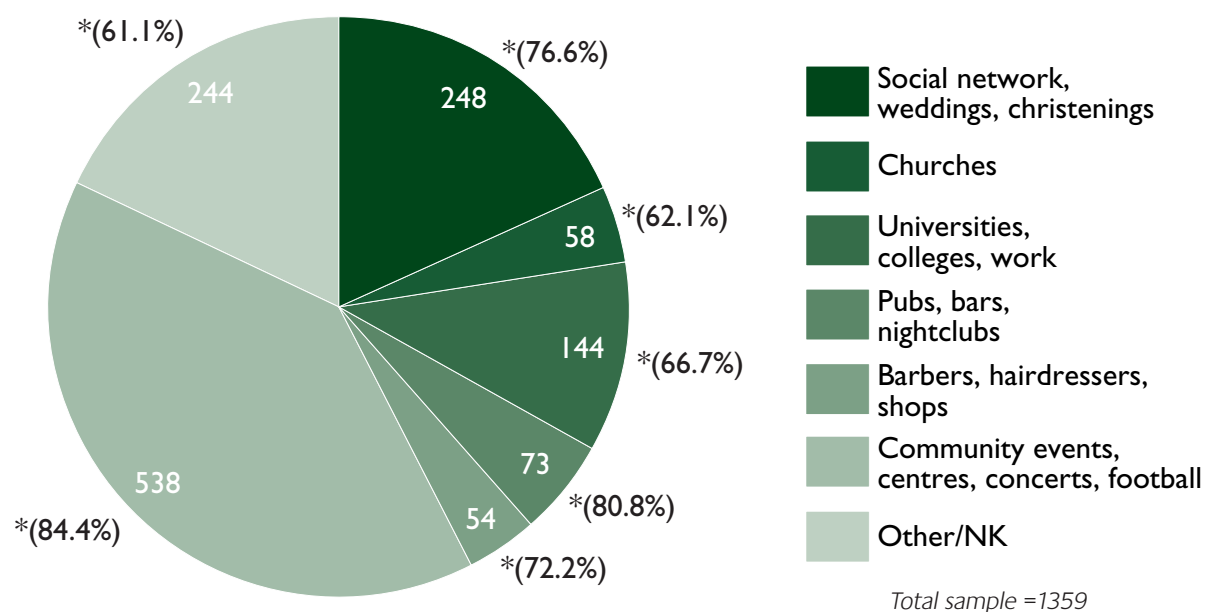
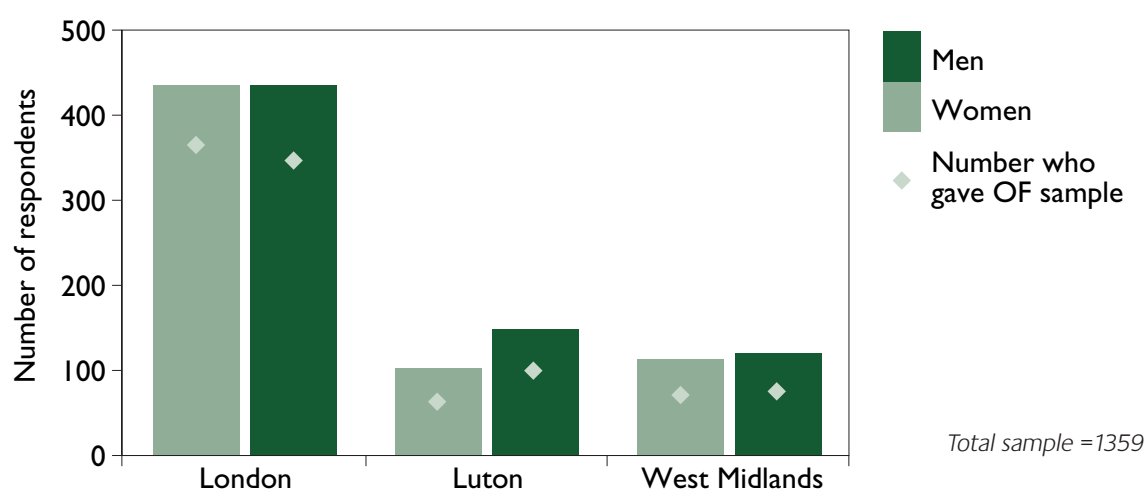


FIGURE 3

Respondents recruited and oral fluid (OF) uptake in the study areas in the Mayisha II community sample



Respondents were then invited to participate in the qualitative study. Those interested in participating in the face-to-face interview completed a tear-off slip on the information leaflet, giving their name and contact telephone number, which was placed in a self-sealable envelope to guarantee no link to the questionnaire and oral fluid sample. A subset of these volunteers were interviewed at a later date by qualitative interviewers experienced in working with African communities. A short screening questionnaire was administered by phone to confirm eligibility and collect basic demographic characteristics. Purposive selection of respondents to

participate in the in-depth interviews was guided by quota controls to ensure diversity and breadth in the qualitative sample. These are summarised in Table 1.

At the recruitment stage, the sample was monitored to ensure diversity in sexual orientation, survey recruitment site and to limit the numbers recruited that were involved in HIV or community related work or other activities. Respondents were provided with information about the aims of the qualitative study and offered a £20 incentive. Interviews were conducted at respondents' homes, or venues chosen by the respondent.

TABLE 1

Quota controls for the Mayisha II qualitative sample

Primary quota controls	Men	Women	Total
Age (years)			
16 to 24	6 - 7	6 - 7	12 - 14
25 to 34	6 - 7	6 - 7	12 - 14
35 and over	6 - 7	6 - 7	12 - 14
Length of residence in UK			
Under five years	-	-	15 - 25
Five or more years	-	-	15 - 25
Location			
London	10 - 12	10 - 12	24
Luton	3 - 4	3 - 4	8
West Midlands	3 - 4	3 - 4	8
Family origins			
Region of higher HIV prevalence	5 - 8	5 - 8	10 - 16
Region of lower HIV prevalence	5 - 8	5 - 8	10 - 16
Region of increasing prevalence	5 - 8	5 - 8	10 - 16
Partnership status			
Single	5 - 8	5 - 8	10 - 16
Co-habiting partner	5 - 8	5 - 8	10 - 16
Non-cohabiting partner	5 - 8	5 - 8	10 - 16
Total	20	20	40

2.6 Analysis and laboratory methods

Barcodes were used to link the anonymous questionnaires and oral fluid samples from the respondents. The questionnaire data was entered in a relational Access database and analysed in Stata version 8.1. Statistical analyses including univariate analysis and tests for trend were carried out comparing the differences between groups.

The oral fluid samples were stored and tested at the HPA Centre for Infections for antibodies to HIV. Each sample was initially tested to establish whether sufficient immunoglobulin G (IgG) was present (Connell et al. 1993). The samples were then quality assessed and tested for HIV antibodies using an enzyme immunoassay screened for anti-HIV-1/2 IgG using a test developed by the HPA and now commercially available (Murex GACELISA) (Parry, Perry, and Mortimer 1987). Reactive specimens were tested using an alternative assay (Clonesystems Detect-HIV and in some cases Western Blotting) according to a tested algorithm. The laboratory results were imported to an access database and linked to the questionnaire data using the barcodes.

The in-depth interviews were audio recorded and transcribed. Verbatim qualitative data was analysed using Framework, a matrix-based analytical tool informed by the principles of grounded theory (Ritchie 2003).

3 Sample characteristics

3.1 Summary points

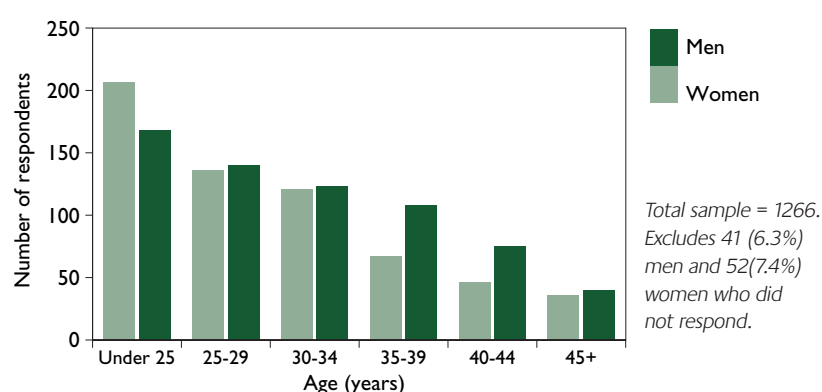
- 1359 eligible black African respondents (872 from London, 252 from Luton and 235 from West Midlands) were recruited in Mayisha II (2004).
- Of the 1359 respondents, 51.9% (706) were men and 48.1% (653) were women. In general, among both men and women, fewer respondents in the older age groups were recruited than those in the younger age groups.
- The sample was very diverse in terms of country of origin with 38 different countries of birth being reported by the sample. The majority of respondents were born in South Eastern and Eastern African (46.5% of women and 47.6% of men) with nearly a fifth born in Horn of Africa and 14.0% born in Western Africa. Region of birth did not vary significantly between men and women.
- Levels of education were high among the respondents, with 76.9% of women and 81.1% of men attaining secondary school or university level education. Unemployment was also high, at 18.0% among the women and 15.4% among the men.
- Marriage and fertility were important for respondents, a third of whom were married. Although half the sample had lived in the UK for over five years, migration had an impact on relationships with around a quarter of married men and women having a partner that lived abroad (27.9% and 23.0% respectively).
- Over half of respondents reported that they regularly attended a religious service, indicating the importance of religion for this sample.

3.2 Sample characteristics

A total of 1608 respondents were recruited in the three areas over the four-month recruitment period; 1056 in London, 292 in Luton and 260 in the West Midlands. However, 213 respondents did not identify themselves as black African and a further 36 respondents were either not eligible as they were under 16 years old or the questionnaire had a very poor completion rate. The following results are therefore based on **1359** eligible black African respondents (872 from London, 252 from Luton and 235 from West Midlands)¹.

FIGURE 4

Age distribution of Mayisha II respondents



Of 1359 respondents, 51.9% (706) were **men** and 48.1% (653) were **women**. A quarter of male (25.7%) respondents and a third of female (33.7%) respondents were aged less than 25 years. Figure 4 presents the **age** distribution of respondents, showing that in both men and women, the majority of respondents were aged less than 30 years.

Table 2 shows that the **region of birth** reported by respondents did not vary significantly between men and women (countries included in these regions of birth are listed in the footnote accompanying Table 2). The highest proportion of respondents were born in South Eastern and Eastern Africa (47.0%) and of these, 36.9% were born in Uganda and 29.4% were born in Zimbabwe.

¹ Throughout the report, the data presented are based on those responding to the question, excluding any respondents that did not answer from the calculations of percentages and proportions. Therefore, base numbers for the tables and figures will vary due to excluded non-response.

TABLE 2

Demographic characteristics of Mayisha II respondents

Demographic characteristics	Number of respondents (%)	
	Women	Men
Region of birth^{2,3}		
South Eastern and Eastern Africa	298 (46.5)	328 (47.6)
Horn of Africa and Northern Africa	129 (20.1)	128 (18.6)
Southern Africa	33 (5.1)	26 (3.8)
Central and South Western Africa	52 (8.1)	65 (9.4)
Western Africa	82 (12.8)	106 (15.4)
Outside Africa	47 (7.3)	36 (5.2)
<i>Base</i>	<i>641</i>	<i>689</i>
Education attainment		
None	14 (2.2)	11 (1.6)
Primary, elementary	38 (5.9)	22 (3.1)
Secondary, high school	179 (27.9)	174 (24.9)
University, college	314 (49.0)	393 (56.2)
Other	96 (15.0)	99 (14.2)
<i>Base</i>	<i>641</i>	<i>699</i>
Employment status		
Employed	250 (39.1)	341 (49.2)
Unemployed	115 (18.0)	107 (15.4)
Home, family, caring	32 (5.0)	8 (1.2)
Education	226 (35.4)	206 (29.7)
Other	16 (2.5)	31 (4.5)
<i>Base</i>	<i>639</i>	<i>693</i>
Relationship status		
Married	191 (29.7)	265 (37.9)
Widowed, separated, divorced	48 (7.5)	29 (4.1)
Living with partner	55 (8.5)	54 (7.7)
In relationship (not living with partner)	85 (13.2)	100 (14.3)
Single	265 (41.1)	251 (35.9)
<i>Base</i>	<i>644</i>	<i>699</i>

The majority of respondents born in Horn of Africa were born in Ethiopia (59.8%), whilst 27.9% of them were born in Somalia. Of the 188 respondents born in Western Africa, 42.0% (79/188) were born in Ghana and 34.0% (64/188) were born in Nigeria. Of the 59 respondents born in Southern Africa, the majority were born in South Africa (43/59) followed by 10 respondents who were born in Namibia. Respondents born outside of Africa, were born in a range of countries, the majority in the UK (84.3%) but also including France, Netherlands, Switzerland and USA. Overall, the sample was very diverse in terms of country of origin with 38 different countries of birth being reported.

Education attainment was high among the respondents; 76.9% of women and 81.1% of men reported that they had attained a secondary school or university education, whilst 6.3% reported that they had attained primary level or no education (see Table 2).

Unemployment within the sample was higher than the national average at 18.0% for women and 15.4% for men.

Around one-third (32.4%) of respondents indicated that they were in some form of **education** (full or part-time), whilst around half of the men reported that they were in employment (49.2%) and 39.1% of women.

More women recruited in the sample reported that they were **single** (41.1%) than were **married** (29.7%), whilst around a third of men reported they were married (37.9%) and a third single (35.9%). Around a quarter of married men (27.9%) and women (23.0%) had a partner that lived abroad (data not shown) and of those respondents who were in a relationship but not married, two-thirds were not living with their partner (64.9% of men and 60.7% of women).

² Countries in UN Geographical Regions of Africa: Eastern and South Eastern Africa: Burundi, Comoros, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Reunion, Rwanda, Seychelles, Tanzania, Uganda, Zambia, Zimbabwe. Horn of Africa: Djibouti, Eritrea, Ethiopia, Somalia, Sudan. Southern Africa: Botswana, Lesotho, Namibia, South Africa, Swaziland. Central and South Western Africa: Angola, Cameroon, Central Africa Rep, Chad, Congo, Equatorial Guinea, Gabon, Sao Tome & Principe, Congo/Zaire. Western Africa: Benin, Burkino Faso, Cape Verde, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Liberia, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, St Helena, Togo, Mali. Northern Africa: Algeria, Egypt, Libya, Morocco, Tunisia.

³ Regions with small cell sizes have been combined.

FIGURE 5

Length of time living in the UK for Mayisha II respondents

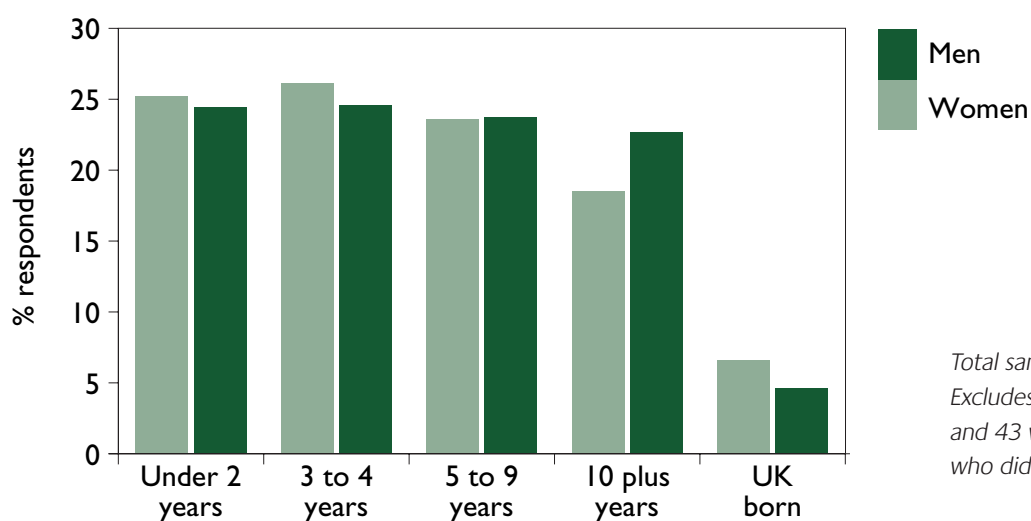


Figure 5 illustrates the **length of time respondents have lived in the UK**. A range of people from both new migrant African communities and established African communities were recruited and there was little variation between male and female respondents. Around two-fifths of respondents had lived in the UK for over five years, half for less than five years and 5.5% were born in the UK.

The majority of respondents identified themselves as having a **religion** (91.2%). More men than women reported they had no religion, 11.9% compared to 5.3% (see Table 3). Of respondents who reported they did have a religion, most were either protestant (37.6%), Roman Catholic (32.5%) and 14.8% were Muslim. More than three-fifths (60.8%) of the women reported that they attended a religious service (not including special occasions such as weddings or funerals) more than once a week as did 51.1% of the men.

TABLE 3

Religious affiliation among Mayisha II respondents

Religion	Number of respondents (%)	
	Women	Men
Roman Catholic	201 (32.3)	185 (27.3)
Protestant	226 (36.3)	220 (32.4)
Muslim	78 (12.5)	97 (14.3)
Other religion	84 (13.5)	95 (14.0)
No religion	33 (5.3)	81 (11.9)
Base	622	678
Attendance at religious services		
Once a week or more	368 (60.8)	326 (51.1)
Once a month or more	133 (22.0)	154 (24.1)
Once or twice a year	65 (10.7)	81 (12.7)
Never/practically never	39 (6.4)	77 (12.1)
Base	605	638

3.3 Qualitative sample characteristics

Forty-four people, twenty-four men and twenty women, from London, Luton and the West Midlands, ranging in age from 16 to 50 years participated in the follow-up depth interviews. The demographic and socio-economic characteristics of the qualitative sample reflect the breadth present in the survey sample. A third of the sample had lived in the UK for less than five years. Over half described themselves as single, although during the interviews, a proportion revealed that they had regular partners in the UK or their home country, and 12 were married or living as married. Just over a quarter of the sample said that their family origins were Ugandan, with the remaining sample originating from 14 different countries, including Congo, Zimbabwe, Kenya, Nigeria and Somalia. The majority of the sample were heterosexual but also included men reporting same sex relationships.

4 Results

4.1 Summary points

Service use and HIV testing

- Around two-fifths of both men and women (37.8% and 43.9% respectively) reported attending a GUM (genitourinary medicine)/ STI (sexually transmitted infections) clinic, the majority of whom had done so in the last five years. Over three-quarters of all respondents had never had an STI diagnosis.
- 50.9% of the female respondents reported a previous voluntary confidential HIV test compared to 42.9% of the male respondents. The vast majority of respondents who had ever HIV tested, had done so in the past five years – 92.4% of women and 87.6% of men.
- Reasons for testing, among the women, included fear of HIV infection due to mistrust of the husband or partner or following rape. Men cohabiting with partners tested following concurrent relationships and both men and women tested before entering new relationships or resuming interrupted long-term relationships. Among respondents that were not in relationships and had not tested for HIV was a preference for having an HIV test with their partner before embarking on a new relationship.

Sexual behaviour

- Substantially more men than women reported two or more new sexual partners in the past year (20.0% compared to 7.9%). Among married and cohabiting men and women, trust in the monogamous nature of their relationship and faithfulness to one partner were highlighted as key values, often underpinned by religious beliefs. However, both men and women's accounts included experiences of concurrent relationships, both their own and their partner(s)'.
- The majority of respondents reported that they in general had partners of the opposite sex (92.2% of women and 91.9% of men who responded). Same sex partners were reported by 8.0% of men and women.

Oral fluid uptake

- Overall uptake of the oral fluid sample in the main study was 75.3% (1023/1359), with slightly more women (76.7%) giving an oral fluid sample than men (73.9%). Key motivational factors in oral fluid uptake were shared perceptions of the study benefits among respondents and trust in the fieldworker to maintain anonymity.
- Qualitative data indicates that despite confidence in the Mayisha II confidentiality procedures and willingness to provide an oral fluid sample, HIV-related stigma and discrimination was sometimes a deterrent to indicating if an HIV test had been taken elsewhere and revealing perceptions of HIV status.
- Uptake varied by area of recruitment; in London 81.7% (712/872), in Luton 65.1% (164/252) and in the West Midlands 62.6% (147/235) of respondents gave an oral fluid sample.

HIV positivity of the Mayisha II community sample

- The overall HIV positivity in the Mayisha II community sample was 14.0%; 15.0% among women and 13.1% among men - substantially higher than the prevalence of HIV in African communities in England, and represents the over sampling of HIV positive Africans, anticipated as part of our recruitment strategy.
- Of male and female respondents who reported that they had never had an HIV test, 10.2% and 9.1% were HIV-infected. Qualitative data indicate that despite confidence in the Mayisha II confidentiality procedures and willingness to provide an oral fluid sample, HIV-related stigma and discrimination was sometimes a deterrent to indicating if an HIV test had been taken elsewhere and revealing perceptions of HIV status.

Diagnosed and undiagnosed HIV infection

- Of the 1006 respondents who gave an oral fluid sample that could be analysed, 141 were HIV antibody positive (14.0%). Of these 141 respondents (74 women and 67 men), 63.1% (89) reported they had previously had a voluntary confidential HIV test, of whom 53.9% (48/89) reported their last HIV test result to be positive.

Future interventions

- Respondents made suggestions regarding interventions that would encourage HIV testing and knowledge of HIV status. HIV testing and knowledge of status was regarded by these respondents as a useful prevention strategy.
- At a personal level, a reduction in fear of discrimination was regarded as key to creating an environment that would be more conducive to HIV testing and knowledge of HIV status. At a general level, respondents requested information about where to test, what happens at a test, testing and pregnancy, rapid testing, effectiveness of treatment, immigration and HIV testing and the difference between HIV and AIDS.

4.2 Service Use

Questions on service use included attendance at antenatal and GUM / STI (sexually transmitted infections) clinics and HIV testing. The majority of female respondents had not attended an **antenatal clinic** in the past five years (65.2%, data not shown). Around two-fifths of both men and women (37.8% and 43.9% respectively) reported attending a GUM / STI clinic, the majority of whom had done so in the past five years; 86.8% of women and 82.1% of men (see Table 4).

TABLE 4

Service use characteristics of Mayisha II respondents

Service use characteristics	Number of respondents (%)			
	Women		Men	
GUM / STI clinic attendance				
Never attended	359	(56.1)	424	(62.3)
Less than 5 years ago	244	(38.1)	211	(31.0)
More than 5 years ago	37	(5.8)	46	(6.8)
Base	640		681	
STI diagnosis				
Never diagnosed	496	(77.9)	539	(78.7)
Less than five years ago	107	(16.8)	90	(13.1)
More than five years ago	34	(5.3)	56	(8.2)
Base	637		685	
Ever had an HIV test				
Never tested	316	(49.1)	397	(57.1)
Less than five years ago	302	(47.0)	261	(37.6)
More than five years ago	25	(3.9)	37	(5.3)
Base	643		695	

The majority (78.3%) of respondents reported that they had never had an **STI diagnosis**. Of those respondents who had had an STI diagnosis 68.6% (197/287) had done so in the past 5 years. This was similar for both men and women.

Just over half (50.9%) of the female respondents reported **ever having an HIV test** compared to 42.9% of the male respondents. The vast majority of respondents who had ever tested, had done so in the past 5 years – 92.4% of women and 87.6% of men. In both men and women, less than half of those who had tested had done so at a GUM / STI clinic (38.0% and 43.7% respectively), the others tested at their general practice (GP) (12.2%), through antenatal testing (5.6%) and at other settings (8.7%), for example hospital (data not shown).

Reasons for testing explored through the qualitative interviews, among the women, included fear of HIV infection due to mistrust of the husband or partner or following rape. Men cohabiting with partners tested following concurrent relationships and both men and women tested before entering new relationships or resuming interrupted long-term relationships. Among respondents that were not in relationships and had not tested for HIV was a preference for having an HIV test with their partner before embarking on a new relationship.

“Because first of all when my husband comes [back from Africa] I have to make sure that he’s never been with anybody, I’m going to send him for a check-up. If he’s clean I don’t have anything to worry about because he’s clean, so he’s my husband, that’s it.”

Woman, age 40.

Anxiety about HIV influenced testing habits of those in long term relationships, for example because of worries about transmission via cuts, lack of confidence in condom use (despite using condoms consistently) or persistent illness. For those in serodiscordant relationships, regular testing was driven by the need to reassure the HIV positive partner rather than a fear of infection alone. Among both men and women, HIV awareness raising events and one-to-one outreach were key factors in motivating them to take a HIV test. Some had taken HIV tests at the request of others, including: for insurance; before donating blood; as a condition of grant sponsorship; and at the suggestion of a sexual health clinic when attending for another reason. Fear and anxiety about the test were present among those that tested for HIV.

“It was scary. You never know what might turn up, despite everything, you know, you think that you’ve been safe and protected but you kind of think of all those times that you had not been, although there are not many particularly, I think of that bloke I slept with when I first came back and what if it’s just sitting around, you know, waiting to pop up, or what if I’m a carrier, apparently there are carriers, people it doesn’t sort of develop in, but you just carry the virus in your body. Yes, it’s scary, yes. It’s frightening.”

Woman, age 33.

Fear of stigmatisation, deportation and expectations of HIV as incurable or as a 'death sentence' continue to deter respondents from taking an HIV test. Men and women associated HIV transmission with promiscuity and inappropriate sexual behaviour and, partly due to their own fears regarding people living with HIV, expected to be stigmatised if they were diagnosed HIV positive.

"[People said] he's sick, he's dying, it's because he slept with someone's wife, yes, or if it's the lady, oh, you know, she was unfaithful, you see."

Man, age 45.

Some felt it probable that their partners would leave them and others were worried that they would have to leave the UK. Some were unsure where they could obtain an HIV test, could not find time to go for a test due to pressures of studies, work and childcare, or were worried about being asked personal questions at a clinic. Low expectations of the efficacy of HIV treatment persist. Similar views were expressed by those that had taken an HIV test and had not collected the results.

Lack of perceived risk was another reason for not testing. Those who did not use condoms at all or used them inconsistently, did not perceive themselves to be at risk of HIV because they were married, had been faithful to the same sexual partner for several years, had few or only had young or sexually inexperienced partners, or knew and trusted their partner(s).

"I don't go to anyone, I was just going to her ... and I told her [that] and she know me because it [home country] is not wide this country, a small country, yes."

Man, age 18.

There is evidence that some, including those with multiple partners, relied on their partners to HIV test, and assumed that their partner(s)' HIV negative result meant that they were also HIV negative. Those respondents that were consistent condom users were confident that their safer sex practices protected them from HIV transmission. Others, although aware of HIV testing, simply did not apply the need to themselves.

"I never even, you know, said, [before we married] oh, you should go and take an HIV test, and yet we used to be told things like that. I think it's, you know when you're, sometimes when you're in love with somebody you forget all the proper logistics I suppose because it's different when you're opening a company, you know, there are rules and regulations that you must [follow], but I think when you're in love with somebody you forget about those proper logistics and you just go with your heart and all these things come a little bit later and then sometimes it's too late."

Woman, age 29.

4.3 Behavioural characteristics

The **number of sexual partners** in the last year reported by respondents are shown in Figure 6a. Nearly one third of women reported they had no sexual partners in the last year (30.7%) compared to 23.5% of men. Substantially more men than women reported two or more sexual partners (33.4% compared to 18.3%).

The proportion of respondents who had **new sexual partners** in the last year is shown in Figure 6b. Those recorded in Figure 6b as having no new sexual partners include both those who had no partners during the past 12 months as well as those who had partners, but none who were new. The majority of women reported they had no new sexual partners in the last year (72.7%) compared to 61.6% of men. Substantially more men than women reported two or more new sexual partners (20% compared to 7.9%). Just under a sixth of respondents (15.5%) did not respond to this question.

Among married and cohabiting men and women, trust in the monogamous nature of their relationship and faithfulness to one partner were highlighted as key values, often underpinned by religious beliefs – indeed marriage to one partner was an aspiration shared by men and women of all ages. However, among married women was a view that they could not fully trust their husbands in this respect and both men and women's accounts of married life included experiences of concurrent relationships, both their own and their partners', leading to breakdown of the relationship in some cases. Among older men, were reports that they had fewer partners since living in the UK, partly because they had matured, but also because of the expense and complexity of concurrent relationships. Those that had had unprotected sex with concurrent partners in the past revealed that they had not discussed these relationships with their regular partner.

FIGURE 6A

Reported number of sexual partners in past 12 months in Mayisha II sample

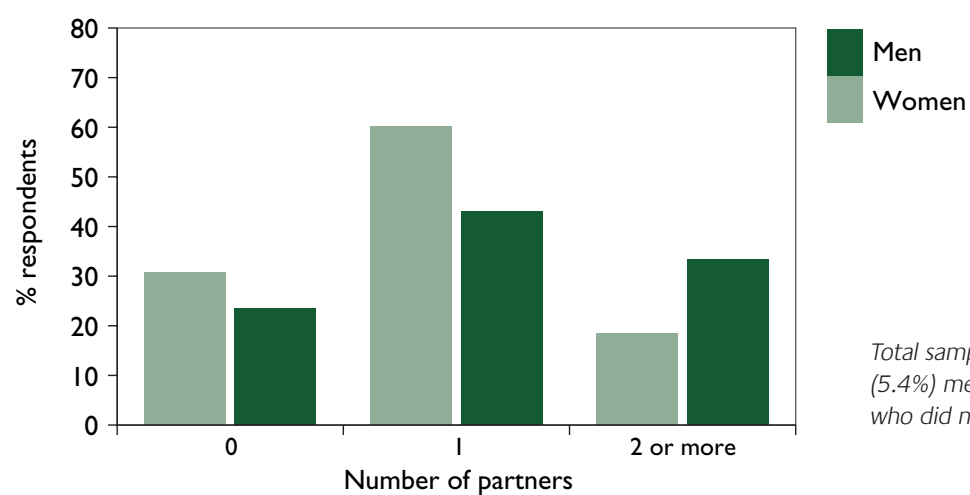
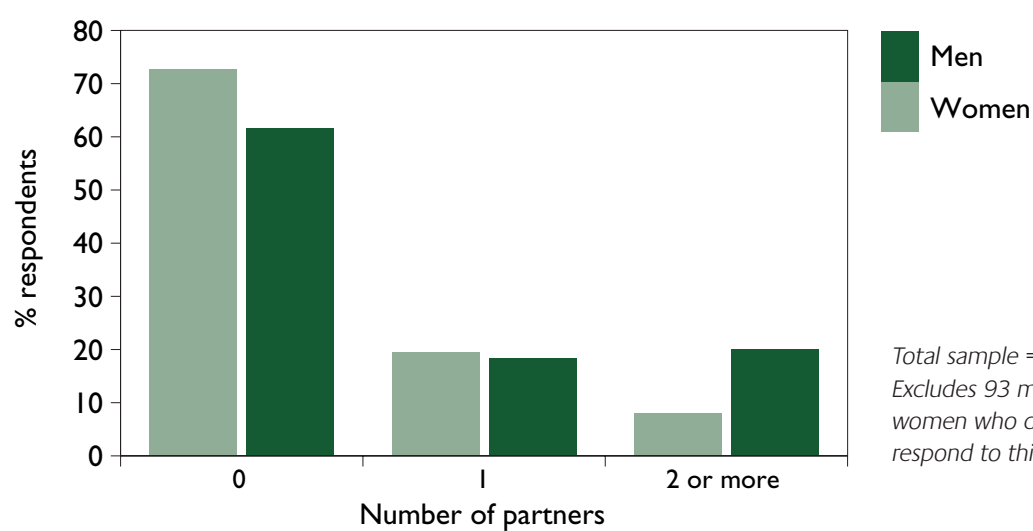


FIGURE 6B

Reported number of new sexual partners in past 12 months among Mayisha II respondents



Women with children were sometimes reluctant to embark on serious relationships, preferring to avoid situations that might disrupt their childcare routine. For some single women and for men and women living apart from their long-term partners, celibacy was regarded as the only effective strategy to avoid HIV – for others it was an undesired consequence of the isolation they were experiencing since migration to the UK. Others described how they preferred to get to know their partner over several months before developing sexual dimensions of their relationship, or intended to wait until they were married before having sex with their partner. Such strategies were used to avoid risk of developing a relationship with someone that already had a partner or would be unsuitable in other ways, as well as to avoid HIV. However, those prescribing abstinence during the early stages of a relationship, also described instances when they were ‘carried away’ and did have sex sooner than they had planned.

“I wasn’t ready but we knew each other for some time and it just happened because we’d been really out of hand for sometime ... I’m a Christian, my religion teaches me not to have sex before marriage..., it just happened. I mean it just happened that time and he gets to London for some time, nothing happened when he was here, we used just to kiss and cuddle, you know, and try to, to not get yourselves in a mood of having sex. I mean like we were kissing, serious kiss, if I say serious kiss it’s not a snog, and cuddling, that’s it. But then he came this year and it happened again. I can count how many times I had sex, you know.”
Woman, age 24.

Over half the male respondents who answered the question regarding **condom use**, reported that they used a condom the last time they had sex (57.4%), compared to just under half of the women (48.8%) (see Table 5). The **main reason for condom use** reported by both men and women was to protect against both pregnancy and HIV/STIs; 62.8% (359/572) reported they had used it for this reason. The majority of the other respondents, had used a condom to protect against either pregnancy or HIV/STIs.

Of those who answered, the majority of men and women agreed or strongly agreed with the statement “I think I could convince a new sexual partner to use a condom, even if they did not want to use one” (93.7% and 91.0% respectively see Table 5).

Generally, condom use was not regarded as necessary or appropriate in marriage or long-term relationships by the Mayisha II qualitative sample, mainly because of expectations of monogamy and trust in the partner to remain faithful, although some couples did take HIV tests together before ceasing to use condoms. For these respondents, faithfulness to one partner was regarded as the most effective strategy for avoiding HIV and other STIs. In fact, once in a monogamous relationship, attempting to use a condom would raise suspicions that the partner had been unfaithful, or that one partner did not trust the other.

“Because even to be seen with a condom it was just like you’re not a good person sort of.”
Man, age 39.



TABLE 5

Condom use and partner acquisition of Mayisha II respondents

Behavioural Characteristics	Number or respondents (%)			
	Women		Men	
Condom use (last act of intercourse)				
Yes	253	(48.8)	347	(57.4)
No	265	(51.2)	258	(42.6)
Base	518		605	
Reason condom used (last intercourse)				
Pregnancy	41	(16.9)	43	(13.1)
HIV/STI	27	(11.1)	84	(25.5)
Pregnancy and HIV/STI	166	(68.3)	193	(58.7)
Other	9	(3.7)	9	(2.7)
Base	243		329	
Ability to convince new sex partner to use condom				
Strongly agree	363	(63.4)	379	(60.2)
Agree	158	(27.6)	211	(33.5)
Disagree	31	(5.4)	23	(3.7)
Strongly disagree	21	(3.7)	17	(2.7)
Base	573		630	
Where met most recent partner				
College, university, work	129	(24.7)	144	(24.2)
Café, restaurant, bar, club	69	(13.2)	78	(13.1)
Social event / interest group	75	(14.3)	106	(17.9)
On holiday	16	(3.1)	18	(3.0)
Internet	12	(2.3)	14	(2.4)
Friends, relatives, neighbours	141	(27.0)	141	(23.7)
Church	44	(8.4)	45	(7.6)
Other	37	(7.1)	48	(8.1)
Base	523		594	

When they were used, condoms tended to be used to avoid pregnancy rather than STIs but many couples preferred other methods of contraception, or desired children – fertility and reproduction being held in high esteem by men and women of all ages.

Dislike of condoms was widespread among men and women. Those that had attempted to use condoms cited discomfort and genital irritation. Women in particular who were married or in long term relationships, described how husbands took the

lead in decisions to use condoms or not. These husbands were very reluctant to use condoms, some preferring temporary abstinence to condom use, for example during treatment for STIs. For women in such relationships, this meant the use of methods, for example withdrawal, that they were not comfortable with. Among the men there was some agreement that they controlled condom use, and that they would be suspicious if their partners wanted to change existing methods of contraception.

Those describing partnerships or encounters that had been concurrent with an existing long-term relationship told how condoms were not used at all or were used inconsistently. Among men, reasons for this included assertions by female partners that pregnancy was unlikely, a lack of awareness of the possibility of STI transmission and sexual desire. Some reported that they would use condoms at the beginning of a new relationship, and some men who had multiple relationships reported condom use when they did not trust their partner. However, respondents added that after a few months, once trust had developed, condom use would cease. Others revealed that they had never used condoms, including those with previous diagnoses of STIs.

For some, safer sex was very important and condom use was a central tenet of this.

“If I can, I will marry quickly, yes. If I can’t, I will use condom...I don’t like it but I don’t have a choice because I like my life. That’s it.”

Man, age 18.

Among these men and women, there was greater discussion about safer sex preferences in relationships and evidence that women felt confident in asserting their wishes in this respect as well as a reluctance to rely their partners’ accounts of their sexual histories. Such views were found among those who had a partner remaining in their home country in Africa.

For example one man recounted how, following trips to his home country, his girlfriend would pack condoms in his luggage on his return to the UK. However, respondents also commented on the cost of condoms and wanted to know where they could obtain condoms more cheaply – GUM services were not used to replenish condom supplies.

“They’re not cheap, I think they’re expensive. I think they are expensive because there are very few in a pack and if you have to use them everyday and depending on, you know, how often you use them so I don’t think they’re cheap... I get surprised why there’s not a centre, maybe there are and I’m not aware about it, where you can get them like they’re readily available and they’re real cheap because I think they should be free.”

Woman, age 29.

Among these men and women, were those who were adamant that condom use would be an ongoing feature of their relationships, whereas others discontinued condom use once faith and trust in the partner had been established. Those in the former group that hoped to have children in future were worried about how to practice safer sex and start a family.

“They say if you can, abstain. If you can’t, use a condom, yes. Not to allow anyone to just have unprotected sex with you, that’s basically it....It’s - it’s hard. Well, that is the best advice I’ve seen but again in life you just, I just think maybe it’s bad luck, that’s what I think, I think maybe it’s bad luck because, well, when you think of like I’ve abstained, I’ve never had penetrative sex yet but I just can’t live forever without a child and I just know at one time I’ll have to take a risk because I need a baby and I don’t know, it might happen.”

Woman, age 18.

The two main ways through which respondents had **met their most recent partner** (see Table 5) was through friends, relatives or neighbours (25.2%) and through college, university or work (24.4%). Relatively few respondents had met their recent partner on holiday (3.0%), via the internet (2.3%) or through church (8.0%).

The majority of respondents reported that in general they had partners of the **opposite** sex (92.2% of women and 91.9% of men who responded). Of those who didn’t, 1.5% had sex with both men and women (this percentage is the same for both sexes). **Same sex** partners were reported by 8.0% of men and women; 5.6% reported same sex only, and 2.4% reported sex with both men and women. These proportions were similar for both men and women (data not shown).

Men reporting **same sex partners** described that these had initially been conducted in secret due to fear of discovery and likelihood of attracting the acute disapproval of homosexuality that pervaded family, friends and faith groups. Those who were openly gay in the UK described difficult emotional journeys to being in such a position, including times when they had been rejected by their family or church. Despite preferences for same sex relationships or identifying as gay, these men also reported a desire for children and to continue their family line, so some had had relationships with women or had been married.

4.4 Unlinked anonymous HIV testing within Mayisha II: Oral fluid uptake

Overall uptake of the oral fluid sample in the main study was 75.3% (1023/1359), and was higher among women (76.7%) than in men (73.9%). Uptake varied by area of recruitment: in London 81.7% (712/872); in Luton 65.1% (164/252); and in the West Midlands 62.6% (147/235) of respondents gave an oral fluid sample. Uptake also varied according to recruitment site (see Figure 2). Where the recruitment site or venue was known, uptake ranged from 62.1% (36/58) in churches to 84.4% (454/538) at community centres and events.

Uptake of the oral fluid sample in the main study did not vary by any demographic, behavioural or service use characteristics. Reported history of a previous voluntary confidential HIV test also had no impact on whether respondents gave an oral fluid sample - of those who had never had an HIV test, 74.8% (537/718) gave a sample compared to 76.5% (482/630) of respondents who reported having had a voluntary confidential test. However, respondents who reported they were HIV positive at their last HIV test were significantly less likely ($p < 0.001$) to give an oral fluid sample than those who had a negative result; 61.4% (51/83) compared to 79.2% (388/490). Behavioural characteristics, such as number of sexual partners and condom use, had little impact on whether a respondent gave an oral fluid sample.

Reasons why respondents provided an oral fluid sample were explored through in-depth interviews in the pilot study. Motivational factors to give an oral fluid sample were informed by two main areas: perceptions of the study benefits, that this was an important research study and that the information and sample they had given would be beneficial for the community and the future; and by trust in the fieldworker to uphold assertions that the respondent would remain anonymous.

4.5 HIV positivity among the Mayisha II community sample

4.5.1 Overall community sample positivity

Of the 1359 eligible respondents, 1023 (75.3%) gave an oral fluid (OF) sample. Of these, 17 (1.7%) were insufficient and could not be analysed. The following results are therefore based on 493 women who gave an analysable sample (representing 75.4% of the women recruited) and 513 men (representing 72.7% of the men recruited), 1006 respondents in total.

The overall **HIV positivity** of the Mayisha II community sample was 14.0% (15.0% in women and 13.1% in men) ⁴. Table 6 illustrates the Mayisha II community sample positivity in each of the three study areas by gender. In London, Mayisha II community sample positivity was 12.5% and did not vary significantly by gender. Outside London, Mayisha II community sample positivity was 17.5% (9.9% in Luton and 26.2% in the West Midlands)⁵.

The data shown from this point is for all three recruitment areas and is based on all those providing a useable oral fluid sample; it includes data on key demographics and service use characteristics. Appendices 1 and 2 summarise the results from Luton and the West Midlands separately.

4.5.2 Demographic characteristics

In both men and women, community sample positivity was highest among respondents in the older **age groups**: 26.8% in men aged 40 to 44 years and 25.5% in women aged 35 to 39 years (see Figure 7). This was higher than in younger respondents; the lowest community sample positivity in both men and women was in those aged under 25 years (8.1% and 4.5% respectively). Community sample positivity was higher in women age 25 to 29 compared to men in this age group (Figure 7).

⁴ It should be noted that the positivity reported is that of the recruited sample and does not necessarily reflect true HIV positivity in black African communities across the UK. The data from this survey will contribute to the Direct Estimate Methodology at the HPA, whereby population prevalence of HIV is estimated from a combination of different survey data (e.g. Natsal, SOPHID, the Unlinked Anonymous Surveys of Pregnant Women and the Unlinked Anonymous Survey of GUM Clinic Attendees). Mayisha II data will further refine these estimates. The sample positivity presented are however useful in their own right, particularly when exploring associations between HIV positivity and sample characteristics (demographic, service use and behavioural) and in determining the diagnosed and undiagnosed proportion of HIV in the sample population.

⁵ The percentages shown in this table are proportions of the area and gender variables, so will not add to 100%, for example of all women providing an oral fluid sample in London, 12.5% (45/361) were HIV positive.

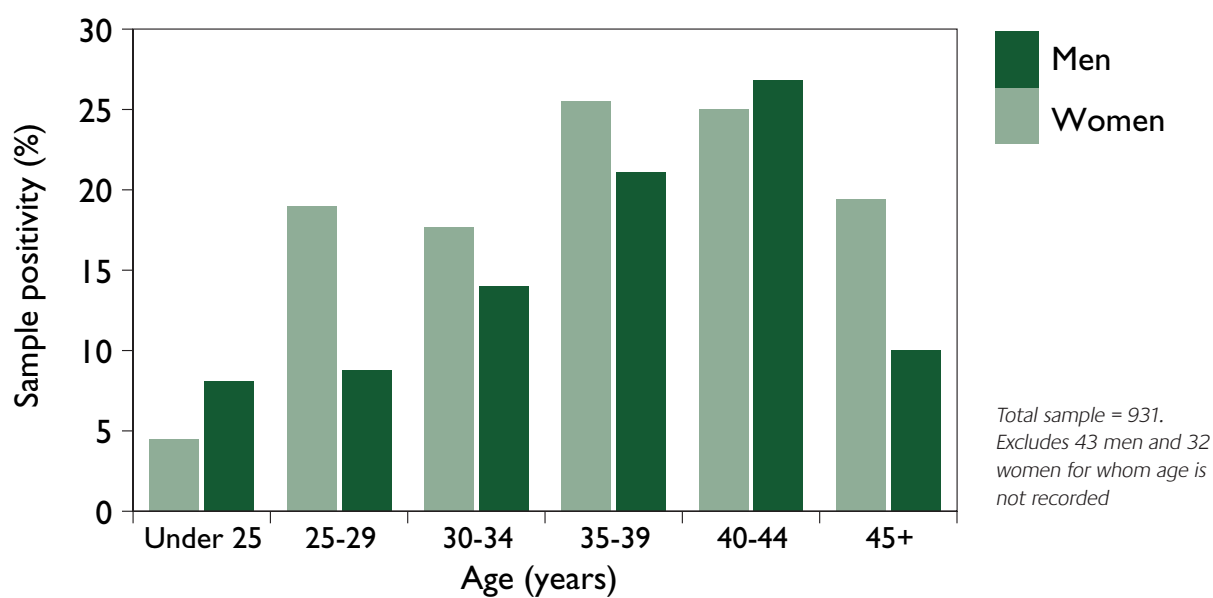
TABLE 6

HIV positivity in the Mayisha II community sample

Recruitment area	HIV positivity in the Mayisha II community sample %	
	Women	Men
London	12.5 (45/361)	12.6 (43/342)
Luton	11.3 (7/62)	9.0 (9/100)
West Midlands	31.4 (22/70)	21.1 (15/71)
Total usable OF sample	15.0 (74/493)	13.1 (67/513)

FIGURE 7

Age groups and positivity in the Mayisha II community sample



Community sample positivity varied substantially by African **region of birth** (see Table 7) and ranged from 23.5% in respondents born in South Eastern and Eastern Africa and 26% in those born in Southern Africa to 3.5% in respondents born in Horn of Africa and zero in respondents born in Northern Africa.

Among both men and women, community sample positivity was lower in those who reported achieving none or up to primary **education** (8.8%) than those who said they achieved secondary or university level education (14.1% and 14.9% respectively, see Table 7).

TABLE 7		
Demographic characteristics and positivity in the Maysiha II community sample ⁶		
Demographic characteristics	HIV positivity in the Mayisha II community sample %	
	Women and men	
Region of birth		
South Eastern and Eastern Africa	23.5	(102/434)
Horn of Africa	3.5	(8/230)
Southern Africa	26.0	(12/46)
Central and South Western Africa	9.1	(7/77)
Western Africa	25.0	(9/36)
Northern Africa	0.0	(0/3)
Outside Africa	5.5	(3/55)
Education attainment		
None / Primary, elementary	8.8	(6/68)
Secondary, high school	14.0	(35/248)
University, college	14.9	(81/543)
Other	11.3	(15/133)
Relationship status		
Married	13.0	(42/324)
Widowed, separated, divorced	32.7	(18/55)
Living with partner	18.2	(14/77)
In relationship (not living with partner)	13.0	(16/123)
Single	11.8	(49/415)

Community sample positivity by **relationship status** is presented in Table 7 and is higher in married men (16.5) compared to single men (9.1%). In women, community sample positivity was 8.8% in married women compared to 14.5% in single women. Higher levels of community sample positivity were present in men and women who said they were widowed, separated or divorced (31.3% and 33.3% respectively).

Among women who reported either mainly **same sex** relationships or reported male and female partners, community sample positivity was zero, compared to 17.4% in women reporting partners of the opposite sex. Community sample positivity in men reporting mainly same sex partners was 22.2% compared to 12.6% in men reporting that they generally had partners of the opposite sex (data not shown).

4.5.3 Service use characteristics

There was no difference in community sample positivity among women who had attended an **ante-natal clinic** in the past five years compared to women who had not (15.2%, data not shown).

Community sample positivity by reported service use is presented in Table 8. Community sample positivity was highest in both men and women who reported **attending a GUM / STI clinic** in the past five years; 27.2% in women and 21.9% in men. Furthermore, community sample positivity was higher in respondents who had reported ever having an **STI diagnosis** ($p < 0.001$) than in those respondents who said they had never had an STI diagnosed (see Figure 8).

Community sample positivity was higher in the sample that reported they had ever had a previous **HIV test** compared to those who reported never having an HIV test (Table 8). Community sample positivity was higher in women who had their last HIV test at a GUM / STI clinic rather than at their GP (38.2% compared to 15.9%) whilst in men community sample positivity was higher in men who had last tested at their GP (16.7% at GUM / STI clinics compared to 26.7% at their GP).

⁶ Variables with small cell sizes have been combined in Tables 7 and 8. Percentages are proportions within variables and do not add up to 100%.

FIGURE 8

Reported STI diagnosis and positivity in the Mayisha II community sample

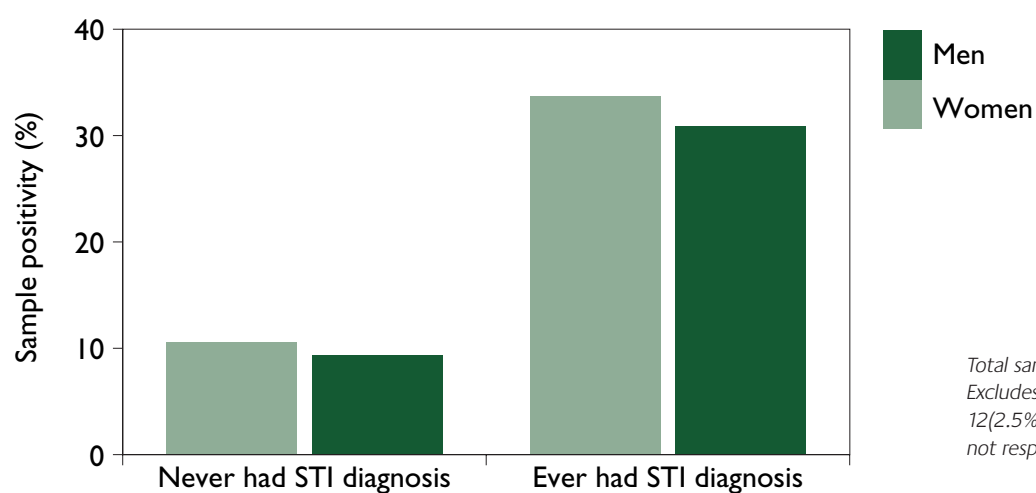


TABLE 8

Service use and positivity in the Mayisha II community sample

Service use characteristics	HIV positivity in the Mayisha II community sample %	
	Women and men	
GUM / STI clinic attendance		
Never attended	8.8	(53/601)
Under five years ago	24.7	(80/324)
Over five years ago	9.1	(5/55)
Ever had an HIV test		
Never tested	9.7	(51/526)
Under five years ago	17.9	(75/418)
Over five years ago	28.6	(14/49)

4.5.4 Diagnosed and undiagnosed HIV infection in the Mayisha II community sample

The proportion of HIV infections detected through unlinked anonymous testing that were undiagnosed was estimated using respondents' reported HIV testing history. Of the 141 respondents that tested HIV positive through unlinked anonymous testing (74 women and 67 men), 63.1% (89) reported they had a previous HIV test, of whom 53.9% (48/89) reported their last HIV test result was positive. Of the other respondents with an HIV positive sample, that reported a previous HIV test, 31.5% (28/89) reported their last HIV test result to be negative, whilst 15.7% (14/89) said they did not know their result or had not collected it.

Overall, two-thirds of respondents with an HIV positive sample, had undiagnosed HIV (66.0%, 93/141), according to their replies to survey questions regarding previous voluntary HIV tests. This result is based on the 51 respondents reporting they had never tested, 28 respondents reporting their previous test to be negative and 14 that said they did not know the result of their previous test. The proportion HIV infections undiagnosed was 71.6% in men (48/67) and 60.8% (45/74) in women. Overall, 9.2% of the Mayisha II community sample that provided an oral fluid sample had **undiagnosed** HIV infection whilst 4.8% had **diagnosed** HIV infection. Both diagnosed and undiagnosed community sample positivity by recruitment area is shown in Table 9.

Estimating diagnosed and undiagnosed HIV infection through reported HIV testing and status relies on accurate reporting of HIV status by respondents. Respondents who were aware of

their infection may have been reluctant to disclose that information on a questionnaire for research purposes.

Although every effort was made to maintain confidentiality and all questionnaires were sealed in a tamper-proof envelope, information from the qualitative component of the study indicated that stigma and fear of disclosure is still common in this population. This may have led to a failure to disclose a previous HIV test result. However, only 1.5% did not respond to the question regarding a previous voluntary HIV test. Furthermore, the proportion of HIV infections undiagnosed is comparable to the proportion of HIV infections detected through antenatal testing that were undiagnosed prior to pregnancy (60% in London and 72% outside London, HPA 2004).

Those that perceived their status to be negative felt this to be the case because they had remained faithful to the same partner; had not varied in their partner or safer sex practices since their last HIV negative test; had tested HIV negative in the past, or their partners had tested HIV negative; did not feel that their partners posed a risk of HIV; and because they felt physically healthy. However, among these respondents were women with more mixed feelings who were concerned that they may be at risk of HIV infection because they were having unprotected sex with a partner they did not fully trust or was known to have concurrent partners. Among those with concurrent or multiple partners, perceptions of HIV negative status were associated with underlying beliefs that HIV was a disease that affected people from other parts of Africa to their home country, or was a 'white' person's disease or was associated with gay men.

TABLE 9

Diagnosed and undiagnosed HIV infection in the Mayisha II community sample

Recruitment area	HIV positivity in the Mayisha II community sample %			
	Diagnosed		Undiagnosed	
London	4.6	(32/703)	8.0	(56/703)
Luton	2.5	(4/162)	7.4	(12/162)
West Midlands	8.5	(12/141)	17.7	(25/141)

Others that had not tested included those who were fearful of being HIV positive because of past sexual encounters or spells of unprotected sex.

Respondent:

"It was the first time I had, I actually had sex with someone who didn't have a condom, that was my thinking and I could have possibly have had it, I wouldn't know. But then as time went past and I was at church for, I don't know how many years, and nothing developed within my body or outside my body and I thought, oh, maybe I don't have it. But it was such a fearful thought and I'm afraid, I mean I had always been afraid of sex but that just made it more real and more scary."

Interviewer:

Did you ever consider testing for HIV?

Respondent:

"Yes, I did but I never got round to it, I was too scared to find out. I'd sort of rather die not knowing."

Woman, age 33.

This anxiety persisted, but uncertainty about how to obtain a test in the UK, lack of time or fear of being unable to cope with a positive diagnosis deterred these respondents from attending for an HIV test. For some this fear arose from expectations of rejection and discrimination, others were worried about causing anxiety to loved ones, such as parents and siblings.

"I think I would really find it hard telling my family back home. I think that would be really difficult. Because back home there is stigma - the stigma is really bad. I mean I hear stories, I hear stories from people, I mean even my friend's husband went home and he's saying a lot of people, you know, nowadays people are talking about it a lot and what's happening is that when people fall ill now with HIV back home they just quietly, when the doctors have detected it's HIV and they diagnose it, or maybe AIDS, they just quietly take them to a village and just keep them, you know, hide them away and let them die. And even the funeral, they don't have big funerals or anything, because nobody wants to come to the funeral, they think they will get infected."

Woman, age 33.

Respondents made suggestions regarding interventions that would encourage HIV testing and knowledge of HIV status. HIV testing and knowledge of status was regarded by these respondents as a useful prevention strategy.

"Yes, don't die of ignorance. They tell everybody don't die of ignorance."

Woman, age 50.

At a personal level, a reduction in fear of discrimination was regarded as key to creating an environment that would be more conducive to HIV testing and knowledge of HIV status. Respondents' accounts suggest that they expected that an HIV diagnosis would trigger a loss of control of their lives in terms of their health, immigration, relationships and care of their children. Interventions that signal how awareness of HIV status can facilitate management of the condition and positive role models would address some of these concerns. Better access to testing was requested by respondents, for example testing at GPs and rapid or same day testing, so that a separate clinic visit does not have to be made to collect results. Encouragement and support from trusted friends and relatives or outreach workers also helped respondents summon the courage to attend for an HIV test.

"It wasn't simple, it wasn't simple, going there, even hearing about the test, it wasn't simple. Stepping into the clinic, you go quaking as if you want to die from that disease but [thinking] if it is this I don't know what I'm going to do so - but of course if she's [girlfriend] there telling you, or I'm there telling her we go, she's confident, she has confidence and of course if you tell her you have never done this she will tell you we go, we have no alternative, we have to go but in the heart, 'oh, no'."

Man, age 26.

At a general level, respondents requested information about where to test, what happens at a test, testing and pregnancy, rapid testing, effectiveness of treatment, immigration and HIV testing and the difference between HIV and AIDS. Suggestions for places to distribute information about HIV included meeting places popular with young people, for example restaurant chains such as Nandos and colleges.

5 Conclusions

5.1 Summary points

- Mayisha II is the largest study of sexual attitudes and lifestyles of African communities in England.
- The success of overall recruitment and the uptake of the oral fluid HIV testing among respondents attest to the acceptability of using participatory methods for study design and implementation and the commitment of African communities to supporting studies of this nature and improving sexual health.
- The data derived from this study will provide updated behavioural estimates for the study partners to develop and evaluate culturally specific HIV health promotion interventions.

Mayisha II (2004) is now the largest survey of sexual attitudes and lifestyles to be undertaken among African communities in England. The study has built upon the findings from the first survey undertaken five years ago and has significantly contributed to our understanding of the epidemiology of HIV infection among African communities in the UK; geographic variations across the country; and the factors associated with HIV infection and high-risk sexual behaviours in this population. In this chapter we examine the key findings of this study in relation to the project's set objectives.

5.2 Feasibility of community-based convenience sample surveys among African communities in the UK

Investigators in the Mayisha II study aimed to carry out a survey of sexual attitudes and lifestyles of 1500 black African men and women aged 16 years and over recruited from social and commercial venues in London, Luton and the West Midlands using a brief, validated, self-completion questionnaire. Although the overall recruitment target was exceeded, only 1359 black African respondents were recruited, the remainder being of other ethnicities – in part reflecting the ethnic diversities utilising 'African' social and commercial venues. Nevertheless, this represents a near doubling of the sample of Africans recruited in the 1999 Mayisha I survey, with the provision, for the first time, of data on Africans resident outside of the greater London area.

The community-based nature of the recruitment also illustrates the diversities within social and commercial venues suitable for recruitment in studies of this nature. The sample included 38 different countries of birth. That only a relatively smaller proportion of our sample were derived from pubs and clubs (as opposed to similar studies within men who have sex with men) is illustrative both of the lack of these social infrastructures as well as the lower importance of these establishments in the social fabric and lives of African communities in England. The venues represent culturally appropriate and acceptable sites for targeting studies of this nature, and are currently the sites where health promotion messages are being delivered. In this regard, Mayisha II provides us with relevant and appropriate information on the target community.

Mayisha once again confirms the feasibility and acceptability of utilising participatory research methods to undertake convenience sample surveying among migrant communities. The high response rates and support from African communities attest to the commitment of African communities to improving sexual health and preventing HIV. However, fear of both HIV- and immigration-related stigma and discrimination present a considerable challenge to undertaking studies of this nature, indicating a need for these issues to be addressed. Future intermittent behavioural surveys of this nature within African communities in the United Kingdom will provide an adjunct to the large scale probability sample studies (e.g. the National Survey of Sexual Attitudes and Lifestyles (Natsal)) whilst providing more detailed information on a wider range of African communities.

5.3 Feasibility and acceptability of collecting oral fluid samples for HIV testing

Mayisha II aimed to evaluate the feasibility and acceptability of providing unlinked anonymous oral fluid samples for HIV antibody testing as part of the community based survey. Three-quarters of the recruited sample agreed to provide an oral fluid sample for HIV testing. This is substantially higher than previous community based samples with other social groups and points to the feasibility of applying this method in future surveys of this nature. Valuable qualitative insights into the factors influencing participation in this component of the study were obtained. In particular, we note that HIV-related stigma and discrimination is sometimes a deterrent to reporting one's HIV status in surveys of this nature, and may also have a negative impact on provision of samples. These insights should help to better inform the application of these methods in community and GUM clinic based seroprevalence surveys. The study results suggest that oral fluid testing for HIV can be incorporated in future behavioural surveys of this nature, and that testing for other, less sensitive, pathogens (e.g. hepatitis B) is likely to be highly successful with this community.

5.4 Updating estimates of high-risk sexual behaviour

Our study provides updated estimates of sexual behaviour and use of sexual health services among migrant African communities in England. It builds upon data from Mayisha I, and the recently completed ethnic minority boost of Natsal 2000. Taken in concert, the data confirm the high levels of GUM / STI clinic attendance (approximately 40%) and HIV testing uptake (between 42 and 50%) among Africans in England. They also provide insight into the patterns and distribution of risk behaviours among a wider range of African communities than do the previous surveys. In particular, we have obtained robust estimates of risk behaviours for communities from Horn of Africa and Western Africa – two communities that were not included in the Mayisha I study. For the first time, the combined use of qualitative techniques has provided data on the contexts surrounding and meanings associated with high-risk behaviours that may be useful for refining health promotion messages.

A key element of future analyses will be to understand the patterns of behavioural change between the Mayisha I and II surveys, taking into consideration the different sample populations and locations. Comparison of our data with data derived from Natsal 2000 will also help to better understand the intersection and overlap between convenience sample and probability sample surveys. These analyses will be presented in peer-reviewed papers in academic journals and will include more detailed analyses of HIV positivity and its determinants; behavioural change over time; and risk behaviours and their determinants. These peer-reviewed papers will also be widely disseminated within the Mayisha II collaborative group and to target communities.

5.5 Measuring diagnosed and undiagnosed HIV infection

For the first time, Mayisha II has provided estimates of diagnosed and undiagnosed HIV infection among the recruited sample and demographic and behavioural associations with HIV infection. We acknowledge the feasibility and limitations of obtaining information on HIV status from respondents in community based surveys of this nature. The high item completion rates suggest some willingness to provide responses to this highly sensitive question, however further analyses will help us to better target future surveys of this nature.

We note the high overall HIV positivity of the Mayisha II community sample and re-iterate that this represents the over sampling of HIV positive Africans, anticipated as part of our recruitment strategy and is likely to be substantially higher than the current prevalence of HIV in African communities in England. The reasons for the over sampling include: convenience of sites for recruitment and willingness of HIV positive people to participate in the survey. These HIV positivity data are nevertheless extremely useful. They will provide further information on the factors associated with diagnosed and undiagnosed HIV infections among African communities. This will be the subject of future research publications.

There is some discordance in the community sample between reported and actual HIV positivity in our sample. Half of respondents who were positive reported that they had previously tested HIV positive. However, this is similar to proportions of previously undiagnosed HIV calculated from STI clinic surveys (Unlinked Anonymous GUM Surveys), and may reflect some participation bias or may be a reflection of the need for further investment in HIV testing initiatives within the community. However, more detailed evaluation of this topic remains a priority area for future work. More specifically, comparison of the data obtained from this community-based survey with similar unlinked anonymous seroprevalence data from GUM / STI and antenatal clinic attendees will provide improved HIV prevalence estimates among African communities in England.

5.6 Informing health promotion strategies

Mayisha II has provided updated information to guide health promotion strategies and development of sexual health services. Our study partners have been involved from the inception of the project and have ensured that the content of the study questionnaire reflects current HIV health promotion needs for the African communities in England today. The expanded range of demographic, behavioural and health service utilisation questions in Mayisha II will ensure our ability to explore new domains of relevance to those working in health promotion and disease prevention with African communities.

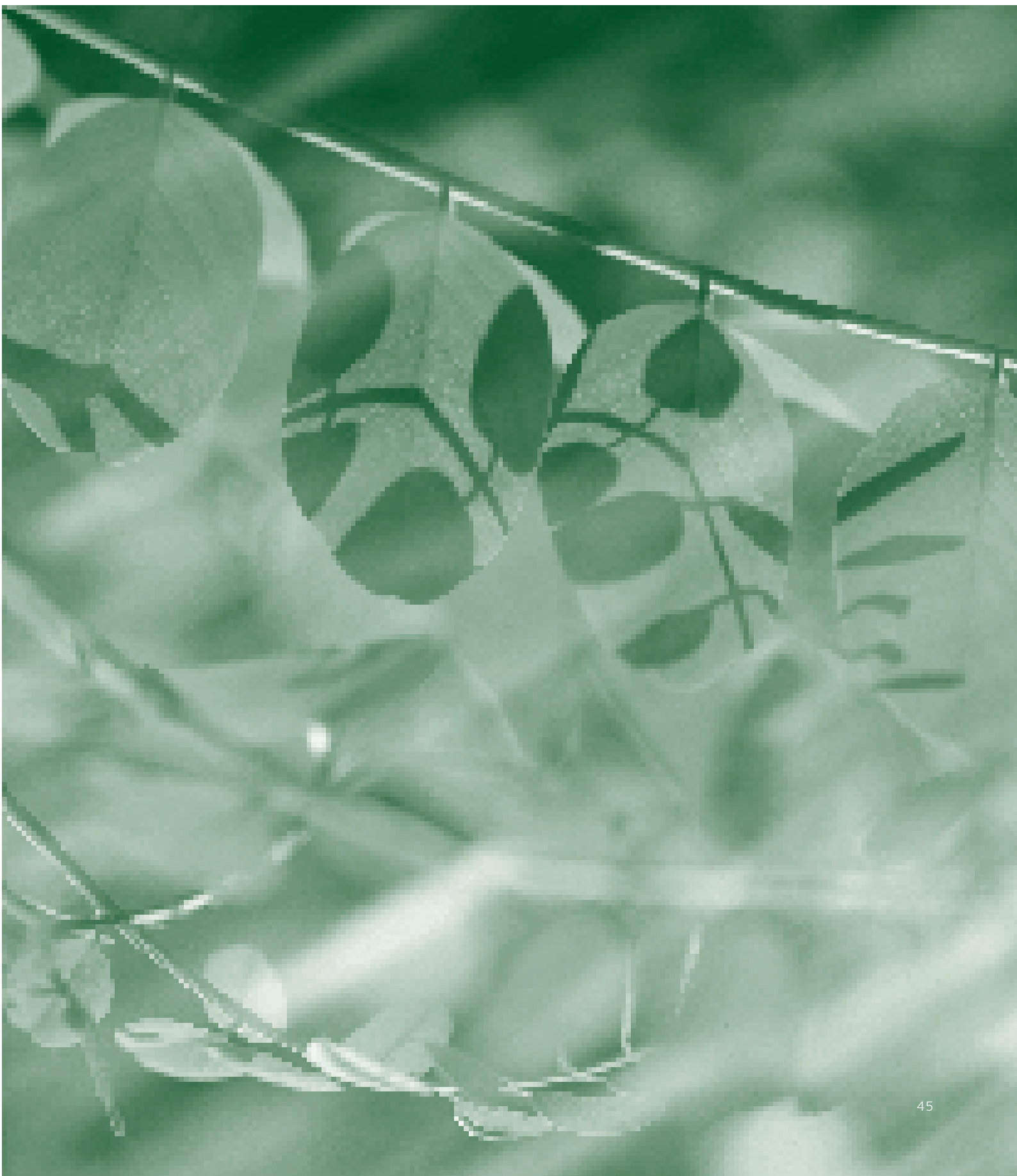
5.7 The cultural and psychosocial contexts

Mayisha II, through the combination of qualitative and quantitative methods, provides a better understanding of the cultural and psychosocial contexts surrounding high-risk behaviours and HIV testing among Africans in England today. The recurring theme of the impact of HIV related stigma and discrimination is worrying, two decades into the HIV epidemic and after numerous publicity campaigns on this issue in England. Our data suggest that these issues remain real to African communities living in England today who have to deal with a range of discrimination issues.

Our study confirms that the impact of discrimination and stigma is widespread within the lives of Africans – influencing their partnership choices, decision to HIV test, uptake of services, risk behaviours, and ability to disclose to colleagues and loved ones. Our data also highlight the importance of religion in the lives of Africans in England and the support that the church provides both to individuals and their communities. This pillar of the African community cannot be overlooked and study findings suggest that further research into the role of religion in HIV prevention and opportunities for the church to tackle HIV related stigma and discrimination would be of benefit. Further analyses arising from this study will be disseminated via peer-reviewed publications.

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7 Appendix I

7.1 Luton summary

Over a period of three months (August-October 2004), 292 people were recruited to Mayisha II in Luton. Of these, 252 respondents identified themselves as being black African; 103 (40.9%) were women and 149 (59.1%) were men.

The following is a summary of the socio-demographic, service use, oral fluid uptake and community sample positivity.

The two main sites of recruitment were through the respondents' social networks (31.1% of women and 23.5% of men) and from universities or colleges (17.5% of women and

22.8% of men). Health promotion and community events, markets, shops and churches were also popular sites for recruitment.

Table 10 presents the characteristics of the Luton sample. Male respondents were slightly older than the female respondents – the highest proportion of women were aged 25 to 29 years compared to men who were aged 30 to 34 years. The majority of men and women were born in South Eastern and Eastern Africa (67.1% and 58.3% respectively), most of whom were born in Zimbabwe (61.1%). A higher proportion of women compared to men were born in Southern and Western African (see Table 10 – data not shown for region of birth).

TABLE 10

Demographic characteristics of Mayisha II: Luton community sample

Demographic Characteristics	Number of respondents (%)			
	Women		Men	
Age (years)				
Under 25	27	(28.4)	28	(19.6)
25-29	31	(32.7)	37	(25.9)
30-34	16	(16.9)	40	(28.0)
35-39	5	(5.3)	18	(12.6)
40-44	7	(7.4)	14	(9.8)
45 and over	9	(9.5)	6	(4.2)
<i>Base</i>	95		143	
Migration length (years)				
Under 2	22	(23.4)	28	(20.7)
3 to 4	46	(48.9)	70	(51.9)
5 to 9	20	(21.3)	21	(15.6)
10 and over	6	(6.4)	16	(11.9)
<i>Base</i>	94		135	
Relationship status				
Married	33	(32.7)	62	(42.2)
Widowed/separated/divorced	13	(12.9)	6	(4.1)
Living with partner	5	(5.0)	10	(6.8)
In relationship (not living with partner)	11	(10.9)	26	(17.7)
Single	39	(38.6)	43	(29.3)
<i>Base</i>	101		147	

The majority of men and women had been living in the UK for less than five years (72.6% and 72.3%). A higher proportion of male respondents were married (42.2%) whereas the highest proportion of females were single (38.6%). Female respondents who were widowed, separated or divorced represented a three-fold higher percentage of the women than the proportion of men (12.9% compared to 4.1%).

The majority of both male and female respondents reported they had never attended a GUM / STI clinic (76.2% and 64.7% respectively see Table 11). Of respondents who reported attending a GUM / STI clinic, most had done so in the past five years (83.3% (30/36) of women and 73.5% (25/34) of men). Over a third of men and women reported ever having an HIV test (34.0% and 46.0% respectively) and of respondents who reported a previous HIV test, the majority had done so in the past five years (89.4% of women and 96.0% of men).

7.2 Oral fluid uptake in the Mayisha II Luton community sample

Overall, oral fluid uptake was 65.1% . This was similar for both men and women (67.1% and 62.1%). The proportion of the

younger (age under 25 years) respondents who gave an oral fluid sample was higher in men than in women (78.6% compared to 66.7%). However, uptake was similar across age groups.

7.3 HIV positivity in the Mayisha II Luton community sample

HIV positivity in the Luton community sample was 9.3% (15/162). The highest HIV positivity was among those aged 40 to 44 years (41.7%). Respondents aged under 25 years had lower levels of infection (5.0%). No HIV infections were found among those aged 35-39 years. All male respondents with HIV infection were born in South Eastern and Eastern Africa, compared to female respondents who were born in South Eastern and Eastern, Southern and Western Africa. Married and single respondents had similar levels of HIV infection. Respondents who reported that they had never had an HIV test had lower levels of HIV infection than respondents who reported that they had – 8.1% compared to 19.2%.

⁷ Small cell sizes have been combined.

TABLE 11

Service use in the Mayisha II Luton community sample⁷

Service use characteristics

GUM / STI clinic attendance

	Number of respondents (%)			
	Women		Men	
Never attended	66	(64.7)	109	(76.2)
Less than five years ago	30	(29.4)	25	(17.5)
More than five years ago	6	(5.9)	9	(6.3)
Base	102		143	

Ever had an HIV test⁷

	Number of respondents (%)			
	Women		Men	
Never tested	55	(53.9)	97	(66.0)
Tested previously	47	(46.0)	50	(34.0)
Base	102		147	

8 Appendix 2

8.1 West Midlands summary

Over a period of three months (August-October 2004), 260 people were recruited to Mayisha II in the West Midlands. Of these, 235 respondents identified themselves as being black African; 114 (48.5%) were women and 121 (51.5%) were men. The following is a summary of the socio-demographic, service use, oral fluid uptake and HIV positivity of the sample.

The recruitment site for respondents in the West Midlands sample was recorded for 43.2% of the sample. Sites included: an African community day event; universities and colleges; shops; hairdressers; and the social networks of the fieldworkers.

Table 12 presents the characteristics of the West Midlands respondents. The sample showed a wide distribution of age

groups. The highest proportion of female respondents were less than 25 years old (31.0%) whilst the highest proportion of male respondents were aged 35 to 39 years (21.6%).

The majority of men and women were born in South Eastern and Eastern Africa (61.2% and 65.8% respectively), most of whom were born in Zimbabwe or Uganda (40.9% and 28.9% respectively). No male respondents born in Western Africa were recruited, whilst 10.5% of female respondents were (see Table 12, data not shown for region of birth).

The majority of both men and women reported living in the UK for less than five years (79.0% and 82.2% respectively). A high proportion of male respondents were married (42.5%) whilst there was an equal proportion of female respondents who were either single or married (34.2%). The proportion of respondents who were widowed, separated or divorced was lower (5.1% overall).

TABLE 12

Demographic characteristics of Mayisha II: West Midlands community sample

Demographic characteristics	Number of respondents (%)			
	Women		Men	
Age (years)				
Under 25	35	(31.0)	22	(19.0)
25-29	24	(21.2)	23	(19.8)
30-34	24	(21.2)	22	(19.0)
35-39	19	(16.8)	25	(21.6)
40-44	6	(5.3)	16	(13.8)
45 and over	5	(4.4)	8	(6.9)
<i>Base</i>	113		116	
Migration length (years)				
Under 2	35	(32.7)	32	(28.1)
3 to 4	53	(49.5)	58	(50.9)
5 to 9	11	(10.3)	13	(11.4)
10 and over	8	(7.5)	11	(9.6)
<i>Base</i>	107		114	
Relationship status				
Married	39	(34.2)	51	(42.5)
Widowed/separated/divorced	6	(5.3)	6	(5.0)
Living with partner	15	(13.2)	11	(9.2)
In relationship (not living with partner)	15	(13.2)	9	(7.5)
Single	39	(34.2)	43	(35.8)
<i>Base</i>	114		120	

TABLE 13

Service use in the Mayisha II West Midlands community sample⁸

Service use characteristics	Number of respondents (%)			
	Women		Men	
GUM / STI clinic attendance				
Never attended	62	(54.9)	65	(55.5)
Attended	51	(45.1)	52	(44.4)
Base	113		117	
Ever had an HIV test				
Never tested	54	(47.8)	60	(50.0)
Tested	59	(52.2)	61	(50.4)
Base	113		121	

Just over half of both male and female respondents reported they had never attended a GUM / STI clinic (55.5% and 54.9% respectively, see Table 13). Of respondents who had attended a GUM / STI clinic, most had done in the past five years; 92.2% (47/51) of women and 86.5% (45/52) of men. The proportion of men and women who reported a previous HIV test was over half (50.4% and 52.2% respectively), the majority of whom had tested within the past five years (see Table 13).

8.2 Oral fluid uptake in the Mayisha II West Midlands community sample

Overall, oral fluid uptake was 62.6%. This was similar for both men and women (62.0% and 63.2% respectively). However, of respondents aged 25 to 29 years, a higher proportion of men gave an oral fluid sample than women (73.9% compared to 58.3%), whilst more women than men in the older age groups gave an oral fluid sample.

8.3 HIV positivity in the Mayisha II West Midlands community sample

HIV positivity in the Mayisha II West Midlands sample was 26.3% (37/141). The highest sample positivity in women was in the 35 to 39 year olds (41.7%) whilst those aged less than 25 years had the lowest (17.7%, data not shown). Of men, the highest sample positivity was detected in those aged 40 to 44 years, whilst those aged under 30 years had the lowest at 15.4%. Married men or those living with a partner had the highest sample positivity (35.7% and 33.3% respectively) whilst in women, sample positivity was higher in those who were widowed, separated or divorced (66.7%). Sample positivity was higher in men who reported they had never had a previous HIV test compared to those men who said they had HIV tested in the past (26.7% compared to 17.1%), whilst sample HIV positivity was higher in women who reported a previous HIV test than those women reporting that they had never tested for HIV (40.5% compared to 21.9%).

⁸ Small cell sizes have been combined.

17 In general are the people you have sex with;

- ☐ Male
☐ Female
☐ Male and Female

18 Thinking of your most recent (or current) sexual partner, what ethnicity are they?

- ☐ Black African ☐ Mixed
☐ Black Caribbean ☐ White
☐ Black British ☐ Asian
☐ Black Other ☐ Other

19 Thinking of your most recent (or current) sexual partner, where did you meet them?

- ☐ College / University / work
☐ Café, restaurant, bar, club
☐ Social event / interest group
☐ On holiday
☐ Internet
☐ Friends / relatives / neighbours
☐ Church
☐ Other (please state)

20 a) What religion are you?

- ☐ Roman Catholic
☐ Protestant (please specify denomination)
.....
☐ Muslim
☐ Other Religion (please state)
.....
☐ No Religion

b) Apart from special occasions (eg Weddings, funerals) how often do you attend religious services?

- ☐ Once a week or more
☐ Once a month or more
☐ Twice a year
☐ Once a year
☐ Never/practically never

21 I do *not* think I am at risk of catching HIV
(please tick the one box that best describes your opinion)

- ☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly disagree

22 How many of your closest friends do you think use condoms with a new sexual partner? (please tick one)

- ☐ Almost all ☐ Less than half
☐ More than half ☐ Almost none
☐ Half

23 I think I could convince a new sexual partner to use a condom, even if they did not want to use one
(please tick one)

- ☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly disagree

24 In this study pack are a series of adverts and posters from an HIV testing campaign for Africans. Have you seen any of these before?

- ☐ No, I have not seen them
☐ I recognise them, but have never looked closely
☐ I have seen them and read some or most of them

Comments about the survey:

Thank you for filling out this questionnaire
Please return to researcher in the envelope provided

9. Appendix 3



Sexual health survey for African Communities

This survey aims to help us develop sexual health services to make them more relevant for you. Some of the questions are of a personal nature, however your replies will be very useful.

This questionnaire is strictly anonymous and confidential. Do not write anything that could identify you

Please answer questions as fully and as accurately as possible.

Study conducted by:
Health Protection Agency, CDSC,
Royal Free & University College
Medical School

Funded by:
Medical Research Council
In collaboration with:
African HIV Policy Network
Terrence Higgins Trust
African HIV Research Forum

Please tick, number or write as appropriate

1 Gender

- ☐ Male
☐ Female

2 Age in years (on last birthday)

.....

3 What is the borough you live in?

.....

(eg Hackney, Croydon, Lambeth)

4 Which ethnicity best describes you?

- ☐ Black African
☐ Black Caribbean
☐ Black British
☐ Black Other
☐ Other ethnic group

5 a) In which country were you born? (Please specify)

.....

b) If born in another country, how long have you been living in the UK?

Years Months

c) If born in another country, why did you first come to live in the UK?

- ☐ To join family ☐ Refugee/Asylum seeker
☐ Employment ☐ Other
☐ Education

6 In what country were you living when you were aged 10-16 years old?

.....

7 Are you currently (tick one or more)

- ☐ Employed ☐ Part-time education
☐ Unemployed ☐ Volunteer
☐ Home/family caring ☐ Other (please specify)
☐ Full-time education

.....

8 What is the highest level of formal education that you have achieved? (please tick one)

- ☐ None
☐ Primary / Elementary
☐ Secondary / High School
☐ University / College
☐ Professional training
☐ Other (please specify)

9 At present, are you (please tick one)

- ☐ Married (partner living abroad)
☐ Married
☐ Widowed / Separated / Divorced
☐ Living with partner
☐ In relationship (not living together)
☐ Single

10 In the last five years, have you attended an antenatal clinic or antenatal service at a hospital or at your GPs in the UK because you were pregnant?

- ☐ Yes
☐ No

11 When, if ever, was the last time you attended a Sexually Transmitted Disease Clinic (STD/VD/GUM)? (please tick one)

- ☐ Never
☐ In the last year
☐ 1 to 5 years ago
☐ Greater than 5 years ago

12 When, if ever, have you ever been diagnosed with a sexually transmitted disease (STD/VD), other than HIV? (please tick one)

- ☐ Never
☐ In the last year
☐ 1 to 5 years ago
☐ Greater than 5 years ago

13 a) When did you last have an HIV test? (please tick one)

- ☐ Never
☐ Less than 1 year ago
☐ More than 1 and less than 2 years ago
☐ 2 to 5 years ago
☐ Greater than 5 years ago

b) Where did you have your last HIV test

- ☐ GP
☐ GUM/STD clinic
☐ Antenatal (pregnancy)
☐ Other (please specify)

c) What was the result of your last HIV test?

- ☐ Negative
☐ Positive
☐ Don't know / result not collected

14 What do you believe to be your current HIV status?

- ☐ Negative ☐ Positive ☐ Don't know

15 a) In the last 12 months, how many different people have you had sexual intercourse with?

- ☐ 0 ☐ 1 ☐ 2 ☐ 3-4 ☐ 5-9 ☐ 10-15 ☐ 16+

b) In the last 12 months how many new people did you have sexual intercourse with for the first time?

New partners

16 Was a condom used the last time you had sexual intercourse?

- ☐ Yes
☐ No

If Yes, was it to stop (please tick all that apply)

- ☐ Pregnancy ☐ Both Pregnancy & STD/HIV
☐ STD/HIV ☐ Other

Mayisha II topic guide

Interview aims

- To understand the social, economic, psychological and cultural context and its impact regarding:
 - sexual health
 - sexual mixing
 - risk behaviour
- Discover risk factors for HIV infection
- Identify strategies for reducing HIV infection and improving sexual health

1 Introduction about the study

- Introduce self (job title; organisation)
 - The Health Protection Agency is a national organisation for England and Wales dedicated to protecting people's health and reducing the impact of infectious diseases and other hazards. We advise the government and support the NHS to protect people from infectious diseases and improving public knowledge.
- Explain project aims (see above)
 - To understand more about people's sexual health and sexual lifestyles in order to improve sexual health of Africans and reduce spread of infections like HIV.
- Who is conducting / funding the study
 - Medical Research Council funded. The MRC is a national organisation that promotes research into all areas of medical and related science with the aims of improving the health and quality of life of the public.

- Study is supported by local and national organisations including African HIV Policy Network, THT, African HIV Research Forum, Royal Free and University College Medical School.

- How respondent was selected

- At random from list of those who volunteered to take part

- No right or wrong answers

- Confidentiality

- Tape recorder / time available for interview

2 Respondent background

- *Life history*
 - Birthplace and age; origins; family migration history
 - Growing up
 - Social-family life and networks; important people and events; places lived
 - Important influences
 - Gender; ethnicity; religion; experiences; parents / family; education; peers; relationships; marriage; economy
 - Development of health beliefs (nature and sources)
 - Keeping healthy; avoiding infections/cleanliness in general; risks to health
 - Development of relationship and gender-related beliefs (nature and sources)
 - Relationship related expectations; desires / values
 - Perceptions of masculinity / femininity; fertility; sexuality
- How life and beliefs have changed since migration to UK; HIV diagnosis; over time
 - Social status; quality of life; self esteem
 - Relevance and importance of African origins; identity
 - Values and beliefs / culture (family, peer, religion, culture)
 - Health beliefs, values and practices
 - Relationship beliefs / sexuality; gender

- How life and beliefs have changed since migration to UK; HIV diagnosis; over time
 - Social status; quality of life; self esteem
 - Relevance and importance of African origins; identity
 - Values and beliefs / culture (family, peer, religion, culture)
 - Health beliefs, values and practices
 - Relationship beliefs / sexuality; gender
- *Life now*
 - Current occupation / main source of income
 - Current marital / partnership status
 - Household composition / children
 - Contact with home country (own and regular partner's); other countries
 - Frequency; reason; relationships
- 'Rules' and practices regarding new partners and partner change / concurrency; compare to peers / compare to life in UK; home country / compared to parents and siblings
 - **Impact of migration on sexual lifestyle e.g. changes in permissiveness; freedom; choice; partners**
 - **How are values acquired in home country maintained; importance of values; changes in values**
- Experiences of STIs
 - Which ones; how became aware (symptoms, PN etc); perceptions of how became infected
 - Response; treatment; GUM experiences (info; treatment; advice; PN; access)
 - Impact (immediate / lasting)
 - Perceptions of whether onward transmission occurred; how; reaction at time
 - Perceptions of whether STIs can be avoided in future; importance on not being infected; if none experienced, perceptions of how avoided

3 Sexual lifestyles

- Partners since first intercourse
 - How many partners over lifetime; different types of partner; attitude towards partners
- **Origins and social determinants of assortative and disassortative mixing e.g.**
 - Partners in the UK and outside the UK; travel abroad
 - **Partners of different ethnicity / tribes / regions of Africa; age groups; locality; paid for sex; social strata**
 - Social networks e.g. are partners part of family/social networks; do partners know each other/ have contact with each other/members of respondent's network; changes in over time e.g. education, social. economic
 - Knowledge of partners' sexual history / health
 - Influences on partner choice/type of relationship/encounter (gender; African; migration; HIV)
- Changes in partnerships over time/**since migration**: type; source; duration; 'control', 'power' and equality in the relationship (making decisions, taking lead, financial support, violence); 'traditional' view's
- Influence of partner(s) on sexual behaviour: type of sex; condom use; children; risk; self esteem
- Condom use
 - Why used or not; perceived importance; who decides
 - Barriers to using condoms; acquiring condoms, difficulty using, relationship situation,
 - Changes over time in using condoms

- Other influences on sexual behaviour; partner choice; type of sex; use of condoms e.g. desire for children; perceptions of risk (emotional, physical, disease); self esteem; peer norms; expectations; soci-eco circumstances / money; pleasure (own/partner's); herbs; polygamy; drugs/alcohol; violence

- Greatest impact...

- Impact of HIV diagnosis on sexual behaviour / relationships / networks

4 Knowledge of and sources of information for HIV

- Knowledge of...
 - Transmission and symptoms
 - Diagnosis and Treatment i.e. nature; impact on progression; impact on life and attitudes to HIV & testing
 - Protection from infection i.e. how; reliability, perceived effectiveness
 - What might increase risk of infection (sdUV/AI; STIs; partner number etc)
 - Types of people at risk of HIV; relevance to respondent / network; riskiest episode
 - Perceptions of impact on home country, UK Africans; own networks; self; why HIV increasing
 - Experience knowing people living with HIV
 - **Views about HIV as a stigmatising disease; impact of HIV diagnosis**
- Impact or not of HIV knowledge on sexual behaviour and experiences and risk reduction
- Sources of information about STIs / HIV; what sources are reliable / have an impact and why:
 - Friends (inc own experiences); Family; Elders; Religious leaders; Voluntary / community organisations; Health professionals; National organisations for HIV / Africans.
- Gaps in information – what areas; concerns; compare to peer group knowledge.

- Changes in knowledge of HIV before participating and after participating in the survey.
- Changes in knowledge since diagnosis.
- Relative importance of HIV in own life.

5 Experiences of testing for HIV

- Accessing sexual health services in home country / UK
- Knowledge of HIV testing
 - Knowledge of where e.g. GUM; ante-natal; GP; hospital; other
 - Who can test; how can get test
 - How test is done / counselling / results

- Experience of testing

Probe if never tested

- Why not tested before
 - Why took part in MAYISHA UA test; expectation of result
- What would influence respondent to test

Probe if tested

- Testing history
 - Circumstances of last test
 - Expectations of result; result
 - Impact of result e.g. changes in behaviour; relationships / attitudes to relationships; condom use
- Perceptions of own and partner(s) status
- Perceived barriers to HIV testing
 - Access to services; Disclosure to partner / family / friends; blood test-related; perceived proximity / relevance of HIV; usefulness of knowing status; fear of status; fatalism / other beliefs

6 Discrimination and stigma

- **Experiences; perceptions of why arises e.g. sources of fear**
- **Impact on health seeking behaviour; disclosure; testing and treatment**

7 Health promotion

- Experiences of sexual health promotion
 - Experiences of specific sexual health programmes / materials produced
 - e.g. NAHIP testing campaign [use visual prompt]; ABC strategy
 - Where seen; picked up; experienced
 - Impact; recall of key messages / knowledge
 - Perceived effectiveness of sexual health promotion
 - Direct changes in own sexual behaviour / HIV/STI testing behaviour / access of services
 - Impact on stigma in community
 - Impact on peer-group / discussion of sexual health with peers
 - Awareness of providers of services; support; info e.g. THT, AHPN etc
 - Where would seek HIV-related info
 - Impact of taking part in MAYISHA; why took part
- Perceptions and impact of media coverage

- Sexual health needs: current; past; during migration
- Ideas for improving health promotion / information messages / testing uptake

Probe

- Methods (posters, radio, tv)
- Where messages are seen (high-impact strategies)
- Where to targeted messages
- Content of messages

8 End interview

- Respondent payment
- Repeat confidentiality assurances
- More information about the study and study results is available– see MAYISHA leaflet for details.
- HIV related info – see leaflet.
- Thanks

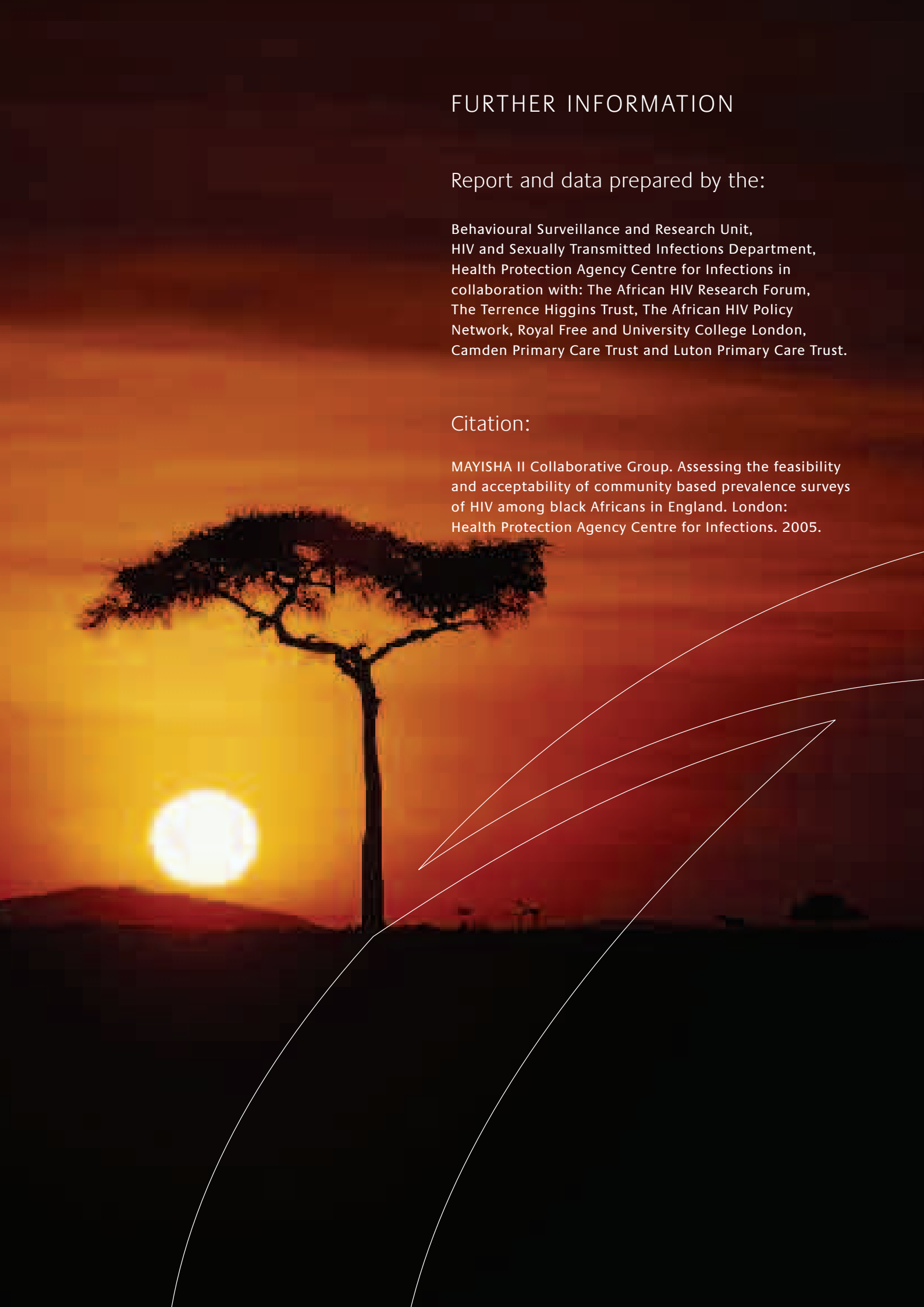
FURTHER INFORMATION

Report and data prepared by the:

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Health Protection Agency

Centre for Infections

HIV and Sexually Transmitted Infections Department

61 Colindale Avenue

London NW9 5EQ

United Kingdom

Tel: +44 (0) 870 084 2000

Fax: +44 (0) 20 8200 7868

Email: HIV/STI@hpa.org.uk

www.hpa.org.uk

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