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**Vulnerability to HIV Infection: An Investigation of HIV/AIDS-
related Knowledge, Attitudes and Practices in the Brazilian
Expatriate Population in England**

José Henrique Resinente

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for the degree of Doctor of Philosophy

Faculty of Arts
School of Cultures, Languages and Areas Studies
Department of Modern Languages and Cultures

I, José Henrique Resinente, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated clearly in the thesis.

A handwritten signature in blue ink, appearing to read 'J. Resinente', with a stylized, cursive script.

José Resinente

London, 18th July, 2019

“Our mission is to build a better world. To leave no one behind. To stand for the poorest and the most vulnerable in the name of global peace and social justice”.

Ban Ki-moon, United Nations Secretary-General, 2014

Abstract

According to the 90-90-90 UNAIDS report (2014), we could end the Human Immunodeficiency Virus (HIV) epidemic globally by 2030, and bring HIV incidence to rare occurrences. In order for that to happen, every country will have to step up their efforts in relation to HIV prevention and treatment. Including HIV education, condom distribution, behaviour change, voluntary male circumcision, availability of HIV counselling and testing, and a human rights approach with key populations (Fast-Track Report, UNAIDS 2014). In England, Black, Asian and Minority Ethnic (BAME) groups are disproportionately affected by HIV. Many of these BAME communities are under researched and very little is known about their prevention needs. The Brazilian expatriate population, for instance, according to Public Health England, has a higher than expected HIV prevalence.

In this PhD thesis I identify some of the HIV prevention needs of the Brazilian expatriate population in England, through a survey of 1018 participants, as well as 30 in-depth interviews, assessing their HIV/AIDS-related knowledge, attitudes and practices. The overall research question of the thesis is to find out how are the HIV/AIDS-related knowledge, attitudes and practices of the Brazilian expatriate population in England impacting on their vulnerability to HIV infection.

My key findings suggest that many members of the Brazilian expatriate population in England speak limited English and are therefore unable to follow sexual health campaigns in that language. Also, because of immigration constraints, they have limited access to GPs and other health services (including genitourinary clinics), which is where they similarly would like to learn about sexual health. The consequence is that they are not aware of current knowledge of HIV prevention and treatments in England, including Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP). In fact, when compared with Brazilians back in Brazil, the sample surveyed in England knew slightly less about HIV and Sexually Transmitted Infections (STIs) in almost all indicators of correct knowledge of HIV transmission. This situation, coupled with increased unprotected sexual intercourse, illicit drug use, and resorting to sex work because of poverty is increasing their vulnerability to HIV infection.

My key recommendations are that a target sexual health campaign is created using the Vulnerability to HIV Infection framework (i.e.: "Information/education, health and social

services, and a supportive social environment”), from AIDS in the World (1992), aiming at the Brazilian expatriate population in England. This has to be in Brazilian Portuguese. This should promote greater access to health services in England for the Brazilian expatriate population, including to genitourinary clinics. Also, increased sexual health outreach in the community with free HIV/STIs counselling and testing, and free condoms are needed, with services equipped with at least one care-worker, nurse or doctor that speaks Portuguese, or easily available language-line services. A sexual health campaign in Brazilian Portuguese using community London-based media (especially Leros Magazine, Brazilian newspapers, Facebook and WhatsApp), and educational leaflets, is also needed. Lastly, I want to make a recommendation to the Brazilian Ministry of Health to create an awareness campaign in Brazil regarding the risks of HIV/STIs that can occur during migration, for prospective travellers to High Income Countries, including the risks of illicit drug use and sex work.

This thesis contributes to knowledge gaps regarding the HIV prevention needs of a vulnerable population in England, with a high HIV prevalence. The information generated in this research can assist public health professionals, policy makers and programme managers in identifying key gaps in local and national responses to HIV/AIDS within BAME communities, enabling more effective planning and interventions to halt the spread of HIV.

I dedicate this thesis to my father Jorge Reis Resinente, and (in memory) to my mother Ondina Maria de Jesus, lastly, to my sisters Márcia, Cristine and Claudinha.

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Abbreviations

A&E	Accident and Emergency
AIDS	Acquired Immune Deficiency Syndrome
AZT	Azidothymidine
BAS	Bi-dimensional Acculturation Scale
BAME	Black, Asian and Minority Ethnic
BCHD	Baltimore City Health Department
BHIVA	British HIV Association
CBOs	Community-based Organisations
CBPR	Community-based Participatory Research
CD4	Cluster of differentiation 4: Is a glycoprotein found on the surface of immune cells such as T helper cells, monocytes, macrophages, and dendritic cells
CDC	Centre for Disease Control
CHEMSEX	Illicit drugs that people take that make them lose inhibition when having sex (crystal methamphetamine, GHB (gamma hydroxybutyrate) or mephedrone, also known as meow meow, which can be snorted or swallowed
ECDC	European Centre for Disease Prevention and Control
G	Gamma-hydroxybutyrate (aka: GHB/GBL/Gina): illicit drug used in CHEMSEX
GAPC	Global AIDS Policy Coalition
GP	General Practitioner
GUM Clinic	Genitourinary Medicine Clinic
HIV	Human Immunodeficiency Virus
HIV+	HIV Positive (a person who has HIV)
HIV-IP	HIV-Intensive Prevention Programme
HOLA	<i>Hombres Ofreciendo Liderazgo y Ayuda</i> = Men Offering Leadership and Help
HoMBReS	<i>Hombres Manteniendo Bienestar y Relaciones Saludables</i> = Men Maintaining Well-Being and Healthy Relationships
HPV	Human Papilloma Virus
ICT	Information and Communication Technology
IDUs	Intravenous Drug Users
KAP	Knowledge, Attitudes and Practices
KS	Kaposi's Sarcoma
LHAs	Lay Health Advisors
LSHTM	London School of Hygiene & Tropical Medicine
MSM	Men who have Sex with Men
NGOs	Non-Government Organisations
NHS	National Health Service
PCAP	Pesquisa de Conhecimento, Atitudes e Práticas (KAP Survey, in Portuguese)
PEP	Post-Exposure Prophylaxis
PEPSE	Post-Exposure Prophylaxis following Sexual Exposure
PHE	Public Health England

PLWH	People Living With HIV
PLWHA	People Living With HIV and AIDS
PrEP	Pre-Exposure Prophylaxis
SASH	Support and Advice on Sexual Health
SEPA	<i>Salud, Educación, Prevención, Autocuidado</i> = Health, Education, Prevention, Self-care
SSW	Street-based Sex Workers
STI	Sexually Transmitted Infection
THAs	Teen Health Aides
THT	Terrence Higgins Trust
UAI	Unprotected Anal Intercourse
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UoN	University of Nottingham
US	United States
USA	United States of America
U=U	Undetectable = Untransmittable (U=U stands for “HIV Undetectable = HIV Untransmittable” – regarding the fact that a person living with HIV, taking antiretroviral medication, and with an undetectable viral load for at least 6 months, would not be able to infect others)
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WHP	Women’s Health Promotion Programme

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CHAPTER 1 Introduction

Preface

As I came out as gay and became sexually active in the mid 80's in my native city of Rio de Janeiro in Brazil, HIV was already a problem in my community. Two of my older gay friends and "gay role models" at the time were already revealing signs of AIDS, such as Kaposi's sarcoma (KS), severe weight loss and chronic diarrhoea. People were afraid of even taking the HIV test because there was no treatment for it. We tried to be strong and encouraging for those displaying signs of having the disease, but in private we panicked that soon our friends would die, just like so many who were being portrayed daily in the national and international media; and indeed, those two close friends of mine did die of AIDS, a few years later.

I moved to London in 1993 at the age of 24, and in 2000 I started working for an HIV charity as part of a placement for a Diploma in Humanistic Person-Centred Counselling I was doing at the time. My job was to reach out to Portuguese speakers (people from Portugal, Angola, Brazil, Mozambique, Guinea-Bissau, Cape Verde and the islands of São Tomé and Príncipe), all over London. The project was divided between sexual health prevention for anyone from these communities and HIV support services specifically for those living with HIV from among these communities. The prevention side of the project included mapping out the needs of the general Portuguese-speaking community in terms of HIV/STI education, condom distribution and HIV/STI counselling and testing. The HIV support part of the project was giving assistance to people living with HIV and their families, including those recently diagnosed. This would include emotional support to deal with the diagnosis, depression, low self-esteem, issues of medication adherence and of dealing with side-effects of HIV treatments, filling out housing and benefit applications, also assistance with immigration advice and referrals.

Judging by the numbers of referrals I was getting from the main sexual health clinics in London back then, I already had an idea that in England there were many Portuguese speakers diagnosed with HIV and other STIs.

Over the years I supported more than 1,000 Portuguese-speaking individuals infected or affected by HIV/AIDS, and their families. The majority of attendees, at least 60%, have always been from Brazil.

In 2008 I participated in the 17th International AIDS Conference in Mexico City. This opportunity allowed me to see my work as a sexual health professional in London in the wider context of fighting the AIDS epidemic globally. I met HIV researchers, doctors, activists, policy makers and PLWH from all over the world. Attending the conference made me realise that there was much more that I could accomplish through my work. On my return to London I decided to apply for an M.Sc in Public Health to develop my academic skills. I started this in 2009 and completed it over two years, at the London School of Hygiene and Tropical Medicine (LSHTM).

My work experience, academic trajectory and my desire to help my community led me to this PhD research project. My intention is to synthesise the knowledge gained from my 18 years of frontline experience and my academic achievements into a thesis that answers this question: are the knowledge, attitudes and practices of the Brazilian population in England impacting their vulnerability to HIV infection?

1.1 HIV in the world

Despite the existing progress made by the biomedical sciences in treating and controlling the Human Immunodeficiency Virus (HIV) since it was first identified in 1981, the fight to end the HIV epidemic is still far from over. Even with considerable development in attaining universal access to HIV prevention, testing, treatment, care and support around the world in the last decade, if we are to succeed in achieving the 6th Millennium Development Goal set up by the United Nations of combating HIV/AIDS, Malaria and other diseases, much more is needed.

UNAIDS estimates in the Gap Report (2014) that since the start of the AIDS epidemic more than 78 million people have been infected with HIV, and 39 million people have died worldwide (UNAIDS 2014). Also, their estimate for 2015 shows that 36.7 million people were living with the virus; 2.1 million of whom acquired the virus that year, and a staggering 1.1 million people died of AIDS-related diseases in 2015 alone (UNAIDS 2015).

In Europe, the prevalence of HIV increased to over 2 million in 2015, with more than 153,000 new cases that year. A 7% increase compared to 2014, and the highest yearly incidence since reporting began in the 1980s, with a third of these people unaware of their infection (WHO 2015).

In the UK, the estimated HIV prevalence for 2015 was 1.6 per 1,000 population, with 101,200 people living with it. Of whom around 13,500 people were unaware of their

infection, and more at risk of passing on the virus. 6,095 people were diagnosed in 2015, representing one of the highest rates of HIV infection in Western Europe. 48% of new infections were among Black, Asian and Minority Ethnic (BAME) communities (PHE 2016), despite BAME communities only making up 14% of the UK population (2011 Census – Office for National Statistics).

1.2 The end of the AIDS epidemic

Notwithstanding the above alarming figures, according to the UNAIDS Gap Report (2014), the number of people who are newly infected with HIV is starting to decline in most parts of the world:

There were 2.1 million [1.9 million–2.4 million] new HIV infections in 2013—a decline of 38% from 2001, when there were 3.4 million [3.3 million–3.6 million] new infections. In the past three years alone, new HIV infections fell by 13%. Among the 82 countries for which the data for determining trends are of sufficient quality, new HIV infections have declined by more than 75% in 10 countries and by more than 50% in 27 countries (Gap Report, UNAIDS 2014).

With such positive indications of progress, on October 2014 UNAIDS launched an ambitious worldwide treatment target to end the AIDS epidemic: the 90-90-90 Report (Figure 1.1). According to this report, the end of the epidemic can be achieved if efforts from every nation are concentrated into making sure that at least 90% of all its people living with HIV know their HIV status, 90% of all those people with diagnosed HIV infection receive sustained antiretroviral therapy and 90% of all those people receiving antiretroviral therapy have viral suppression. Global health modellers commissioned by UNAIDS for the 90-90-90 Report suggest that achieving these targets by 2020 will enable the world to end the AIDS epidemic by 2030, making the disease rare, rather than widespread. This in turn would generate profound health and economic benefits globally, as the burden of this disease starts to loosen its grip on humanity (90-90-90 Report, UNAIDS 2014).

To achieve this ambitious target however, effective HIV prevention programmes that address vulnerability to HIV infection will be needed, with programmes that go beyond medicines and which include HIV education, condom distribution, behaviour change, voluntary male circumcision, availability of HIV counselling and testing, and a human rights approach to programmes with key populations (Fast-Track Report, UNAIDS 2014). In the

case of England for instance, this programme would have to take account of one of its fastest growing communities, the people from Latin America.

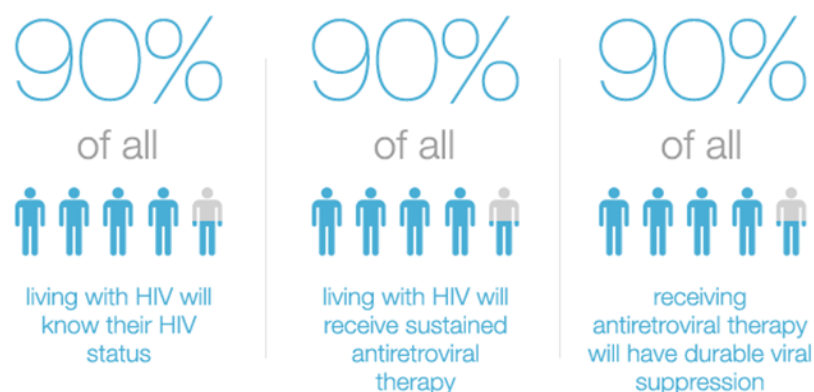


Figure 1.1: 90-90-90 Report - UNAIDS 2014

1.3 Definition of Latin American

The term Latino is used in most papers used in the literature review for this study for Spanish-speakers who have migrated from Latin America to the U.S. This is the accepted U.S. term for Latin American migrants and their U.S. born descendants. Since this research is about the Brazilian expatriate population in England, however, I am going to use the term Latin American to describe people from an unidentified Latin American country, and the specific national adjective where the identity is known, ie Mexican, Puerto Rican etc. Brazilians will be identified as Brazilians.

1.4 The Brazilian expatriate population in England and HIV

Brazilians make up the largest Latin American expatriate group in the UK (McIlwaine et al., 2011). In fact, immigration from Brazil to the UK has increased considerably since 1990 (Kubal et al., 2011), with flows increasing even further after 2000, as a result of inequalities created by neoliberal macro-economic policies in Latin American countries, in the 1980s and 90s (Evans et al., 2017).

Comparative data from the British Census shows that in 2001 there were only 8,000 Brazilians residing in the UK, increasing to 52,000 in 2011 (Census, 2011; Evans et al., 2015). These official figures however do not take into consideration the many Brazilians that overstayed. Some researchers estimate the real size of the Brazilian population in the UK to

be well over 100,000 (Evans et al., 2015; MRE, 2015), with leaders of the Brazilian community in England speculating that the total figure might be higher than 200,000.

According to PHE data, rates of HIV infection are high among the Brazilian population in England. Evidence shows that between 2007 and 2011 alone, Brazilian men who have sex with men (MSM) had the highest rate of HIV diagnoses in London among Black, Asian and Minority Ethnic (BAME) communities (7%), and second only to the white British population. The second highest MSM BAME diagnosis rate after the Brazilian population in that same period was less than 3%, seen in the Spanish community (Figure 1.2), less than 50% of the diagnoses seen in the Brazilian population.

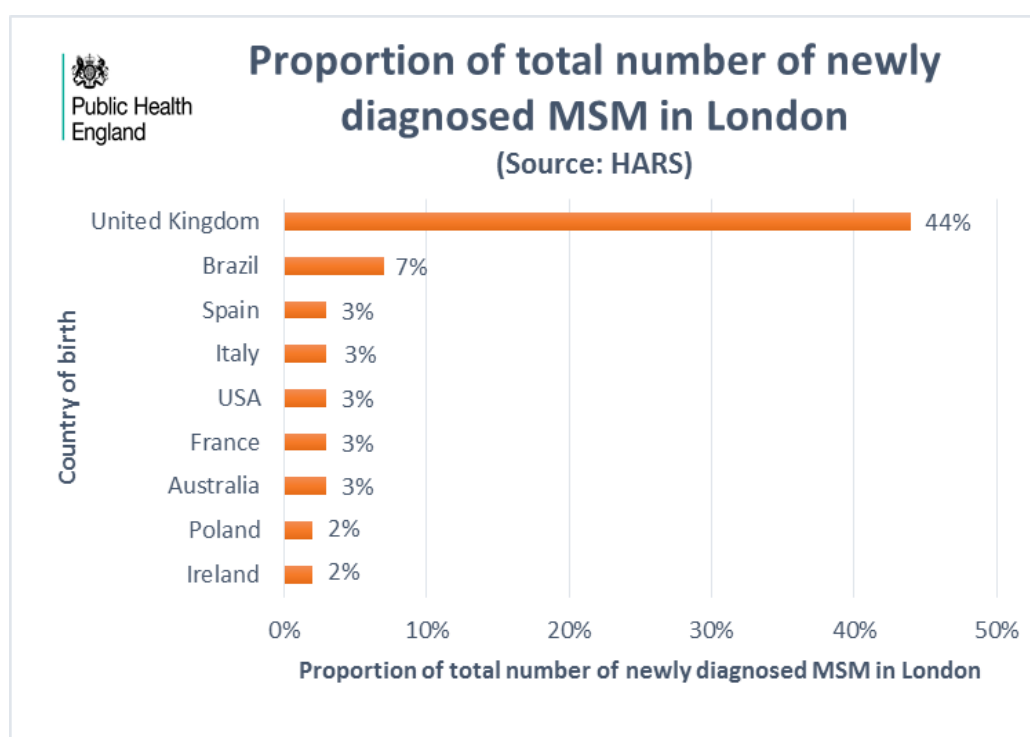


Figure 1.2: PHE 2013 – London HIV prevention needs assessment, Epidemiology review

Recent internal data from PHE also shows that the trend of HIV diagnosis among Brazilian MSM seen between 2007 and 2011, and indeed among Latin Americans in London, has increased, year on year, since then (Table 1.1).

Number of new HIV diagnoses (MSM)			
Year of diagnosis	Place of birth reported as Brazil	Place of birth reported as other Latin America country	UK
2007	92	132	2,850
2008	78	147	2,800
2009	103	167	2,850
2010	101	153	2,860
2011	102	176	2,950
2012	107	189	3,180
2013	83	170	3,230
2014	113	194	3,360
2015	124	213	3,570
2016	130	231	2,810

Table 1.1: Source PHE (HARS) 2018

Remarkably, in the *Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK* report (PHE 2017), data was presented of the first decline in 30 years of new HIV diagnoses in gay and bisexual men. The report found a 21% decline, from 3,570 in 2015 to 2,810 in 2016. Unfortunately, the same declining trend in HIV diagnosis has not yet been seen among Latin American MSM in the UK, as evidenced in figure 1.3 below.

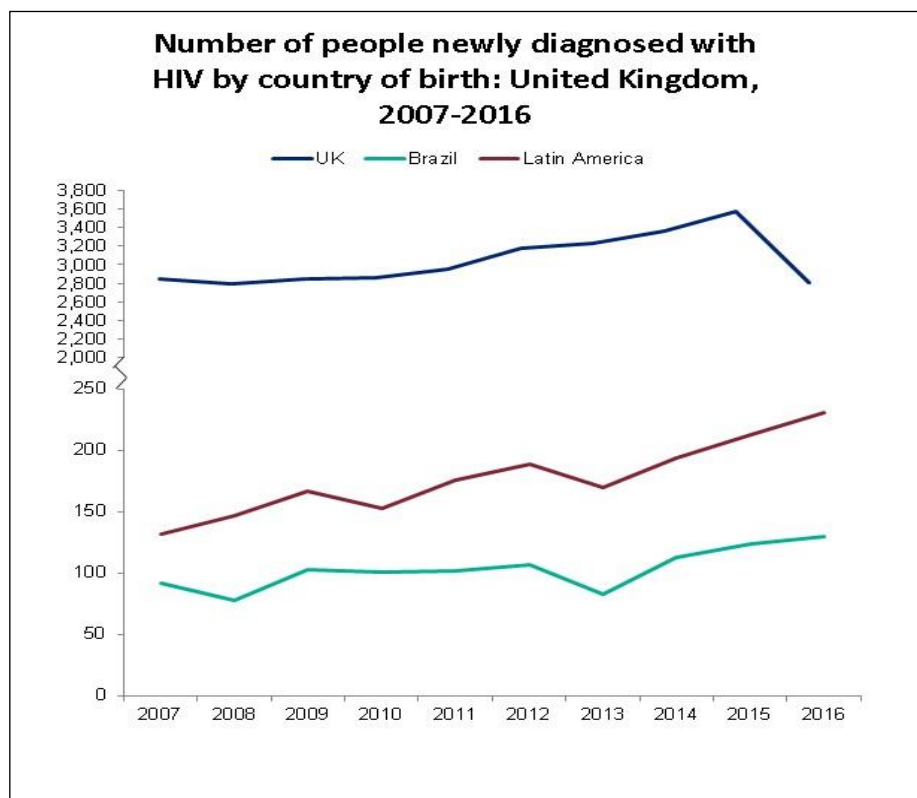


Figure 1.3: Source PHE (HARS) 2018

The PHE report made the following public health recommendations in line with the UNAIDS 90-90-90 Report:

With progressive strengthening of combination prevention (including condom use, expanded HIV testing, prompt ART and availability of pre-exposure prophylaxis (PrEP)), HIV transmission, AIDS and HIV-related deaths could be eliminated in the UK. The recent encouraging changes [decrease in new infections] are dependent upon sustained prevention efforts. The inconsistencies between groups and geographies demonstrate that combination prevention needs to be replicated for all those at risk of acquiring HIV, whoever they are and wherever they live.

If it is the case that 'combination prevention' will continue the observed decline in new diagnoses of HIV, then it must be worked out how to bring this combination prevention to

the Brazilian expatriate community in England. Clearly, they are not accessing this yet as there has been no decline experienced by Brazilians in England in HIV diagnoses.

1.5 HIV/AIDS-related KAP Surveys of Latin Americans in High Income Countries and in Brazil

Surveys of HIV/AIDS-related knowledge, attitudes and practices (KAP) are one of the most commonly used research methods, in many countries, to collect information regarding behaviours that put vulnerable populations at increased risk of HIV/AIDS. Data from such surveys can help identify if a certain population is engaging in high-risk or protective behaviours, as well as if they have enough knowledge of how HIV is transmitted and how to effectively prevent infection. It also helps to assess their attitudes and practices in relation to the disease itself, and towards PLWHA (DiClemente et al, 1987; Fishbein et al, 1993).

Many published articles, identified and relevant to this research project, however, have pointed to the fact that high levels of correct HIV-knowledge alone are not enough to avert HIV infection. Although HIV/AIDS information may help to increase knowledge levels of HIV prevention and transmission, knowledge alone is not sufficient to sustain HIV protective behaviour or address the stigma and discrimination caused by HIV/AIDS (Fisher J, 1992; Tanaka et al, 2008; Munene E, 2012). Nevertheless, there is a general consensus among the above cited papers that HIV/AIDS-related knowledge is one of the first and most important steps towards HIV prevention and should be a priority of any worthwhile intervention: finding out the levels of HIV knowledge a community has in order to plan adequate interventions.

The HIV-related KAP of Latin American immigrants in high income countries such as the United States of America and Canada for instance, has already been well researched (McQuiston et al., 1998; Organista et al., 1998; McQuiston et al., 2000; Raj et al., 2001; Loue et al., 2003; Villarruel et al., 2003; Shedlin et al., 2006; Hovey et al., 2007; Knipper et al., 2007; Bauer et al., 2010; Rhodes et al., 2010; Albarran et al., 2011; Hacker et al., 2011; Rhodes et al., 2011; Shedlin et al., 2011; Chen et al., 2012; Chavez L, 2012; Calabrese et al., 2012; Castillo-Mancilla et al., 2012; Holmes S, 2012; Gilbert et al., 2013; Rhodes et al., 2013; Rhodes et al., 2015; Sanchez et al., 2016).

There is also some available data regarding HIV/AIDS-related KAP of Latin American migrants living in France, Spain, Portugal, Switzerland and Australia (Korner H, 2007; Ríos et

al., 2009; Hammer et al., 2010; Brussa et al., 2010; Dias et al., 2011; Darling et al., 2013; Hoyos et al., 2013; Rodríguez-Álvarez et al., 2013; Ochoa et al., 2014).

Many of these studies show that the Latin American population in these countries is indeed disproportionately affected by HIV/AIDS. In fact, an article by Mikawa et al indicates that as early as 1992 Latin American immigrants in the U.S. already had one of the highest rates of HIV prevalence of all ethnic groups (Mikawa et al, 1992).

In England, internal data from PHE shows that the Latin American population has a high prevalence of HIV infection, with Brazilians leading these statistics. However, a search of published and unpublished articles regarding HIV/AIDS-related KAP in any Latino community in the UK produced no result; an indication that neither the Brazilian population nor other Latin Americans received adequate attention in the planning of culturally appropriate sexual health interventions for them, a gap in knowledge that this thesis aims to address.

On the other hand, in Brazil, every four years since 2004, the Brazilian Ministry of Health uses a HIV/AIDS-related KAP survey (**P**esquisa de **C**onhecimentos, **A**titudes e **P**ráticas - **PCAP**) to monitor the needs of the Brazilian population. The survey questionnaire instrument they use was formulated following UNAIDS guidelines of HIV/AIDS-related KAP indicators (UNGASS, UNAIDS 2007).

The information gathered through these surveys is then used to inform the Brazilian Ministry of Health programmes and policies, and to create their yearly national sexual health campaigns, such as in the example in figure 1.4 below. These sexual health campaigns started in the early 80s, as a response to the AIDS epidemic, and never stopped, with a new campaign launched in time for each Brazilian carnival. The Brazilian Ministry of Health uses different models representing each segment of society. They have heterosexual couples, transgender people, lesbians, and gay couples on their posters and leaflets. Each message is tailored to each target group. As in the postcard in figure 1.4 targeting transgender people, the message is to use condoms and have regular HIV testing in one of the centres provided free of charge by the State. Contact details are provided.

Authorisation from the Brazilian Ministry of Health was obtained in order for me to use their survey questionnaire (PCAP) with the Brazilian expatriate population here in England. Please see quantitative results on Chapter 3.



Figure 1.4: Brazilian Sexual Health Campaign - Source: Ministério da Saúde do Brasil - 2015

1.6 Research question and objectives

The overall research question of this thesis is: “How are the HIV/AIDS-related knowledge, attitudes and practices of the Brazilian expatriate population in England impacting on their vulnerability to HIV infection?”

Since this is a first research study exploring this topic, and given the size of the sample itself, I hope that this information will be useful as a pilot study in understanding the reasons behind the high HIV prevalence in the Brazilian community in England. I hope this information will be useful for health services when planning HIV prevention for this community. I also hope that this study might promote future investigations on this topic.

1.7 Structure of the thesis

Following this introduction (Chapter 1), Chapter 2 (Literature review) will summarise the literature related to the study topic. Two research questions were formulated to condense specific areas of particular interest. The first question is about the factors that might increase vulnerability to HIV infection in Latin American immigrants in high income countries. The second question is on HIV prevention awareness, approaches and frameworks used with this population in high income countries. The inclusion and exclusion criteria used are discussed, and a flow diagramme presented.

Chapter 3 (Quantitative method: survey) shows survey results regarding knowledge, attitudes and practices relating to HIV infection and STIs, from 1,018 members of the Brazilian expatriate population in England. This was accomplished using UNAIDS guidelines on which such surveys are based. The Brazilian government allowed me to use their own version in Brazilian Portuguese, meaning I was able to compare the HIV/AIDS-related KAP of Brazilians in Brazil and Brazilians in England for this research project.

Chapter 4 (Qualitative method: in-depth interviews) presents in-depth some of the issues identified through the literature search and survey, creating an opportunity to explore issues that required open-ended questions which allowed the respondents to provide their own testimony, and in this way making sure that the richness of people's experience could be captured. Interviews were conducted with 30 members of the Brazilian expatriate population in England to explore their vulnerability to HIV infection by investigating the reasons behind their responses in the survey.

Chapter 5 (Discussion) brings together the findings from the thesis. The thesis contributes to knowledge gaps regarding the HIV prevention needs of a vulnerable population in England with a high HIV prevalence: that of the Brazilian expatriate population. The information generated through this thesis, based on empirical findings, has the potential to assist public health professionals, policy makers and programme managers to identify key gaps in local and national responses to HIV/AIDS with BAME communities, enabling more effective planning and interventions to halt the spread of HIV.

1.8 Methodology

The methodology will operate as follows:

1. Review the literature on qualitative and quantitative studies regarding HIV/AIDS-related KAP and vulnerability to HIV infection among Latin American immigrants (including Brazilians) to high income countries, in academic libraries/databases
2. Conduct a validated cross-sectional survey of HIV/AIDS-related KAP with 1,000 members of the Brazilian expatriate population in England to assess levels of knowledge, attitudes and practices of HIV transmission
3. Conduct in-depth interviews with 30 key members of the Brazilian expatriate population in England to gain detailed information regarding their HIV/AIDS-related KAP, and further explore their vulnerability to HIV infection

4. Make recommendations based on findings on ways to improve HIV prevention strategies specific to the needs of the Brazilian expatriate population in England

The methodology will be expanded upon in the following three sections. Section 1.8.1 presents the conceptual framework utilised throughout the thesis. Section 1.8.2 provides an overview of the data sources for the study and how they tally with the objectives; and Section 1.8.3 outlines funding and ethical approval for the study.

1.8.1 Conceptual framework: Vulnerability to HIV Infection

When HIV was first identified in 1981 people were afraid to even touch a person who had contracted the infection. This emotional reaction of fear was underpinned by a lack of knowledge – before attitudes and practices could change, knowledge had to be disseminated worldwide. It is essential that the approach to tackling HIV should be international because when experiences are shared, there arises a consensus. I therefore intend to use a conceptual framework that emphasises, following UNAIDS best practice, the importance of both international co-operation and individual engagement at a civil level. I will derive my conceptual framework from projects that involve cross-border publications and projects. This is how I will assess vulnerability to HIV infection in the Brazilian expatriate population in England, from their own perspectives and experiences.

In 1991, exactly a decade after the HIV virus was first identified in North America, a group of epidemiologists and human rights advocates connected to the Harvard school of Public Health (Ayres et al., 2006) created the Global AIDS Policy Coalition (GAPC), with financial support from the François-Xavier Bagnoud Association. This was one of the first attempts to understand and tackle the HIV epidemic on a global level. The ambition of the coalition was to start tracking the evolving HIV/AIDS pandemic, to critically analyse the global response so far, and to encourage policy analysis and advocacy activities.

The first major project undertaken by the coalition was a book published in 1992, *AIDS in the World, a Global Report* (Mann, Tarantola, Netter, 1992; Lopes, 2003). This book was produced to serve as a guide, offering retrospective as well as current analysis of the pandemic's dimensions, shape, and impact, along with the range of current societal responses. Giving a global vision of how our world was confronting the epidemic at that point, and to influence future responses.

The advantage of *AIDS in the World* was the creation of an international steering committee formed by professionals from a variety of backgrounds from both developing and

developed nations. This generated an opportunity for health workers, scientists and educators from around the world to gather data in the first serious attempt to achieve a global overview. This concerted effort would provide a model that allowed for co-operation on international solutions – essential when tackling a pandemic.

The book *AIDS in the World* predicted that from the mid-1990s and beyond, there would be an increase in global vulnerability to HIV and AIDS. This publication brought together the expertise of its editors: Jonathan M. Mann, the coalition coordinator and general editor of *AIDS in the World* was also a Professor of Epidemiology and International Health at the Harvard School of Public Health, and Director of the International AIDS Centre of the Harvard AIDS Institute. Daniel J. M. Tarantola was the scientific editor, as well as a Lecturer in International Health at the Harvard School of Public Health. Finally, Thomas W. Netter, was the managing editor of the book, and was a journalist at the time, specializing in international public health.

The preface of their book started with a series of questions that were as relevant in 1992, as they are today:

The HIV/AIDS pandemic is entering a new, more dangerous phase. As the global threat increases, there are many signs of growing complacency, persistent denial, and resurgent discrimination. What is wrong? Why is it so difficult to mobilize nations against AIDS? And what is to be done?

AIDS in the World, 1992, Preface xiii

They concluded that an adequate response to dealing with the epidemic requires, in their words, “reaching beyond traditional approaches to protecting public health; it [needs a response that] engages – and challenges – the health and social systems itself” (*AIDS in the World*, 1992, page 1). Mann, Tarantola and Netter’s influence on leading doctors and scientists was largely responsible for the unprecedented levels of co-operation that led to understanding the global epidemic and standardising treatment. For example, their publication shared country data that some scientists would not otherwise have had access to. I believe that one implication of this approach is that countries were required to be open to such information in a way that, perhaps, they had not been before. Mann et al further concluded that to tackle the epidemic, it would be necessary to have a coherent picture and essential understanding of the epidemic, the response, and of the concept of vulnerability, all three of which are explored in the following section.

Vulnerability to HIV Infection

AIDS in the World shows us that at a biological level, given specific circumstances, most people are vulnerable to HIV infection if exposed to the virus through blood, breast milk or through unprotected sexual intercourse. Even though susceptibility to HIV is so high, many people today still believe that their risk of infection, as well as the risk of those they have sex with, is close to none. Understanding the actions and behaviours that facilitate transmission is key, as they are needed for prevention to occur.

Mann, Tarantola, Netter (1992) point out that between biological susceptibility to HIV infection and limited behaviour-based modes of HIV transmission, we can find forces, factors and influences that will either diminish, sustain, or accelerate the progress of the HIV epidemic throughout the world. They stress that people's behaviour is the ultimate factor determining vulnerability to HIV infection, and thus the progress of the HIV epidemic. They say that emphasis on the individual is required, however, they are also quick to point out that individual behaviour alone is not enough to reduce vulnerability:

Individual behaviour is both mutable and societally connected, varying over a person's lifetime (e.g., sexual behaviour at adolescence, middle, and old age), changing in response to personal history and experience, and strongly influenced throughout by key individuals (family, lovers, friends), communities, and larger societal and cultural entities, such as religious and nation states.

They advocate taking into consideration the community, as well as national and even international factors when assessing an individual's vulnerability. And they propose the following definition list of individual vulnerability to HIV/AIDS:

- **In absolute terms:** unprotected
- **In relative terms:** exposed to a higher-than-average risk
- **In epidemiological terms:** exposed to higher risk of HIV infection
- **In medical terms:** unable to avail of an optimal level and quality of medical care
- **In operational terms:** requiring a higher degree of protection and care
- **In human rights terms:** exposed to the risk of discrimination or unfair treatment challenging basic principles of equity and human dignity
- **In social terms:** deprived of some or all social rights and services
- **In economic terms:** because of financial constraints, unable to offset the risk of infection or to access the optimal level and quality of care

- **In political terms:** unable to achieve full representation or lacking political power

To facilitate analysis, Mann, Tarantola, Netter (1992) proposed that vulnerability to HIV could be considered on the following three interdependent levels, **personal**, **programmatic**, and **societal** (Figure 1.5):

Personal vulnerability

Personal vulnerability to HIV/AIDS (or in general) involves both cognitive and behavioural dimensions. Cognitive factors involve informational needs – about HIV/AIDS, sexuality, and services – for reducing vulnerability to HIV infection. Behavioural factors can be considered in two overlapping categories: personal characteristics, which include emotional development, perception of risk and attitudes towards risk-taking, personal attitudes towards sex and sexuality, and history of sexual and substance abuse (including alcohol); and personal skills, such as the ability to negotiate sexual practices, including safer sex, and the skills needed to use condoms.

Programmatic vulnerability

Programmatic vulnerability focuses on the contributions of HIV/AIDS programmes toward reducing or increasing personal vulnerability. Programmatic vulnerability has been defined broadly in terms of the three major prevention elements identified by WHO: information and education, health and social services, and non-discrimination towards HIV-infected people and people with AIDS. Efforts to reduce programmatic vulnerability have principally involved ensuring and strengthening the availability and accessibility of key programme elements, the quality and content of each element, and the process through which the elements are designed, implemented and evaluated.

Societal vulnerability

Research and empirical observations have demonstrated that personal behaviour is so profoundly influenced and conditioned by broader, societal factors that a focus on change in personal behaviour without influencing the relevant societal factors could never be sufficiently effective (Mustard et al., 1991; Fishbein et al., 1989; Bandura, 1994; Catania et al., 1990; Evans et al., 1994; and Frank, 1995). For example, inferior economic and social status limits the ability of many women to refuse unwanted or unprotected sexual intercourse, regardless of how much they know about AIDS or wish to adopt recommended individual risk-reduction practices (Berger et al., 1993). Similarly, it has become evident that

HIV/AIDS programmes are created within, and therefore constrained by, the larger society. Thus, for example, governmental refusal to inform the public about condom use for HIV prevention or allow harm reduction strategies for injecting drug users severely handicaps and influences the national AIDS programme; in contrast, the programme would benefit from overall public and official support for anti-AIDS efforts (Feldman, 1995). Social vulnerability focuses directly on the contextual factors which define and constrain personal and programmatic vulnerability. Vulnerability analysis recognises that broader, contextual issues such as governmental structures [health policy for immigrants, for instance], gender relationships, attitudes towards sexuality, religious beliefs, and poverty, influence the capacity to reduce personal vulnerability to HIV, both directly and as mediated through programmes.

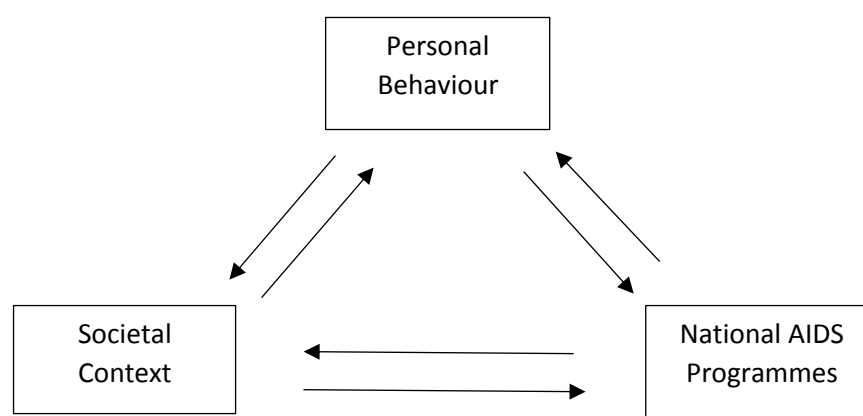


Figure 1.5: Vulnerability to HIV Infection (AIDS in the World, 1992, page 580)

After taking in consideration all the factors that increase an individual's vulnerability to HIV infection, including their own behaviours and other programmatic and societal dimensions, the researchers concluded that: "Personal empowerment is the antithesis of vulnerability" (AIDS in the World, 1992, page 579).

Key to the success of reducing vulnerability to HIV infection and of promoting personal empowerment is access to information/education and health and social services. This greatly depends on the quality and nature of the community or national sexual health programmes; and the broad societal influences that increase, sustain, or reduce personal empowerment. A weak national sexual health programme that lacks commitment and has a fragile and moving structure, with limited resources and a growing sense of complacency, will not serve its purpose. Meanwhile, more people will become infected because they do not have sufficient access to information and services.

According to Mann, Tarantola and Netter (1992), for HIV prevention to be successful, these three key and essential elements are required:

1. Information/education
2. Health and social services
3. A supportive social environment

Mann, Tarantola and Netter (1992) were categorical in their conclusions from analysing worldwide prevention strategies:

The capacity to design, deliver, and improve this prevention package engages individuals and their partners, HIV prevention programmes, and social systems. Whether they involve [over stayers], homosexual men, injecting drug users, sex workers or adolescents, the combination of these three elements in creative, innovative, and courageous ways have proven their ability to slow HIV transmission. Yet if any of the three elements are missing, it can be stated unequivocally that prevention is not being given a fair chance to succeed.

Information/Education

Information and education are the first and most important aspects of prevention. There is plenty of evidence of increased awareness about modes of HIV transmission and information on how to avoid becoming infected among participants following interventions (Mhalu et al., 1991; Pleak Meyer-Bahlberg, 1990; Chikwem et al., 1988; Wilson, Mehryar, 1991; Selwyn et al., 1987; Kleiman et al., 1990; Weisman et al. 1989; Seltzer et al., 1989; Rotheram-Borus et al., 1991; Lorenzetti et al., 1990; Carroll, 1988; Thomas et al., 1989; Gray, Saracino, 1990; Abraham et al., 1991; Ibanga et al., 1985; Hingson et al., 1990; and Sugerman et al., 1991). This is not to forget that these interventions (messages) need to be delivered in a sensitive way that is adequate (culturally and linguistically) for each target group. The best way of doing this is to involve the targeted people the programme is trying to reach in the design and implementation of it, to ensure adequacy and relevance.

A second step of the information/education programme is to ensure that channels of communication are appropriate to the target group, as well as to ensure that the messages have been well received. There are many different ways this can be accomplished such as through radio, newspaper, television, brochures, posters, counselling, theatre, and outreach or support groups. Programmes need to be evaluated to ensure optimal success.

Although information/education is the first step of prevention, it is important to be aware that this in itself is insufficient to change behaviour for some people. Human nature is complex and change for some requires more than information. It is only when health and social services, and a supportive social environment are added to prevention initiatives that change has a better chance to take place.

Health and Social Services

There is plenty of evidence that prevention initiatives not only increase awareness of HIV transmission, but have also resulted in bringing behavioural changes to many intervention participants (Hausser et al., 1991; Van Haastrecht et al., 1989; Cochran et al., 1990; de Vroome et al., 1991; de Wit et al., 1990; Ekstrand, 1990 and Pollak, 1989). Some of the observed changes are an increase in condom use, a decline in the number of sex partners, changes in sexual venue, a decrease in drug use, and modification of needle-using and sharing practices. In all of the above cited projects, information and education were complemented by supportive health and social services.

If people are to translate what they have learned about HIV from information/education initiatives into good practices, they will need a combination of supported services, such as free access to HIV/STI testing and counselling, free condoms and lubricants, treatment programmes for drug users, and support groups. This service must also be adequate for the community being targeted, so that the predictable health and social service needs of each particular group are anticipated and met. It needs to be geographically accessible, financially affordable, occur in a favourable environment (quality of interpersonal contact, confidentiality, tolerance, compassion), delivered by skilled personnel, and be sustainable over time.

Supportive social environment

The last of the three components of a successful prevention initiative makes us consider the importance of the broad social environment within which information/education and health and social services are sited. To ensure the success of any prevention initiative, a supportive social environment must be created, or at least promoted (Mann, Tarantola, Netter, 1992). It is here that the concept of “empowerment” proposed by Mann et al is discussed. According to the authors:

The term empowerment is useful to describe the process through which individuals assume for themselves the power to determine their behaviour. An individual is not

empowered by others, rather, a person must empower himself or herself.

Therefore, the positive role of the social environment is to remove barriers to personal empowerment and to facilitate this process.

AIDS in the World, 1992, page 339

I intend to develop this framework to assess vulnerability to HIV infection in the Brazilian expatriate population in England, by identifying what the community's needs will be, based on existing research on similar communities or groups of vulnerable people.

1.8.2 Data sources

The study was designed using mixed methods which were chosen in order to better contribute to the body of knowledge regarding vulnerability to HIV infection. I wanted to offer estimates of trends about vulnerability to HIV infection among the sample of the Brazilian expatriate population in England, who participated in this research. The quantitative survey was administered with the support of the Brazilian government, who provided the survey questionnaire, and Public Health England, who provided software and iPads. To recruit participants, I and my team of volunteers went to the Brazilian consulate. From this location I was able to recruit most of the 1018 Brazilians, the majority of whom lived in London. The in-depth interviews were done with 30 members of the Brazilian expatriate population in London, who I was able to recruit through my work as a sexual health outreach worker.

The importance of this PhD research is because as well as providing the first HIV/AIDS-related KAP of the Brazilian expatriate population in England, it also identifies future questions which need to be answered and areas in which data needs to be collected. If England wants to be successful in HIV prevention and achieve UNAIDS 90-90-90 guidelines, it needs to understand the requirements of migrant populations such as this one.

1.8.3 Funding and ethical approval

This PhD was self-funded, but received considerable financial support through the University of Nottingham's WH Revis Bequest Fund, in the form of direct deductions from tuition fees. In addition, financial support was also granted via the University of Nottingham's School of Cultures, Languages and Area Studies Doctoral Funding, to assist with external training, such as STATA and NVivo; and with the initial costs of transcriptions of in-depth interviews. Public Health England part-funded the in-depth interviews, and also matched funding from the University of Nottingham to pay for the transcriptions. Funders

had no role in the study design, data collection, data analysis, data interpretation, or writing of the thesis.

Ethical approval for the study was granted by the University of Nottingham's Faculty of Arts Ethics Committee, on 28th of May 2015 (Appendix 1).

CHAPTER 2 Literature review

It is important to note that the reason for focussing this literature review on Latin American immigrants rather than Brazilians is because no papers focusing only on the Brazilian community were found. In fact, very little research which mention HIV/AIDS-related KAP of Brazilian immigrants to High Income Countries exists. The few research papers that include Brazilians in them are actually focussing on the broad Latin American community.

Over the years, public health researchers have focussed on a growing range of social and health factors that place affected immigrant populations at increased risk of HIV infection during the migration process from Low and Middle to High Income Countries. To better understand the factors that affect Latin American immigrants, a literature review was conducted. The aim of this literature review is to summarise qualitative and quantitative studies regarding HIV/AIDS-related KAP and vulnerability to HIV infection among Latin American immigrants to High Income Countries. A methodological critique of studies in this area is provided, as well as gaps in the literature being identified where more research may be needed.

Multiple databases were searched between 11/09/16 and 31/03/17 in conducting this review, including Medline, PsycInfo, PubMed, Embase, Cochrane Library, Lilacs and Web of Science. Search terms combined using Boolean operators related to the following topics were applied in each database: HIV, AIDS, Knowledge, Attitudes, Practices and Immigration. Truncation was used to broaden the search. A last search was conducted on 29/06/19 to double check if new research relevant to this work has been published since 31/03/17, however, no new information was found.

Inclusion and exclusion criteria were applied to search results, to select individual studies for review. These criteria were kept deliberately quite broad to ensure all literature relating to these topics was captured through the searches. The criteria applied are detailed in the table 2.1 below.

Table 2.1 Inclusion and exclusion criteria for the literature review:

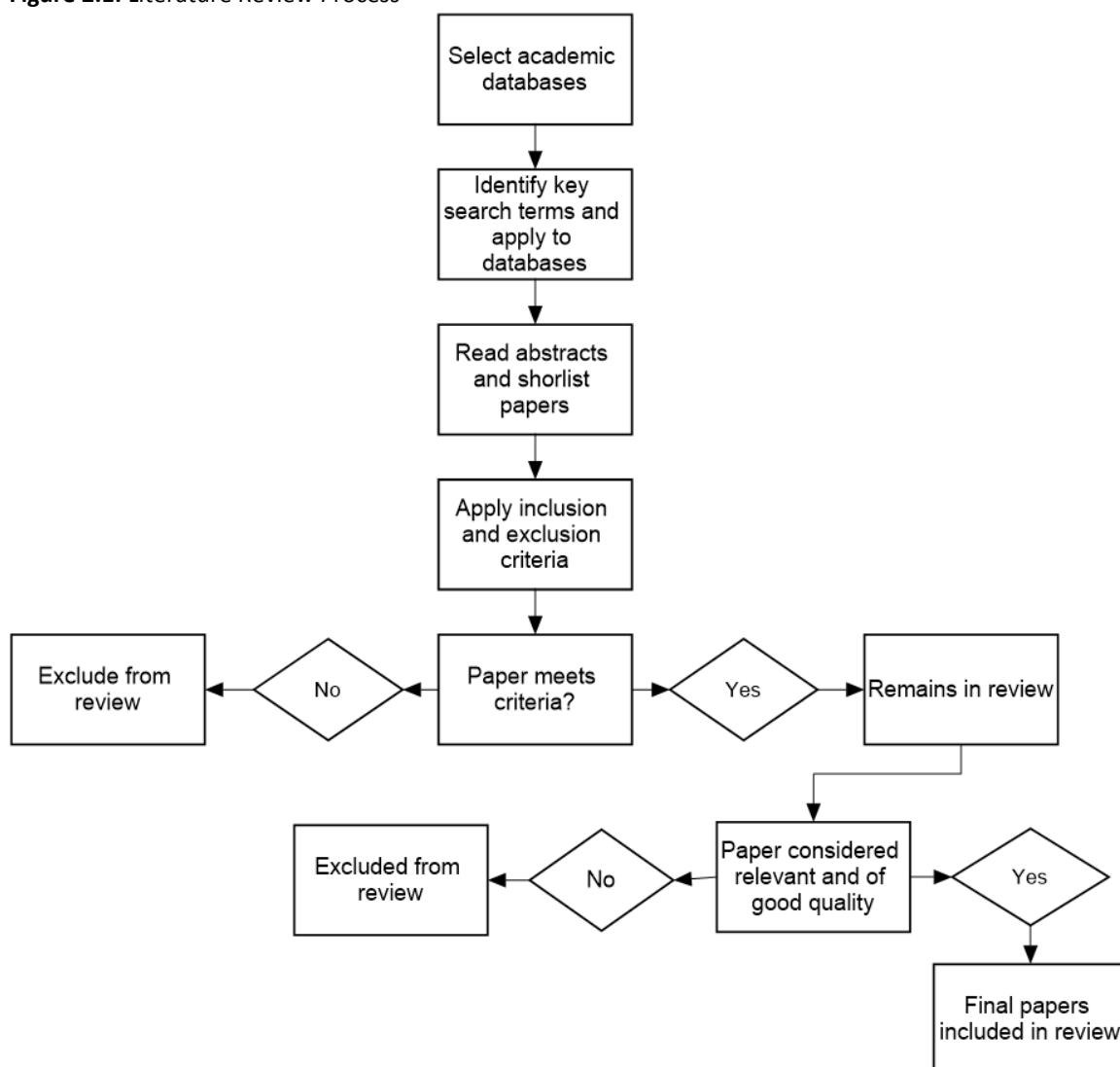
Inclusion criteria	Studies that focus on Latin American immigrants
	Studies that contains elements of HIV-related knowledge, attitudes and practices
	Studies in English, Portuguese or Spanish
	Studies using data related to High Income Countries
	Studies from 1980 to 2017
Exclusion criteria	Studies using data from Low or Middle Income Countries
	Studies using data from internal migration (rural to city or city to rural)
	Studies using asylum seeking data only
	Studies using refugee data only
	Studies using conflict zones data only
	Studies using 'transit stations' data only (border towns, port cities, areas where mobile populations congregate)

Table 2.1 Inclusion and exclusion criteria for the literature review

For studies that met the inclusion criteria, an assessment of their quality was also made by scrutinising the methodology used, for example, the data sources and application of analysis approaches. Studies judged to be of poor quality were excluded from the review.

Bibliographies of reviewed articles were also searched for potentially relevant papers to include in the review, for which inclusion/exclusion criteria were also applied. The flow diagram in figure 2.1 below outlines the process undertaken in conducting this literature review.

Figure 2.1: Literature Review Process



2.1 Data abstraction

A data abstraction form was created to facilitate an overview of each eligible study included in the review. Studies were evaluated, categorized and entered in the form according to country, author, journal, year, language, title, topic, methodology, key findings and limitations. The form can be found in Appendix 2.

Table 2.2 below presents the methodological summary of the studies that met the inclusion criteria. Each study was also evaluated according to the use of internationally accepted indicators for HIV/AIDS-related KAP following guidelines on construction of core indicators proposed by the United Nations General Assembly Special Session on HIV/AIDS (2008).

Table 2.2

Methodological summaries of studies meeting the inclusion criteria	
	Number of studies
Qualitative study design	9
Quantitative study design	14
Mixed methods study design	9
Literature reviews	3
Use of internationally accepted key indicators for HIV/AIDS-related knowledge, attitudes and practices	23
Results for HIV/AIDS indicators disaggregated by age or gender	27
Procedures for selecting samples discussed	29
Procedures for determining statistical power discussed	16
Explicit description of inclusion and exclusion criteria	25
Study monitored or reviewed by an institutional review board or other similar ethics review committee	18
Utilized one or more behavioural models	15
Used validated questionnaire/survey instrument	18
Questionnaire/survey instrument back-translated	6
Questionnaire/survey instrument appended	0
Trained interviewers	22
Performed statistical tests and analysis	22
Named statistical software	16
Performed descriptive analysis	26
Performed inferential analysis	11
Stated limitations and biases	23
Stated conclusions or provided recommendations	35

Table 2.2 Methodological summaries of studies meeting the inclusion criteria

2.2 Results

Initial results from the literature searches yielded a total of 365 published academic papers. 283 of them were excluded from the main review after the inclusion and exclusion criteria were applied, because they focussed on Low or Middle Income Countries. The 82 articles remaining were kept for further analysis. Initial exploration of the bibliography of these 82 articles produced a further 11 extra articles, adding to a total of 93. Of the 93 focussing on migration to high income countries, 35 were found to deal specifically with Latin Americans allowing me to narrow my inclusion and exclusion criteria to include just those 35.

Ever since the beginning of the HIV epidemic, researchers used qualitative, quantitative and mixed method approaches to investigate and gather data on the sexual health needs, as well as, on the vulnerability to HIV infection of Latinos in High Income Countries.

32 out of the 35 studies reviewed used participant observations, interviews, surveys, focus group discussions, in-depth interviews, content analysis, or ethnographic accounts to gather data on HIV/AIDS. As Esther Munene (2012) stated in her PhD thesis assessing knowledge, attitudes, behaviour, and practices related to HIV/AIDS in a USA-based refugee population:

Qualitative research was especially effective in obtaining culturally specific information about values, opinions, behaviours, and social contexts of specific populations. Studies utilizing focus group methodology found that forming small, nonthreatening groups gave participants the courage and opportunity to discuss sensitive topics such as sexual behaviour and share experiences that they had never before discussed openly.

Munene E, PhD Thesis, 2012, page 14

This supports my academic experience thus far which has demonstrated that mixed methods are the most appropriate and effective way of gathering information in public health research. Quantitative research alone cannot create a full and useful picture.

Quantitative approaches consisted of cross-sectional HIV/AIDS-related KAP studies and field surveys. 9 studies were solely qualitative, 14 were solely quantitative, and 9 combined both quantitative and qualitative methods. 3 studies were literature reviews.

In terms of using internationally accepted key indicators for HIV/AIDS-related KAP, only 23 studies specified theirs, and only 18 confirmed that they used in their survey a validated tested questionnaire survey instrument. None of the studies had their questionnaire/survey appended. All 35 papers stated their conclusions and provided recommendations.

This review draws attention to the need for more scientific-based evidence specific to the Brazilian community. This will guide the development of targeted HIV prevention programmes for Brazilian immigrants in vulnerable situations in England. Effective methods to assess HIV risk are needed in order to design adequate HIV prevention programmes for this particular population, because efforts within particularly affected communities such as Brazilians in the UK are key in preventing the spread of HIV at large.

According to Brabant and Raynault (2012), when gathering the necessary scientific evidence, particular attention must be paid to the migration process, not simply the status of the migrant in their new migrant community.

Three phases of migrant's trajectory render them vulnerable to STIs and HIV: a troubled past in their country of origin, the migration journey and their precarious status when they arrive at their destination.

Brabant and Raynault, 2012, pages 330-344

In the case of Brazilians, we have to think of what brought them here: did they go first to another country? Did they have higher risk of HIV in Brazil or in another country before arriving in England? For instance, some people came to England but they might have put themselves in a lot of debt by doing so. In order to clear this debt, they might have to engage in sex work. We have to have a holistic view of their journey, not just that they are here now. Brabant and Raynault's conclusion is important to this project because it impacts the questions asked, making sure they focus on the life of the migrant pre-migration.

2.2.1 Factors which increase vulnerability to HIV infection among Latin American immigrants in High Income Countries

It has been well documented that traditional goals continue to influence migration among Latin Americans to High Income Countries, such as to help the family, send money home, obtain better education for themselves and for their children, and to obtain better medical care (Shedlin et al., 2006). However, throughout the migration process, some of these immigrants become vulnerable and higher risk for HIV infection (Cochran et al, 1990 and Albarrán et al., 2011). In the United States for instance, Mexican migrants, both farm workers and day labourers, were found to be part of a marginalised group that lacks resources and suffers poor health outcomes (Apostolopoulos et al., 2006; Villarejo, 2003), including an increased risk of HIV infection (Sanchez et al., 2004). In fact, data from the Centre for Disease Control and Prevention website (CDC, 2018), shows that in 2015, Latin Americans accounted for about one quarter (24%) of all new HIV diagnoses in the United States, despite representing only about 18% of the total population (CDC, 2018).

This precarious situation experienced by Latin Americans in North America seems to be replicated in other developed countries too. For instance, a research paper by Korner (2007) in Australia regarding late HIV diagnosis of people from culturally and linguistically diverse backgrounds in Sydney, which included eight Latin Americans, found that people in Australia who were born in non-English speaking countries were disproportionately affected by HIV. Korner concluded that there may be cultural and linguistic barriers to accessing information about HIV and HIV testing (Korner 2007).

Similarly, in Spain (Barcelona), Ríos et al (2009), in a research paper to describe and compare the HIV/AIDS-related KAP of Latin Americans and Maghrebi users of medical centres, found that 53.8% of participants had inadequate knowledge of HIV/AIDS (Ríos et al., 2009).

Likewise, a research paper from the International AIDS Conference 2010, focussing on migrant sex workers in the European Union, shows that this population is highly vulnerable in regards to having their rights respected and accessing HIV prevention services (Brussa et al., 2010).

In Portugal, research in 2011 regarding factors associated with HIV testing among immigrants, including Brazilians, found that only about half of the participants reported having ever been HIV tested. It also showed that most participants declared that they preferred to get HIV information from doctors. However, only 9.2% respondents declared that they had sought HIV information at the National Health Service (Dias et al., 2011). In my opinion, this low percentage could be explained by the fear that some immigrants have of accessing State provided services. In the U.S. (Massachusetts) for instance, Hacker et al (2011), researching the impact of immigration and customs enforcement on immigrant health (including 18 Brazilians), concluded that participants had high levels of stress due to fear of deportation, which affected their emotional wellbeing and their access to health services (Hacker et al., 2011).

In Switzerland (Lausanne), research by Darling et al (2013), regarding access to primary healthcare among street-based sex workers (including Brazilian sex workers), found that whether through mobility, insufficient education or language barriers, the sex workers who took part in the research were unaware of the services they were entitled to. With half the participants reporting no HIV testing. There was a clear need to enhance awareness of available facilities as well as to increase provision and uptake of HIV testing (Darling et al., 2013).

Another research project in Spain by Hoyos et al (2013), focussing on the prevalence of HIV and perceived barriers to HIV testing, found that Latin Americans had a low perceived risk of HIV infection (Hoyos et al., 2013). Also, Rodríguez-Álvarez et al, in that same year, researching the social factors that explain the differences in knowledge with regards to HIV/AIDS among immigrants in the Basque Country (Spain), concluded that inadequate knowledge of HIV/AIDS was associated with place of birth, sex, a lower level of education,

immigration status, difficulties in understanding Spanish, and not receiving advice about HIV/AIDS in primary care (Rodríguez-Álvarez et al., 2013).

Finally, Ochoa et al (2014), in a research paper titled “Risk perception and vulnerability to STIs and HIV/AIDS among immigrant Latin-American women in Canada”, found that the majority of women reported difficulties in accessing sexual and reproductive health services. Women’s vulnerability to HIV/AIDS/STIs was determined by their experiences during their lifetime: their migratory status, which was associated with sexual abuse, abuse at work, language barriers and lack of social support networks; and their ability to access health services (Ochoa et al., 2014).

A thematic analysis of the main topics identified in the 35 papers included in this review and which might increase risk of HIV infection among Latin Americans in High Income Countries is presented below:

Inadequate knowledge of HIV/AIDS: Biomedical model v Lay model

According to McQuiston et al, in a paper titled “After-the-fact strategies Mexican Americans use to prevent HIV and STIs” (1998), there is plenty of evidence which shows that Latin Americans know about the biomedical model of HIV transmission (perinatal, sexual intercourse, shared needles) but believe in casual modes of transmission (Aruffo, Coverdale, & Valvona, 1991; Flaskerud & Calvillo, 1991). Although their knowledge of the major modes of transmission is similar to that of other ethnic groups, knowledge among Latin Americans varies by ethnic subgroup, with Mexican Americans least likely to identify routes of transmission consistent with the biomedical model (Biddlecom & Hardy, 1991). Furthermore, there are major differences in HIV knowledge between Latin Americans and non-Latin Americans with regard to casual transmission (Biddlecom & Hardy, 1991; Flaskerud & Calvillo, 1991; Marín & Marín, 1990). Latin Americans are more likely than other ethnic groups to believe in casual transmission of HIV, including transmission from saliva, toilet seats, from mosquitoes, being coughed or sneezed on, sharing eating utensils, or living near someone with AIDS. Belief in casual transmission varies by education (Biddlecom & Hardy, 1991) and level of acculturation (Marín & Marín, 1990). Another research paper by Organista et al (1998) found that Mexican Americans also believed they could contract HIV from kissing and from the HIV test itself (Organista et al., 1998, p. 96-103).

The most significant finding by McQuiston et al (1998) was that participants in their research project were using preventive strategies for HIV that were conceptually consistent with their perceptions of both models for gonorrhoea prevention and casual transmission of HIV. Participants did not discriminate between HIV prevention and the prevention of other STIs. Furthermore, the participants' definition of prevention was very different from that which is commonly used (i.e., the biomedical model). Participants included acting after exposure as a method of disease prevention. Within the gonorrhoea model, the idea of using post-sexual encounter check-ups by the doctor is logical from a lay perspective. Because gonorrhoea is treatable, people can potentially expose themselves, go to their health care provider, and be treated before they become symptomatic or acutely ill. Therefore, seeing a health care provider soon after exposure is viewed as a method of preventing symptoms and, therefore, disease. Similarly, checking out a partner as prevention also seems logical, for example, abstaining from sex because of visible vaginal discharge (observing for discharge was only mentioned by the men) is also a method of prevention that fits within the gonorrhoea model. Although this model may be viewed as useful for gonorrhoea "prevention" (not from a public health point of view), it is potentially dangerous in the age of HIV and AIDS (McQuiston et al., 1998, p. 406-422).

Also a research project mentioned before, done in Spain with 238 Latin American and Maghrebi immigrants in Catalonia, regarding their knowledge of HIV and STIs (Ríos et al., 2009), found that participants' correct knowledge of the means of HIV transmission and prevention were very low, with half of the participants believing that HIV can be acquired by sitting on public toilets, or using public swimming pools (Ríos et al., 2009, p. 533-538). This was confirmed by another research paper in Spain, discussed previously, conducted by Rodríguez-Álvarez et al (2013), analysing social factors associated with the knowledge about HIV of immigrants in the Basque country. The study revealed deficiencies in knowledge about HIV across all the groups of immigrants in the sample. The percentage of people who correctly identified all the routes of transmission was low, misconceptions with regards to the acquisition of the disease by sharing food with People Living with HIV and AIDS (PLWHA) and in the linking of the appearance of a person with HIV infection being the most common. These misconceptions, on the other hand, reinforce stigma and discrimination, and on the other, weaken motivation to adopt safe sexual practices (ECDC, 2013; UNAIDS, 2013). Inadequate knowledge was found to be associated with place of birth, a lower level of education, being an irregular immigrant and difficulties with the local language (Rodríguez-Álvarez et al., 2013, p. 24-33).

In terms of where Latin Americans would like to receive sexual health education from, a research study on Mexican adolescents in the USA found that 95.1% of participants stated they would prefer to receive sexual health education from health professionals because they were “a good and trusted source of HIV information” (Villarruel et al., 2003, p. 193-206). Grieb et al (2015) in a qualitative HIV prevention research study in Baltimore (USA) also stressed that the way information is transmitted to participants is key to the success of the programme. Some Latin Americans showed disinterest in the HIV information given to them because of the way it was passed on in public places. Once the group distributing the information left, participants threw away the leaflets saying they did not need those because they did not have AIDS (Grieb et al., 2015, p. 118-124).

Language barriers

The language barrier seems to be the biggest hurdle faced by Latin Americans in High Income Countries in obtaining any sort of health care provision. For example, lack of Spanish-speaking providers and cultural knowledge has made health care for recently arrived Latin Americans in North Carolina inaccessible or unacceptable (McQuiston et al., 1998). Clinical interventions, which have been successful with other ethnic groups, are not always appropriate for this “new” cultural group. Most clinicians are not equipped with the language skills or cultural competence to provide culture-specific care for newly settled Latin Americans (Aguirre-Molina, National Coalition of Hispanic Health and Human Services Organisation, 1998). McQuiston et al also concluded that the level of information given to Latin American migrants is also important. Men often have more education and better English language skills than the women. The men typically are employed outside the home and are in frequent contact with English speakers. The women often stay at home and depend on their husbands and children to teach them English. The women in McQuiston’s study suggested that information was too technical, and the men said that it was too superficial. Therefore, HIV and STIs information need to be delivered at different levels for men and women (McQuiston et al., 1998, p. 406-422).

In Australia, people born in non-English speaking countries, including Latin Americans, were disproportionately affected by HIV/AIDS. This situation gives an indication that there may be, among other things, cultural and linguistic barriers to accessing information about HIV and HIV testing (H. Körner, 2007). In Curaçao (Netherlands Antilles), Hammer et al (2010), realised that Latin American adolescents have limited access to informational sources

regarding HIV/AIDS and other STIS, because of linguistic as well as cultural barriers (Hammer et al., 2010, p.287).

Machismo/Gender roles/Gender norms

Machismo has been explained widely and often in the literature as a common phenomenon in Latin American culture. Villarruel et al (2003) explain that the concept has been well explored by others, such as the classic work of Mexican psychologist Díaz-Guerrero (1982):

The Mexican with an active sex life is more of a man. Behaviours consistent with male gender role expectations include unprotected sexual behaviour, multiple sexual partners, and negative attitudes toward condom use. For women, gender role expectations centre on devotion and duty to the family, virginity, fidelity in relationships, and surrendering decision making, including sexual decision making, to men.

Villarruel further explains that these prescribed values may serve to support safer sex behaviour among adolescents, especially those related to virginity, abstinence, and fidelity. It may also be a barrier to the negotiation of condom use and other safer sex practices. He further points out that among Mexican adolescents, fear or failure to negotiate safer sex practices has been attributed to female gender role expectations (Castro-Vazquez, 2000; CONASIDA y Secretaría de Salud, 1999, Villarruel et al., 2003, p. 193-206). To be accepted within macho culture, the woman cannot raise her voice or be seen to impose her own will on a man. This is often referred to as Marianism in the literature, since *marianismo* is used as the counterpart to machismo. *Marianism*, is a term that indicates a woman is expected to model her behaviour on the Catholic construction of the Virgin Mary. She must remain pure, self-sacrificing, and subservient, which in real terms usually means being subordinate to her husband and tolerating his unfaithful behaviour. These cultural beliefs are indicative of extreme power imbalances in relationships (Albarrán & Nyamathi, 2011, p.178).

Low levels of perceived risk of HIV infection

When Latin American men and women were asked if they considered themselves to be at high, moderate, or low risk for HIV and AIDS, the majority of respondents perceived their risk as low (McQuiston et al., 1998; Hoyos et al., 2013). Most Latin Americans do not feel that they can get HIV (Biddlecom & Hardy, 1991; Flaskerud et al., 1991; Nyamathi et al., 1993). In fact, many researchers have shown a striking lack of association between HIV knowledge and HIV risk. Although knowledge is important for behaviour change to happen,

it is not sufficient to effect change in risk behaviour (Peragallo N, 1996). This situation can be even more hazardous if we take in consideration an important point raised by Loue et al (2003):

It should be noted as well that actual risk for HIV transmission depends not only on one's behaviours but also on the prevalence of HIV in the community in which one is engaging in risky behaviours (Loue et al., 2003).

This was reinforced by Shedlin et al (2006), who pointed out that travel and migration patterns, particularly when they involve mobility to higher risk environments, have been related to increases in risky behaviours and HIV prevalence. Siegal et al., for example, found that an important predictor of becoming infected with HIV among Intravenous Drug Users (IDUs) in Ohio was having travelled to New York City, an AIDS epicentre (Shedlin et al., 2006; Siegal et al., 1991).

Castillo-Mancilla et al (2012) also reinforce that previous point in their study on differences in sexual risk behaviour and HIV/AIDS risk factors among foreign-born and US-born Latin American women. They explain that mobility and immigration to a foreign country are well-documented risk factors for the acquisition of HIV infection (Deane et al., 2010), particularly when individuals migrate from a low-prevalence area, like most countries in Latin America, to a higher prevalence area like the USA. Specifically, migration has a direct influence on sexual behaviour because it can modify an individual's propensity to engage in risky activities, which increases the risk for HIV infection. Migrants often find themselves lonely and isolated, living in sub-standard conditions and most of them undergo prolonged periods of time away from home and family. In addition, migrants may be faced with new and more sexually permissive norms and customs which they have not experienced in their country of origin. This new environment can give the migrant a sense of anonymity that facilitates risky behaviour. The researchers further explain that migrants may also face depression, anxiety and loss of self-esteem, all of which have been associated with high-risk sexual practices such as casual sex with random partners, frequent access to commercial sex workers, illicit drug use and same-gender sexual activity such as oral and anal sex, among others (Organista & Organista, 1998; Magis-Rodríguez et al., 2009; Hirsch et al., 2002). Lastly, migration is also a risk factor for financial distress, homelessness and other social factors that increase the risk of HIV and other STIs (Loue S, 2003; Castillo-Mancilla et al., 2012, p. 89-99).

The combination of increased risk of HIV infection and low levels of perceived risk of HIV infection is a problematic situation. In Sydney (Australia), a semi-structured in-depth interview research paper by Körner (2007) with 29 HIV positive non-English speaking migrants, and focusing on HIV prevention, shows that none of the participants expected a HIV positive result when they were diagnosed. Körner points out the participants had two modes of making sense of HIV risk prior to infection. Those who had no understanding of the nexus between HIV and AIDS had no awareness of what constituted a risk of transmission and saw no relationship between their own practices and HIV transmission. The other mode of understanding risk was in terms of 'risk group' membership, more specifically, conforming to a stereotypical idea of certain groups at risk, e.g. prostitutes and drug users. As participants did not identify with these stereotypes, they did not perceive themselves at risk (Körner, 2007, p. 168-178).

Low levels of condom use

The lack of perceived risk of contracting HIV may account in part for limited condom use among Latin Americans (McQuiston et al., 1998). Evidence shows that Latin American women had unprotected sex more frequently than European American or African American women (Harrison et al., 1991). Also, in a research paper by O'Donnell et al (1994), among 620 sexually active women, 65.1% did not use condoms with their main partner, and 44.8% said they would not use condoms with their main partner even if that partner was HIV positive (This was before knowledge that HIV Undetectable = HIV Untransmittable became available). Latin American men did not consistently use condoms. In one study, 91% of Latin American men did not use condoms with their main partner, and 80% did not use them with their extra partners (O'Donnell et al, 1994). Other studies reported the range for condom use with secondary partners from less than 20% to greater than 60% (Sabogal et al., 1993). Additional studies on Mexican migrants in the US also indicates problematic knowledge about HIV and very low condom use (Bletzer, 1990; Bronfman et al., 1996; Organista et al., 1996). Self-efficacy to use condoms has been shown to be predictive of condom use (Bandura, 1994).

Organista et al (1998) in a research paper exploring the AIDS-related KAP of 32 female Mexican migrant workers, using a modified version of the unpublished Hispanic Condom Questionnaire developed by Marín and associates, found that participants indicated a considerable lack of basic, proper knowledge of condom use. This was in line with findings

by Marín and Marín (1990) that Latin Americans, who are poorly acculturated, have a high need of fundamental HIV and condom-related education (Organista et al., 1998, p. 96-103).

Many other researchers have also pointed out that condom use was very low among Latin Americans (O'Donnell et al., 1994; Sabogal et al., 1993; Villarruel et al., 2003). In 2000, for instance, a focus group study on condom use by McQuiston and Gordon with 31 Mexican Americans regarding their views of condom use showed that the majority of the women in the sample trusted their partners and did not consider themselves vulnerable to HIV infection. They also stated that the major difference between men and women included an emphasis on trust as both antecedent and a requirement for communication by the men: "The women needed to communicate to trust, and the men needed to trust to communicate" (page 277-90).

Once communication or trust was established, the women and men felt that sex with their partner was safe, even though they may never have discussed sex or the need for protection. (McQuiston & Gordon, 2000). Another research study done with Mexican adolescents, discussed previously, regarding their knowledge of HIV/AIDS, attitudes towards condom use, and information needs regarding HIV prevention (Villarruel et al., 2003) found that participants had a high level of correct knowledge about HIV/AIDS (mean = 98.4%) but the majority was not using condoms (86.4%). A little more than half of the participants (61.7%) indicated that they did not know how to use condoms correctly (Villarruel et al., 2003, p. 193-206).

Knipper et al (2007) in a research paper regarding condom use among heterosexual Latin American migrants in the USA identified four characteristics associated with increased likelihood of using condoms (after data was adjusted for relationship status): having sought healthcare information from family members; greater knowledge of HIV transmission and prevention; greater self-efficacy in using a condom; and greater adherence to traditional masculine norms (Knipper et al., 2007, p. 442).

Calabrese et al (2012) call attention to the need to investigate pleasure, or loss of pleasure, associated with condom use in Unprotected Anal Intercourse (UAI) among Latin American men who have sex with men (MSM). This research conducted in the New York City metropolitan area, focussed on 380 Latin American participants (including 115 Brazilians), who engaged in insertive and/or receptive unprotected anal intercourse. Their results show that greater loss of pleasure associated with condoms was perceived in the insertive position relative to the receptive position among MSM who had enacted both positions

with and without condoms. Additionally, results showed that greater perceived pleasure loss associated with condoms in each position predicted the incidence of recent UAI in that position (Calabrese et al., 2012, p. 430-435).

Calabrese recommended that policy makers responsible for public health efforts should review medical standards that impose sizing restrictions on condoms made available free-of-charge to those that cannot afford buying their own supply. They should also ensure that the full variety of condoms available commercially should be available and easily accessible in prevention campaigns, local markets, community clinics, and other condom distribution sites. Potentially, this would allow men to discover more comfortable and pleasurable options, reduce perceived pleasure loss, thereby increasing likelihood of use (Calabrese et al., 2012, p. 430-435).

A research study by Rhodes and McCoy (2015) regarding condom use among 190 immigrant Latin American MSM in North Carolina (USA), shows that 3 factors were consistently associated with increased odds of condom use across most analytical approaches used by the researchers: increased HIV/STI knowledge, decreased frequency of experiences with homophobia, and increased condom use self-efficacy. These findings suggest that individual-level or group-level interventions designed to reduce risk among Latin American sexual minorities may benefit from increasing HIV/STI knowledge and increasing condom use self-efficacy (Rhodes & McCoy, 2015, p. 27-43).

Low levels of HIV testing

A research study in Portugal by Dias et al (2011) with 1,513 immigrants, almost half of them from Brazil, has shown that only 51.2% of the sample reported ever having been tested for HIV. According to Dias et al, in 2007 Portugal was considered one of the western European countries with the highest burden of HIV infection (EuroHIV 2007). They concluded that innovative strategies to promote and generalise HIV testing should be developed, focusing mainly on addressing hard-to-reach groups such as undocumented migrants (Dias et al., 2011, p. 559-566).

It is useful to note that in this study, HIV testing was higher among Brazilians than the other ethnicities, which included migrants from several Portuguese-speaking African countries (34.8% of the sample), some Eastern European countries (11.9%), and a small proportion from Asia (2.9%). 55.9% of Latin Americans (most of whom were Brazilian, as noted above) had been tested for HIV, compared to 51.7% of Africans, falling to 36.4% for Asians and

33.7% for Eastern Europeans. This could suggest that language is a key factor impacting whether individuals access HIV testing.

Chen et al (2012) reached similar conclusions to Dias et al in their research regarding HIV testing behaviours among Latin Americans in English-speaking Baltimore (USA). Latin Americans in Baltimore can be a hard-to-reach group which often has limited access to healthcare and HIV testing, particularly the foreign-born Latin Americans who have the highest risk of late presentation to HIV care. Other factors such as low levels of HIV knowledge (London et al., 2000) and low self-perception of HIV risk (López-Quintero et al., 2000) can contribute to low testing rates (Chen et al., 2012, p. 540).

It is logical to hypothesise that Brazilians in England could be a hard-to-reach group, in part due to the language barrier, meaning that the research of Chen et al and Dias et al provides important evidence in relation to how the knowledge and attitudes of Brazilians in England impacts their vulnerability to HIV.

Limited access to health services was also observed by Chavez (2012), in a research paper investigating undocumented immigrants and their use of medical services in Orange County, California. His findings show that undocumented immigrants had relatively low incomes and were less likely to have medical insurance, they were more likely to experience stress in their lives; and underutilise medical services when compared to legal immigrants and citizens (Chavez L. 2012, p. 887). Holmes (2012) also points out that unauthorised indigenous Mexican migrants faced many barriers to health care in other parts of North America too. There was also evidence of some patients having difficult interactions with health professionals inside the clinics which caused obstacles for them to receive healthcare. These obstacles included rushed appointments, power differentials between patients and professionals, simple misunderstandings, and more complicated sociocultural assumptions and perceptions related to the fact that these migrants had completely different backgrounds to those professionals they were in contact with. Also, language barriers, unstable funding, patchy medical records, and the irregular work schedules of patients created further barriers and prevented them from accessing health services (Holmes, 2012, p. 873-881).

As noted in 1.4, research suggests that the size of the Brazilian community in England could be much larger than previously thought. Though official figures put the number of Brazilian immigrants at 52,000, leaders in the Brazilian community estimate that the number could be closer to 200,000 including a significant number of undocumented migrants. The

findings above, therefore, are highly relevant to this thesis, in directing investigation both quantitatively and qualitatively.

Darling et al (2013), in a research paper with Street-based Sex Workers (SSW) in Switzerland (including Brazilian sex workers), highlight two main concerns. Less than a third of the participants in Darling's research knew where they could go to get free primary healthcare and gynaecology services, which are free-of-charge regardless of residence and insurance status (e.g., *Point d'Eau* service). The second concern was an indication that a high number of SSW had not been HIV tested (Darling et al., 2013, p. 371-375). Darling et al's conclusions further support the need for outreach programmes and targeted sexual health campaigns.

This information is important because it confirms the evidence gathered in my professional experience with the Brazilian population in England as a sexual health outreach worker, thus supporting the legitimacy of the need for this thesis.

Among other reasons for not testing for HIV were concerns about test results, particularly how information might be disclosed and repercussions of a positive test result. To expand HIV testing, these concerns must be addressed (Gilbert & Rhodes, 2013, p. 628-636).

Alcohol and drugs

Rhodes et al, in a research paper regarding HIV and STIs risk among male Latin American migrant farmworkers in the Southeast of the U.S., pointed out that alcohol and drugs are some of the factors increasing HIV risk in this population. In fact, of the 113 Latin Americans who took part in this study, nearly 10% reported drinking alcohol every day or nearly every day, while a quarter reported drinking one to four times per week. Although 32% reported drinking at least once per week, the majority of participants reported drinking alcohol two to three times or less per month. Binge drinking was substantial in this sample, with nearly 58% reporting binge drinking during the past year. Nearly one fifth of the sample reported binge drinking one or more times each week, and over one third reported binge drinking at least monthly. About 40% of the sample reported consuming three or more drinks on a typical drinking occasion during the past 3 months. 40% of those who reported engaging in sex during the past 3 months reported being under the influence of alcohol at least once while engaging in sex (Rhodes et al., 2010, p. 979).

In terms of illicit drug use, 15 participants (13.0%) reported lifetime histories of any type of illicit drug use; 12 reported using marijuana; and 4 reported using cocaine. None reported

ever injecting drugs that were not prescribed by a provider or having sex while under the influence of illicit drugs during the past 3 months. One participant reported sharing needles or equipment for injecting drugs (Rhodes et al., 2010, p. 979).

Through this study, Rhodes et al were able to assume that according to their findings, there is no evidence that Latin American farmworkers drink more alcohol than others, although they concluded that binge drinking (defined as drinking more than five or more drinks in a single drinking occasion) might pose as a problem. This type of drinking pattern has been referred to as “fiesta drinking”, or drinking occasionally during events and celebrations, including holidays, and birthday and family celebrations (Worby and Organista, 2007). Of particular interest in the case of HIV risk is the fact that among those who reported sex during the last 3 months, a substantial proportion indicated that they had had sex while under the influence of alcohol. This finding is particularly important because alcohol use may impair the judgement of an individual about initiating sex. Within some populations, alcohol use behaviour has been found to be associated with indiscriminate forms of sexual behaviour or risk taking (e.g., having multiple partners or engaging in “casual” sexual intercourse) but not with actively protective behaviours such as condom use (Rhodes et al., 2010, p.981).

Albarrán and Nyamathi (2011) in a research study about HIV and Mexican migrants in the USA points out that Duke and Carpinteiro (2009) found that the long-term separation of migrant workers from their families, combined with stressful working conditions and worry about their undocumented status, led to problem drinking and sexual risk behaviours. Although there is limited drug and alcohol research on migrant workers, there is growing anecdotal evidence that this is a serious issue warranting further investigation. Alcohol has also been identified as a coping mechanism for migrants in dealing with loneliness, depression, and the physical difficulties of work (Apostolopoulos et al., 2006). Injection drug use has been reported as high as 19% in one sample (Denner et al., 2005); in another study, almost a quarter of respondents reported having used drugs at least on one occasion. Previous research has also shown that drug use is an avenue for migrants to increase productivity at work, demonstrating the effect of work stress on HIV risk (Apostolopoulos et al., 2006; Albarrán & Nyamathi, 2011, p.179).

Fear of Deportation

In many High Income Countries, Latin Americans who do not have secure visa status avoid health services because of fear of being reported to immigration officials. As Körner states

in a research study in Sydney (Australia) in 2007: “The fear of deportation can be a barrier to seeking healthcare, including HIV testing and to disclosing HIV-positive status”. This situation is a major barrier for migrants in order to access health services (Körner, 2007, p. 168-178).

In the U.S., for instance, following highly publicised immigration raids in rural areas, and the unlawful detention of legal immigrants, several health centre patients in Illinois reported to the medical staff that they were reluctant to leave their homes for doctor’s appointments or to pick up prescription medicines from the pharmacy, for fear of detention and possible deportation. For this reason, undocumented farm workers in the U.S. typically avoid interaction with any institution that may directly or indirectly reveal their immigration status (Bauer et al., 2010, p. 709).

This has also been confirmed by Hacker et al (2011) researching the impact of immigration and customs enforcement on immigrant (documented and undocumented) health in Massachusetts, through 6 focus groups. This research paper included 18 Brazilians. The researchers point out that many undocumented immigrants worry that by disclosing their legal status they will be vulnerable to law enforcement actions and therefore some of them avoid using the health care system. Participants noted that fear of deportation exacerbated their chronic diseases such as depression, high blood pressure, and anxiety while also producing a range of physical symptoms (hair loss, headache). When immigrant communities do not trust their community institutions, they are less likely to fully engage as members of the community. This also has implications for the health of the city in which they live. When immigrants avoid health care for communicable diseases, it becomes difficult to maintain public health (Asch et al., 1998; Davis & Henderson, 2003; Lysakowski et al., 2009; Hacker et al., 2011, p. 591-592).

2.2.2 HIV prevention awareness, approaches and frameworks that have been used to address risk of HIV infection among Latin American immigrants in High Income Countries

The many issues identified in the 35 research papers included on this review show that multiple factors indeed contribute to the increased risk of HIV infection of migrant Latin Americans in High Income Countries. This has been summed up by McQuiston and Gordon:

We have past the midpoint of the second decade of the AIDS epidemic in the United States [Now nearing its 4th decade]. During that time we have learned much about interventions with gay men, drug users, women, and people of colour. Yet

we still have much to learn about HIV/AIDS prevention interventions for Latinos that are sensitive to their cultural needs” (McQuiston, & Gordon, 2000, p. 277-90).

This was also pointed out by Raj et al (2001) in another research paper with 162 Latin American women in the U.S.:

The lack of programmes focusing on Latinos is especially troubling given the recognition of cultural competency – that is, messages and methods specifically tailored to target audiences – as a hallmark of effective programmes (Raj A et al., 2001, p. 599-607).

A thematic analysis of the main topics identified in the 35 papers included in this review and which might help prevent HIV infection among Latin Americans in High Income Countries is presented below:

Acculturation

Acculturation refers to a process of adaptation to, and adoption of, a new culture (Franco, Cuadra, Tabol, Zea, & Peterson, 1998). According to several investigators, prevention efforts with Latin Americans should always take into consideration the impact and the influence of cultural factors when addressing HIV risk. Mikawa et al (1992), in a research study investigating the cultural practices of Latin Americans in the USA which had implications for HIV prevention, stated that many HIV prevention initiatives with Latin Americans have assumed that all known cultural factors have an equal influence on their risk of acquiring HIV, and have attempted to include broad-based, culturally sensitive materials. Mikawa argues that this “shotgun” approach may have been expedient and necessary for the initial stages, however, focusing on specific cultural factors may be required to increase the effectiveness and cost-effectiveness of prevention efforts (Mikawa et al, 1992, p. 421-433).

Mikawa et al used the acculturation scale questionnaire developed by Cuellar, Harris, and Jasso (1980) to assess the acculturation levels of their participants. The scale has an English and a Spanish version, and it assesses a broad spectrum of acculturation, including items on language usage, ethnic origin of friends and peers, food preferences, ethnic identity, and generational background. The scale is oriented toward Mexican Americans although items include choices for other Latin American groups too. The scale differentiates five levels of acculturation: (a) very Mexican, (b) Mexican-oriented bicultural, (c) “true” bicultural, (d) Anglo-oriented bicultural, and (e) very Anglicized. Their most consistent findings were that

those participants who were low in acculturation compared to those who were high in acculturation reported more machismo, less fear of AIDS, and more willingness to believe in fate. Most people in the sample were low in acculturation (Mikawa et al, 1992, p. 421-433).

Their findings lead to several suggestions for those implementing HIV-prevention programmes directed at Latin Americans: 1] the least educated among Latin Americans, especially recent immigrants, should be targeted for HIV prevention. 2] Education levels as well as acculturation levels should be part of the routine assessment of populations prior to implementing HIV prevention programmes. 3] it should be recognised that cultural factors may have differential effects depending on education and acculturation levels (Mikawa et al, 1992, p. 421-433).

Another acculturation measurement instrument discussed in a research paper by Loue et al (2003) regarding HIV risk among a sample of Mexican and Puerto Rican men and women in the U.S. is the 24-item Bi-dimensional Acculturation Scale (BAS) for Hispanics (Marín G, Gamba RJ, 1996). The BAS includes 12 items per cultural domain, Spanish-speakers and non-Spanish-speakers, across the three subscales of Language Use, Language Proficiency, and Electronic Media. Items on the Language Use subscale relate to the frequency of usage of both English and Spanish and include questions such as “How often do you speak English with your friends?” and “How often do you think in Spanish?” The Linguistic Proficiency subscale asks the respondents to indicate how well they speak, write, and understand English and Spanish. Items included, for example, “How well do you understand radio programmes in English?” and “How well do you speak Spanish?” The Electronic Media subscale focuses on the frequency with which the respondent watches television or listens to music or the radio in English and in Spanish. Responses for the three subscales are measured on 4-point Likert-type scales. Two scores indicate the level of acculturation in each cultural domain, resulting in the classification of each individual as Hispanic [Latino], non-Hispanic [non-Latino], or bicultural (Loue et al., 2003, p. 550-565).

Respeto & Personalismo

A focus group exploratory study with 31 newly-arrived Mexican American immigrants, both male and female, and conducted in the South-eastern metropolitan area of the U.S., found that one important aspect of communication and information sharing with Latin Americans is their need to be provided with warmth and a sense of realness. This request from the community reflects specific cultural values of Mexican Americans [and many Latin American cultures], including *respeto* (showing proper respect to others) and *personalismo* (being

open and available) (Singer, 1991; Weeks, Schensul, Williams, Singer, & Grier, 1995). HIV and STI information for Mexican Americans must be delivered within the context of *respeto* and *personalismo*. As one woman so clearly states, “You need to feel you are talking to a person” (McQuinston et al., 1998, p. 406-422).

Familialism

Familialism and culturally prescribed, gender-based roles were examined as a means to support healthy behaviour as well as to minimise risky behaviour. Familialism refers to strong identification with and attachment to the family and feelings of loyalty, reciprocity, and solidarity with family members. The concept has been used in HIV risk prevention interventions as a means by which to examine the consequences of behaviour, to elicit support for safer sex behaviours and as a framework for decision making (Villarruel et al., 2003, p. 193-206).

According to Knipper et al, using existing family networks may serve as an effective delivery channel to increase condom use and thus decrease HIV and STI exposure and transmission among Latin American men. Opportunities to train men to reach out to their extended family networks including sons, brothers, cousins, and so on may exist and may be potentially effective (Knipper et al., 2007, p. 443).

Community-Based Participatory Research

Community-Based Participatory Research (CBPR) has been cited and used by quite a few academic papers included in this review (Knipper et al., 2007; Rhodes et al., 2010; Hacker et al., 2011; Rhodes et al., 2011; Gilbert & Rhodes, 2013; Rhodes et al., 2013; Sanchez et al., 2016). As Knipper et al explain in a 2007 research paper regarding condom use among heterosexual immigrant Latin American men in the South-eastern U. S., traditional “outside-expert” approaches to research and practice have been noted to be ill suited for complex health problems, such as racial and ethnic disparities in HIV infection. This often results in insufficient understanding of health phenomena and ineffective interventions. Knipper further argues that researchers and practitioners aiming to understand and to eliminate health disparities and to promote community health have begun to focus attention on community-academic partnerships as integral elements within the research enterprise. Knipper goes on to explain that health professionals, including researchers and public health practitioners, may benefit from establishing partnerships with community

members and representatives from community-based organisations (CBOs) and agencies, all of whom possess expertise as “insiders”.

According to Knipper (2007), CBPR is designed to ensure and to establish structures for participation by members from the communities affected by a specific issue, representatives of CBOs and agencies, health care providers, and researchers and practitioners in all aspects of research. CBPR seeks to ensure that (a) bridges are created and trust is built between community stakeholders (e.g., representatives from the community, CBOs, and public health agencies) and providers and researchers from academic institutions, (b) research is authentic to community experiences, (c) research questions are relevant, (d) research design and methods are culturally and educationally appropriate, and (e) infrastructure is built to promote successful implementation and longer term sustainability when appropriate. Community-academic partnerships can enhance the quality, use, relevance, and interpretation of the data, and they can ensure appropriate dissemination of study findings (Israel et al., 1998; Rhodes & Benfield, 2006; Knipper et al., 2007, p. 437-438).

Research Participant Recruitment

Among the 35 papers included in this review, a research paper by Shedlin et al (2011) examined the importance of the recruitment process for participants in behavioural research projects among Latin Americans in High Income Countries. The study aimed to identify contextual factors as well as attitudes, experiences and beliefs affecting HIV risk among recent Latin American immigrants in New York. The authors point out that conventional probability sampling is usually neither feasible nor suitable for recruiting subjects from hard-to-reach populations (McMahon et al., 2003), and the main challenge is the lack of an existing “sampling frame” for the study of these groups (Magnani et al., 2005). In addition, any recruitment of study subjects from hidden or stigmatised populations such as illicit drug users, undocumented immigrants, men who have sex with men (MSM), sex workers, poses difficulties due to the many complex issues which exist in obtaining individual and community collaboration in research, including fears relating to stigma and the possible consequences of the exposure of illegal/clandestine behaviours and activities (McMahon et al., 2003). These issues call for sensitive, flexible and innovative recruitment methods that build on the legitimisation of the research and researchers and the development of a trusting relationship which assures that contact will be confidential and safe for potential respondents (Shedlin et al., 2011, p. 353).

Shedlin et al further explain that recruitment strategies frequently used in community studies include target sampling (Watters & Biernacki, 1989) and respondent-driven sampling which is also a type of snowball sampling (Heckathorn, 1997). The method of snowball sampling was chosen to recruit participants for Shedlin's study owing to the hard-to-reach characteristics of the Latin American population under investigation, and the sensitive nature of the topic researched. While snowball approaches have been criticised as contradictory to conventional sampling, as Atkinson and Flint (Atkinson & Flint, 2001) point out, this technique of "chain referral" may give the researcher the advantage of being considered an insider within the study population and hence, provide access to settings where special populations can be reached while enabling the recruitment of some of the study respondents as "informal research assistants" to establish rapport. This also implies appropriate and sensitive communication in carrying out recruitment, especially if researchers and subjects are from different backgrounds, have unequal power relationships and do not have the same motivations for establishing contact with one another (Somerville & Perkins, 2003). The research population's vulnerability, due to their possible undocumented status, recent migration, lack of established social infrastructures, language barriers and economic status emphasised the need for establishing a rapport with the community first in order to identify key community members and the initial group of participants who will then aid in referring other community members they know for participation in the research study (Shedlin et al., 2011, p. 353).

Easy access to health services (including HIV testing)

In most High Income Countries, according to this literature review, undocumented immigrants, including Latin Americans, have barriers to accessing health services. One exception was noted in a research by Dias et al (2011), who point out that in Portugal, since 2001, immigrants are entitled to health care regardless of legal status, including free health care for pregnant women and recent mothers, users of family planning programmes and individuals with transmissible diseases (Dias et al., 2011, p. 560).

In the U.S., one example of a targeted health service made available to the Latin American community was presented by Chen et al (2012) in a research study investigating HIV testing behaviours among Latin Americans in Baltimore. The researchers explain that given that the new influx of Latin American immigrants posed different challenges to HIV education and risk behaviour reduction efforts, in 2008, in response to the growing need for culturally-sensitive services for Latin Americans, the Baltimore City Health Department (BCHD)

established a Latino Outreach Programme staffed by Spanish-speaking community workers to provide HIV education and voluntary counselling and testing (VCT) for the Latin American community. The BCHD Latino Outreach team conducts HIV education and VCT and syphilis screening in the Latin American community. Their activities are generally targeted to locations with high concentrations of Latin American residents and businesses to provide HIV/STI screening for the general Latin American population. Typical BCHD outreach sites are Latin American community-based organisations (CBOs), clinics that predominantly serve Latin American patients, community fairs, bars, or neighbourhoods with a predominance of Latin American residents and businesses. The BCHD team is often accompanied by a mobile healthcare van in which two private counselling rooms and phlebotomy services are available. Individuals who agree to services undergo a short standardised BCHD demographic and risk behaviour assessment (Chen et al., 2012, p. 541).

Education/Skills building/Empowerment interventions

A study involving 250 Latin American women, predominantly immigrants to the U.S. of Mexican descent showed that a 12-minute slide-tape AIDS education programme was successful in producing pre-test to post-test gains in HIV/AIDS knowledge that were maintained at the two-to-three months follow-up in the experimental group compared with the control group. Positive changes in attitudes were also found pre-test and post-test, but these were not maintained at the two-to-three months' follow-up. The authors concluded that experiential learning is needed rather than simply HIV/AIDS education alone. This was also confirmed by Hovey et al (2007), in a study on Mexican migrants.

They concluded that integrating educational material with group discussions enhances the social reality of the learning, thus providing for longer-lasting knowledge and behaviour changes (Hovey et al., 2007, p. 147-156).

A research study done in 2001 by Raj et al had the aim of evaluating two health programmes in relation to their ability to promote sexual risk reduction among young Latin American women in the U.S.: The first was a 12-week general women's health promotion programme (WHP), which included HIV as well as other health topics and used psychoeducational strategies (that is, education and skills building). This was compared with a 12-week HIV-intensive prevention programme (HIV-IP) that included solely HIV and related health topics and used psychoeducational strategies as well as Freirian participatory and empowerment approaches to adult education (group problem solving, critical thinking). 170 Latin American women took part in the study (Raj et al., 2001, p. 599-607).

The WHP was a 12-week women's health education psychoeducational intervention relying on didactic education and skills training exercises. Although no specific theoretical framework was used to underlay this programme, theoretical concepts included in the model came from rational-cognitive behavioural theories, including social cognitive theory (Bandura A, 1977; Bandura A, 1989), theory of reasoned action (Ajzen I, Fishbein M, 1980; Fishbein M, Ajzen I, 1975), and the health belief model (Becker M, Joséph J, 1988; Becker MH, 1974; Rosenstock IM, 1974). Socio-structural theoretical concepts were not included in developing this programme (Raj et al., 2001, p. 599-607).

The HIV-IP was a 12-week intensive HIV prevention programme based on social cognitive theory (Bandura A, 1977; Bandura A, 1989) and an empowerment model based on Freirian (Paulo Freire) concepts (Freire, 1970), self-in-relation theory (Amaro H, 1995; Miller JB, 1986; Surrey JL, 1991), diffusion of innovation theory (Rogers E, 1983), and theory of gender and power (Connell RW, 1987). According to Raj et al, this programme differed from traditional psychoeducational models of HIV prevention by including participatory education strategies, such as critical reflection, codification and theme generation, root cause identification, and social action. Programme content included information on the transmission and prevention of HIV and other sexually transmitted infections (STIs), as well as sexual and reproductive health. The programme also integrated HIV risk with substance use, partner violence, body image, and socio-structural health risk factors, such as economics and oppression (Raj et al., 2001, p. 599-607).

Raj et al concluded that both the WHP and HIV-IP groups were more likely to report increased condom use among participants, from pre-test and post-test, and from pre-test to follow-up, than participants assigned to the waiting list. Their findings also reviewed increased HIV testing solely for the WHP group and increased sexual communication solely for the HIV-IP group, suggesting that different programmes and settings may affect some risk-reduction behaviours differently (Raj et al., 2001, p. 599-607).

Villarruel et al (2003), in collaborative efforts between nurse researchers in the U.S. and Mexico to decrease the risk of sexually transmitted HIV infection among Mexican adolescents in both countries, explain that the main aim of their collaboration was to design theoretically based and culturally relevant HIV prevention interventions to reduce risk of HIV infection. The intended intervention was based on a randomised clinical trial previously funded by the National Institute of Nursing Research (Villarruel et al., 2003, p. 193-206).

As Villarruel et al explain, the theoretical basis for the study and for the intervention content was the theory of planned behaviour/reasoned action (Ajzen, 1985; Fishbein & Ajzen, 1975) and social cognitive theory (Bandura, 1986). According to the theory of planned behaviour, specific behavioural intentions are the determinants of behaviour. Intentions are determined by attitudes toward the behaviour, subjective norms regarding it, and perceived behavioural control over it. In the previous study conducted by Villarruel et al (1999), adolescents were randomly assigned to an HIV risk-reduction intervention or a general health promotion control intervention. The theoretical basis was the same for both intervention conditions.

Villarruel et al further explain that the intervention and study design were based on extensive preliminary work conducted with urban Latin American adolescents, parents, and community members. Each intervention had the central theme: *¡Cuidáte!*, which means “Take care of yourself”. Interventions were similar in structure and were both 6 hours in length. The HIV risk-reduction intervention focused on developing knowledge, skills, attitudes, and beliefs (i.e., behavioural, normative, and control) to support behaviours that could reduce the risk of sexually transmitted HIV infection. On the other hand, the health promotion control intervention focused on other behaviours linked to diseases, such as nutrition, exercise, smoking, alcohol, and drug use. Both interventions were translated into Spanish and incorporated Latin American music, spokespersons, videos and games to generate a sense of cultural pride and unity. The Spanish and English versions of the curriculum were functionally equivalent (Villarruel et al., 2003, p. 193-206).

An important point regarding prevention was raised by Körner (2007) with regards to BAME migrants in Australia: that rational models of health presume a rational actor who is informed and weighs costs and benefits in order to maximise gain. This assumption that individuals have the necessary resources to make relevant decisions, as well as sufficient control over their environment, has been challenged in favour of an ecological perspective, which understands HIV risk in terms of the environment which shapes the choices and opportunities of individuals (Neff & Crawford, 1998). Körner states that awareness of risk status is necessary but not necessarily sufficient for seeking a HIV test as the fear of a positive result and the prospect of stigma may be greater than the perceived benefits. He advocates for a multi-pronged approach to prevention, which addresses differing needs and constraints according to gender and sexuality, as well as a focus on understanding the stigmatisation of HIV/AIDS in each BAME community in order to support and encourage them to be tested (Körner, 2007, p. 168-178).

Hovey et al (2007) evaluated a programme called *Infórmate*, which used theatrical presentations as a means of disseminating knowledge of HIV/AIDS risk factors to Mexican migrant farm workers. According to Hovey, *Infórmate* literally means to “inform yourself”. The *infórmate* Teen Health Programme focuses on health issues relevant to adolescent farmworkers. These include HIV/AIDS, substance abuse, violence, self-esteem, informed decision-making, and occupational health and safety. The programme is conducted by Teen Health Aides (THAs) who are adolescent farmworkers trained as peer health educators. The *Infórmate* programme uses THAs of the same ethnicity, culture, and socioeconomic status as the target population in the belief that they are ideally suited to provide information on sensitive issues, increase access to services, and offer peer support. Under the training and supervision of a Programme Coordinator, the THAs facilitate both one-on-one and group prevention activities in farmworker communities. Hovey et al concluded after the evaluation that a significant increase in knowledge about HIV/AIDS can be achieved using theatrical presentations such as *Infórmate*, however, since some participants still held false beliefs regarding actual and erroneous modes of HIV transmission after attending the theatre programme, they suggest that programme coordinators consider integrating theatre programmes with other types of prevention activities to provide a more intense educational experience (Hovey et al., 2007, p. 147-156).

Bauer and Kantayya (2010) produced a research study about improving access to primary care and health outcomes for migrant farm worker populations in the U.S. It suggests that the Community Health Worker model is a highly effective strategy that engages migrant farm workers as active participants in their health care. This model is more widely-known in the Latin American community as *Promotores de Salud*. In this construct, the target population is more than just the recipient of health care; rather, they play a vital role in improving the health status of the entire community. *Promotores* are recruited for their natural leadership qualities and their interest in promoting health and wellness. They receive ongoing education and support to conduct health outreach and advocacy in their communities. *Promotores* also model positive health behaviours at the workplace and within their own family and social networks, employing popular education techniques that are grounded in the work of the Brazilian educator and social theorist, Paulo Freire. *Promotores* reduce many of the traditional barriers to health care through advocacy and by serving as “patient navigators” who help their peers develop the skills necessary to negotiate the health care system. Ultimately, *Promotores* programmes nurture leadership

and build capability within migrant populations to improve the health status of the community as a whole (Bauer et al., 2010, p. 706-718).

A research paper by Brussa and Munk based on a presentation at AIDS 2010, outlining the then situation of sex workers in the EU, stated that there was a lack of political commitment and governmental responses focussing on reducing sex workers' vulnerability to HIV and an absence of adequate public health approaches appropriate for this highly marginalised population. They concluded that in order for HIV prevention for sex workers to be effective comprehensive service provision that responds to the diverse health and social care needs of sex workers is required; it should be psychologically and physically accessible to both indoor and street-based sex workers; include low-threshold harm reduction services in relation to both sex work and drug use; and operate within accepted good practice guidelines and protocols. In addition, successful HIV prevention needs to reach the majority of sex workers within each country. Therefore, it is essential to ensure both geographic and temporal coverage of all sex work settings operating within the country. Access to both health and social care services as well as strengthening the capacity of multi-sectorial services are imperative for reducing the vulnerabilities of sex workers. These initiatives should fall in line with a human rights framework if they are to be effective in reducing vulnerability to HIV/AIDS and enhancing the health and well-being of all sex workers (Brussa L & Munk V, 2010, p. 61-62).

Rhodes et al (2011) argue that there is a dearth of culturally congruent interventions to prevent HIV among some vulnerable populations, including Latin Americans. They stress the efficacy of the HoMBReS-2 intervention (HoMBReS = *Hombres Manteniendo Bienestar y Relaciones Saludables* = Men Maintaining Well-Being and Healthy Relationships). This intervention and increased consistent condom use and HIV testing among a community-based sample of 72 heterosexual immigrant Latin American men. Rhodes explains that the intervention was in small groups designed to be interactive and activity-based. It included rapport and trusting building activities; didactic teaching; DVD segments that served as role modelling and triggers for discussion; role plays; group discussion; and skills building, practice, and feedback. It was based on social cognitive theory (Bandura, 1986) and empowerment education (Freire, 1973), blended locally collected data on risk among heterosexual active Latin American men, and addressed the priorities established by the CBPR partnership, including [1] increasing awareness of the magnitude of HIV and STIs among Latin Americans in the US; [2] providing information on types of infections, modes of transmission, sign and symptoms, and local counselling, testing, care, and treatment

options; [3] increasing condom use; [4] bolstering the positive and reframing the negative aspects of what it means to be a man, a Latin American man, and an immigrant Latin American man; and [5] increasing the use of health care within an environment that lacks bilingual and bicultural services and within communities in which anti-immigration sentiment often is high. Rhodes further stresses that the intervention is designed to build a foundation of knowledge about HIV, given that these immigrant Latin Americans have had very limited exposure to HIV information and have high levels of misconceptions (Rhodes et al., 2011, p. 1764-1775).

In 2013, Rhodes et al refined a new intervention known as “HOLA: *Hombres Ofreciendo Liderazgo y Ayuda*” (Men Offering Leadership and Help) to promote sexual health among Spanish-speaking, less-acculturated Latin American MSM. The HOLA intervention, using a CBPR approach, includes the deliberate selection, careful training, and ongoing support of Latin American MSM to serve as lay health advisors (LHAs). The intervention priorities included [1] Increase awareness of the magnitude of HIV and STIs; [2] Provide information on types of infections, modes of transmission, and signs and symptoms; [3] Offer guidance on local counselling, testing, care, and treatment services; eligibility requirements; and “what to expect” in health care encounters; [4] Build condom use skills (e.g., how to communicate effectively, how to properly select, use, and dispose of condoms); [5] Change health-compromising norms of what it means to be an immigrant, a Latino man, a gay man, and an MSM; [6] Build supportive relationships and sense of community; and [7] Provide skills building to successfully help others (Rhodes et al., 2013, p. 607-616).

In 2015, Grieb et al assessed HIV prevention challenges and opportunities among Latin American immigrant men in Baltimore. Interventions using Information and Communication Technology (ICT) were found to improve access to HIV testing and prevention services. Grieb et al noted that the use of such intervention strategies could be [1] individually tailored, [2] accessible in their environment as opposed to clinical sites, and [3] delivered by their peers. ICT may improve the effectiveness of HIV messaging (including messaging regarding general health care access) so that it more easily and appropriately addresses which desires. According to Grieb et al, ICT has been increasingly used for healthcare service delivery and education, including for HIV (de Tolly et al., 2012; Hardy et al., 2011). In particular, support is growing for mobile health (mHealth) programmes that have a potentially greater likelihood of reaching vulnerable populations, although further evaluation is warranted (Gurman et al., 2012). Latin Americans are more likely than non-Hispanic Whites to use mobile phones and other mobile devices to access the Internet,

send and receive text messages, access health information, and track or manage their health. (Leite et al., 2014) found high acceptability of receiving health information including health education (73.1%), HIV education (70.2%), and HIV test results (68.8%) via text messaging among 209 Spanish-speaking Latin Americans in Baltimore. Thus, mHealth offers exciting opportunities for addressing HIV testing and prevention needs (Grieb et al., 2015, p. 118-124).

Sánchez et al (2016) in a research study evaluating a culturally-tailored HIV risk reduction intervention (SEPA: *Salud/Health, Educación/Education, Prevención/Prevention, Autocuidado/Self-care*) among 110 Latin American women immigrants in the farmworker community of Miami-Dade County, Florida, concluded that although the SEPA intervention was effective in increasing HIV knowledge and decreasing HIV risk behaviours, it did not promote changes in self-efficacy in the sample. According to Sánchez et al, SEPA is an evidenced-based small group level intervention culturally tailored for heterosexually active Latin American women aged 18-50. SEPA focuses primarily on building knowledge, self-efficacy and communication skills and targets the confluence of HIV and other STI risk behaviours including substance abuse and intimate partner violence among heterosexual Latin American women (CDC, 2013b). SEPA is based on Social Cognitive Theory, which suggests that behaviour change requires more than simply increasing knowledge of HIV transmission and the benefits of condom use. Rather, the adoption of healthy and safer sex behaviour is developed through interaction between person, behaviour, and others in the environment. According to the Social Cognitive model, performance of a behaviour is a function of outcome expectancies (expectations of more positive than negative outcomes) and self-efficacy (confidence in the ability to perform a behaviour). SEPA enables participants to build self-efficacy through practice and role-playing exercises. Social Cognitive theory is a relevant theoretical approach for the examination of Latin American women sexual behaviour (Wingood & DiClemente, 1996). It is built on the premise that individuals who believe they have the capability to perform an action are more likely to engage in the action. The SEPA intervention employs demonstrations, role-play, and other capacity building exercises that together strengthen the confidence and self-efficacy of Latin American women in condom use, condom negotiation, and partner communication (CDC, 2013b). According to the researchers, it is likely that specific social and structural barriers faced by Latin American women that may directly or indirectly impact self-efficacy for HIV prevention were not addressed in the intervention, and hence the lack of self-efficacy promotion among participants (Sánchez et al., 2016, p. 245-262).

2.3 Discussion

This literature review clearly shows a lack of academic research papers regarding HIV/AIDS-related knowledge, attitudes and practices solely focusing on the Brazilian expatriate population in High Income Countries. I have decided to expand this review to include all Latin Americans for that reason. However, Brazilians have their own unique characteristics that require further research to understand their prevention needs. This is crucial if appropriate HIV/STI messages, campaigns, and interventions are to be successful with this vulnerable population. For example, most studies included in this review are on Mexican farmworkers in the USA. Sociodemographic information on that population shows they have a lower level of education than the Brazilian population in England.

My aim in doing this literature review was to investigate factors which increase vulnerability to HIV infection among Latin American immigrants in High Income Countries; and HIV prevention awareness, approaches and frameworks that have been used to address risk of HIV infection among Latin American immigrants in High Income Countries.

Finding from this literature review will inform the focus I will give to the quantitative and qualitative chapters of this PhD thesis. Above all I will include a focus on acculturation, machismo/gender roles/gender norms, alcohol and drug use and sex work, which will be predominantly useful for future HIV prevention for the Brazilian expatriate population in England, in particular, information pertaining to men who have sex with men, since they have the highest HIV prevalence (London HIV Prevention Needs Assessment, PHE 2013).

As seen in this Literature review, it is indisputable that the migration process from Low and Middle to High Income Countries puts some migrants in a vulnerable position that facilitates HIV infection (Selik et al., 1988; Singer et al., 1990; Cochran, 1989; Albarrán et al., 2011). To be effective, HIV programmes with vulnerable populations must therefore be tailored to respond to the specific contexts within which HIV risk behaviour occurs.

2.4 Conclusion

This review summarises the literature on qualitative and quantitative studies regarding HIV/AIDS-related KAP and vulnerability to HIV infection among Latin American immigrants to High Income Countries. In addition, it presents the different HIV prevention frameworks, approaches and techniques that have already been shown to work with Latin Americans in different High Income Countries.

Future initiatives to lower the risk of HIV transmission must include multidimensional, theory-based interventions that address individual and contextual variables as well as socio-cultural variables such as gender, class and ethnicity, and their influence on sexual behaviour. Numerous cultural and socioeconomic factors unique to migrants from Low and Middle Income Countries must be given consideration while developing HIV/AIDS interventions. Adaptation might be required, preferably using a Community-Based Participatory Research approach (Knipper et al., 2007; Rhodes et al., 2010; Hacker et al., 2011; Rhodes et al., 2011; Gilbert & Rhodes, 2013; Rhodes et al., 2013; Sanchez et al., 2016). This is particularly important for new communities that don't yet speak the language of the host country, or understand the local culture and systems.

England has a vibrant Brazilian population, with very proactive community leaders and organisations that can support this community (e.g., Consulado do Brasil, NAZ, SASH, Leros Magazine, Casa do Brasil, London Help 4U, ABRAS, Queen Mary University, among others). Researchers and programme managers should try to make use of these existing resources when reaching out to Brazilians in England.

CHAPTER 3 HIV/AIDS-related KAP of the Brazilian expatriate population in England (PCAP England - 2016)

The aim of this chapter is:

1. To report on a cross-sectional survey of HIV/AIDS-related KAP with 1000 members of the Brazilian expatriate population in England to assess their levels of knowledge, attitudes and practices regarding HIV transmission.
2. To compare the HIV/AIDS-related KAP results of the Brazilian population in England in 2016, with results from the Brazilian population survey in Brazil in 2013, by the Brazilian Ministry of Health, with 12,000 respondents.
3. To assess levels of access to health services of the Brazilian population in England.

3.1 Materials and Methods

In October 2015 I started working in collaboration with PHE under the guidance of Dr Valerie Delpech to focus on the HIV/AIDS-related KAP survey questionnaire which I received from the Brazilian Ministry of Health in order to adapt it to the local context of Brazilians living in England. Although the research was carried out in England, the majority of participants were recruited in London, which is where most Brazilians reside.

The original survey was organised in modules which contained the following sections:

- Knowledge regarding transmission and prevention of HIV
- Prevention and control of HIV and STIs
- Access to HIV and STI testing
- HIV/AIDS prejudice and discrimination
- Access to prevention resources such as male and female condoms and lubricants
- Sexual practices including the age when sex was initiated and current and past number of sexual partners
- Condom use with regular and casual partners
- Key populations
- Drug use

Added questions pertinent to the migration process, such as immigration status, knowledge of the English language, and access to NHS services, as these can become barriers to accessing services. Research has shown a link between barriers to preventative

interventions and health care and an increase in HIV infections among immigrant populations to high income countries.

Since I am using the Brazilian Ministry of Health survey in this study, I will refer to it by its original acronym in Portuguese, **PCAP**, which stands for **P**esquisa de **C**onhecimentos, **A**titudes e **P**ráticas, i.e., **K**nowledge, **A**ttitudes and **P**ractices (**KAP**) Survey, in English. To differentiate it from the Brazilian PCAP (PCAP 2013) I will call it “**PCAP England**”. The Brazilian government has used the PCAP survey every four years nationally since 2004, to monitor the sexual health needs of particular populations and applies this detailed information in planning for their sexual health programmes and policies. The PCAP England survey questionnaire (in Portuguese) can be found in Appendix 3.

Data was collected through an online platform using PHE’s SNAP Survey software and through the use of four tablets (iPads) provided by PHE, which had the PCAP England survey uploaded on them. Six trained volunteers and I did regular outreach sessions at the Brazilian Consulate (Westminster), where we met most of our respondents. The Consulate attracts a wide variety of Brazilian people living in England, including those with irregular visas who want to return to Brazil, also those newly arrived wanting to register as new migrants, those wanting to register marriages, register the birth of their children, or attending for other reasons. These factors led to 82% of the participants being from London, 15% from the rest of England, 1.1% from Scotland, 0.2% from Wales, with a remaining 1.3% constituting missing data. The data from Scotland and Wales is not statistically significant, so I have limited discussion to Brazilians in England.

We also worked through community-based organisations in London frequented by the Brazilian community, such as NAZ Vidas (Hammersmith), Casa do Brasil (Brent), ABRAS (Brent), LondonHelp4U (Kensington & Chelsea), and two Brazilian Christian churches (Brent). The above organisations also disseminated the survey through their websites. I moreover had the support of *Leros* Magazine, a London-wide Brazilian magazine considered ‘the bible’ of Brazilians residing in England (www.leros.co.uk), because it is the first point of call for all sorts of information in Portuguese regarding London life. *Leros* Magazine advertised a link for the PCAP England survey, for free. The main intention for recruiting participants online, at other NGOs, in bars, clubs and in churches was to increase the diversity of the sample.

Given the ‘hard-to-reach’ characteristics of the Brazilian expatriate population in England, such as great mobility and a considerable proportion with irregular immigration status, a

convenience sampling method was used. This constitutes a specific type of non-probability sampling that relies on data collection from population members who are conveniently available to participate in the study.

The six volunteers distributing iPads were trained in the aims and objectives of this study, in the instruments to be used, the definitions of the variables, the procedure for data collections and in interviewing techniques. Given the delicate nature of this research, i.e., sexual health, participants were briefed of the importance of its findings in terms of the potential to influence future HIV/STIs prevention programme for the community in England.

Confidentiality was explained to participants, and assurance was given that their answers would not be linked to their names or their identity. Partakers felt comfortable that there was no request for them to enter personal details such as name or address, apart from the first part of their postcodes, unless they wanted to take part in a raffle. Each person who completed the survey face-to-face was given an iPad and taken to a private space to do so. I was always on site in case of complex questions that the interviewers were unable to answer or deal with. All six interviewers, two males and four females, were from Brazil, the same country of birth as interviewees. On average each survey took 40 minutes to complete.

3.1.1 Variables

The variables of interest for this survey are based on the same variables for the PCAP 2008 and 2013 from the Brazilian Ministry of Health in Brazil. Five questions which are internationally monitored (UNAIDS, 2010) were included:

- Knows that someone looking healthy can be HIV positive
- Agrees that being in a monogamous relationship with someone who is HIV negative decreases the risk of infection
- Knows that using condoms is the best way to avoid HIV infection
- Knows that HIV is not transmitted through insect bites
- Knows that HIV cannot be passed through cutlery sharing

The percentage of individuals who knew the correct ways that HIV can be acquired was considered an indicator of knowledge in the community. On top of the above indicators I also checked for the percentage of individuals who correctly answered that HIV cannot be acquired from toilet seats; the percentage of individuals who agreed that HIV could be

acquired through sharing needles; the percentage of individuals who agreed that HIV could be acquired through having unprotected sex; the percentage of individuals who knew there was no cure for HIV; and the percentage of individuals who agreed that if a HIV positive pregnant woman received adequate HIV treatment it would decrease the chances of passing the virus to the child.

In respect of control and prevention of STIs, I analysed the following indicators: regular sexual health screenings including smear tests for sexually active females, and the occurrence of penile discharge and receiving medical treatment among sexually active males. Other indicators of interest among those who were sexually active were the percentage of those who declared ever having a previous STI such as discharge, sores, blisters or warts in the genital area, as well as the frequency they reoccurred, and the most recent episode. Also of interest was the percentage of people that looked for medical care and who they went to see (e.g. pharmacist, medical doctor, another person, or no-one). Among those who had a previous STI and looked for professional help I asked if they received advice to use condoms, notify partners, and test for HIV and Syphilis.

I was also interested to know the customer satisfaction indicators for those that used the NHS: Did they feel they were listened to? Did they trust the medical judgement? Were they included in the decision making of their treatment? Were they respected? What was their overall experience accessing the NHS service?

In relation to sexual behaviours and HIV transmission the following indicators were used: percentage of sexually active individuals (ever and in the last 12 months); percentage of individuals who initiated sex before reaching 15 years of age; percentage of individuals who had more than ten sexual partners ever; percentage of individuals who had more than five casual sexual partners in the last 12 months; percentage of individuals who declared having same gender sex ever; also the percentage of individuals who declared having sex in the last 12 months with regular partners, casual partners or people they met through the internet.

The survey also permitted us to investigate those subgroups at more risk of HIV infection: men who have sex with men (MSM), sex workers and drug users. Indicators of interest were the percentage of those who had sex with someone of the same gender, percentage of those who received money for sex ever and in the last 12 months; and the percentage of those who used drugs ever and in the last 12 months. In relation to drug use the percentage of those who used licit and illicit drugs once in their life time, or/and those who

still use them today, such as alcohol, tobacco, cannabis, crack, cocaine and heroin were considered indicators.

With regards to HIV testing, indicators were the percentage of sexually-active individuals who had access to a HIV test ever and in the last 12 months, the percentage who had access here in England or in another country; also the percentage of those who had ever had access to a rapid HIV test; the percentage of those who had a HIV test and obtained a result; the percentage of those who are HIV positive and in treatment; the reasons for having a HIV test; the average time it took to obtain a HIV test result; the distribution of countries where they were first diagnosed; and the average time it took for HIV treatment to be offered after diagnosis.

In relation to having access to free male and female condoms, lubricants, and also awareness regarding PEP, I analysed indicators of the percentage of individuals who knew where to obtain condoms and lubricants, the percentage of those who actually collected them for free in the last 12 months, also the percentage of those who do not know where to get free condoms or lubricants, and the percentage of those who had to buy them instead. Also of interest was the location where condoms and lubricants were obtained: if for free from the NHS, an NGO, a school, or if bought at a pharmacy, supermarket, or another place. I also measured the number of people who stated they did not need condoms (although this information was not as useful as it could have been because I did not ask why they did not need condoms. It could be because someone is in a monogamous relationship with someone who is HIV negative, or maybe with someone who is HIV positive and undetectable for more than six months, but could also be because someone does not like using condoms, or did not believe in their efficacy). Regarding safe sex practices among those sexually active, I was interested in the use of male and female condoms (if used since first sexual encounter, if used always, if used with regular partners and casual partners). I also measured as indicators the percentage of those who had awareness of PEP, including where to access it if needed.

To measure stigma and discrimination towards gay people (homosexuals), the indicators were the percentage of responses to the following questions: "Agree or disagree that gay couples can adopt children" and "would accept having gay friends; or maybe would accept having gay friends; or would never accept having gay friends". To measure stigma and discrimination towards people living with HIV/AIDS I measured as indicators the percentage of responses to the following questions: Agree or disagree that "If there was a HIV positive

child in the same class of your children you would still allow them to attend that school”; “If you knew that the person selling fruit and vegetables in the corner shop was HIV positive you would still buy their products” and “If a teacher is HIV positive but is not sick she/he can still carry on teaching in any school”.

3.1.2 Statistical Analysis

Descriptive statistics were employed to describe the results, using Stata/SE 14.0 software to analyse the data. A professional statistician from the Brazilian Ministry of Health who analysed their survey (PCAP 2008 and 2013), Silvano Oliveira, was also employed to execute the analyses of these results (PCAP England 2016) under my supervision, following my specific instructions. PHE gave me an Excel spreadsheet with raw data which I collected using their SNAP Survey. I passed this file securely on to Mr Oliveira, with instructions as to which variables I wanted analysed, and which combinations of indicators to use. There were 1,018 observations and 292 variables. I requested that Mr Oliveira first transformed the data from string to numeric data. Subsequently I informed Mr Oliveira of the aims of my research, and the objectives, and which indicators I wanted him to extract from the data, so that he had an understanding of what was expected. I also asked Mr Oliveira to keep a do-file of the data so that I could use it to justify step-by-step what he had done. Mr Oliveira informed me that the first phase of his analysis would have to be the cleaning of the raw data, as adjustments were necessary. In particular some data was missing because of minor mistakes in the uploading of the questionnaire on the SNAP Survey software. To facilitate Mr Oliveira, I also grouped all the questions into categories using colour coding, to separate each question into groups: **Sociodemographic Information**, **Knowledge**, **Attitudes**, **Practices**, **STIs**, **Access to Health/STIs Services** and **Use of the NHS**.

I further instructed Mr Oliveira to describe continuous variables through mean, median and standard deviations, while categorical variables were described as frequencies (counts and percentages). The Pearson Chi-square (χ^2) test was used to calculate statistically significant differences among proportions of categorical variables. P-values less than 0.05 were considered significant. In this study the majority of variables of interest (HIV/AIDS-related KAP) were tabulated by gender, age (14-24; 25-34; 35-49; 50-81 years), ethnicity, sexual orientation, place of birth (Region), marital status, education level, education status, religion, immigration status and employment.

Mr Oliveira created 101 Excel spreadsheet tables with the combined data. I then chose the most relevant information to create 52 Word document tables, before editing and adding

them to this thesis. Eleven tables are displayed on the body of this chapter, and 41 tables are included in appendices for reference.

3.1.3 Limitations

This quantitative research has several limitations worth mentioning. For example, the size and nature of the questionnaire, i.e. sexual health and sexuality. Some respondents complained it took too long to finish, and that some questions were too personal. This could have impacted on the quality of the answers, even though participants completed the survey in private, no personal identifiable data was required, and they were assured about confidentiality.

Also, another possible limitation is the comparison I have made between data from this research and that of the Brazilian government in Brazil. Our sample in England was a lot smaller than that in Brazil. It would have been ideal for both samples to be of similar sizes, and have other similar characteristics, for a more robust comparison. However, as stated above, my sample is the only sample of exclusively Brazilians in England surveyed on sexual health.

There was no data regarding the breakdown among the 12,000 respondents from the Brazilian research of how many were HIV positive. Usually people living with HIV tend to know more about sexual health issues than the general population. Because of my job as a sexual health worker, I had easy access to PLWHIV, and hence, this group is over sampled among participants of the PCAP England 2016 survey.

3.1.4 Data Analysis

PCAP England – 2016

The sample of the Brazilian expatriate population in England which took part in this survey (between 11/11/15 and 13/04/16) included 1,018 participants aged between 14 and 81 years old: 529 (52%) female, 487 (47.8%) male, and 2 transgender (0.2%)¹. 184 (18.1%) were between 14-24 years old, 374 (36.7%) between 25-34, 385 (37.8%) between 35-49, and 75 (7.4%) were between 50 to 81 years old. In terms of ethnicity (in Brazil defined by skin colour), 650 (63.9%) self-identified as white, 71 (7%) as black, 28 (2.8%) as yellow, 164

¹ Given the low number of transgender people participating in the PCAP England survey (2 participants), I decided not to present their data in tables divided by gender, although they were counted among the 1,018 participants.

(16.1%) as mixed, 20 (2.0%) as indigenous people, and 85 (8.3%) as other. This information for me is important because it confirms what is known about the social status of black people back in Brazil. Even though black people account for the majority of the Brazilian population, they have less economic power and fewer opportunities to migrate. With regards to sexual orientation 361 (35.5%) men reported as heterosexual, 487 (47.8%) heterosexual women, 107 (10.5%) gay, 17 (1.7%) lesbians, 13 (1.3%) bisexual men, 17 (1.7%) bisexual women, and 16 (1.6%) of the sample preferred not to disclose their sexuality. Regarding the region in Brazil where participants came from (place of birth), the majority (54.9%) came from the most affluent region of the Southeast (Rio de Janeiro, São Paulo, Minas Gerais and Espírito Santo). With 455 (44.7%) participants reporting as currently married, and 248 (24.4%) as single. 648 (63.6%) of the sample stated having reached higher education levels (complete or incomplete). 285 (28.0%) of the total sample are currently undergoing some form of education in England, with a higher percentage of men in education than women. This does reflect however the fact that women have reported prior to immigration having a higher level of education than men. 626 (61.5%) people professed religious belief, with 82.4% of them identifying as Christian. In terms of immigration status 974 (95.7%) were here legally and 44 (4.3%) had overstayed, although 491 (48.2%) out of 1,018 were allowed to reside in England because of their dual nationality, Brazilian and European. 229 (22.5%) people reported as currently unemployed, with women twice as likely to be unemployed as men. Finally, in terms of being able to communicate in the English language, 239 people (23.4%) stated they could not speak the language at all, or had very basic comprehension of it, with women having twice as much difficulty as men. This could explain why more women are out of work. The complete sociodemographic of the PCAP England 2016 is in Appendix 4 (Table 3.1).

PCAP Brazil – 2013

The Brazilian Ministry of Health PCAP survey in 2013 in Brazil had 12,000 respondents. The population researched was recruited from private residential homes in all geographical areas of Brazil, from both urban and rural settings, and excluded military bases, campsites, prisons, nursing homes, police stations, ships, orphanages, care homes, convents and hospitals, as well as the homeless. The geographical operational basis for selecting the sample was based on the Brazilian demographic census of 2010, and included stratifications in terms of age range, gender, marital status, and education level. Literacy was taken in consideration and support for illiterate participants was offered in order to ensure participation. Only one participant per home was allowed.

Their age range was between 15 and 64 years old: 6,133 (51%) female, 5,867 (49%) male. 3,142 (26.2%) were between 15-24 years old; 3,015 (25.1%) between 25-34; 3,555 (29.6%) between 35-49; and 2,288 (19.1%) were between 50 to 64 years old. In terms of ethnicity 4,699 (39.5%) self-identified as white, 1,701 (14.3%) as black, 194 (1.6%) as yellow, 5,248 (44.1%) as mixed, and 55 (0.5%) as indigenous people. With regards to sexual orientation, of the 11,051 participants who were sexually active, 424 (7.9%) men reported having had sex with other men, and 281 (5.1%) women reported having sex with other women. 10,346 reported as heterosexuals. 949 individuals were not yet sexually active and did not disclose their sexuality. Regarding the region in Brazil where participants came from (place of birth), like the sample in England, the majority (43.1%) of participants were from the most affluent region of the Southeast (Rio de Janeiro, São Paulo, Minas Gerais and Espírito Santo). With 6,770 (56.4%) out of 12,000 participants reporting as currently living with a partner, and 5,230 (43.6%) as living alone. In terms of education levels, 4,823 (40.2%) of the sample stated they had reached the equivalent of A-levels or higher. 9,241 (77.0%) people professed religious belief. Lastly, 5,013 (41.8%) people reported as currently unemployed, and like the sample in England, women were twice as likely to be unemployed as men (PCAP 2016, Ministério da Saúde).

Comparison between PCAP England and PCAP Brazil

Table 3.2 below shows comparison data from both samples. As can be seen, some of the results from both questionnaires (PCAP 2013 in Brazil and PCAP England 2016) are not identical, and hence some discrepancies exist in the table. This happened when I was adapting the questionnaire to include, for instance, questions about transgender people, which are not included in the Brazilian survey. I also wanted more detailed breakdown of people's sexuality (heterosexual man, heterosexual woman, gay man/homosexual, lesbian, bisexual man, bisexual woman, prefer not to say) than the one used by the Brazilian Ministry of Health, which focussed more on whether or not people had had same sex experiences. The questionnaire also required adapting on questions of marital status and education level. Finally, our survey asked all 1,018 participants if they had ever been diagnosed with HIV. This data was not available from the PCAP 2013 report because the Brazilian survey did not ask participants about their HIV status. I added this question to my survey because through my work experience in London and through the PHE data presented in Chapter One I knew that HIV prevalence among Brazilians in England was high, so I included the question.

Table 3.2

Sociodemographic Comparison Table					
PCAP England (2016)			PCAP Brazil (2013)*		
Variables	N	%	Variables	N	%
Total	1,018	100	Total	12,000	100
Gender			Gender		
Male	487	47.8	Male	5,867	48.9
Female	529	52	Female	6,133	51.1
Transgender	2	0.2	Transgender	0	0
Sexual Orientation			Sexual Orientation		
Heterosexual man	361	35.5	Heterosexual man	5,443	45.3
Heterosexual woman	487	47.8	Heterosexual woman	5,852	48.8
Gay man/homosexual	107	10.5	Man who has sex with man	424	3.5
Lesbian	17	1.67	Woman who has sex with woman	281	2.4
Bisexual man	13	1.28	-	-	-
Bisexual woman	17	1.67	-	-	-
Prefer not to say	16	1.57	-	-	-
Region of birth (Brazil)			Region of birth (Brazil)		
North	33	3.24	North	935	7.8
Northeast	97	9.53	Northeast	3,228	26.9
Southeast	559	54.9	Southeast	5,177	43.1
South	170	16.7	South	1,761	14.7
West	136	13.4	West	899	7.5
Missing data	23	2.26	Missing data	0	0
Age range			Age range		
14 - 24 years	184	18.1	14 - 24 years	3,142	26.2
25 - 34 years	374	36.7	25 - 34 years	3,015	25.1
35 - 49 years	385	37.8	35 - 49 years	3,555	29.6
50 - 81 years	75	7.37	50 - 81 years	2,288	19.1
Marital status			Marital status		
Never married or cohabited	248	24.4	Lives with a partner	6,770	56.4
Married	455	44.7	Lives without a partner	5,230	43.6
Cohabiting	152	14.9	-	-	-
Cohabited before but not now	63	6.19	-	-	-
Separated or divorced	96	9.43	-	-	-
Widowed	4	0.39	-	-	-
Education Level			Education Level		
GCSE	46	4.52	GCSE (incomplete)	3,957	33.0
A-level	324	31.8	GCSE (complete)	3,219	26.8
University (incomplete)	248	24.4	A-level (complete, or more)	4,823	40.2
University (complete)	227	22.3	-	-	-
Postgraduate (incomplete)	30	2.95	-	-	-
Postgraduate (complete)	143	14.0	-	-	-
Ethnicity (in Brazil defined by skin colour)			Ethnicity (in Brazil defined by skin colour)		
White	650	63.9	White	4,699	39.5
Black	71	6.97	Black	1,701	14.3
Yellow	28	2.75	Yellow	194	1.6
Mixed	164	16.1	Mixed	5,248	44.1
Indigenous	20	1.96	Indigenous	55	0.5
Other	85	8.35	Other	0	0
Follow any religion			Follow any religion		
Yes	626	61.5	Yes	9,241	77.0
No	392	38.5	No	2,759	23.0
HIV Status			HIV Status**		
Positive	43	4.2	Positive	Unknown	Unknown
Negative	975	95.8	Negative	Unknown	Unknown

Table 3.2 Sociodemographic Comparison Table

*PCAP – Ministério da Saúde – Brazil 2016

** UNAIDS 2016 – HIV and AIDS Estimates for Brazil: Adult aged 15 to 49 HIV prevalence rate of 0.6 [0.4 - 0.8].

3.2 Results

3.2.1 Knowledge regarding HIV Transmission and Prevention

Table 3.3 below and table 3.4 (Appendix 5) show composition and comparison of data regarding the percentage of correct answers to the HIV transmission and prevention questionnaire in our sample of 1,018 individuals from the Brazilian expatriate population in England.

I compared my data with those of the latest research done in Brazil (2013) by the Ministry of Health, with 12,000 Brazilians. Both research studies, in Brazilian Portuguese, included the same eight questions on HIV knowledge and prevention, with the English study adding further questions on immigration status, language capabilities and access to the NHS.

Seventy percent ($5,702/8,144 \times 100$) of Brazilians living in England had the correct knowledge of HIV transmission and prevention, against 74% ($71,472/96,000 \times 100$) of Brazilians living in Brazil. It is not a huge difference between these two averages, but when comparing the 8 indicators, as will be seen, this is part of a trend that knowledge is lower in England than in Brazil. Statistically significant differences were observed in seven out of the eight indicators of HIV-related knowledge and prevention. Although the high proportion of Brazilian expatriates with HIV suggested knowledge was poor, it was surprising that knowledge in England was in general lower, sometimes significantly so, than in Brazil. Since the Brazilian data was available, it was used – but a difference between Brazilians in Brazil and Brazilians in England was unexpected.

90.5% of individuals in our sample in England agreed that someone living with HIV can still look healthy. In the Brazilian sample it was 90.8% (p-value 0.375). The majority (91.7%) of the sample in England agrees that using condoms is the best way to prevent HIV being passed through sexual intercourse. This figure is slightly lower than what was found in Brazil, where 94.0% of the 12,000 participants agreed with the same statement (p-value 0.002). 74.3% of our sample agreed that having a monogamous sexual relationship with someone who is known to be HIV negative decreases the risk of HIV infection. In Brazil 78.5% of people in the sample agreed with the same (p-value <0.001). Also, 72.8% of our sample in England agreed that there was no cure for HIV. That figure was higher in the Brazilian survey, with 80.4% of respondents agreeing with that same statement (p-value <0.001). The comparisons here go from the statistically insignificant to a difference of 8.2%. Overall trend of knowledge being lower in Brazilian expatriate community in England.

Within this thesis' conceptual framework, for someone to avoid the risk of contracting HIV, they have to have the knowledge of how HIV is transmitted and thus how to avoid transmission. Historically, it was commonly known that condom use is the most effective method of prevention – this is borne out by the data above, with the majority of both Brazilian expatriates in England and Brazilians in Brazil agreeing that using condoms is the best way to prevent HIV being passed through sexual intercourse. This is to do with time – this message has been being propagated since the very start of the epidemic, so has had more time to filter through a wider section of society. It is also more widely known because this advice was being given at a time when HIV was much more talked about and the campaigns were very impactful. Condoms were also already familiar as a method of birth control, so more people already knew where to get them and how to use them.

In 2 out of the 8 indicators, Brazilian expatriates had a higher level of knowledge than Brazilians in Brazil. The percentages of correct answers to the following statements “a person cannot contract HIV through sharing cutlery, foods or drinks” (p-value 0.006) and “a pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth” (p-value 0.003), in England were respectively 77.4% and 70.9%. In Brazil this was the only data which was slightly lower than ours, at 73.8% and 66.6%. These differences of around 4% are statistically insignificant, so they do not tell us much about the trend of knowledge being lower in England than in Brazil. However, it is still significant that knowledge in England on HIV transmission regarding food sharing and pregnancy is much lower than knowledge on condom use. I wanted therefore to go on to include questions concerning these indicators in the in-depth interviews.

One of the worst performances in relation to HIV knowledge and prevention verified was in relation to the answers to the following the statement “a person living with HIV who is successfully taking HIV medication has less risk of passing the virus on to another person”. In our sample in England 23.3% knew that information correctly, where in Brazil 33.1% agreed with the same sentence (p-value <0.001). This shows very poor results in both samples.

Correct knowledge of Brazilians in England of how condom use impacts HIV transmission is 91.7%, but correct knowledge of the risk of passing on HIV when successfully using medication is only 23.3% -- 68.4% lower. It is also useful to note the difference in knowledge between Brazilians in England and Brazilians in Brazil regarding medication as

prevention. Despite the Brazilian data being three years older than the English data, the knowledge among Brazilians in England is significantly lower. As mentioned in Chapter 1, the Brazilian government has been very proactive in publicising preventative measures compared with the English government. One example of the respective governments' differing approaches to tackling HIV, is the roll-out of PrEP (discussed in greater depth later in the chapter) in 2017 in both countries: Brazil made this medication free for all, England made it free on a trial basis to 10,000 at-risk people. Further to this, it will be useful to explore how Brazilians in England have been impacted by language barriers in accessing any English publicity on the topic of developments in HIV medication. Even when the English government has been proactive (funding Terence Higgins Trust campaigns) the results might not have been accessed by some Brazilians in England due to lack of English literacy skills. This will be explored further in the qualitative research.

In England 59.2% of Brazilian respondents agreed that HIV is a chronic disease that can be controlled by medication. In Brazil 78.4% of the respondents already knew that (p-value <0.001).

Knowledge of controlling HIV with medication is higher in both Brazil and England compared with knowledge of preventing transmission with medication. However, this indicator is the largest difference in knowledge between Brazilians in Brazil and Brazilians in England, with those in England knowing nearly 20% less.

When it was found that medication could make the HIV virus undetectable in an HIV positive person, this was highly significant information. It is essential to investigate why this new information had so much less of an impact on the Brazilian expatriate community in England than in Brazil. The qualitative research will go on to explore language as a factor, along with Brazilian attitudes to accessing this kind of information. From my professional experience, I might expect that Brazilian migrants are not prioritising seeking out this information because of their other concerns, eg earning money, finding shelter – these thoughts will be pursued in the in-depth interviews.

The two most significant differences between Brazilians in Brazil and England concerned indicators of knowledge about HIV medication. People know about condoms but not medication. Therefore policy makers should push to increase knowledge about medication.

Table 3.3

Composition of the distribution of Total Participants with correct Knowledge regarding HIV Transmission and Prevention, England (2016) and Brazil (2013)

	Brazilians in England (%)* (2016)	Brazilians in Brazil (%)** (2013)
Having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection	756 (74.3%)	9,420 (78.5%)
A person living with HIV can look healthy	921 (90.5%)	10,896 (90.8%)
Using a condom during penetrative sex is the best way to avoid HIV infection	934 (91.7%)	11,280 (94.0%)
A person cannot contract HIV through sharing cutlery, foods or drinks	788 (77.4%)	8,856 (73.8%)
A pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth	722 (70.9%)	7,992 (66.6%)
There is no cure for HIV	741 (72.8%)	9,648 (80.4%)
A HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person	237 (23.3%)	3,972 (33.1%)
HIV is a chronic illness that can be medically controlled	603 (59.2%)	9,408 (78.4%)
TOTAL SCORE	5,702 (70%)	71,472 (74%)

*Source: PCAP England 2016

**Source: PCAP Brazil 2013 (Brazilian Ministry of Health)

Brazilians in England denominator: 8,144

Brazilians in Brazil denominator: 96,000

The data from the sample in England with regards to knowledge of HIV transmission (Appendix 6), shows that analysis of the eight indicators divided by gender had a similar knowledge without significant differences. It is possible to note that only a few indicators present any significant differences between male and female. Men had a slightly better knowledge that “having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection” (77.2%) in comparison with women (71.6%), p-value <0.001. Yet, women had almost the same knowledge that “a person living with HIV can look healthy” (90.6%), in comparison with men (90.4%), p-value 0.614. Women however had a better knowledge that “a person cannot get HIV through sharing cutlery, foods and drinks” (80.2%) than men (74.3%), p-value 0.081.

When asked if “a HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person”, both genders had a low percentage of correct knowledge (men: 27.5%, women: 19.3%), p-value 0.008.

Results of HIV/AIDS knowledge indicators divided by age groups (Appendix 7) shows that the best percentage of HIV knowledge throughout this table has been observed in the “35 to 49” years bracket, on all eight questions/indicators. While the lowest percentages were observed on both “14 to 24” and “50 to 81” years brackets.

Regarding “the use of condoms as the best way for HIV prevention”, all age brackets scored higher than 84.8% correct. The difference in knowledge among most age brackets was statistically significant in almost every question.

66.7% participants aged “50 to 81” years agreed “there is no cure for HIV”, a percentage that increased to 75.3% on the “35 to 49” age bracket. In relation to the statement “a HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person”, the highest percentage of agreement with this affirmation was 26.0% among the “35 to 49” age bracket, and the lowest between the “50 to 81” age bracket (16.0%), followed by the “14 to 24” age bracket (22.3%).

Indicators of HIV/AIDS knowledge divided by marital status (Appendix 8), separated in two groups, those who “live with a partner” and those who “do not live with a partner”, shows that only three indicators had a statistically significant difference of HIV/AIDS knowledge between them. Although merely 73.8% of those “living with a partner” agreed that “having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection”, a higher 74.9% of those “not living with a partner” said the same. However, when asked “a person cannot get HIV through sharing cutlery, foods and drinks” 81.4% of those “living with a partner” got that right. It falls down to 71.5% among those “not living with a partner”. Also when asked “HIV is a chronic illness that can be medically controlled”, 63.9% of those “living with a partner” had better knowledge than the 52.3% among those “not living with a partner”.

When analysing the HIV/AIDS knowledge indicators according to education level (Appendix 9), it was observed that Brazilian participants in England with more formal education also had a higher level of correct knowledge of how HIV is transmitted. There was statistically significant difference between the educational levels in every indicator. Those with higher education managed to get a greater proportion of correct answers on all eight questions regarding knowledge about HIV transmission than those with basic education. While 92.8%

of people with higher education demonstrated correct knowledge that “a person living with HIV can look healthy, this proportion among those with basic education fell to 89.0% (p-value 0.014). Also, in respect of the statement “a HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person”, 27.0% of people with higher education got that right, falling to 20.9% among those with basic education (p-value 0.024). Knowledge about the importance of using condoms was higher than 80% in both education levels, basic education = 89.5%, and higher education = 95.0% (p-value 0.003). Also, amongst those with higher education, 84.5% correctly knew there was “no cure for HIV”. That percentage however fell to 65.2% among those with basic education (p-value <0.001).

With regards to differences in knowledge of HIV transmission by ethnicity there were statistically significant differences in half of the indicators (Appendix 10). The lowest level of knowledge was observed among those who self-identified as, following correct Brazilian conventions when talking about race, “other skin colour (yellow, indigenous and others)”. While those that self-identified as “white” had a higher percentage of better knowledge. 76.6% of “whites”, for instance, correctly affirmed that “there is no cure for HIV”, while “black and mixed” was 67.7% and “other skin colours” was 63.2% (p-value 0.006). More than 90% of “whites” and “black and mixed” correctly answered that “a person living with HIV can look healthy”, among the “other skin colour” group that percentage fell down to 79.7% (p-value <0.001). In relation to the indicator “a pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth”, the percentage of correct guesses were 72.6% among “whites”, 74.0% among “blacks and mixed” and 57.1% among “other skin colour” (p-value 0.002). Knowledge about the use of condoms as a way to prevent HIV infection was greater among “whites” (94.3%), followed by “black and mixed” (90.6%), but much lower among “other skin colour” (80.5%). This difference was also statistically significant (p-value <0.001).

There were few observed differences in knowledge of HIV transmission when the group was divided by “religious” and “non-religious” (Appendix 11), however, there was a statistically significant difference to the statement “There is no cure for HIV”, with 80.1% of “non-religious” people getting that right, against 68.2% of “religious” people (p-value <0.001). It might be that some religious people believe that God can cure them of the virus – I will discuss the religious attitudes to HIV relevant to this sample in the discussion section of this chapter (3.3).

No marked statistically significant differences were observed in any of the eight indicators of knowledge about HIV transmission when the group was divided by Employment, “working” or “not working”, (Appendix 12).

3.2.2 Access to Health/STI Services

The Brazilian expatriate population in this research were asked if they had seen a doctor either in England or elsewhere in the world. 157 (15.4%) accessed a doctor less than 2 weeks before the date of the survey. 79 (7.8%) saw a doctor in the previous 15 to 30 days. 211 (20.7%) in the previous 30 days to 3 months. A further 23.3% of the sample accessed a doctor between 3 months to a year prior to the date that the survey was carried out, and 32.8% (334 respondents) have not accessed a doctor in the last 12 months (Appendix 13).

34 participants (3.3%) reported that STIs had been their primary reason for going to see a doctor, even though the guidelines in the UK are for sexually active adults to have a full sexual health check-up at least once a year (more often for MSM).

80.3% of the sample stated they had access to a doctor in England since arriving here (NHS or private), and 71.1% of the women knew where to get free contraception. Also among the women, 80.9% had a gynaecological examination in the last 3 years. With 5.5% having had one examination 4 to 5 years ago, and 2.1% having one more than 5 years ago. 37 women (7.0%) had never had an examination, and 4.5% did not even know if they had one or not. Of the 428 women who had a gynaecological examination in the last 3 years, 398 (93.0%) of them had a Pap smear test done, the test to check for cervical cancer.

3.2.3 Prevention and Control of STIs

In relation to the distribution in the sample of people who confirmed as ever having had an STI, 104 people had a previous infection, with some of them having more than one infection at the same time. 66 (6.5%) people from our sample stated having genital sores at least once in their life time, 61 (6.0%) had blisters in the genitals, and 53 (5.2%) had genital warts (Appendix 14). When this data was stratified by gender, age range or sexual orientation, there was not much difference in the percentage of distribution of these infections among them.

There were also in this sample 72 (7.2%) cases of chlamydia, 44 (4.4%) cases of gonorrhoea and 22 (2.2%) cases of syphilis, at least once (Appendix 15). Not much difference in the distribution of these STIs was noticed when the data was stratified by age range, however, statistically significant differences were observed when the data was analysed by gender,

with men having a higher proportion of these STIs than women (chlamydia = men had 8.5% and women had 6.1%; gonorrhoea = men had 8.4% and women had 0.8%; and syphilis = men had 4.3% and women had 0.4%). When the data was further analysed by sexual orientation, it became clear that homosexuals carried more than double the amount of STIs than bisexuals and heterosexuals, although bisexuals also had twice as much STIs as heterosexuals.

When asked about the occurrence of STIs in the last 12 months (Appendix 16), out of the 72 respondents who had had chlamydia, 17 confirmed diagnosis within the last year. Out of the 44 who had had gonorrhoea, 7 people (15.9%) also had it in the last year. Finally, out of the 22 who had had syphilis, 9 people (40.9%) also had it in the last year. There was no statistically significant difference among the groups when divided by gender, age range or sexual orientation.

According to the data (Appendix 17), of the 104 people who had an STI (anywhere in the world), 98 (94.2%) received some form of treatment, although only 46.2% were seen by a doctor, with 51 (49.0%) stating as having no professional contact following infection. When asked about the orientation they received following infection, statistically significant difference was noted between males and females with regards to having a syphilis and hepatitis B and C test (p-value <0.001, on both questions). In relation to taking a HIV test (p-value 0.033), males (80.6%) received this orientation more often than females (56.8%).

As can be verified in Table 3.16 below, only 20.4% of respondents (205 Brazilians out of 1007) have ever been to a sexual health clinic in England. The only statistically significant difference observed in this table was among the sexual orientation group, where it shows that homosexuals (57.7%) visited the clinics more often than bisexuals (25.0%), and bisexuals more often than heterosexuals (14.7%), (p-value <0.001). Males (22.8%) were more likely to have attended a clinic than females (17.7%). In terms of age groups, the “35 to 49 years” (23.7%) had attended more, and the age group with least attendance were the younger ones “14 to 24 years” (11.5%). Ethnicity did not show any statistically significant difference whether an individual attended an STI clinic or not (p-value 0.654).

Table 3.16

Distribution of individuals who have ever been to an STI clinic in England, according to sociodemographic information

Variables	Total	Have ever been to an STI clinic in England		
	N	N	%	p-value
Total	1007	205	20.4	-
Gender:				
Male	486	111	22.8	0.003
Female	519	92	17.7	
Transgender	2	2	100	
Age range:				
14 to 24 years	183	21	11.5	0.007
25 to 34 years	371	80	21.6	
35 to 49 years	379	90	23.7	
50 to 81 years	74	14	18.9	
Sexual orientation:				
Heterosexual	842	124	14.7	<0.001
Homosexual	123	71	57.7	
Bisexual	28	7	25.0	
Marital status:				
Is in a relationship	601	114	19.0	0.183
Is not in a relationship	406	91	22.4	
Education level:				
Basic education	613	106	17.3	0.003
Higher education	394	99	25.1	
Ethnicity (skin colour):				
White	643	128	19.9	0.654
Black or Mixed	232	52	22.4	
Other	132	25	18.9	
Religious belief:				
Yes	620	107	17.3	0.002
No	387	98	25.3	
Has a job:				
Yes	782	164	21.0	0.367
No	225	41	18.2	

Source: PCAP England

The 20.4% of the sample who had been to a sexually transmitted infection clinic in England were asked about their experience of the service (Appendix 18). 95.6% found the doctors to be trustworthy and safe. 86.3% stated that the doctors gave them an opportunity to discuss their treatment options. When asked if they received enough information about their illness and treatment received, 88.8% said they received enough information, 7.3% said the

information was not enough, 1.5% (3 people out of 205) received information but could not understand because they could not speak English, 0.98% (2 people) were not given any information about their condition or treatment. 97.6% of respondents stated they felt their privacy was respected. Lastly, when asked what their overall experience of the service was, 43.9% of the participants stated the service was excellent, 50.2% stated the service was good. 3.4% (7 people) found the service bad, and 1.5% (3 people) thought the service received was very bad.

In relation to HPV vaccination among female participants (Appendix 19), 90 out of 529 (17.0%) Brazilian women stated having received it, with statistically significant difference among the age range group (p -value <0.001). With the younger generation (14 to 24 years) having the highest proportions of having had the vaccination (37.7%). The vaccination was first approved in 2006 and is targeted at younger girls as effectiveness can wane the older they become, because they can be exposed to HPV through sexual activity.

3.2.4 HIV Testing

551 (54.1%) of Brazilians stated ever having an HIV test in their lifetime (Table 3.19 below), with 40.8% of them having had the test in the last year. All of them stated having a rapid HIV test. Statistically significant differences were noted with those who were in a relationship having more tests (59.1%) than those not in a relationship (46.7%). Differences were also noted among the sexual orientation group, with homosexuals and bisexuals having more HIV tests (76.6% and 63.3% respectively) than heterosexuals (50.8%). People in the higher education group also tended to have more HIV tests (68.5%) than those with basic education (44.8%). Lastly, it was observed that ethnicity (skin colour) and employment status, did not seem to have impacted on a person's decision to have a HIV test, with no statistically significant differences observed in either of them (P -values 0.306 and 0.111 respectively).

Table 3.19

Distribution of HIV testing, according to sociodemographic information

Variables	Total	At least once		In the last 12 months ⁽¹⁾		Had a rapid HIV test ⁽¹⁾	
	N	N	%	N	%	N	%
Total	1,018	551	54.1	225	40.8	225	40.8
Gender:							
Male	487	241	49.5	103	42.7	72	29.9
Female	529	308	58.2	120	39.0	63	20.5
Transgender	2	2	100	2	100	2	100
p-value	-	-	0.050	-	0.116	-	0.014
Age range:							
14 to 24 years	184	32	17.4	16	50.0	10	31.3
25 to 34 years	374	217	58.0	99	45.6	64	29.5
35 to 49 years	285	263	68.3	100	38.0	57	21.7
50 to 81 years	75	39	52.0	10	25.6	6	15.4
p-value	-	-	<0.001	-	0.175	-	0.290
Sexual orientation:							
Heterosexual	848	431	50.8	161	37.4	86	20.0
Homosexual	124	95	76.6	51	53.7	44	46.3
Bisexual	30	19	63.3	11	57.9	4	21.1
p-value	-	-	<0.001	-	0.021	-	<0.001
Marital status							
Is in a relationship	607	359	59.1	92	47.9	59	30.7
Is not in a relationship	411	192	46.7	133	37.1	78	21.7
p-value	-	-	<0.001	-	0.016	-	0.048
Education:							
Basic education	618	277	44.8	117	42.2	76	27.4
Higher education	400	274	68.5	108	39.4	61	22.3
p-value	-	-	<0.001	-	0.302	-	0.348
Ethnicity (skin colour):							
White	650	338	52.0	138	40.8	72	21.3
Black or Mixed	235	137	58.3	54	39.4	40	29.2
Other	133	76	57.1	33	43.4	25	32.9
p-value	-	-	0.306	-	0.437	-	0.083
Religious belief:							
Yes	626	314	50.2	123	39.2	77	24.5
No	392	237	60.4	102	43.0	60	25.3
p-value	-	-	0.006	-	0.111	-	0.799
Has a job:							
Yes	789	430	54.5	173	40.2	112	26.1
No	229	121	52.8	52	43.0	25	20.7
p-value	-	-	0.111	-	0.862	-	0.480

Source: PCAP England Note: (1) Percentage calculate based on those who had a HIV test at least once

Of the 225 (22.1%) Brazilians in this sample who stated they have had HIV tests in the last 12 months (Appendix 20) it was observed that 68.4% of the sample (154 out of 225) had one HIV test in that period, 20.9% had two HIV tests, and 10.7% of the sample had three HIV tests in the last year, with females (78.3%) having more tests than males (58.3%).

Of the 551 (54.1%) Brazilians who have had at least one HIV test in their lifetime, I was interested to know the location and reason for having the test (Appendix 21). In total merely 54% of the sample were tested in England, with 26% having the HIV test at an STI clinic (GUM Clinic). 9.4% had the test at their GP practices, 15.8% had the test at an NHS Hospital, 2.2% had the test at a private hospital, and 0.7% at NAZ Vidas (a London based sexual health NGO). The other 45.9% were tested either in Brazil, or in another European country, prior to their migration to England.

When asked about the reason for taking the test, the majority (27%) had the test because they were curious to know their HIV status. 8.3% stated sexual risky behaviour as the reason for having a test. No statistically significant difference was observed regarding the location where the HIV test was taken when the data was separated between male and female groups (p-value 0.034). Although a statistically significant difference (p-value <0.001) was observed regarding the reason for having the HIV test, with males being more curious to know their status (32%) than females (22.7%).

Data regarding the logistics of the HIV tests taken by those Brazilian participants who had at least one HIV test in their lifetime, in England or elsewhere (Appendix 22), and divided by gender, shows that 20.1% obtained the result on the same day, 42.1% in less than a week, 31.4% received their results within a month, 4.5% between one and two months, and 1.8% took more than two months to receive their results. Of the 551 people who had a HIV test, 533 know their results.

Of these, 43 people (8.1%) were diagnosed with HIV. The majority (58.1%) of participants living with HIV were diagnosed in England. The second largest number (27.9%) were diagnosed in Brazil, and 14% of the sample were diagnosed in another European country prior to migrating to England. 53.5% had a follow-up appointment with a HIV doctor within a week of receiving their diagnosis. There was no statistically significant difference when data was analysed by gender, with the exception of HIV positive results, with more males (15.5%) in our sample having been diagnosed with HIV than females (2.3%). The category of 'male' contains the category of MSM, which, as seen in PHE's data (see Chapter 1), has a very high incidence of HIV.

When data regarding the logistics of the HIV tests taken by participants was analysed by sexuality (Appendix 23), statistically significant difference (p-value 0.003) was observed in terms of when people received their results, with 34.7% of homosexuals receiving their results on the same day compared with 17.4% of heterosexuals, and 10.5% of bisexuals. Also of interest in this table was the realisation that among the 43 people who are HIV positive in our sample, 74.4% are homosexual, 4.7% are bisexual and 20.9% heterosexual.

Table 3.24 below presents data on Brazilian participants' self-perceived risk of HIV infection according to demographic information. Risk of HIV infection was divided between "no risk", "low risk", "medium risk" and "high risk". Statistically significant differences (p-value <0.001) were observed when the data was divided by gender, sexual orientation, marital status (is or is not in a relationship), and according to whether or not the participants identified as religious. Among the Brazilian women, 44.4% considered themselves to have no risk of infection, 49.8% considered themselves to be at low risk, 2.9% at medium risk and 2.9% considered themselves to be high risk. Men, on the other hand, 34.6% considered themselves to be at no risk of infection, 49.2% considered themselves low risk, 14% considered themselves medium risk and 2.7% considered themselves at high risk of HIV infection. In terms of sexual orientation, in all three groups, the majority considered themselves to be at a low risk of HIV infection, with 41.7% of heterosexuals assuming no risk of infection, and 49.3% low risk of it happening to them. Among homosexuals, 18.5% said they were at no risk of infection, and 54.3% reported low risk. 32.1% of bisexuals thought they had no risk of infection, and 53.6% reported low risk. 4.3% of homosexuals stated they were at a high risk of HIV infection, 2.9 of heterosexuals, and none of the bisexuals thought they were high risk. Overall, heterosexuals perceived themselves to be least at risk, while homosexuals perceived themselves to be most at risk, while bisexuals perceived themselves somewhere between the two. Self-perception of risk of HIV infection in this case is correct, with heterosexuals being, in reality, less at risk of HIV infection than homosexuals. However, this correct understanding is still worrying because low self-perception of risk also correlates with taking fewer precautions.

Table 3.24

Distribution of the percentage of self-perceived risk of HIV infection, according to demographic information

Variables	Total	No risk		Low risk		Medium risk		High risk		p-value
	N	N	%	N	%	N	%	N	%	
Total	975	388	39.8	482	49.4	77	7.9	28	2.9	-
Gender:										
Male	451	156	34.6	222	49.2	61	14.0	12	2.7	<0.001
Female	522	232	44.4	260	49.8	15	2.9	15	2.9	
Transgender	2	0	0.0	0	0.0	1	50.0	1	50.0	
Age range:										
14 to 24 years	184	74	40.2	85	46.2	19	10.0	6	3.3	0.063
25 to 34 years	366	133	36.3	189	51.6	32	8.7	12	3.3	
35 to 49 years	357	143	40.1	178	49.9	26	7.3	10	2.8	
50 to 81 years	68	38	55.9	30	44.1	0	0.0	0	0.0	
Sexual orientation:										
Heterosexual	839	350	41.7	414	49.3	51	6.1	24	2.9	<0.001
Homosexual	92	17	18.5	50	54.3	21	23.0	4	4.3	
Bisexual	28	9	32.1	15	53.6	4	14.0	0	0.0	
Marital status:										
Is in a relationship	594	256	43.1	298	50.2	24	4.0	16	2.7	<0.001
Is not in a relationship	381	132	34.6	184	48.3	53	14.0	12	3.1	
Education:										
Basic education	593	250	42.2	269	45.4	53	8.9	21	3.5	0.009
Higher education	382	138	36.1	213	55.8	24	6.3	7	1.8	
Ethnicity (Skin colour):										
White	627	244	38.9	323	51.5	46	7.3	14	2.2	0.302
Black or Mixed	218	93	42.7	97	44.5	21	9.6	7	3.2	
Other	130	51	39.2	62	47.7	10	7.7	7	5.4	
Religious belief	603	280	46.4	264	43.8	42	7.0	17	2.8	<0.001
Has a job	758	294	38.8	375	49.5	68	9.0	21	2.8	0.113

Source: PCAP England

Table 3.25 below shows data on the distribution of knowledge regarding places to get a free HIV test in England among the Brazilian expatriate population who took part in this research study, according to sociodemographic information. Of the 1,018 participants, fewer than half (46.5%) knew where they could go to get a free HIV test in England. Females (48.2%) were slightly more knowledgeable than males (44.4%) on where to get their free HIV tests. Statistically significant difference (p-value <0.001) was noted among the sexual orientation group, with homosexuals (79.8%) more aware of where to get free HIV tests than heterosexuals (42.0%), or bisexuals (43.3%). Statistically significant

difference (0.002) was also noticed among the age range groups, with the “35 to 49 years group” (51.9%) more aware of where to get the tests, followed by the “25 to 34 years group” (47.3%), and “50 to 81 years group” (41.3%). The age group with least awareness of where to get a free HIV test was the “14 to 24 years” one, with 35.3% aware of where they can go to have a free HIV test. In terms of religiosity, 53.1% of non-religious people were more knowledgeable than religious people (42.3%). This information was statistically significant (p-value 0.001). Using all the knowledge indicators from the survey, the data shows that religious people in the sample know less in general about HIV. Their knowledge might be impacted by their attitudes to HIV, which will be discussed in the discussion section at the end of this chapter. No statistically significant difference (p-value 0.342) was noted in terms of ethnicity (defined by skin colour).

Table 3.25

Distribution of knowledge regarding places to get a free HIV test in England, according to sociodemographic information

Variables	Total	Free HIV test	
	N	N	%
Total	1,018	473	46.5
Gender:			
Male	487	216	44.4
Female	529	255	48.2
Transgender	2	2	100
p-value	-	-	0.148
Age range:			
14 to 24 years	184	65	35.3
25 to 34 years	374	177	47.3
35 to 49 years	385	200	51.9
50 to 81 years	75	31	41.3
p-value	-	-	0.002
Sexual orientation:			
Heterosexual	848	356	42.0
Homosexual	124	99	79.8
Bisexual	30	13	43.3
p-value	-	-	<0.001
Marital status:			
Is in a relationship	607	275	45.3
Is not in a relationship	411	198	48.2
p-value	-	-	0.368
Education:			
Basic education	618	267	43.2
Higher education	400	206	51.5
p-value	-	-	0.010
Ethnicity (skin colour):			
White	650	291	44.8
Black or Mixed	235	115	48.9
Other	133	67	50.4
p-value	-	-	0.342
Religious belief:			
Yes	626	265	42.3
No	392	208	53.1
p-value	-	-	0.001
Has a job:			
Yes	789	381	48.3
No	229	92	40.2
p-value	-	-	0.030

Source: PCAP England

With regards to the Brazilian individuals from our sample who received or donated blood, 62 (6.1%) participants out of 1,018 stated having at least once received blood in their life time and 288 (28.3%) at least once donated blood (Appendix 24). This question was asked because it was part of general UNAIDS structure but no one in this sample contracted HIV from a blood transfusion, because cases such as this are very rare. The relationship between blood transfusion and HIV transmission does not fall within the remit of this thesis. No statistically significant difference was found when the sample was analysed according to gender (“At least once received blood”: P-value 0.921 and “At least once donated blood”: P-value 0.057).

3.2.5 Sexual Practices

Among the Brazilian expatriate population in England aged between 14 and 81 years, who took part in our research, 92.1% declared having sex at least once in their lifetime, with 89.1% of them having had sex during the previous 12 months, and 88.0% in the last month. Analysis of these indicators show that men had slightly higher percentages in most of them: 92.2% had had sex at least once in their lifetime, 91.1% had sexual intercourse in the last 12 months, and 88.8% in the last month, although such differences were not statistically significant when compared to women. The proportion of participants who initiated sex before their 15th birthday was 25.1%, with statistically significant differences observed between male and female groups (p-value <0.001): Among men, 40.5%, while among women, 10.9%. The proportion of participants who had had more than one sexual partner in their lifetime was 83.5%, and 35.6% declared more than ten partners. Through this research study it was evident that men had in total a somewhat greater number of sexual partners than women: while the proportion who had had more than one sexual partner among men was 87.1%, among women it was 80.1%. Comparing this with the Brazilian PCAP 2013 survey, the difference is much greater, with 81.5% of men having had more than one sexual partner in their lifetime compared with 57.0% of women. A possible explanation for this could concern the mindset of people who migrate as opposed to people who stay at home. For example, women in Brazil are under greater pressure to abide by the Marianistic culture that prevails in Latin America. The proportion of individuals who had a sexual encounter with someone of the same gender was 26.0%, with men having more than double (40.5%) that experience compared to women (12.3%) in our sample. Among those who stated having sex in the last 12 months, 27.9% had more than one sexual partner, 10.8% had more than five sexual partners, 84.1% had sexual intercourse with fixed partners, 26.9% with casual partners, 50.7% had casual sex with people they met through

the internet, and 14.7% paid someone for sex. I observed a higher proportion among men on all indicators, except in relation to “fixed partners”, of which the proportion was higher among women (92.0%), than men (75.8%).

Table 3.27

Distribution of individuals’ sexual practice/behaviour indicators in relation to HIV transmission, according to gender

Population	Sexual practice/behaviour	Total (N = 1.018)		Male (N = 487)		Female (N = 529)		p-value
		N	%	N	%	N	%	
Total population	Had sex at least once	938	92.1	449	92.2	487	92.1	0.936
	Had sex in the last 12 months	836	89.1	409	91.1	425	87.3	0.118
	Had sex in the last month	736	88.0	363	88.8	371	87.3	0.770
Sexually active population	Had sex before age 15 years	235	25.1	182	40.5	53	10.9	<0.001
	Had more than one sexual partner	783	83.5	391	87.1	390	80.1	0.004
	Had more than 10 sexual partners ⁽¹⁾	279	35.6	198	50.6	79	20.3	<0.001
	Had same gender sex	244	26.0	182	40.5	60	12.3	<0.001
Sexually active population (last 12 months)	Had more than one sexual partner	233	27.9	173	42.3	58	13.7	<0.001
	Had more than five sexual partners	90	10.8	82	20.1	7	1.7	<0.001
	Had sex with fixed partners only	703	84.1	310	75.8	391	92.0	<0.001
	Had sex with casual partners	225	26.9	160	39.1	63	14.8	<0.001
	Paid someone for sex ⁽²⁾	33	14.7	32	20.0	1	1.6	<0.001
	Had sex with people met on the internet ⁽²⁾	114	50.7	93	58.1	20	31.8	0.001

Source: PCAP England

Notes: (1) Percentage calculated only from those who had sex at least once

(2) Percentage calculated only from those who had sex with casual partners in the last 12 months

When sexual practice/behaviour indicators were analysed according to age groups (Appendix 25), it was observed that 77.7% of the “14 to 24 years” age group had already initiated sexual intercourse, with 88.1% stating they had sex in the last 12 months, and 84.9% in the last month. It is important to note that these age groups refer to the age of participants when they took part in this research project. Also, in relation to initiating sex before the age of 15, the highest proportion was in the “14 to 24” age group too (39.9%). Among the young adults (25 to 34 years) the proportion was 29.6%. With regards to the number of sexual partners, there was no statistically significant difference in any of the age groups in our sample. The highest proportion of people with more than one sexual partner was observed in individuals from age group “25 to 34 years” (87.5%) and “35 to 49 years”

(82.2%). The proportion of people who had more than ten sexual partners in their lifetime was higher in the “35 to 49 years” (39.8%), followed by age group “25 to 34 years” (37.8%) and those of the “14 to 24 years” (25.9%). Although this last age group were the ones who stated having more same gender sex than any other group (40.6%). My theory is that this age group could have been more exposed to positive messages about homosexuality. Same sex marriage which was introduced 2 years earlier in Brazil than in England – 2011 vs 2013, resulting in not only more same-gender sexual encounters but also greater honesty in reporting these sexual encounters. Indicators regarding sexual intercourse in the last 12 months have shown that young people (14 to 24 years) were the age group who specified having more than one sexual partner in this period (51.6%), and also more than five sexual partners (16.7%). Approximately 40% stated they had sex with casual partners in the last 12 months, and 32% met people through the internet, the lowest level of any age group. I have noticed however that the proportion of people who had sex with a fixed sexual partner was much higher in all age groups than in the “14 to 24 years” equivalent.

When the same data was analysed according to sexuality, statistically significant difference (p -value <0.001) was observed in 8 out of the 13 indicators (Appendix 26). For example, 47.9% of homosexuals stated having initiated sex “before the age of 15 years”, bisexuals were at 24.1%, and heterosexuals 21.6%. When those who had sex at least once were asked if they “had more than 10 sexual partners” in their lifetime, 76.6% of homosexuals said yes, as well as 37.5% of bisexuals and 28.3% of heterosexuals. When asked about their sexual behaviour in the last 12 months, homosexuals (22.9%) had a higher rate of paying for sex (p -value 0.045) than heterosexuals (11.8%).

No bisexuals (0.0%) stated they paid for sex in this period. When asked if they “had sex with people they met on the internet”, 82.9% of homosexuals, 66.7% of bisexuals and 34.0% of heterosexuals said yes.

When sexual practices were analysed according to marital status (here divided, following the Brazilian survey, as “Is in a relationship” and “Is not in a relationship”), the proportion of people who initiated sex under the age of 15 years was higher among those who belonged to the “Is not in a relationship” group, at the moment this research was carried out (30.1%). This group was also identified as having more sex with people of the same gender (39.6%), with more than 10 sexual partners (45.2%), as well as having sex in the last 12 months with more than one sexual partner (58.0%), with more than five sexual partners (23.1%), with casual partners (53.5%), and with people they met on the internet (54.3%).

Almost all indicators had statistically significant differences between the two groups, as can be verified in Table 3.31 (Appendix 27). This could be explained by the fact that some people who are not in a relationship can have more sex with a greater number of sexual partners. Also, many of the people in this sample who had had sex before the age of 15, had often had sex much earlier – 60 participants had initiated sexual activity before the age of 12. This constitutes sexual abuse as the age of consent in Brazil is 14 years old (in England 16 years old) and therefore may have had an impact on their attitude to relationships and sexual behaviour later in life. This is supported by my own counselling experience working with survivors of sexual abuse. There is also the factor of the migration mindset – away from home culture, if you are single, you may feel free to have sex with as many people as you like. So the correlation is clear, but the causation is not – it could be that having more sex with a greater number of partners causes you to be less likely to be in a relationship; or it could be that not being in a relationship causes you to have more sex with a greater number of partners.

In relation to condom use, Table 3.31 below shows the distribution of sexually active individuals in the last year who used condoms, divided by gender. 33.7% of the total sample admitted using condoms in the last sexual intercourse, although this figure includes fixed and casual sexual partners. When asked if they used condoms with all sexual encounters with casual partners, 67.6% confirmed using them. This can be compared with our earlier statistic on knowledge regarding condom use: 91.7% of the sample in England agrees that using condoms is the best way to prevent HIV being passed through sexual intercourse. So why do people not use them? Is it a question of access? Often MSM campaigns distribute free condoms in gay bars and pubs, whereas heterosexual people are less likely to frequent environments where free condoms are distributed.

When asked about the use of condoms with casual partners the last time they had sex, 60.0% of people used condoms. When asked about the use of condoms in the last 12 months with casual partners however, 49.3% used condoms. When the sample was asked about the use of condoms in the last 12 months with any sexual partners however, 25.5% used a condom. Overall men stated using condoms more than women in all indicators, although statistically significant differences ($p\text{-value} < 0.001$) were observed only regarding “used condom in last sexual encounter” and “used condom on all sexual encounters in the last 12 months with all sexual partners”.

Table 3.31

Distribution of individuals' sexual practice/behaviour indicators, in the last 12 months, in relation to Condom use, according to gender

Condom use	Total (N = 836)		Male (N = 409)		Female (N = 425)		p-value
	N	%	N	%	N	%	
In the last sexual intercourse	282	33.7	165	40.3	115	27.1	<0.001
In sexual intercourse with fixed partner	311	37.2	151	36.9	130	30.6	0.053
In sexual intercourse with casual partner(1)	152	67.6	113	70.6	37	58.7	0.088
In the last sexual intercourse with casual partner(1)	135	60.0	100	62.5	33	52.4	0.166
In all sexual intercourse with fixed partner (last 12 months)	185	22.1	105	25.7	78	18.4	0.011
In all sexual intercourse with casual partner (last 12 months)(1)	111	49.3	81	50.6	28	44.4	0.406
In all sexual intercourse with any partner (last 12 months)	239	25.5	146	32.5	91	18.7	<0.001

Source: PCAP England

Notes: (1) Percentage calculated only from those who had sex with casual partners

There was no statistically significant difference when data regarding the distribution of individuals' sexual practice/behaviour indicators was analysed divided in age groups (Appendix 28), with the "50 to 81 years" group (39.6%) having used more condoms in the last sexual intercourse than any other group. The age group "25 to 34" (29.0%) were the group that least used condoms in their last sexual intercourse. No statistically significant difference (p-value 0.304) was observed when participants were asked if they used condoms "on all sexual intercourse with casual partners in the last 12 months", however, all age groups had less than 50% of condom use, apart from the "35 to 49 years" group who reported using condoms 56.5% of the time. Also, no statistically significant difference was observed in relation to sexual practice/behaviour and education levels (Appendix 29), with both groups, "basic education" and "higher education" quite similar in their use of condoms, although people in the "higher education" group used incrementally more condoms in every indicator, than the other group. A more marked difference was noticed in the question "used condoms in the last sexual intercourse with casual partners", where the "higher education" group fared better (71.1%) than those with "basic education" (53.5%), p-value 0.009.

3.2.6 Access to Condoms and Lubricants

In relation to Brazilians in England and how they manage to have access to condoms, Table 3.34 below shows that 24.3% (247 out of 1,018) had access to free condoms, and 42.3% (431 out of 1,018) bought their own supply. Statistically significant difference (p-value 0.006) was observed when data was divided by gender, with 26.9% of males stating they got their condoms for free, against 21.4% of women. Both transgender participants also got their condoms free of charge. 52.0% of males bought their condoms, against 33.6% of females. The age range that got more free condoms was the “35 to 49 years” group (26.5%), and the age group that received the least free condoms were the “50 to 81 years” group (16.0%).

Table 3.34

Distribution of individuals who had access to male condoms, according to sociodemographic information

Variables	Total	Male condoms			
		Free		Paid	
	N	N	%	N	%
Total	1,018	247	24.3	431	42.3
Gender					
Male	487	131	26.9	253	52.0
Female	529	113	21.4	178	33.6
Transgender	2	2	100	0	0.0
p-value	-	-	0.006	-	<0.001
Age range					
14 to 24 years	184	41	22.3	80	43.5
25 to 34 years	374	92	24.6	183	48.9
35 to 49 years	385	102	26.5	146	37.9
50 to 81 years	75	12	16.0	22	29.3
p-value	-	-	0.236	-	0.002
Sexual orientation					
Heterosexual	848	178	21.0	356	42.0
Homosexual	124	59	47.6	52	41.9
Bisexual	30	9	30.0	18	60.0
p-value	-	-	<0.001	-	0.145
Marital status					
Is in a relationship	607	135	22.2	221	36.4
Is not in a relationship	411	112	27.3	210	51.1
p-value	-	-	0.067	-	<0.001
Education					
Basic education	618	162	26.2	251	40.6
Higher education	400	85	21.3	180	45.0
p-value	-	-	0.071	-	0.167
Ethnicity					
White	650	141	21.7	284	43.7
Black or Mixed	235	69	29.4	93	39.6
Other	133	37	27.8	54	40.6
p-value	-	-	0.037	-	0.500
Religious					
Yes	626	148	23.6	249	39.8
No	392	99	25.3	182	46.4
p-value	-	-	0.559	-	0.037
Has a job					
Yes	789	192	24.3	343	43.5
No	229	55	24.0	88	38.4
p-value	-	-	0.921	-	0.174

Source: PCAP England

In terms of female condoms, Table 3.36 (Appendix 30) shows the breakdown of indicators of those participants who knew about female condoms, and those who had used them in the past, according to sociodemographic data. Of the 938 participants who answered this particular question, 756 (80.6%) knew about female condoms, however, only 82 (10.8%) ever used one. When this data was broken down by gender, it was evident that more than 74.4% of male, female and transgender knew about female condoms, however, only 12.3% of males, 9.5% of females and 50.0% of transgender ever used them. In terms of sexual orientation, 12.1% of heterosexuals and 16.7% of bisexuals used female condoms.

Table 3.37 (Appendix 31) shows the distribution of indicators of those participants who know about intimate lubricants and those who have already used them, according to sociodemographic information. Of the 938 Brazilians in our survey who completed this question, 828 (88.3%) know about intimate lubricants, and 432 (52.2%) have already used them. No statistically significant difference (p-value 0.848) was observed when the data was analysed according to gender, with more than 88.0% of males, females and transgender aware of intimate lubricants. Statistically significant difference (p-value <0.001) was observed among those who have already used lubricants, with males (61.3%) having used it more than females (43.9%), and females less than transgender (50.0%). In terms of sexual orientation, no strong statistically significant difference (p-value 0.068) was noted in terms of knowing about intimate lubricants, with more homosexuals (94.2%) knowing about them than bisexuals (93.1%) or heterosexuals (87.4%). In terms of having already used lubricants more bisexuals (74.1%) stated having already used intimate lubricants than homosexuals (70.2%) or heterosexuals (48.2%). The fact that more homosexuals use lubricants could be because the practise of anal sex requires lubricant, whereas vaginal sex does not necessarily require it. Free lubricant is often available to MSM through sexual health campaigns in gay venues.

3.2.7 Alcohol and Drug Use

Table 3.38 (Appendix 32) presents data regarding the distribution in our sample of participants' views on whether they think that alcohol or recreational drug consumption can impact a person's decision to use condoms, and also if this had ever happened to them. This data was analysed according to sociodemographic information. Of the 938 Brazilian participants who answered this question, 807 (86.0%) of them agreed that alcohol and drugs can impact a person's decision to use or not use condoms during sex. 327 (34.9%) stated that this had already happened to them. When the data was analysed divided by

gender, no statistically significant difference (p-value 0.907) was observed in terms of agreement that alcohol and drugs impact a person's decision to use condoms, however, a significant difference (p-value <0.001) was observed when asked if this had happened to them, with men (45.7%) almost twice as likely as women (24.8%) to have had sex without condoms because of alcohol and/or drugs. In terms of sexual orientation, homosexuals (49.6%) were more likely to have sex without condoms because of alcohol and/or drugs than heterosexuals (33.0%), or bisexuals (31.0%). This difference was statistically significant (p-value 0.002). Education level did not seem to make a statistically significant difference as both "basic education" and "higher education" groups agreed that alcohol and/or drugs can impact a person's decision to use condoms (p-level 0.965), and also they both reported the same level of this having already happened to them (p-value 0.467).

When individuals' alcohol and drug use data was analysed (Appendix 33), it was observed that 828 (81.3%) of the Brazilian expatriate population in our sample had used alcohol in the past, and that 515 of those (62.2%) still use alcohol currently. 366 (36.0%) used cannabis in the past, and 121 of those (33.1%) use it presently. In terms of amphetamines, 150 (14.7%) participants used them in the past, and 42 of those (28.0%) still use them today. 147 (14.4%) used cocaine in the past, and 28 (19.1%) of them still use it today. 7 (0.7%) people used heroin in the past, 2 (28.6%) of them are still using it today, 4 (57.1%) of them shared objects when using heroin. When analysing this data by gender, in all modalities of drugs, males used them more than females. When comparing with distribution of usage along lines of sexuality, homosexuals also use more in all modalities of drugs. I will investigate in the in-depth interviews whether both of these statistics can be explained by MSM.

When alcohol and drug use were analysed divided by the different age groups (Appendix 34), it was observed that the "35 to 49 years" (84.4%) group stated having had more past experience of alcohol use, however, the age group currently drinking most alcohol is the "14 to 24 years" group (68.8%). In terms of cannabis, highest past use was in the "25 to 34 years" group (43.6%), and highest current use was in the "14 to 24 years" group (57.1%). Amphetamine use in the past was more common in the "25 to 34 years" group (17.7%), and current amphetamine use more common in the "14 to 24 years" group (37.5%). In terms of cocaine, the age group with the most past use was the "25 to 34 years" group (16.8%), and current cocaine use is the "14 to 24 years" group (28.6%). Heroin was only used by 7 Brazilians in our sample, with no statistically significant difference in use by the various age

groups. The “14 to 24 years” age group had the highest rate of present drug use in almost all modalities (alcohol, cannabis, amphetamines and cocaine).

When the distribution of individuals’ alcohol and drug use was analysed according to sexual orientation (Appendix 35), statistically significant difference (p-value <0.001) was noticed in almost all indicators. Homosexuals had a higher rate of alcohol, cannabis, amphetamine and cocaine use than bisexuals and heterosexuals. Heroin however was more used by heterosexuals and bisexuals than homosexuals, although only 7 Brazilians stated using heroin in the past, and 3 in the present. It is well known that MSM tend to combine drugs and sex in a practice known as Chemsex. This involves amphetamines such as crystal meth, GHB and ecstasy, along with alkyl nitrites like poppers and tropane alkaloids like cocaine. This could explain the significantly higher usage of amphetamines and cocaine by homosexuals.

When the distribution of individuals’ alcohol and drug use (Appendix 36) was further analysed in terms of marital status (is or is not in a relationship), it was observed that statistically significant differences were very much present in almost all indicators. With people who are not in a relationship consuming more alcohol and drugs than those in a relationship; both in the past and in the present.

When the distribution of individuals’ alcohol and drug use was analysed according to education level (Appendix 37), statistically significant difference (p-value <0.001) was found in terms of alcohol use. With people in the “higher education” group stating having more past and present alcohol use than the “basic education” group. Education level did not seem to have a strong association with regards to cannabis, amphetamine, cocaine use or heroin.

In terms of religiosity (religious vs. non-religious), Table 3.43 (Appendix 38) shows that the non-religious group had a higher level of alcohol and drug use, both past and present, than the religious group. This difference was statistically significant (p-value <0.001) for “past use” of alcohol, cannabis, amphetamine and cocaine. This could be expected because of religious teachings advocating caution about substances that cause loss of self-control as is the case with alcohol and drugs. No statistically significant difference was found for “present use” among the two groups for cannabis (p-value 0.278), amphetamine (P-value 0.941) or cocaine (p-value 0.264).

3.2.8 Abortion

Abortion in Brazil is considered a crime against human life, being prohibited in all circumstances by articles 124-127 of the Brazilian Penal Code. The only circumstances in which women are allowed to terminate a pregnancy is to save the mother's life, or in cases of rape. This does not mean that the law in Brazil regards abortion in these cases as a "right", but only that women who commit this "crime" will not be punished (Lemos da Silva, 2010).

Table 3.47 (Appendix 39) shows the distribution of individuals' opinion regarding abortion, according to sociodemographic information. In total, 35.7% of the Brazilian expatriates who took part in our research agreed that women have the right to have an abortion. 21.7% disagree, 29.9% said that it depends on the situation, and 12.8% preferred not to say what they thought. Statistically significant difference (p -value 0.002) was found when the group was divided by gender, with more females (36.7%) agreeing with abortion than males (34.5%), and with more males (26.9%) disagreeing with the procedure than females (17.0%). Statistically significant difference (p -value <0.001) was also noticed in terms of sexual orientation, education level, ethnicity (skin colour) and religiosity. Homosexuals (54.8%) were more likely to agree that a woman has the right to an abortion than bisexuals (40.0%) and heterosexuals (32.7%). Also, people in the "higher education" group (48.3%) were more likely to agree with abortion than the "basic education" group (27.5%). In terms of ethnicity (in Brazil defined by skin colour), those who self-identified as "white" (38.9%) were more likely to agree with abortion than those self-identified as "other" (30.1%), or those self-identified as "black or mixed" (29.8%). Finally, religion also seemed to have an impact on people's opinion about abortion, with 23.2% of religious people agreeing that a woman has the right to an abortion if she chooses it. Brazil has the highest population of Catholics in the world; the Catholic church is still anti-abortion because they believe life begins at conception. Pentecostal churches are also anti-abortion for the same reason. The Pentecostal church is one of the fastest-growing churches in Brazil and according to the 2010 census in Brazil has the second highest number of adherents after Catholicism. This religiosity is, in my experience, reflected in the Brazilian expatriate community in England.

3.2.9 Post-Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP)

265 (26.0%) people out of 1,018 Brazilian participants in our research knew what PEP was, and 148 (55.8%) of those who knew about PEP also knew where they could get it (Table

3.45). Statistically significant difference (p-value <0.001) was observed in the sexual orientation group, with homosexuals (65.3%) more likely to know about PEP than bisexuals (36.7%) or heterosexuals (20.0%). Education level also seemed to have an impact (p-value <0.001) as people in the “higher education” group (32.0%) were more likely to know about PEP than those in the “basic education” group (22.2%). However, no statistically significant difference (p-value 0.904) was observed in terms of either group knowing where they could go to get PEP if they needed it. In terms of religiosity, the non-religious (33.2%) seemed to know better about PEP than the religious (21.6%). This difference was statistically significant (p-value <0.001). Religiosity does not necessarily cause less knowledge about PEP, nor does knowledge about PEP cause people to be less religious. The likely link concerns sexuality. Because of religious attitudes towards sexuality, in my experience, this causes fewer gay people go to church than straight people. Gay people also tend to know more about PEP as seen above.

Table 3.45

Distribution of individuals who knew about PEP, according to sociodemographic information

Variables	Total	Knows about PEP		Knows where to get PEP(1)	
	N	N	%	N	%
Total	1,018	265	26.0	148	55.8
Gender					
Male	487	137	28.1	84	61.3
Female	529	126	23.8	63	50.0
Transgender	2	2	100	1	50.0
p-value	-	-	0.017	-	0.179
Age group					
14 to 24 years	184	61	33.2	23	37.7
25 to 34 years	374	84	22.5	48	57.1
35 to 49 years	385	101	26.2	68	67.3
50 to 81 years	75	19	25.3	9	47.4
p-value	-	-	0.062	-	0.003
Sexual orientation					
Heterosexual	848	170	20.0	86	50.6
Homosexual	124	81	65.3	55	67.9
Bisexual	30	11	36.7	7	63.6
p-value	-	-	<0.001	-	0.031
Marital status					
Is in a relationship	607	132	21.7	74	56.1
Is not in a relationship	411	133	32.4	74	55.6
p-value	-	-	<0.001	-	0.945
Education					
Basic education	618	137	22.2	77	56.2
Higher education	400	128	32.0	71	55.5
p-value	-	-	<0.001	-	0.904
Ethnicity (Skin colour)					
White	650	173	26.6	89	51.4
Black or Mixed	235	58	24.7	35	60.3
Other	133	34	25.6	24	70.6
p-value	-	-	0.838	-	0.089
Religious					
Yes	626	135	21.6	75	55.6
No	392	130	33.2	73	56.2
p-value	-	-	<0.001	-	0.922
Has a job					
Yes	789	206	26.1	120	58.3
No	229	59	25.8	28	47.5
p-value	-	-	0.917	-	0.141

Source: PCAP England

Notes: (1) Percentage calculated only among those who knows about PEP

With regards to PrEP, since the medication was only aimed at the MSM community in England at the time of this research, I was only interested in asking this particular group if they knew what PrEP was (Table 3.46). Out of 125 people who self-identified as MSM in our sample, 74 (59.2%) knew what PrEP was. Knowledge about PrEP increased in every age group, with the younger generation less aware of PrEP than the older generations (p-value 0.047). Homosexuals (63.3%) were much more knowledgeable than bisexuals (28.6%) regarding PrEP (p-value 0.044).

Table 3.46

Distribution of individuals (MSM only) who know about PrEP, according to sociodemographic information

Variables	Know about PrEP		p-value
	N	%	
Total	74	59.2	-
Age range			
14 to 24 years	8	36.4	0.047
25 to 34 years	23	57.5	
35 to 49 years	37	66.1	
50 to 81 years	6	85.7	
Sexual orientation			
Homosexual	70	63.3	0.044
Bisexual	4	28.6	
Marital status			
Is in a relationship	26	57.8	0.808
Is not in a relationship	48	60.0	
Education			
Basic education	35	53.8	0.205
Higher education	39	65.0	
Ethnicity (Skin colour)			
White	45	58.4	0.483
Black and Mixed	20	55.6	
Other	9	75.0	
Religious	26	50.0	0.077
Has a job	59	56.2	0.117

Source: PCAP England

3.2.10 Male Circumcision

84 (17.2%) out of the 487 Brazilian men who took part in this research were circumcised. No statistically significant difference was observed when the data was analysed according to sociodemographic information (Appendix 40). In this sample, the older age group “50 to

81 years" (32.0%) were more likely to be circumcised than the younger age group "14 to 24 years" (10.1%). In terms of education, those in the "higher education" group (23.0%) were more likely to be circumcised than those in the "basic education" group (14.4%). Male circumcision is important because, according to the WHO, it decreases the likelihood of heterosexually acquired HIV infection in men by up to 60%. Therefore it is important to understand why older and more educated men have a higher rate of circumcision. I might suggest that it is due to the perception in Brazil of circumcision as being more hygienic – this is related to education and class, but it is beyond the remit of this thesis.

3.2.11 Prejudice and Discrimination

In relation to the following affirmation: "A gay couple have the right to adopt a child", Table 3.49 (Appendix 41) shows that 746 (73.3%) out of 1,018 Brazilians from our sample agreed that a gay couple have the right to adopt a child. Statistically significant difference (p-value 0.003) was observed in terms of gender, with women (77.7%) more likely to agree with this affirmation than men (68.4%). No statistically significant difference (p-value 0.541) was observed among the various age groups, with the "50 to 81 years" (80.0%) more likely to agree with gay couples adopting children than the "14 to 24 years" (71.2%) group. Homosexuals (96.0%) and bisexuals (96.7%) were also more likely to agree with this affirmation than heterosexuals (69.6%). This difference was statistically significant (p-value <0.001). This could be due to homosexuals and bisexuals being personally invested in their own ability to adopt children. Religion could also play a part, because in this sample more heterosexual people are religious than homosexual people and the Catholic and Pentecostal churches tend to say that the basic family unit should consist of one male parent and one female parent.

Education (p-value <0.001) also seemed to have an impact on people's opinion on this topic, with those in the "higher education" (86.3%) group more likely to accept gay people adopting children than those in the "basic education" (64.9%) group. Ethnicity (in Brazil defined by skin colour) also seems to have had an impact on whether individuals agreed with gay couples having the right to adopt children or not, with those in the "white" (76.2%) and "other" (71.4%) skin colour groups more likely to agree with this statement than the "black" (66.4%) skin colour group. This was statistically significant (p-value 0.013). Religiosity (p-value <0.001) also had an impact on this question, with those in the "non-religious" (84.9%) group more likely to agree that a gay couple have the right to adopt children than those in the "religious group" (66.0%).

When the 1,018 Brazilian expatriates from our sample were asked if they would have gay friends (Appendix 42), the majority (93.1%) said “yes”. 13 people (1.3%) said they would “never” have gay friends, and 57 (5.6%) people said “maybe” they would have gay friends. Of interest in this table is the fact that out of the 13 people who said they would “never” have gay friends, 9 of them were male and 4 female, 12 were heterosexual, 11 had basic education only, and 10 were religious. Also of interest is the fact that out of the 57 people who said “maybe” they would have gay friends, 34 of them were male and 23 female, 51 were heterosexual, 44 had basic education, and 45 were religious.

Three distinctive affirmations have been created to assess levels of discrimination towards HIV/AIDS among the Brazilian expatriate population in our sample (Appendix 43).

Affirmation 1 (A1): “If there was a HIV positive child in the same class as your children you would still allow them to attend that school”; Affirmation 2 (A2): “If you knew that the person selling fruit and vegetables in the corner shop was HIV positive you would still buy their products” and Affirmation 3 (A3): “If a teacher is HIV positive but is not sick she/he can still carry on teaching in any school”. Out of 1,018 participants in our research, 903 (88.7%) people stated they would allow their children to attend school even if there was a HIV positive child in their class. 747 (73.4%) stated they would buy fruit and vegetables from a HIV positive person. 898 (88.2%) stated they agreed a HIV positive teacher who is not sick should still be allowed to carry on teaching in any school. Gender (p-values A1 = 0.525, A2 = 0.535, A3 = 0.839) did not seem to have a major impact on whether participants agreed or not with any of these three affirmations. In terms of sexual orientation statistically significant difference (p-values A1 = 0.002, A2 = <0.001 and A3 = 0.003) was observed, with homosexuals (A1 = 98.4%, A2 = 95.2% and A3 = 97.6%) more likely than bisexuals (A1 = 90.0%, A2 = 76.7% and A3 = 90.0%) or heterosexuals (A1 = 87.7%, A2 = 70.3% and A3 = 87.1%) to agree with any of these three affirmations. Education level (p-values A1 = 0.008, A2 = <0.001 and A3 = <0.001) also seemed to have an impact on these affirmations, with people in the “higher education group” (A1 = 92.0%, A2 = 84.5% and A3 = 93.5%) more likely to agree with all of the three affirmations than those in the “basic education” group (A1 = 86.6%, A2 = 66.2% and A3 = 84.8%). Religion (p-values A1 = 0.059, A2 = <0.001 and A3 = 0.015) seemed to have a negative impact on people’s level of discrimination towards those living with HIV/AIDS, with those in the “non-religious” group (A1 = 91.1%, A2 = 80.6% and A3 = 91.3%) more likely to agree with the three affirmations than those on the “religious” group (A1 = 87.2%, A2 = 68.8% and A3 = 86.3%).

3.2.12 Sex work/Gratifications

Table 3.52 (Appendix 44) displays the distribution of individuals from our sample of the Brazilian expatriate population who confirmed they had casual sex in the last 12 months and received money/gratification for sex, as well as their condom use with these partners. Of the 225 participants who stated having casual sex in the last 12 months, 29 people (12.9%) received money for sex. Out of these 29 people, 24 (82.8%) of them used condoms some of the time, and 22 (75.9%) stated they used condoms every single time. This data shows that 24% of the sample did not use condoms with casual partners when money/gratification was exchanged for sex. Though this is a very small sample, even having just 5 people who never used condoms when exchanging sex for money or gratifications in the last 12 months, has significance when discussing the transmission of HIV. No statistically significant difference (p-value 0.789) was noticed among the gender groups in terms of who received money for sex, with females (12.7%) slightly more likely than males (12.5%). However, when asked if they used condoms every time (p-value 0.334), women (87.5%) were more likely to have used condoms than men (70.0%). Bisexuals (100%) and homosexuals (83.3%) were more likely to use a condom (p-value 0.593) than heterosexuals (71.4%). The age group (p-value 0.109) most likely to have used condoms every time was the “37 to 49 years” group (100%), and the age group that used the least condoms was the “14 to 24 years” group (50%). This could be because younger generations might have been less exposed to the fears when HIV/AIDS was first discovered, also maybe less exposed to the more frightening sexual health campaigns of the early responses to the epidemic. People in the “higher education” (100%) group were also more likely (p-value 0.166) to have used a condom every time than the “basic education” (70.8%) group. Even though this is a very small sample, we can see a big difference when it comes to education, with 17.2% of [sex workers] having higher education compared with 82.8% having basic education. This could be a sign that people with higher education have a more stable financial status, so are less likely to exchange sex for money or gratifications.

3.3 Discussion

The aim of this chapter was to conduct a validated cross-sectional survey of HIV/AIDS-related KAP with 1,000 members of the Brazilian expatriate population in England to assess their levels of knowledge, attitudes and practices regarding HIV transmission; to compare results from this study with those from the latest HIV/AIDS-related KAP (PCAP 2013) of the

Brazilian population in Brazil; and finally to determine levels of access to health services of the Brazilian population in England.

No attempt was made to claim that this sample is representative, as the real size of the Brazilian population in England is unknown, as discussed previously.

Results show that the participants from the Brazilian expatriate population in England who took part in this study have, in general, a moderate to good level of knowledge of how HIV is transmitted, and of which ways their behaviour can increase or decrease their risk of HIV acquisition. However, when results from this survey were compared with those from the latest survey in Brazil, a slightly lower level of knowledge in the sample in England (2016) was observed in six out of the eight indicators of knowledge, compared to those observed in Brazil (2013).

This indicates that the Brazilian population living in England knows relatively less about how HIV is transmitted and how to prevent it than those Brazilians living in Brazil. I am aware, however, that the difference in sample size, and other characteristics, might have played a role in the differences I found. One example is the fact that the Brazilian research did not determine the HIV status of their participants. It is commonly known that people living with HIV know more about HIV than the general population.

One of the poorest performances in the sample in England was in relation to knowledge and prevention concerning HIV medication. For example, the answers to the following statement: “a person living with HIV who is successfully taking HIV medication has less risk of passing the virus on to another person”. In our sample in England 23.3% knew that information correctly, where in Brazil 33.1% agreed with the same sentence. In both cases, they show how much Brazilian people need more current knowledge about HIV treatment efficacy and treatment as prevention. As discussed initially in section 3.2.1, despite the Brazilian data being three years older than the English data, the knowledge among Brazilians in England is significantly lower. This could be due to the English government not only being less active in campaigning, but Brazilians not being able to understand the campaigns that do exist. This is not necessarily a criticism of English government policy on campaigning, because the English need is less due to the English HIV rate being lower.

Further to this, it will be useful to explore how Brazilians in England have been impacted by language barriers, as discussed at the beginning of the chapter.

Knowledge of treatment as prevention is even more critical given that the Brazilian sample in England showed very limited knowledge about PrEP and PEP. With 265 people out of 1,018 (26.0%) knowing what PEP is, and 148 people out of 1,018 (14.5%) knowing where to access PEP, if needed. This could not be compared with the sample of Brazilians in Brazil, because the Brazilian PCAP did not ask questions about PEP or PrEP. It is also not possible to compare Brazilians in England with the general population in England as data is not readily available on the general population's knowledge of PEP. However, it is still relevant to note the difference, within this thesis' sample, in knowledge of methods of prevention. As said at the outset, the majority of Brazilians in England surveyed understand that successful condom use prevents HIV transmission. Here, we see only 26% knowing about PEP.

I also specifically asked the MSM participants in our cohort in England if they knew what PrEP was. Among the 125 men who self-identified as MSM in our sample, 74 (59%) of them knew about PrEP. This is unique to my research and therefore should be highlighted as this is the first insight into the KAP of MSM Brazilians in England concerning this kind of HIV medication.

There were not many observed differences in knowledge of HIV transmission when the data on Brazilians in England was divided by "religious" or "non-religious" (Appendix 7), however, there was a statistically significant difference to the statement "There is no cure for HIV", with 80.1% of "non-religious" people getting that right, against 68.2% of "religious" people (p-value <0.001). My assumption is that faith might have a part to play in such difference in knowledge, with some religious Brazilian people believing that God can cure those who are HIV positive through faith and prayer alone. I think it is important to keep this potential aspect in mind when working on HIV prevention strategies with religious people from Brazil. I remember one incident during an outreach session through my work as a sexual health advisor, in a Brazilian Pentecostal church, in 2016 in London. When the pastor introduced me, she explained I was attending their service to offer free rapid HIV tests. The pastor then turned to the congregation and added: "Not that we need HIV tests, because we are all holy people here". The implication could be that "holy people" do not have extra-marital sex including homosexual sex. It could also relate to biblical teachings such those on the body being the temple of the Holy Spirit (1 Corinthians 6:19). Protecting this temple would require a person not to inject illegal drugs – the pastor could therefore also be implying that the congregation is not at risk of contracting HIV as they will not be

sharing needles. The result was that not a single person came to talk to me that evening, to take a free rapid HIV test.

As has been already confirmed by other researchers with regards to HIV/AIDS-related KAP with various other nationalities around the world, good knowledge about how HIV is transmitted and ways to prevent transmission alone does not always translate into safe sex behaviour. In this study for instance, in terms of HIV testing, 54.1% of the Brazilian expatriate population in England had a HIV test in their lifetime (either in Brazil or elsewhere), but only 20.4% had visited a sexually transmitted disease clinic in England, despite the fact that 46.5% of respondents knew where they could get a free HIV test. Interestingly when they were asked if they felt they were at high risk of contracting HIV, 2.9% of the sample stated they were high risk. With 7.9% believing they were of a medium risk, 49.4% believing they were low risk, and 39.8% stating that they were not at any risk at all. It is dangerous to believe you are at low or no risk – this impacts behaviour by causing people to take fewer preventative measures.

92.1% of the Brazilian population that took part in our research are sexually active (89.1% in the last 12 months, and 88.0% in the last month), however, only 49.3% used a condom in all sexual intercourse with casual partners in the last 12 months despite the fact that 91.7% agreed that using condoms during penetrative sex is the best way to avoid HIV infection. The reason for this could be in part explained by the fact that only a small percentage (24.3%) of Brazilian individuals had access to free condoms in England. It could also be due to self-perception as having low or no risk of acquiring HIV, as discussed above. It could also be related to alcohol and drug use, which can impact ability to assess risk correctly. Along with conclusions drawn from the quantitative data of the survey, I will investigate this further in the in-depth interviews.

Alcohol and drugs are commonly used by the Brazilian community in England. 81.3% of our sample have used alcohol in the past, 36.0% used cannabis, 14.7% used amphetamine, 14.4% used cocaine, and 0.7% used heroin. When participants were asked if they thought that alcohol and drugs could impair a person's decision to use condoms, 86% of respondents said yes, and 35% of them have confirmed they had had sex without condoms because of these.

Receiving money or gratifications in exchange for sex is part of the life of many members of the Brazilian expatriate population in England, divided equally between males and females. Among the 225 people who had had casual sex in the last year for instance, 12.9% received

either money or some sort of gratification for sex, with 24% of these participants admitting to not having used condoms during these interactions. One reason for people engaging in casual or full-time sex work might be due to their financial situation. Their financial situation might also lead them to not use condoms. Sex work is not necessarily exploitation, but if you are desperate for money, you might agree to perform unprotected sex and/or other risky sexual behaviours if the alternative is not earning anything. From my work experience I gained the knowledge that many Brazilian sex workers, especially MSM sex workers, are offered more money if they take drugs during the sexual encounter. As previously established, drug-taking impairs people's decisions regarding condom usage. I will explore this important topic in the in-depth interviews.

3.4 Conclusions

This chapter concerns quantitative research into the HIV/AIDS-related knowledge, attitudes and practices of the Brazilian expatriate population in England. Although findings from this study show a moderate to good level of knowledge of how HIV is transmitted in this population, and how their behaviour can increase or decrease their risk of HIV acquisition, there was evidence that Brazilians in England are not getting the required level of information to keep up-to-date on how to use all methods of HIV prevention, including PEP and PrEP.

One of the main conclusions to be drawn from this quantitative analysis is that correct knowledge of the use of medication to control and prevent HIV must be increased. In future, Brazilians in England should know as much about PEP and PrEP and U=U as they do about condom use. This is particularly important given the high level of engagement with sex work, alcohol and drugs within this community.

Increased knowledge must be combined with improvements to attitudes and practices regarding HIV transmission. For instance, Brazilians should be encouraged to use condoms more – they are not doing this even though they know it is the most effective way to prevent the transmission of HIV. The data suggests this is largely because they do not have access to free condoms. HIV testing should also become more frequent amongst the Brazilian expatriate community in England. Information about where to access free testing and free condoms should be distributed in Portuguese.

CHAPTER 4 In-depth Interviews

The aim of this qualitative research was to answer questions triggered by the survey results, for example, why condom usage is low despite knowledge of effectiveness being high and what barriers might prevent access to healthcare, including HIV testing and PrEP and PEP. I achieved this by conducting in-depth interviews with 30 members of the Brazilian expatriate population in England to gain detailed information regarding their HIV/AIDS-related KAP, and to further explore factors that increase their Vulnerability to HIV infection. I did not choose my subjects based on their proportional representation of the Brazilian population in England at large, but instead based on their representation of the main issues concerning vulnerability to HIV infection – these vulnerabilities will be explored throughout the chapter.

Results from Chapter 3 (PCAP England - Survey) show that even when the sample of Brazilians in England had a good level of knowledge about HIV and how to avoid transmission, they still knew slightly less about HIV/AIDS and how to prevent infection, in almost every indicator, than those Brazilians who participated in the research in Brazil, done by the Brazilian Ministry of Health in 2013. Furthermore, while neither the sample of Brazilians in England nor in Brazil had a good level of knowledge, the Brazilians in England still knew less. The knowledge gap is worrying since correct knowledge of how HIV is transmitted and how to avoid transmission is the first step to avoid infection.

As shown in Figure 1.3, between 2015 and 2016, cases of HIV infection in the Brazilian community in England were continuing to increase, whilst cases in the UK population were sharply declining. According to Valerie Delpech of PHE, this sharp decline is due to increased condom use among MSM and increased rates of HIV testing which in turn led to earlier diagnoses. In PHE's 2018 report, *Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK*, it can be seen that there is a steady decrease among all sexualities except for gay and bisexual men, for whom HIV diagnoses sharply declined only between 2015 and 2016. This is the first decrease in diagnoses since the virus was first identified in 1981. Despite the Brazilian community in England having good knowledge of the effectiveness of condoms in preventing the transmission of HIV, actual usage is still too low. The interviews will enable analysis as to why this is. They will also answer questions concerning low access to HIV testing among the Brazilian community in England. I will investigate how these factors impact Brazilians in England through the qualitative research explored in this chapter.

4.1 Materials and Methods

4.1.1 Sample Selection and Participants Characteristics

Study participants were purposely selected from the Brazilian expatriate population in London because the survey showed that the incidence of people living with HIV, transgender people, and sex workers was highest in London. I wanted to include subjects such as these to provide a range of perspectives regarding all aspects of HIV/AIDS-related KAP and Vulnerability to HIV infection.

There were 14 women, 12 men and 4 transgendered participants. They came from a variety of backgrounds: 17 self-identified heterosexuals (including 4 transgender), 2 bisexuals, 6 gays, and 5 lesbians. Their age range was from 21 to 58 years. The majority had reached higher education. 6 participants were black, 9 were mixed race and half of the sample were white Latino. 5 participants were working even though their visas had expired, and another 5 participants were on a tourist visa (6 months) which was about to expire. There were 11 sex workers among the sample, and 2 participants had worked as sex workers before but had then changed jobs. Seven participants did not speak any English, and 13 participants only spoke very basic English. 8 participants were HIV positive. 13 participants were not registered with a GP, and two participants although then registered, had had difficulty registering. 10 participants had illicit drug use problems (Chemsex). Also, in terms of other STIs apart from HIV, there were two cases of gonorrhoea, 2 cases of hepatitis B, 3 cases of hepatitis C, 1 case of herpes simplex, 2 cases of HPV, 2 cases of syphilis, one person had gonorrhoea and syphilis, and another person had had gonorrhoea, chlamydia and syphilis in their life time. I intentionally included in this sample people who migrated to England a long time ago and are settled, as well as those who migrated recently, in order to gain a broad view of their experiences.

All names used on this study are fictitious, in order to maintain the confidentiality of participants.

4.1.2 Data Collection and Management

Data was gathered through individual semi-structured in-depth interviews (Interview schedule in Appendix 45) between 02/06/16 and 31/10/16. All 30 interviews were conducted in London by the researcher, in Brazilian Portuguese.

Detailed information about the research study was given to participants (Appendix 46). Informed consent was gained prior to starting data collection, and also to digitally record

the interviews (Appendix 47). Interviews took place in private spaces, usually at the premises of community-based organisations. Hand-written notes were also made during the interviews. Audio recordings from the interviews were transcribed and analysed in Portuguese. Translation to English was only done after the analysis, in order to write this thesis in English.

4.1.3 Analysis

Interview data was coded using QSR International NVivo 11 Pro. A coding scheme was developed using an inductive-deductive approach, with themes and codes developed partly through reading and re-reading the data, and partly based on the HIV/AIDS-related KAP conceptual framework used in the survey, and which also informed the semi-structured in-depth interview schedule. The initial coding scheme was piloted, reviewed and refined until no new codes emerged from the data. This code scheme was then applied to all interview transcripts to the point of saturation.

A thematic analysis approach was used to analyse the data. Coded transcripts were grouped according to themes. These themes were mostly informed by the interview schedule, plus other themes that emerged from interviewees' responses. Key dimensions within sub-themes were identified and grouped into categories. Categories were then used to give an overview of the data for presentation. As themes developed from the raw data, they were crosschecked among the different participants' interview transcripts to check consistency across interviews, or to check for differences of opinion.

4.1.4 Limitations

Due to limited funding it was not possible for me to have another researcher to code interviews to compare with my own coding, to further validate the research. Also due to time constraints it was not possible to show participants transcripts of their interviews to check for accuracy.

Another possible research limitation is the fact that I am a migrant from Brazil, and at the time this research was conducted, I was working for a sexual health non-governmental organisation in London, specifically supporting Portuguese speakers, including Brazilians. This could also have added some bias to the interpretation of the data. Although I used a self-reflective approach throughout the research process, and discussed this in supervision, to limit the possibility of researcher bias occurring.

4.2 Results

4.2.1 Experiences of migration

Financial gains and financial pressures

The desire for economic independence was cited by all 30 interviewees as one of their reasons for migration. This was the case for those who came directly from Brazil to England, and also for those who first moved to another European country, such as Italy, Portugal or Spain. Often these countries were the first choice for Brazilians because of factors such as cultural links, ancestral family connections and therefore rights of migration, and language similarities. Later, because of the economic crises in these countries, many Brazilian migrants chose to further migrate to England. These combinations of push and pull factors can be seen in the experience of Carlos, a 55 y.o. white bisexual man living with HIV. His intention to migrate was purely related to the economy. First he left Brazil for Portugal, and when he was settled there, including securing his immigration status, he came to England, because he could make more money here than in Portugal.

Other participants in this study also stated that prior to arriving in England, they had travelled or resided in other High Income Countries first. Cláudia, a 35 y.o. white heterosexual woman, came from Brazil to England, but had previously lived in other High Income Countries too. She spent the last 3 years living between Spain and Portugal, and even Norway. Similarly, Roberta, a 21 y.o. white Trans woman, who is HIV positive and who sell sex for a living, arrived in England last month, passing through France and Belgium. Finally, Amélia, a 46 y.o. white lesbian, and Francisco, a 29 y.o. white heterosexual man, who sells sex in a gay venue in London, both lived in Portugal before moving to England. They mentioned reasons for moving such as the stronger pound.

As well the financial gains of coming to England, many Brazilian migrants also experienced financial pressures. Accommodation was a concern for some, as Nonato, a 24 y.o. white heterosexual man on a tourist visa, puts it: “accommodation in London is one of the most expensive things”. Nonato was lucky that he had friends already living here, and who organised a place for him to stay in their house.

Interviewees without the social safety net of established friends or family when they first arrived in England experienced major problems with the kind and condition of accommodation they encountered. Overcrowding in substandard housing was common, often being charged extortionate rents for such lodgings. This is especially hard for those

Brazilians who migrated first from Brazil to another European country, where they remained until their visa was secured, learned the local language and had some levels of independence. For some people it took 6 to 10 years or longer for them to secure an indefinite leave-to-remain visa. Moving to England after that stage meant starting again from square one. As Mauro, a 37 y.o. black MSM sex worker explained, “In the beginning you have to rent rooms from Brazilian people whose main job is renting rooms. That’s how they make their money, and they will exploit others. Now I know where to find cheap accommodation. I know where to find it”. Pedro, a 46 y.o. White MSM, sex worker, and living with HIV also said:

I was living with a friend and.... there were another seven people sharing our bedroom. It was a small room too (laughter). While some people were getting up to go to work, others were getting ready to get into their beds to sleep.

Friends and Family

The testimonies of participants portray an array of experiences of migration and motivation to look for change. It seems that having friends and relatives settled in England, and who could give a supporting hand during the migration process, was a good reason, or at least, an important contributor for choosing England as a destination. This was certainly the case for Beto, a 31 y.o. undocumented white heterosexual man, who explained in his interview that finding work in London when he arrived “was not that difficult” because some of his friends from Brazil were already settled in London, and they offered support. Beto explains that he did not need to go job hunting as his friend assisted him in finding work. Also, another positive aspect of getting help from his friends is that he did not need to take the risk of being employed by the “wrong crowd”: those people who are here to exploit others in vulnerable positions, as had happened to some unlucky Brazilian people he knows.

As Manuel, a 24 y.o. White heterosexual man on a tourist visa about to expire explained: “I am glad my friend Miriam was already living here in London and offered me support. She called me in Brazil and invited me to come over. Then I thought ‘I will go, and if I like the experience, I can always try to sort out my documents then, isn’t that so?’ And that is how I ended up in London. I studied English in Brazil, this was also an opportunity to practice, and to explore Europe a bit. Miriam said she would look after me here. And so I came. In fact, I am still deciding if I want to stay or not. I can see if I stay I can make some money though.”

Some interviewees mentioned that migration was never part of their initial plans, but that they were invited by friends who were already settled in England and made a last minute decision to leave everything behind and travel.

Friends can also be a push factor causing Brazilians to migrate away from them to England. Maria, a 34 y.o. black lesbian who resided in Portugal before moving to England, explains that here in England she is single, but in Portugal she was married to a Portuguese woman. They lived together for 9 years. When their relationship ended, Maria moved to London, where she lived on and off for a few years near some Brazilian friends. At the moment she is based in London.

Thus far, it is easy to see that upon arrival in England, some of the 30 interviewees were lucky and got support from family and friends to settle, however, others were faced with all sorts of financial pressures – some of which could be exacerbated by friends and family back home in Brazil. As Sara, a 32 y.o. black heterosexual woman, living with HIV, and who used to sell sex puts it, it is very hard for Brazilians at first, to pay expensive rents, give one month's deposit to secure accommodation, buy a travel card, buy food, and they often still need to have some money left to send back home, to help family back in Brazil. They have to work extra hours for that. This financial pressure results in migrants focussing on ways to make money rather than worrying about perceived secondary concerns such learning English, navigating the NHS and integrating into their new society – all of which can impact prevention of HIV transmission within their community.

Language barrier and culture shock

Language as a barrier was an initial difficulty exemplified by Tiago, a 43 y.o. white MSM HIV positive sex worker. Tiago explains that he found moving to England particularly difficult because he had never had any contact with the English language prior to moving here. As he puts it, the language was a massive barrier in his first 12 months living in London. Maria, a 34 y.o. black lesbian also had problems. She explains that even after many years here she still has difficulties, hence her dependency on the local Brazilian community. Also for Clara (22 y.o.), who migrated to England with both her parents, says her elderly parents found it particularly difficult to learn any English. Conversely, for João, a 31 y.o. white MSM sex worker, learning English in England was a good experience. He credits that to the fact that he came from Brazil as a student, with accommodation already sorted before his arrival. Initially, his only responsibility was to attend school and to learn the English language. This

is a far cry from Diana's experience (27 y.o.), an undocumented black heterosexual woman, who says simply she cannot even think in English, much less say any words.

As Beto hinted when talking above about the importance of having a safety net of friends in London, exploitation among the Portuguese-speaking community in England occasionally happens. The fact that many of our interviewees arrived here on a tourist visa, for instance, meant that they were not eligible for any kind of public funding and could not access any sort of State provided social support. Not being able to speak English also meant that they had to rely initially on other more experienced Portuguese-speaking community members to help them find work and give them guidance. This in itself has proven to be a problem for some, as the same people that offered support used this advantage to exploit them. Not to mention that many Brazilians who overstay their six-month tourist visas end up going underground to avoid immigration officials. This situation makes them even more vulnerable. Mônica (23 y.o.) for instance, a white heterosexual woman, and Nonato (24 y.o.), a white heterosexual man, both had their visas expiring in the same week or so when they participated on this research study. They were both very anxious about how they would manage, as they described their own situation, as "illegal immigrants". And as Amélia (46 y.o.) explains, not being able to speak the English language, "forces you into dealing only with the Brazilian community", something that Amélia was trying to avoid:

Aaah... The Brazilian community here... They lie too much, they cheat too much, and they want to take advantage of everyone, do you understand? Here, the bigger fish tries to swallow the smaller ones.

Nunes, a 41 y.o. White bisexual man, sex worker, and living with HIV further explains:

They abuse you.... and... and.... There is lots of abuse happening to people that can't speak English in this country. Especially in terms of work. Sometimes you are verbally contracted to do a job, and the job is not real. And the person does the job but doesn't get paid. I have seen many Brazilian people going through that here. A lot of exploitation of people that are newly arrived.

Another major difficulty experienced by some of the newly arrived Brazilian population in England was isolation, a cultural shock in terms of how people interact back in Brazil, and how reserved they perceived British people to be. . Some reported this being one of the most difficult aspects of adaptation when they moved to England. As Tiago (43 y.o.), a white MSM sex worker living with HIV points out:

“English people don’t get involved with us foreigners. They don’t harm us, but they don’t help us either. I find it extremely hard to approach them”.

Tiago then goes on to explain how he felt lonely in his first years living in England, and how this loneliness influenced his decision to try illicit drugs, to cope emotionally with the demands of his new life in England:

“....and also... You don’t see.... I mean, I felt terribly lonely, in my first.... first years, I mean.... I kind of developed a bit of depression. I believe that this depression is what motivated me to try things [illicit drugs] that wasn’t very good for me. (...) ...also, when you are an immigrant and you receive a diagnosis such as this [HIV], it is a lot harder, because you are far from family and friends, in a foreign country. It is too much to manage at the same time.”

The cultural shock felt by some Brazilian participants in their interactions with the native British people was mentioned by many. Another example is that experienced by Amélia (46 y.o.), a white lesbian working as cleaner in people’s houses. Amélia explains that her life in England is the opposite of her life in Brazil. There she had her own house, had a car, she lived in total comfort. Although she does understand the changes she had to go through to move here, she accepts that here in England she is a “foreigner”. She does not yet speak the language. “I am a foreigner”, she says out loud! Amélia explains that in Brazil her mother employs a cleaner who comes regularly to help. The woman is Korean. Her family treats the Korean woman as one of them, “In our family we treat everybody as a human being, and full stop. However, here, we don’t feel that that is the case. Here we are not always treated well. It is a big shock. Usually English people are very cold with us. Sometimes they can also be offensive. They only smile at us when they want something”. Amélia’s perception is that foreigners in Brazil are treated well, but foreigners in England are not.

The difficulty of making friends with English people was also noted by Nunes (41 y.o.), a white bisexual man living with HIV, who sell sex for a living. Nunes explains that he now recognises that English people are very different from Brazilian people, that relating to them is very difficult. That is why many Brazilian people here end up lonely. However, Nunes comprehends that this is simply the case in London, as it is the case in any big metropolitan city. Nunes understands that it is hard to make friends in any big city around the world.

Prejudice at home and abroad

Some of the gay and lesbian interviewees reported experiences of discrimination in Brazil, with regards to sexuality, by their own family members and by society as a whole as their reason for wanting to migrate.

Amélia, for instance, a 46 y.o. white lesbian, stated that she left Brazil purely because of being homosexual. In Brazil, Amélia explained, she comes from a well-off family, but also she had her own business, and it was doing rather well. She was very successful. However, emotionally, she was constantly down. Amélia's own family was totally against homosexuality. It came to a point where Amélia had to choose between two options: staying in Brazil unhappy or leaving everything behind and starting a new life elsewhere. This experience was also shared by Fatima, another 38 y.o. white lesbian. Fatima explained that she moved to England to "live her homosexual life in peace". She suffered a lot of discrimination in Brazil and was always scared for her life. Fatima migrated to England in search of happiness and tranquillity. In her opinion, here in England, people do not constantly criticise you for being different, for being gay. Even in Italy, where she first lived before coming to England, she experienced prejudice towards her sexuality, even from gay men.

The same sense of running away from Brazil because of homophobia was experienced by Paulo, a 33 y.o. white MSM sex worker. Paulo talks about how much prejudice he experienced from his own family, back in Brazil, which he describes as a "living hell". All Paulo wanted was to "escape the grasp of his family", as he explains. He went first from the countryside to São Paulo, and then when the time was right, he left for England.

Social Class and Education

With the exception of one or two, the majority of participants came from a working class background, with parents that had only basic education or none at all. Most of these parents worked in the Brazilian service industry to provide for their families, usually the father was the breadwinner and the mother a housewife. Only one participant did not conform to this trend, having two professional parents: one a solicitor, the other a civil servant. The majority of our 30 participants themselves managed to reach higher education level (complete or incomplete) before migrating, although none of them are working in their chosen fields of expertise after arrival in England, with all of them starting work either

as cleaners or nannies, moving on to doing waiting jobs once they learn the English language. Building and decorating are also popular options for men.

Clara, for instance, a 22 y.o. white heterosexual woman, was studying economics at university in Brazil. She abandoned her studies and is working in London as a building maintenance janitor. Likewise, Juliana, a 58 y.o. black heterosexual woman, living with HIV, graduated in pedagogy in Brazil, and is working in London as a cleaner. This is also the case with Francisco, a 29 y.o. white heterosexual man who is selling sex in gay venues in London. Francisco was studying Law in Brazil.

Renata (32 y.o. Black undocumented heterosexual woman): “At the moment I am working both as a nanny and as a cleaner. I do both. In Brazil I was studying to be an economist. I took time off from the course and travelled to England. Here you can work and with the little money you make you can live well. At first I was seeing it as an experience, to practice my English, but now I realise I can make more money here doing manual labour, than I can make in Brazil with a proper job”.

Sex work

Many Brazilians arrive in England with little resources, find a challenging culture different from home, feel lonely, have to pay for expensive accommodation, food, transport, and still suffer pressure to send money home. Thirteen participants in our research started life in England doing manual work, such as cleaning or waiting tables, and changed jobs once they realised there was a more lucrative option in the sex work industry.

Paulo (33 y.o.) for instance, a white MSM sex worker, explains that he found a job as soon as he arrived in England. Like many new migrants, his first job was distributing newspapers on the streets of London. However, he soon started to have financial difficulties and was faced with homelessness. He slept rough in a car-park for 3 days in winter. That was when a Brazilian friend of his told him about sex work, that he could make a lot of easy money in no time. That was the first time Paulo sold sex.

Letícia (53 y.o.), a white Trans woman sex worker, also had a similar experience. In the year 2000, Letícia had a very good job in London in the hospitality business but was not happy with the salary. Some of her Brazilian friends were making a lot more money as sex workers and they invited Letícia to try it out. Letícia made a lot of money in just a couple of months more than what she had made in her full time job in years. In the end Letícia decided to leave her job to concentrate in being a sex worker.

Some Brazilians in our sample, however, were already selling sex back in Brazil prior to migrating to England. This is the case of Roberta, for example:

Roberta (21 y.o. White Transgender, sex worker, HIV+): “For me, it was a way.... Well, not really a way, but, kind of, my salvation, because.... my family.... because my mother was a drug addict ...I had to live far from my relatives. My mother didn’t have an education. She was also HIV positive like me. In fact, she died of it. ...and my father, I don’t know who he is. because of drugs, my mother always went to the poorer areas of the city to sell her body to pay for drugs. Because I was too little and dependent on my mother, I always followed her. Ever since, prostitution has become a way for me to get everything I need.”

Overall experiences

Some interviewees mentioned other motives for leaving Brazil such as wanting to learn English, and a yearning to travel and see other cultures as a motivation factor. Migration rules also impacted movement between High Income Countries. Gilson, for instance, a 28 y.o. white MSM sex worker, went back and forth between Brazil and Canada a few times before travelling to England. In fact, he is waiting for an answer on a work visa application to go back to Canada. As the visa was taking too long, a Brazilian friend in London invited Gilson to come over and wait here. Gilson explains that he had no difficulties passing immigration here, and that his friend took him to work as a sex worker in a gay brothel in London, on the same day he arrived.

The main reason for these interviewees to migrate to England was money. The desire for financial independence does not inherently increase vulnerability to HIV. However, the combination with other factors, such as some participants’ experience of the lucrative nature of sex work, can cause risk-taking behaviour. Migrants will often prioritise financial gain over personal safety.

The fact that many Brazilians arrive in England without knowledge of the language, local culture, or how the health system works, often leaves them feeling lost, lonely or being open to exploitation. This lack of supportive social environment, delineated in the Literature Review as key to the elimination of HIV, disempowers some migrants – some of them do not have the power to always determine their own behaviour, as outlined on the Vulnerability to HIV Infection framework used for this thesis.

4.2.2 Knowledge related to increased risk of HIV infection

Knowledge of HIV/AIDS/STIs

General knowledge about HIV/AIDS/STIs among the 30 Brazilian participants was very low, independent of HIV status. Interviewees were chosen to represent as wide a range of experiences as possible, therefore many people with increased Vulnerability participated. This would explain the low level of general knowledge compared to the reasonably high level of knowledge in the overall survey results. However, within the group of interviewees, as per my expectations, gay and/or HIV positive interviewees knew more than heterosexual and/or HIV negative interviewees.

In the case of HIV knowledge, the level of information they had was outdated and reflected the reality of the epidemic before the introduction of highly active antiretroviral medication, when HIV was seen as an acute fatal disease, rather than a chronic manageable condition. Furthermore, when asked if they knew what HIV was, many people simply answered it was a “sexually transmissible disease”, with most people not knowing the difference, or the relationship between HIV and AIDS.

This was the case of Gilson (28 y.o. White MSM, sex worker, on a tourist visa), for example, who said in his interview that “he thought HIV and AIDS were the same thing”.

Even among the eight participants living with HIV, correct knowledge about HIV/AIDS was also low. When asked if they knew about the “Undetectable = Untransmittable” (U=U) information – regarding the fact that a person living with HIV, taking antiretroviral medication, and with an undetectable viral load for at least 6 months, would not be able to infect others – most people had never heard of U=U. Even the few who had heard of this concept were not sure about the full extent of this information. As Tiago (43 y.o. White MSM, sex worker, HIV+) puts it, he did not know that U=U was possible. Tiago finds this information “very interesting”, because he now understands how it can act as prevention. He had never been informed or seen any information regarding U=U in England.

Tiago, who has HIV and hepatitis C, explains that although he was in contact with a sexual health project for sex workers even before he got infected with both diseases, he was not well informed on how to prevent STIs. He explained that once a week, sexual health professionals attended the gay brothel where he sold sex. These professionals went there weekly to do sexual health outreach work. Most of the sex workers at that brothel were Brazilians. The professionals distributed condoms, offered sexual health screenings, and

gave advice. However, Tiago complains he was never informed about hepatitis C, about how it can be acquired through sex. Tiago feels let down that no one ever told him about this disease, especially after he was diagnosed with HIV. Although he explains that it could have been due to the language barrier, since the service these sexual health experts offered was either in English or Spanish, not Portuguese.

Of the 30 participants only three knew what chlamydia was. 11 participants were not sure how it was transmissible, including two participants who had the infection in England in the past. 16 participants had never heard of chlamydia before, despite the fact that chlamydia is the most prevalent STI in England.

Among the 14 participants who had been sex workers in the past, the majority continue to be sex workers currently. Although some of the more experienced sex workers knew more about sexual health in general than most participants, their knowledge could still be improved. Their knowledge was better because the more experienced sex workers had likely survived as sex workers for so long, in part, due to their better knowledge of how to protect themselves from contracting HIV. Areas for improvement for these participants include more knowledge about other STIs and up-to-date knowledge about HIV medication as prevention.

This far it is evident that the Brazilian expatriate population members who took part in this research know very little about HIV and STIs in general, from believing syphilis to be incurable, to believing electric shavers and tight trousers can cause chlamydia. Many of the participants also mentioned toilet seats as a way to acquire HIV and STIs – this is included in the UNAIDS survey as an indicator of knowledge because this specific misconception is so prevalent. Interviewees also mentioned with regularity that they are not receiving sexual health education here in England, for a variety of reasons: mostly because of language barriers, but also because of not having access to health services, where usually they would get this kind of information in Brazil. For example, when Clara once saw an outreach initiative offering free STI tests on the street, she did not stop because workers spoke in English. Nunes explained that whilst sexual health information leaflets might be offered within GP surgeries, many Brazilians do not access GP services because of the language barrier and also, he says, because of being undocumented. Experiences of accessing healthcare in London will be explored further in this chapter.

The interviewees also discuss not seeing sexual health campaigns or educational materials here in England as they are used to seeing regularly in Brazil, contributing to the idea that

there might not be a sexual health problem here in England. As previously discussed, there is also a perception amongst some Brazilians in England that High Income Countries do not have a problem with HIV – the disease is associated so strongly with poverty, that some assume wealthier countries are not at risk. Low perception of risk means people are less likely to use prevention.

The few who have seen sexual health campaigns have only seen them in English. It is not a matter of people coming here and expecting to be catered to, it is a matter of public health professionals targeting at-risk communities in order to protect the wider community at large. This was evidenced in the Literature Review, where other High Income Countries were using outreach initiatives that employed members of the community who spoke the language and had similar culture to gain access to the people who are deemed hard-to-reach.

Knowledge of PrEP and PEP

The concept of 'Post-Exposure Prophylaxis' (PEP) has existed for more than 2 decades. It refers not to a drug, but to a method of treatment: administering a drug after exposure to a pathogen in order to prevent contraction of the disease. Azidothymidine (AZT), also known as Zidovudine, was approved as the first medication for the treatment of HIV and AIDS in 1987, in the U.S. It also started being used around that time by healthcare workers internationally to prevent HIV infection after percutaneous exposure to HIV-infected blood. Research results show that this practice dramatically decreased the incidence of seroconversion among healthcare workers when done under certain conditions (Cardo et al., 1997). From clinical trials AZT was not only established as a good medication for the treatment of HIV, but also as a way to prevent mother-to-child transmission, and as a HIV prevention method following exposure (Shih et al., 1991; Katz et al., 1997). AZT was later replaced by other more tolerable antiretroviral medication to avoid patient noncompliance. In 2015, the British Association for Sexual Health and HIV (BASHH) suggested the drugs Truvada and Raltegravir as the regimen of choice to be used for HIV Post-Exposure Prophylaxis Following Sexual Exposure (PEPSE). In England, PEP is available free of charge in any sexual health clinic or A&E of any NHS Hospital, following an assessment of risk done by a professional. It has to be initiated within the first 72 hours after exposure, and taken for at least 28 days (BHIVA, 2015).

PrEP is one of a number of HIV prevention strategies for people who are HIV negative but who also have a higher-than-average risk of contracting HIV. This includes sexually active

adults such as men who have sex with men, people who engage in injection drug use, and serodiscordant sexually active couples. Truvada is usually the medication of choice of most health organisations. Patients on PrEP take Truvada every day and must also agree to see their healthcare provider at least every three months for follow-up testing. When used as directed, PrEP has been shown to be highly effective, reducing the risk of contracting HIV by 92% (Jiang et al., 2014). Although evidence abounds on the effectiveness of PrEP as a prevention mechanism it is not widely available in England as it is in many other countries around the world, including Scotland and Brazil. In December 2016, NHS England decided to only make PrEP available to 10,000 'at risk' people, on a 3-year trial basis (BASHH, 2019). In May 2017 in Brazil, the Brazilian Ministry of Health made PrEP available to anyone at risk who needs it, with a nationwide campaign to advertise the initiative and break down stigma (Ministério da Saúde, 2019).

According to the results of this study's quantitative research (Chapter 3), the Brazilian expatriate population in England knows very little about PEP or PrEP. Given the increased vulnerability to HIV infection experienced by this population, and the importance of PEP and PrEP for HIV prevention, it is alarming how little they know, therefore this was a topic to be explored in the in-depth interviews. It is difficult to compare with the general English population's knowledge of PEP and PrEP because this information is not available, but as can be seen from the survey, Brazilians in Brazil know more than Brazilians in England about PEP and PrEP. As discussed, this is likely to be because Brazil is more proactive in disseminating information concerning HIV.

19 people out of the 30 interviewees had never heard of PrEP or PEP before, including the three heterosexual sex workers who participated in this research, one of them been a heterosexual man selling sex in a gay brothel in London. The concept of using medication as HIV prevention was completely new to them.

Among the 11 sex workers who had some knowledge of PrEP and PEP (7 MSM and 4 Transgender), their knowledge of them was not equal. The majority only heard of PEP, with only a few of the sex workers having heard of PrEP. The majority got confused and could not specify the difference between PrEP and PEP. None of them knew where to get PrEP free-of-charge in England. Most of the sex workers knew where to get PEP for free, although only two sex workers had taken it before.

The excerpts below give an account of what is known by some of the sex workers regarding knowledge of PrEP and PEP:

Gilson, for instance, a 28 y.o. White MSM, sex worker, on tourist visa, knew about PEP but was confusing PrEP and PEP, and also how the medication is dispensed. He knew where to get PEP but believed some blood tests would have to be done before the medication was dispensed. Gilson likes the idea of PrEP too, but says: “Although I like the idea of PrEP, there is also a negative side to it. Because now, people have stopped using condoms all together. They now say: “No, let’s have unprotected sex, don’t worry because I am taking PrEP. There is no risk of me passing it to you”. [Gilson showed confusion as to who is protected using PrEP, when in fact he is describing U=U]. Gilson also raised his concerns about the risk of contracting other STIs by having unprotected sex, as he explains, because since PrEP and PEP became available, bareback sex has become the norm in the gay scene again.

Others said:

I heard about PrEP and was shocked, and stopped reading the article. I saw that you can take antiretroviral medication and get protection against the HIV virus. I have many friends doing it. I don’t know how to explain, but it is a strange concept, isn’t it? Well, there is PrEP and PEP. To be honest, I don’t know the difference between them. I only know that the end result is to have sex without condoms.

Janaína (48 y.o. Black Transgender, sex worker)

There is PEP and PrEP. PEP is after you fuck up, or something happens, like a broken condom, and you have 70 hours to take PEP, right? Although the sooner the better. PrEP is the one you take before having sex. I just don’t know where you can get PrEP for free in England. I know you can get PEP from GUM clinics, or any A&E. But PrEP I haven’t got a clue.

Flávia (45 y.o. White Transgender, sex worker)

There are three levels of knowledge within the interviews – having heard that PEP and PrEP exist; knowing what they are; knowing where to access them.

All the transgender interviewees had heard of PEP and PrEP because in Brazil, trans people usually work as sex workers because it is so hard for them to get any other job. So they have high levels of HIV vulnerability, meaning they are targeted by campaigns in Brazil. This is further evidence that highly focussed outreach leads to increased knowledge.

Most of these trans interviewees knew the correct purpose of PEP and PrEP, but only the ones that had been in London for a long time, and therefore had better English, knew where to access PEP and PrEP.

Among MSM participants, there was inconsistent knowledge of the existence of PEP and PrEP and, when aware of their existence, much confusion between the two. The ones that knew most were, again, those who had been here longer and thus spoke the language.

Heterosexual interviewees knew the least. This is not unexpected given the trends which appeared in the quantitative survey that heterosexual people have the lowest level of self-perception of being at risk of contracting HIV. This could explain levels of knowledge of PEP and PrEP because since, if you do not perceive yourself to be at risk, you might be less likely invest energy in finding out about medication and prevention of HIV. Heterosexuals are also less targeted by HIV campaigns, both in Brazil and in England. This would also lower levels of knowledge concerning PEP and PrEP.

HIV positive people had generally good knowledge of the existence of PEP and PrEP although, again, there was some confusion between the two. This knowledge was best among interviewees who were also MSM and spoke English. Knowledge levels could also have been impacted due to the fact that many HIV positive Brazilians in England regularly access HIV clinics. In my 18 years of professional experience as a sexual health project co-ordinator for Portuguese speakers in London, after the shock of diagnosis, all the HIV positive Brazilians with whom I had contact, wanted to access treatment. Therefore, they participated in the three (later 6) monthly check ups monitoring CD4 and viral load and thus had access to up-to-date information from the clinic concerning HIV in general. For this reason, HIV positive, English-speaking Brazilians in England can be expected to have better knowledge of PEP and PrEP.

4.2.3 Attitudes related to HIV/AIDS, Sex work, Homosexuality and Abortion

Attitudes towards HIV and AIDS

In this section of the chapter, I wanted to capture a variety of attitudes towards HIV and AIDS from different participants' perspectives: attitudes towards the disease itself by all participants; attitudes towards the risk of contracting HIV by HIV negative participants; attitudes towards people living with HIV by all participants; and the attitudes of participants living with HIV towards their own condition.

The 30 interviewees have shown generally some levels of empathy towards people living with HIV/AIDS. This was seen, for instance, in the way that all interviewees *agreed* that they would buy fruit and vegetables from a seller who is HIV positive. Also, that they wouldn't mind if in their own child's class there was a child living with HIV. This was agreed by all, with the exception of two female participants. Denise, a 27 y.o. White undocumented heterosexual woman, felt uncomfortable with the idea of putting a hypothetical child at risk of contracting HIV from an HIV positive child, at school. Dolores, a 30 y.o. White undocumented heterosexual woman who is a sex worker, and the only participant in this study who actually has a child. Dolores said she wouldn't be comfortable with her child playing with a HIV positive child at school, in case they cut themselves while playing, and blood was shared between them. For Dolores this was a real concern, not simply a thought experiment.

When asked if they would be able to have sex with a HIV positive person, the majority of participants who are HIV negative said no. Evidenced in their answers was a sense of self-preservation, that they wanted to protect themselves from getting infected with HIV. This shows that they still do not have enough information to know what constitutes risk to self, in terms of sexual involvement with a person living with HIV who has had a suppressed viral load for longer than 6 months. The concept of U=U does not exist for these HIV negative participants yet. HIV positive people have more exposure to this information than HIV negative people, because they attend HIV clinics and because they search for more information independently.

Of interest among HIV negative participants, was the general perception that they were at very low risk of contracting HIV. The main reasons given were the fact they were in a monogamous relationship, or for a few other participants, because they always used condoms in every instance of sexual intercourse.

In terms of HIV positive people disclosing their HIV status to others, most participants did not think that this should be done indiscriminately to everyone. This should be done on a need-to-know basis, just among sexual partners. Some people even went as far as to say that only if the relationship becomes more serious and stable. This is not unexpected: the reason was based on the fact that prejudice and discrimination towards people living with HIV is still strong in today's society. Along with incorrect knowledge on how HIV is transmitted regarding U=U, from my professional experience, many believe that HIV positive people are not only infectious, but also dirty and immoral.

The attitudes of people living with HIV towards their diagnosis were also very varied, mostly, in terms of how participants managed their HIV status, if they felt comfortable letting other people in their lives know about their diagnosis, and how they coped with their condition generally. The majority of participants chose not to tell many other people about their condition, out of fear of suffering discrimination. Another reason for not telling others, was to protect their loved ones from worrying unnecessarily about them and their HIV diagnosis. The general feeling was that their family members would not have enough information about HIV/AIDS to know that they would be well with this condition.

Attitudes towards Sex Work

Attitudes towards sex work were very relaxed overall. In this section I tried to capture the diversity of opinions and attitudes about this topic, from the different participants' perspectives: people who made sex work a lifelong career, both in Brazil and England, and are proud of their choices; people who resorted to it for a short while here in England, due to having no better financial options; and religious and non-religious people who would never consider this option neither here nor in Brazil. Later in this chapter, I will focus on the practices surrounding sex work by exploring the experiences of those who sold sex, either in Brazil or England.

There was an attitude across the interviews that Brazilians in England are perceived, both by Brazilians and by English people, as being particularly likely to sell sex. This perceived reputation is backed up by data: according to McGrath-Lone et al's 2013 study on the sexual health of male sex workers in England, migrant sex workers reported 50 countries of origin, with 39% coming from South America, of which 97% were Brazilian.

Furthermore, *Open Doors* a London-based NHS service for sex workers has identified a large influx of Latin American female sex workers. In response, Homerton University Hospital set up an ongoing weekly clinic for these Latin American female sex workers – this clinic offers Portuguese translation as one third of the project's off street client base is Brazilian. On average, 30 female Brazilian sex workers access advice services at the clinic every month.

Most of the 30 participants agreed that poverty is what is driving so many Brazilians into sex work in England. They agreed that many Brazilians come to England to make money to help themselves and their families back in Brazil, to become financially independent. The majority had intentions of returning home to Brazil, once they achieved their dreams: To

have enough money to buy a house, pay for further education, buy a car, start their own business, help family members, look after their health, and save for the future.

Overall, the 30 participants interviewed, religious or not, were very understanding of why their compatriots are choosing to do sex work in England. The majority stated that as long as it is not forced on them, that they know what they are doing and not harming others, that it is up to them to do what is right for them. Some, however, resented the decision of so many Brazilians choosing to sell sex, because it gives the Brazilian community in England a bad name. Others, however, are not so bothered by it at all.

As discussed previously, transgender people often found the only job opportunities available to them in Brazil were as sex workers. Therefore the transgender sex workers interviewed in this study had more experience of, and a more relaxed attitude to, selling sex. MSM attitudes to sex work are also relaxed because selling and paying for sex is very common within the MSM community, therefore less stigmatised. Gay magazines in London openly advertise rent boys and other MSM selling sex.

There is an established network of Brazilians in London who sell sex or who know people who sell sex and who disseminate this information among local Brazilians under financial pressure, such as newly arrived migrants. This illuminates how heterosexual interviewees who had had no plans to sell sex prior to arriving in London, might have taken up sex work because the opportunities were so readily available and because of the relaxed approach of their peers.

The financial drive is therefore supplemented by the ease of getting this kind of work – not only can you make more money than by being a waitress, but you can get cash much more quickly without the constraints of, for example, needing documents to work, having a bank account, paying tax, or speaking English.

The attitudes of the interviewed heterosexual sex workers to their profession is more mixed, with a greater number experiencing the psychological burden of stigma. As explored further in this chapter's section on the practices of sex workers, Dolores, a 30 y.o. White undocumented heterosexual female sex worker, says that selling sex "is something that can have a massive impact on your mental health. I only did it for the money." In my own professional experience I spoke to many heterosexual sex workers who felt conflicted by the financial advantages and the social cost, such as a female sex worker for whom I

interpreted in a sexual health clinic. She started to cry and talk about the house she had bought in Brazil with the money earned from selling sex in London, questioning how she was going to go back to that house and live there with her children. She talked about waking up and looking at the ceiling and knowing how she got that house, every day of her life. There was a sense that she felt sex work was in some way immoral and therefore she did not want her children exposed to it in any way. This could also have a gendered element, given the relevance of Marianism, as discussed in Chapter 2, and its emphasis that women should not be promiscuous.

All these attitudes to sex work could impact the transmission of HIV in various ways. All sex workers interviewed were offered more money for unprotected sex – given that financial pressure is a very important driving factor pushing people to sex work, this could lead to greater risk of the transmission of HIV. The relaxed attitudes of many MSM and transgender people within the Brazilian community in England, along with an established network of Brazilians offering sex work opportunities, contribute to more inexperienced people trying sex work for the first time without a great deal of thought, increasing those people's vulnerability to HIV infection. The difficulties experienced by some heterosexual sex workers in reconciling their desire to earn money with their feelings that sex work might be immoral can also contribute to their vulnerability because any stigma reduces open conversation, which in turn reduces knowledge, which thus increases the risk of contracting HIV. For example, sex workers who are embarrassed or ashamed about selling sex might not talk openly to a healthcare professional, who therefore cannot gain a full picture of the levels of risk. This would prevent these sex workers from getting the help that they might need.

Attitudes towards Homosexuality

In this section of the chapter I describe the attitudes of participants in terms of homosexuality, from their different perspectives. More specifically, participants were asked if they agreed that a gay couple should be allowed to adopt children and what they thought society thinks today about homosexuality. Overall, the majority agreed that gay people should be allowed to adopt. There were a few interviewees who questioned it, not in terms of the sexuality of the people adopting children, but in terms of the psychological capacity of individuals to be parents. They stated that anyone, gay or not, should be checked thoroughly for their suitability, before children were placed in their care.

Only three out of the 30 participants showed reservations in terms of gay people having children. One man stated that he was against gay couples doing artificial insemination because for him that wasn't natural, but he explained that gay couples could adopt instead. The other two participants who also had reservations, stated that their concerns were in relation to how the children would feel growing up in such a gay environment. One participant worried if the children's sexuality would be affected by the gay couple. And the other participant worried if the children would be bullied by society for having gay parents. They both felt it was unnecessary to place children under such burden.

In relation to gay people adopting children, I have to confess that I still have my prejudices. I'm not totally against it, but I still have preconceived ideas about it. Maybe because it is still a new phenomenon for gay people to adopt children today. I haven't... We haven't seen many cases of children who can say: «Well, I was brought up by gay people. I am now 20 years old..., 30 years old, and I was brought up by gay parents».

Cláudia (35 y.o. White heterosexual woman)

The other 27 participants however, were in favour of giving children a better chance in life, within a gay home, rather than growing up without a family.

In terms of participants' opinion about what society thinks of homosexuality today, most participants agreed that society's opinion has changed dramatically in the direction of being more accommodating of gay people, but discrimination still exists. Some Brazilian gay and lesbian participants stated they left Brazil for England because they did not feel welcome in their own families, back in Brazil, because of their sexualities.

I feel that we homosexuals are still discriminated against because of our sexual orientation. Society still sees us as against God's will. We do everything that is an abomination before God. Every disease that appears is the fault of homosexuals. In fact, society still believes that homosexuals are responsible for destroying families. I can't understand it. Their prejudice is totally irrational towards us: "Well, he is gay.... That is it..., he is a pervert. He has diseases... He destroyed a family". Even in Brazil, my situation was so dire for being gay that I had to leave my own home, my parents, everything, to be able to live in peace elsewhere.

Amélia (46 y.o. White lesbian)

There is a sense in the interviews of accepting the LGBT members of the Brazilian community in London, however, there are still some reservations below the surface. Whilst Nonato was happy for homosexual couples to adopt, he was anti-artificial-insemination because it is “not natural”. “Unnatural” is a charge long-levelled at gay people in order to criticise their lifestyles. The fact that Flávia was concerned about encouraging homosexuality in a child shows that having a straight child is still preferred by some.

These attitudes show that there could still be a lack of education on gay issues, this lack of education in turn could increase homophobia. If people are not accepted, they hide – stigma makes it more difficult for people to open up about their life experiences, including their sexual experiences. Building up an idea of the attitudes towards homosexuality of those Brazilians interviewed in this study provides a snapshot of how, even within the LGBT community, there is still room for greater understanding, as in the case of trans woman Flávia.

Attitudes towards Abortion

There was consensus between the majority of the 30 participants that abortion should be legal and available, depending on the circumstances in which the pregnancy happened. There was an emotional argument that it should be a right for woman, in cases of rape, or if it is known that the foetus is unwell or has a disability.

Some of the more religious among participants initiated discussion saying they were against abortion completely but changed their view as to whether, in cases where the women were raped, they should keep the baby. One participant explicitly explained that although his religion, Catholicism, is against abortion, he would go against his faith, and would agree that in some cases abortion is necessary.

Well, in certain cases I do agree that abortion is necessary. For example, when sex was not consensual. In reality it's very complicated because effectively you are killing a human being. Ending a life. So, I am not sure to which extent it is appropriate. However, if a woman has been raped and becomes pregnant, it is a different situation.

Gilson (28 y.o. White MSM, sex worker, on tourist visa)

Although I am religious, I don't agree with everything the church teaches us. I agree that women should have a right to abortion, depending on the situation.

Manuel (24 y.o. White heterosexual man on a tourist visa, about to expire)

These responses do not seem that far away from the views of the English population concerning abortion, as reported by the 34th British Social Attitudes report. This 2017 report, conducted by Britain's largest independent social research agency NatCen, states that 70% of British respondents believed women should have the right to terminate a pregnancy "if a woman does not want the child". The report also shows that between 1985 and 2016 Catholic support for allowing abortion if a woman does not want the child almost doubled, from 33% to 61%. This chimes with Manuel's statement: "Although I am religious, I don't agree with everything the church teaches us." It is impossible to generalise from this small sample size the attitudes of the Brazilian population in England at large. But it is interesting to note that the only two people who were vehemently opposed to abortion under any circumstances were the trans woman Roberta and the lesbian Ana. This could be because their LGBT status makes it impossible or more difficult to become pregnant - as Ana says, "So many women out there dreaming of being a mother but can't conceive for many reasons." Men interviewed, though less firm, were also generally less accepting of abortion. Of the people who could get pregnant, some of whom had already had abortions, there was greater tolerance for terminating a pregnancy in a variety of circumstances.

Access to abortion services by the Brazilian community in England is limited by similar problems as is access to sexual health clinics. Undocumented status prevents people from registering with GPs; language barriers prevent from finding and using services; and general lack of knowledge also contributes. As abortion is not legal in Brazil, certain women do not know it is legal in the UK. In my professional experience, far fewer people accessed the charity's sexual health services in order seek advice concerning abortions than to seek advice about HIV.

4.2.4 Practices that might increase the risk of HIV infection

Alcohol and Illicit Drug Use

The 30 participants were questioned about their alcohol and illicit drugs intake. They also gave accounts of what they know about alcohol and illicit drug use among their fellow Brazilian expatriates in England.

Many interviewees stated that they had had problems with alcohol and drugs in the past, the majority of these experiencing these problems after arriving in England, with many still having problems today. Crystal meth was mentioned more often than other drugs. Alcohol and drug misuse is more prevalent among the MSM and transgender participants, than

among lesbians or heterosexuals. Sex work also seems to be interlinked with an increased risk of alcohol and illicit drug use, as well as an increased risk of HIV infection.

The mesmerising effect of moving from Brazil to England and finding easy access to sex, alcohol and drugs in London's gay scene, where a culture of sex work, CHEMSEX and sex parties seems to be the norm, has often been mentioned by interviewees.

In the excerpts below, a variety of experiences are presented:

I believe that the rise of HIV/STIs among the Brazilian expatriate population in England, especially among MSM, is due to the many sex parties available in London, which take place on a daily basis. Before it used to happen in Gay Saunas, such as the one in Vauxhall, but now it is done through Gay Apps, such as Grindr. People are always sky high on drugs in these parties. Mephedrone, G, Methamphetamines. They use the stronger ones. They have orgies going on every day. You can go to a cubicle in the saunas with 2, 3, 4, 5 people at once. They also have glory holes, dark rooms. These were available in two gay saunas I visited. The majority of people did not even care about condoms. Especially those who already knew their HIV status was positive. The problem of taking so many drugs is that there comes to a point when you lose your capacity to think. You just don't care and start having sex without condoms. It was what happened to me. I spent about a year to 18 months in this situation. Lost because of drugs. I was fed up with my life, and I decided to explore something new. It was when I started using illicit drugs. It was during that period that I had sex without condoms a few times.

Mauro (37 y.o. Black MSM, Sex Worker)

When I moved from Brazil to England I had such a cultural shock that I ended up depressed and isolated. It was too great a difference between both cultures. Latino culture is much more open to total strangers, in the way they greet and talk to people on the streets. You don't see that here. I felt very isolated in my first years. I believe that this initial negative experience is what has prompted me to try things that were not good for me. Such as I did when I met other Brazilians who were all involved in illicit drug taking. I really believe that the high incidence of HIV among the Brazilian community in England is due to these drugs. It is a catch 22: drugs lead to sex work, and sex work leads to drugs. Some clients will pay you more if you use drugs with them. Some clients want you to spend all night with them. I also used

drugs at the many sex parties I took part in, where drugs and unprotected sex are the norm.

Tiago (43 y.o. White MSM, sex worker, HIV+)

I've noticed that many English people on the gay scene uses a lot of drugs, and then they like to have sex without condoms. The problem is that Brazilians here are copying them.

Carlos (55 y.o. White bisexual man, HIV+)

I have already participated in a sex party here in England. In Canada Water. It was great! It was a heterosexual party, with men and women. There were loads of drugs available. Pills mainly. It was the only time I tried them. I didn't have sex with men, only women. I didn't use a condom because I'm a lesbian. I never use condoms.

Maria (34 y.o. Black lesbian)

I was invited to participate in many sex parties in London. I actually went once to see how it was. I entered the door, had a look and left. Because I didn't feel comfortable at all. There was a pile of drugs on the table, and an orgy going on. Right there in the living room. Everybody with everybody. I entered the house, I looked, and left. It was too much for me.

João (31 y.o. White MSM, sex worker)

I am completely unstable because of crystal meth. I met a boyfriend who was injecting and I tried it. I ended up using for 18 months. Every day. With injection marks all over my body. It destroyed my whole life. I am crazy now, paranoid, and can't function. The relationship ended, but I'm still struggling with drugs. In the last two months I only used twice. Unfortunately, once you start, you live for your next fix. In fact, by now I have tried all types of drugs. It makes people careless. I have had sex many times without protection as a result.

Paulo (33 y.o. White MSM, sex worker)

Some interviewees talk about how they are drawn into the London drugs scene – they mention the isolation of being a Brazilian migrant to England, who does not know the language or understand the culture. The desire to therefore establish a social network can lead to increased openness to new social activities and increased vulnerability to peer pressure. Among sex workers, particularly MSM sex workers, financial incentives also play a part, for example, Tiago's experience of being offered more money to have sex whilst on drugs.

Drug use also seems to have a huge impact on condom use. Reports of people relaxing their safe sex behaviours was mentioned more than once in this sample, once they are under the influence of illicit drugs. This was particularly evident in the various accounts of sex parties described by many, where most people are under the influence of drugs (CHEMSEX). According to the MSM, transgender and even lesbian participants, these sex parties happen with frequency in different areas of London. Some of our interviewees organise these kind of parties themselves, in their residencies, or at specific clubs they run. And although they make sure that condoms are always available, they explain that people do not want to use them, once the drugs take effect.

These testimonies bear out the analysis in previous chapters of this thesis: that increased use of alcohol and drugs leads to increased risky behaviour. This is due to not thinking or worrying about preventative measures such as wearing condoms, a practice which is one of the most important when preventing the transmission of HIV.

Condom Use

The majority of the 30 interviewees stated that they do not know where they can access free condoms or lubricants in England. This was markedly evident among heterosexuals in general, and also among recently arrived MSM and transgender participants.

Condom use does not seem to be consistent in interviewees of any gender, sexuality or HIV status. Many of the sex workers interviewed, for instance, mentioned that some clients offer more money for sex without condoms. Although they associate condom use with their sex work clients, they have a more relaxed approach to using condoms with their fixed partners. This has prompted some to recognise that their real risk of contracting HIV/STIs is from their fixed partners, rather than from sex work clients. Although this admission, as they explain, is not enough to prompt behaviour change.

Among the lesbian participants, protection was never used. They believe their risk of getting HIV/STIs is low because of been in a monogamous relationship. Neither of them use any form of prevention method to avoid infection.

The concept of HIV Undetectable = Untransmittable (U=U), and the availability of PrEP, have also influenced the way participants think of condom use at present. This was noticed mainly among MSM and transgender participants, with and without HIV. Some of the HIV positive participants, for instance, said they would have sex without condoms with HIV negative partners, if their sexual partners accepted that they were undetectable, and understood the concept of U=U. Others also agreed to have sex without condoms if their partners were using PrEP.

Tiago stated that many sex work clients at the gay brothel in London offerered them more money to have sex without condoms. Especially those under the influence of drugs (CHEMSEX). Tiago further explains that when he was HIV negative he always said no to sex without condoms, because he did not want to take risks with his health. However, now that he lives with HIV, he has relaxed condom use because he does not have to worry anymore about it.

Others also stated:

When I first arrived in England, I was mesmerised with everything here. I started having sex with anyone at all. After three or four months I started to feel unwell. No strength in my body to go to work. I decided to return to Brazil. I believe during this short stay in England was when I was infected with HIV. Although I never touched drugs before in my life, up to that moment, in fact I used to hate even the idea of drugs, however, I always had sex without condoms. If people wanted to use condoms, I would be ok with it, but my preference was always without. I never considered the risks I was taking, even though I was aware of them. I chose not to worry about the risks.

Pedro (46 y.o. White MSM, sex worker, HIV+)

I have often, in the past, had sex without condoms. Sometimes even with someone I had just met. Without really knowing anything about them. This stupid idea that you would recognise if someone had HIV by looking at them.

Cláudia (35 y.o. White heterosexual woman)

Nowadays, I only have sex without condoms if the person accepts my HIV status. Before, when I was using drugs, I used to get really horny and then I didn't care about using condoms. Although even today, when my clients come to see me at home, I don't believe they pay me to suck their cocks with condoms. They are used to having sex with their women at home without condoms, and that is what they expect from us.

Roberta (21 y.o. White Transgender woman, tourist visa, sex worker, HIV+)

In Brazil, when you are about to have sex with someone and mention condoms, immediately they ask if you have STIs. Here in England, especially when I am having sex with heterosexual clients when I'm dressed as a woman, when you mention condoms, they ask: "What for?". Heterosexual clients don't like to use condoms at all. The majority of them will give the excuse that they won't be able to keep an erection. They give a thousand excuses for not wearing condoms. They are either this way or the complete opposite. There are also those that won't even touch you for fear of catching STIs. They only want to masturbate in front of us. We see all kinds.

Paulo (33 y.o. White MSM, sex worker)

I do have unprotected sex, but only with my boyfriends. Not at work. I usually get free condoms and lubricants from the sex workers' projects, and also from Dean Street GUM clinic, where I have regular sexual health check-ups.

Flávia (45 y.o. White Transgender, sex worker)

Flávia is a key example of having the knowledge of where to access condoms, but, in practice, only using them during commercial sex. Several interviewees spoke of not using condoms with fixed partners, suggesting there is an emotional element to the behaviour – trust and intimacy seem to be at odds with condom use. This becomes even more of a problem when supposedly fixed relationships are, in fact, often transient. Even in long-term monogamous relationships, a person can ultimately only be responsible for their own actions. Therefore it is necessary to educate Brazilian migrants in England who are

vulnerable to HIV on all the possible opportunities for infection, including in fixed relationships.

However, when considering the desire to not use condoms, for example when in a long-term fixed relationship, or when wanting to conceive, one must also consider U=U, and PrEP. Greater education on these subjects would allow people to lower their risk of contracting HIV without necessarily using condoms. It should still be stressed that this does not protect from other sexually transmitted infections.

For the situations where lack of condom use was unintentional, such as having taken too many drugs to make a decision, or having used a condom that broke, PEP is also an important HIV prevention method. The interviewees had a low level of knowledge concerning U=U, PEP and PrEP, with even those who had heard of it, not knowing where to access it.

As discussed in the section on drug and alcohol use, these substances decrease condom use, as does low self-perception of risk, such as believing a monogamous partner to always be faithful. Sex workers and HIV+ people tend to have more contact with health professionals; therefore it follows that the sex worker and HIV+ interviewees had higher levels of knowledge about condom use and where to get free condoms. The same cannot be said for recently arrived migrants or heterosexual interviewees.

Sex Work Experiences

As discussed earlier in this chapter, the attitudes towards sex work influence practices. I will explore the practices mentioned by interviewees within this section.

A few of the participants who currently sell sex in England, both male and female, gay and heterosexual, already had, on and off, sold sex in Brazil prior to migrating. Some others, especially heterosexuals, started selling sex here in England, after facing hardship on arrival.

In Brazilian culture, being transgender is synonymous with sex work. The majority of transgender people in Brazil sell sex at night, on the streets of major cities. They usually have difficulties in being absorbed into the job market and are barred from doing ordinary work. The four transgender people who took part in this research study are all selling sex here in England too.

Most of the heterosexual Brazilians who were interviewed for this research study, and who also engaged in sex work here in England, talk about a Brazilian/Portuguese network that

exists here which recruits newcomers, both on arrival England or in Brazil, prior to migration. There is no shortage of money in this profession. Anyone can enter, even if undocumented or if they cannot speak any English. For many without other options, this can be seen as a life saver. They talk about houses, all over London, where they go to work with other Brazilians and with a manager who organises the deals. Many of these heterosexual Brazilians enter into sex work unprepared emotionally, psychologically or in terms of being equipped to look after their own sexual health.

That same experience was shared by Francisco, a 29 y.o. heterosexual man, who had financial difficulties here in England and was informed by his Brazilian hairdresser about a gay brothel in London, where he could sell sex. Francisco never considered that option in his entire life before, neither here or in Brazil, nor in any other European country he visited before. Driven by the prospects of finally making quick money in England, he decided to give it a try. Francisco explained that he is only able to do this job with the use of Viagra, on a daily basis. His Brazilian girlfriend, who he met here in England, has also started selling sex.

Among the gays who sell sex in England interviewed for this research study, the majority mentioned starting at the same London gay brothel. This brothel has been running for over 20 years. Most of their sex workers are Brazilian gay men.

Newly arrived Brazilian gay men looking for work will inevitably hear about this gay brothel as an option of making easy and quick money. A network also exists among the Brazilian gay community that helps spread information about this option. In fact, some interviewees mentioned that they already knew about the gay brothel, even before migrating from Brazil to England, and that it was already part of their migration plan to work there, on arrival. The fact that the manager is also Brazilian helps to smooth things over for those who cannot speak English.

According to accounts of the more experienced sex workers, once they establish themselves in England, learn English, and become independent, they can leave the gay brothel and start working as sex workers independently, often renting flats with other sex workers, or alone, and putting advertisements in various gay magazines and websites, to promote their services. These options proved so profitable that two of the more experienced transgender interviewees are half way through paying their mortgages in London, in a very upmarket area of the city. Others have invested their money in Brazil, where they have bought houses and other investments for the future.

A problem that seems to be very much part of the experience of gay sex workers in England is drug use. Accounts of clients demanding that sex workers also use drugs during long sessions with them, for better payment, are very common. This experience was not reported by heterosexual sex workers in the same fashion. Although they did complain that some of their clients were sometimes drugged up.

Below are some accounts of the experience of those who engaged in the sex work industry either in Brazil or here in England:

I never thought about selling sex in Brazil. I started in Spain (Barcelona). Shortly after I decided to try to sell sex here in London too, to make more money. Sometimes I go back to Spain to sell sex there again. But I'm now based in London. For me, selling sex has a negative psychological and emotional impact on myself. The options were, cleaning or selling sex. If I chose cleaning, I would not be able to afford to study. With sex work I can go to English language schools. I hope that soon I can get a better job and stop selling sex.

Mauro (37 y.o. Black MSM, Sex Worker)

Sex work for me is what saved my life. My mother was also a prostitute and a drug addict, back in Brazil. She died of AIDS. I was then left without adequate support when I was 15 y.o. Selling sex was my only option. Here in London I share a flat with another young Brazilian transgender person. We both sell sex.

Roberta (21 y.o. White Transgender, sex worker, HIV+)

I am going to be honest with you. I have already worked as a prostitute here in England. It is something that can have a massive impact on your mental health. I only did it for the money. I am not doing it now, but if you ask me if I would do it again in the future, I would probably say yes. I had never done such a thing in Brazil. My first ever time was here. I don't feel too bad doing it, to be honest. I met some Brazilian girls, some legal and some not. They are the ones who told me about this job. They told me that I was going to kill myself doing cleaning jobs here in England. They told me I should take some provocative pictures of myself and that they would help me find clients. That is how it all started. I ended up going occasionally to sell sex with them in a flat and with other Brazilian girls. At that time, I was still cleaning in the day time, and working as a prostitute at night, whenever a client

called us. Sometimes we had no clients. We stayed awake all night for no reason. It was then that one of the girls received a call from a Portuguese man who runs a brothel in Ilford. This man had more than 10 such houses in that area. The girl he called had seen about 25 men the night before and was very tired. She sent me instead. I worked from 6:00pm to 4:00am non-stop. It was pure exploitation. Because I was the new kid on the block that evening all the men wanted to have sex with me. I must have had sex with 15 men that evening alone. Most of them were drugged up. They could not even perform the sexual act properly. Each client paid £150: £75 for me and £75 for the house. It was a horrible experience, because many of these men were not even clean.

Dolores (30 y.o. White undocumented heterosexual woman, sex worker)

I had never had sex with men before. My first experience with men was selling sex. It was a bit disastrous. Strange. It was a novelty for me. I can only do it if I take Viagra. To be honest with you, I often feel dirty because of what I am doing. I hate it. I don't feel well, but I do it regardless. My first ever client was there at the gay brothel. It was a Brazilian friend who is also my hairdresser who told me about it. He is gay and knew about my financial difficulties. He said I could make easy money if I could manage to have sex with men. I had never sold sex before. I never even imagined I could ever do that. Now I know many Brazilians selling sex here in England.

Francisco (29 y.o. White undocumented heterosexual man, selling sex in a gay venue in London)

I had two Brazilian friends who I met here in England over 10 years ago, who became transvestites and started a brothel for themselves in Soho. They are the ones who invited me to join them. At that time, I had a very good job in hospitality. I was a manager. I told them: «I have a university degree, I have a good job as a manager. I cannot become a prostitute now». And so it happened that during my holidays I was short of money to buy a car. They invited me to work with them for a week. To try it out. And so I went... In that same week alone, I made enough money to buy my dream car. I went back to my regular employer and gave my notice. I am still selling sex today. I managed to get a mortgage and am buying my own flat in London.

Letícia (53 y.o. White transgender, sex worker)

I started in Europe, and now here in England. I sell sex. I am a sex worker. I have done all sorts of jobs before. I am a trained nurse and also a hairdresser. But I prefer to sell sex. I had no option but to move to England because of the financial crises in all the other European countries. My first experience here in England selling sex was through a Brazilian person who could speak English, and she managed me and kept 50% of my money. Now that I am learning some English, I can work for myself now. Sex work has given me many opportunities in life over the years. I come from a poor family and had nothing. It all changed 12 years ago, when a Brazilian woman (madam) living in Spain paid my ticket from Brazil and got me jobs. She charged me 7000 Euros for bringing me over. Once I paid her, I was free to start travelling the whole of Europe selling sex. I bought a flat in São Paulo for me and helped my mother too.

Janaína (48 y.o. Black transgender, sex worker)

I feel great doing sex work, because it is something I really enjoy doing. For me I see it as my profession. I control it like I would do in any other job. I have a time to start, to finish, I have days off, and annual leave too. I cannot allow my professional life to interfere in my private life. I try to keep both lives very separate. When I go out my door, I am no longer a sex worker. If I go out to enjoy myself, to a bar or a party, I don't talk about sex work. Not because I am ashamed, but because I am not working at that time. My first ever client was in Brazil, before moving to England. I was very young. Maybe 14 or 15 years old. In those days I was still dressing as a boy. My first client in England was a very funny experience, because I could not yet speak any English. I was already dressing as a girl. The only thing I knew at that moment was that I needed money very quickly to pay my bills. Even though selling sex here was never part of my plans. The reality is that my intention was to find a boyfriend. I was actually avoiding selling sex. However, every man that approached me here in England at that time, the first question they would ask me was how much I charged. I tried to reason with a few of them that I was not going to charge them. Often I was left talking to myself. This is how I started charging people for sex. I've been so successful that I managed to get a mortgage to buy my own flat in London.

Flávia (45 y.o. White Transgender, sex worker)

In practice, sex work can be very profitable, as seen in the experience of Flávia and Letícia. As discussed earlier in the chapter, the relaxed attitude of the community along with the existence of established networks allows people to begin selling sex very easily. For some, this solves their financial problems, but for others the experience can be traumatic. There are those that end up misusing drugs and alcohol and those who are financially pressured into not using condoms, therefore increasing their risk of acquiring HIV.

4.2.5 Experience of having had STIs and living with HIV

Among the 30 Brazilian participants in this research study, there were eight HIV positive people, four cases of syphilis, three cases of HPV, one case of genital herpes, four cases of gonorrhoea, one case of hepatitis B, four cases of hepatitis C, and two cases of chlamydia. In this sample, the majority of people with STIs were the same people who had HIV. This was the case especially among MSM. All participants were linked into HIV care in England. However, not all of them were registered with a GP. They all have very different experiences in terms of living with HIV and/or STIs.

In term of HIV acquisition, some participants believe they contracted the virus in Brazil prior to moving to England, some others contracted it in the European countries where they resided before migrating to England, and others contracted HIV here in England. All of them were linked into HIV services in whichever country they were residing, prior to moving to England. None of them were diagnosed late and all of them were receiving medical treatment.

Tiago for instance, believes he was infected with HIV in Brazil. He had a HIV test in 2015 in Brazil, but moved to London before he collected his results, and was finally diagnosed after being tested in London that same year. He believes he subsequently got hepatitis C in Scotland, in a gay sauna.

Pedro believes he got HIV here in England. He first came as a tourist 13 years ago and stayed for 3 months. He attributes his infection to the fact that he never liked condoms and the fact he went mad on the gay scene in London when he first arrived. After a while, he couldn't stand the cold and was getting sick all the time. He then decided to return to Brazil. It was then that Pedro was diagnosed with HIV.

Carlos (55 y.o. White bisexual man, HIV+) on the other hand, who used to be married to a woman in Brazil, explains how he enjoyed his sexual freedom in Portugal, when he

migrated alone for financial reasons. He concludes: “I got HIV, hepatitis C and gonorrhoea in Portugal, all in that same period of feeling free to do whatever I wanted”.

Diana (27 y.o. White heterosexual woman, HIV+) explains that she was born with HIV in Brazil. For her, taking HIV medication is part of who she is now. She had some difficulties before she got married and always tried to hide her pills. But now, it is no longer a problem. She also had hepatitis B as a child. Probably from her father who used to be a drug user and died of AIDS. Today, Diana sees herself as a winner. Nothing stops her from getting closer to her dreams.

Roberta (21 y.o. White Transgender, tourist visa, sex worker, HIV+) explains that on top of having HIV, she also had HPV. Regardless of receiving treatment for HPV regularly, it just kept bouncing back. This is the reason she started taking her HIV medication. Her CD4 was below 300, and her doctors insisted she took the HIV medication. Roberta was diagnosed with HIV in Brazil in 2014, prior to migrating to Europe. Roberta further explains that she tried to avoid the HIV medication out of fear of being discriminated against by her peers and also fear of getting lipodystrophy. Today Roberta is happy to adhere to the medication because she knows it controls both the HIV and the HPV.

It is important to note that, despite the lack of access to many English health services by Brazilian migrants, all HIV+ Brazilians interviewed were receiving medical care either in Brazil, wider Europe or in England. Many who had received their diagnosis abroad got in touch with organisations, such as the London charity for which I worked, in order for HIV care to be put in place before they arrived in England. Of those who were diagnosed in England, they had been living here for a long time and already had GPs because they were more familiar with the language and the healthcare system. Also, those who perceived themselves as being at higher risk, or who had been experiencing symptoms, were more likely to seek out testing.

HIV/sexual health clinics operate differently to GP surgeries and hospitals. Once a diagnosis has been given, it becomes a public health concern – the clinic will regularly and persistently follow up with HIV+ patients, not only out of concern for the individual’s health, but for the safety of other people at risk of being infected. These clinics want to ensure adherence to the taking of medication, the usage of condoms and the continuing education of people living with HIV. This means that all of the HIV+ interviewees were receiving treatment throughout the conducting of this study.

4.2.6 Barriers to Health Services

In this section, I will discuss three barriers limiting Brazilian migrants' access to health services in England, using the context of the interviewees' experiences. I used a specific set of questions designed to understand the experiences of people who had had difficulty accessing NHS services. I will investigate the experiences of people who had successfully accessed some level of healthcare in section 4.2.7.

Barriers to healthcare include language, inadequate knowledge of the NHS and fear of accessing healthcare services, due to, for example, being undocumented. Often these barriers will lead to migrants seeking expensive private healthcare, returning to Brazil for treatment, or not accessing treatment at all.

Information and education, and health and social services, are two key tenets of this thesis' conceptual framework, as laid out in chapter one. This section will therefore discuss the need for information to be better disseminated among Brazilian migrants, so that they can understand and access the health system in England, including the NHS.

Language Barriers

Most of the 30 participants were not registered with a GP, regardless of the time they have been living in England. It is essential for Brazilians in England to have access to a GP because, despite the fact that the Brazilians interviewed who are HIV+ are already accessing clinics, prevention is just as important as treatment. Where HIV and sexual health clinics deal with the after-effects of having already contracted a disease, GPs are the first port of call for people who may not have acquired an STI or HIV, but are vulnerable to infection. Therefore, it is equally important that Brazilians in England have access to general healthcare as well as specialised sexual health services. As stated earlier interviewees preferred to access information about sexual health through having an actual conversation with a person such as a GP.

The participants attributed not being registered with a GP to, among other reasons, the fact that they do not speak the English language. This language barrier makes it difficult for many Brazilians to obtain the right information to navigate the system. Even among those fortunate enough to have been registered with the NHS, there were reports of communication difficulties. Carlos (55 y.o. White bisexual man, HIV+), for example, attends a HIV clinic in Central London for his HIV care, after being supported to register there by a London based HIV NGO because of his language difficulties. Carlos explains that he tried to

register with his local GP in Willesden Green, as advised by his HIV consultant, in order to start his hepatitis C treatment. That was a condition made by his HIV doctor. Carlos, who has dual nationality, Brazilian and Portuguese, could not communicate with the GP practice receptionists. They understood that Carlos was unwell, and sent him instead to A&E. Not knowing what was happening, Carlos went to A&E thinking he was about to finally be registered with a GP. He was then sent back from A&E to the GP practice, wasting his time, and that of the GP and A&E.

Another type of language difficulty observed through this research study is that experienced by Gilson (28 y.o. White MSM, sex worker, on a tourist visa). He explains that at the gay brothel in London where he works, he receives regular sexual health check-ups by an outreach service for sex workers. Gilson further explained that the sexual health project staff who visit the gay brothel speak either English or Spanish. They offer many different types of sexual health tests to sex workers, however, because of the language barrier, Gilson does not know exactly which tests were done on him. He knows they checked his hepatitis vaccine levels, and that all test results were negative.

An additional language barrier to health services in England was that experienced by Amélia (46 y.o. White lesbian): “I managed to register with a GP here in England, and it was a terrible experience for me. It is as I explained to you before, if you don’t speak English, they treat you very badly. They are not patient with you, and if you request an interpreter, they will spend more of the consultation time having a go at you, because of the interpreter, than consulting your health. In fact, in my experience, the consultation always ends up unsatisfactory”.

Interviewees believed that language is a huge barrier to accessing health services, because even if they manage to overcome the hurdle of registering with a GP, there can still be problems. For example, Carlos not being able to book an appointment through the surgery’s reception or Amélia feeling unfairly criticised for using an interpreter. I have experience as a community interpreter for Portuguese-speakers, mainly Brazilians, in sexual health clinics in London. For my training, I was taught skills in being assertive in challenging any health worker who was failing to act in the patient’s best interests. This demonstrates that there is occasionally a need for intervention on the behalf of non-English-speakers accessing sexual health services in London, due to healthcare professionals not treating individuals who have need of an interpreter in the same way that they treat other patients.

Even in other healthcare settings, participants experienced communication issues: Gilson was tested for STIs and understood that the results were negative, but did not know which STIs he had been tested for. This impairs his ability to consent, further excluding him from the societal conversation about STIs and the learning that could have been gained from that interaction. As discussed elsewhere in the thesis, it is important to communicate about HIV and sexual health in general in a migrant's native language in order to educate and disseminate information.

Inadequate Knowledge of the NHS

There is a lot of confusion among the 30 Brazilian participants regarding the NHS. This was particularly evident among those participants who are recently arrived, both documented and undocumented. Although, even participants who are registered with a GP, and have regular contact with the NHS, still have doubts about the system. Participants showed confusion about the roles of GPs, as well as regarding pathways to see specialist doctors in secondary care, for instance. This makes clear the need for information to be better disseminated among Brazilian migrants, so that they can understand the health system in England, including the NHS.

I have also noticed confusion about the NHS among a group of sex workers who received specific sexual health outreach services from sexual health experts who visited the gay brothel in London. These sex workers wrongly assumed they were registered with a GP because they were receiving regular sexual health check-ups. They thought that the outreach workers who offered them sexual health screenings and gave them condoms were actual doctors. This could have been due to language barriers, since the sexual health professionals dealing with the Brazilian sex workers could not speak Portuguese. This could also explain why their knowledge regarding HIV/STIs, and PrEP and PEP was so low, as evidenced through their answers regarding these topics. Among heterosexual women, an evident concern was about not knowing where they could access contraceptive methods in England.

Below are some examples of participants' experiences, and evidence that shows inadequacy of their knowledge of the NHS, and the health system in general:

Before I moved from Spain to England, I searched online for information about the health system in England. All the information I found was in English. I was only able to have a vague understanding of how the health system worked. I still don't really

know much about the NHS. I am lucky that I was registered with a GP through the sex workers' project [Mauro was referring to the sexual health clinic, not a GP].

Mauro (37 y.o. Black MSM, Sex Worker)

If I am registered with a GP? Yes! The sexual health professionals that visit the gay brothel in London [João was referring to specific sex workers' sexual health projects, not GPs]. It is easy for the Brazilian population to get confused about the NHS, because they arrive here with zero information. I, for instance, didn't find any information about the health services in England in Portuguese. I still don't know exactly what the NHS is and what services it offers.

João (31 y.o. White MSM, sex worker)

I haven't yet registered myself at the GP here in England. Because I don't know what I have to do. Even my parents who are here in England with me are not registered either. It is not easy getting the right information as to what we have to do. It is easier to find community-based organisations than the NHS, because of the language barrier. I can see that other Brazilians too will have huge difficulties in registering with a medical doctor here in England. It is complicated. I can talk through our own experience. When we first arrived in England, we didn't find any clear information on how to register with a GP. The information we get through other Brazilians is very confusing. Some Brazilians will tell you one thing, some others will tell you a completely different story. So, it's a mixture of confusing information with language problems. We can't go directly to the NHS service to get the right information because we don't speak English.

Clara (22 y.o. White heterosexual woman)

I don't know the health services in England at all. I have no idea where I can get free condoms, or contraception methods. I heard you need prescriptions. However, I didn't manage to get a prescription yet. I don't know how you can get prescriptions here. I have no idea. In fact, I don't know anything about the NHS. How it works. Nothing. I wish the information about contraceptive methods through the NHS were better shared for the Brazilian community. It is very

important. Especially among Brazilian women. We don't know where to find it. Not even to buy it. We are not using any methods because of this.

Renata (32 y.o. Black undocumented heterosexual woman)

To tell you the truth, I still don't comprehend the health system in England. Even after all the years I've been using the service. The NHS, the GP, I can't understand it. Probably because of the language barrier. Unfortunately, there isn't much orientation out there for people like me about where we can go to get informed.

Fátima (38 y.o. White lesbian)

Even after living in England for more than 15 years, up to now, I still don't know how the NHS really works.

Flávia (45 y.o. White Transgender, sex worker)

When Brazilians arrive in the UK there can be a lot of confusion about how GPs work. As evidenced by the interviews of Mauro and João, Brazilian migrants often mistake other healthcare workers for GPs.

This can in turn confuse the issues that Brazilian migrants report, for example, when talking in general terms about whether they like or dislike the NHS. This is often because they do not distinguish between, for example, HIV clinics and GP surgeries. Therefore it is important for this research study to point out that the dissatisfaction is usually with GPs as the gatekeepers of healthcare services rather than other aspects of the NHS.

Inadequate knowledge also means that migrants can make risky healthcare decisions. Mônica, for example, was unsure about how to get a prescription for contraceptive pills, so was considering asking her mother to post some from Brazil – this is common practice within the Brazilian community in London. If the pills were not to arrive on time, this could increase the risk of an unplanned pregnancy.

Even for participants such as Flávia, who has been living in England for over 15 years and thus has a better grasp of the language and culture, the NHS was still a confusing system. This shows that the onus is not simply on migrants to learn the language in order to gain adequate knowledge of how healthcare works – the NHS must do better in reaching out to migrant communities.

Fear of accessing the NHS

Fear acting as barrier to accessing NHS has been mentioned often by the Brazilian participants in this study. This was particularly the case for those who were on a tourist visa, expired visa, or those who were undocumented.

The bad experiences of some Brazilians while trying to register or use the NHS in England, including GP practices, have been shared among the community, causing fear and reluctance to even try to register within a GP. These bad experiences are both old and recent. Even though current NHS policy allows undocumented immigrants to register with a GP in England, in practice, GP surgeries are still denying access to migrants without a valid visa to reside in this country.

Meanwhile, private Brazilian/Portuguese GP surgeries in London are cashing in on the opportunity, by being the only medical alternative for those Brazilians without access to the NHS. Some participants paid between £60 or £80 for a consultation alone, plus whatever treatments were needed.

Below are a few of the examples showcasing fear of accessing the NHS in England:

I can tell you, most Brazilians have difficulties in accessing health services here in England. I know this because I created a WhatsApp group for the Brazilian community, and they talk often about it. I know of people who have been living here for more than two years, without having registered with a GP, merely because they don't have papers. They are afraid of going to their local GPs. I know about a lot of people in this situation. This is why they are even opening a new private Brazilian clinic in Willesden Green. The only option for these people is the private clinics. They have to pay £60 just to see the doctors. At least the service is in Portuguese.

Maria (34 y.o. Black lesbian)

I know of many Brazilians who won't even try to register with a GP because they are illegal. They get sick and there is nothing they can do about it. In fact, I'm a member of a WhatsApp group for the Brazilian community here in England, and there was a Brazilian young woman asking for advice because there was blood in her urine. She was asking the group what medication she should take. She was

going through this for over a month and the bleeding did not stop. Everybody started telling her to go straight to A&E. However, she was reluctant because her visa had expired. And so, everybody started to give their own opinion and suggest homemade remedies she could try. And so this lady tried a few of these remedies. Once she realised they were not helping, she ended up going to a private clinic, as someone in the group has suggested to her. She was prescribed antibiotics. This happened three months ago.

Sara (32 y.o. Black heterosexual woman, sex worker, HIV+)

I was born with HIV. In Brazil I had free access to any type of test I needed through the Brazilian equivalent of the NHS. However, when I arrived in London, I could not access the NHS because I was illegal and could not register with a GP, even though I tried. So, when I got very sick, I usually went directly to A&E. I told them what I was feeling, and they would give me medication. That was it. As far as I know, people still cannot register with a GP, unless they are legal in this country. Every time I needed a doctor when I was illegal, I either went to a private Brazilian clinic or I went to A&E. I know of many illegal Brazilians who are terrified of trying to register, because at the GP reception they take photographs of your passport and some even check what type of visa you have.

Diana (27 y.o. White heterosexual woman, HIV+)

I know many Brazilians, like me, who are afraid to register with their local GPs. Afraid of the Home Office. They think the Home Office will be able to find out who is undocumented, through their GPs. I know a Brazilian lady who has been living in London for the last four years doing cleaning jobs. She developed a knee problem and refuses to try the GPs out of fear of the Home Office. I know of many cases like hers.

Dolores (30 y.o. White undocumented heterosexual woman, sex worker)

I have not yet registered with a GP. Because I don't have papers. My husband and I did try, because he developed kidney problems, and had to be admitted to hospital out of the blue. The GPs refused to register us in Epsom, because we only had

tourist visas. They refused to even give us the registration forms. We were afraid to insist and left the GP practice.

Mônica (23 y.o. White undocumented heterosexual woman)

It is clear that fear is a very important barrier to accessing healthcare. Even when one migrant had a hole in her breast oozing liquid, she was more afraid of going to the hospital than not going to it. In this case, she feared deportation – many other migrants fear being turned away or being charged a large sum of money.

Even though the law does not require it, in practice, many GP surgeries are refusing people who cannot provide identification or proof of address. There has also been an update to the law regarding rights of undocumented patients: now the NHS will no longer have to share immigrants' data with the Home Office. The change came after MPs, doctors' groups and health charities warned that the practice was scaring some patients from seeking NHS care for medical problems. Again, however, on the ground some healthcare workers are still passing on such data. Furthermore, with language barriers and general inadequate knowledge of the NHS, many undocumented migrants will not know that the law has been changed and therefore will not have any reduction in their fear of seeking medical help.

The result of this is that many Brazilians in London rely on private healthcare, or, for those who cannot afford it, information from within the migrant community. For example the woman mentioned in Sara's account, who tried home remedies suggested on a WhatsApp group to address the problem of blood in her urine.

The climate of fear and confusion means that even when Brazilian migrants do manage to access healthcare, for some their experiences are negative, as will be seen in the next section. This can make them less likely to try again in future, or cause them to wait until they can return to Brazil for treatment, or to mistrust the recommendations of healthcare professionals.

4.2.7 Experiences of the Health System in England

In this section, I wanted to capture the experiences of the 30 Brazilians who participated in this research, and those among them who had the opportunity to access any type of the health system in England, both private and/or the NHS.

Overall, those who had access to a GP were not happy with the service they received, complaining of a culture in which doctors only prescribe paracetamol for any illness. They

did not feel that GPs were there to listen to them, but rather that they were gatekeepers whose main role was to prevent access to specialist doctors. There are also not the same time limits on the length of consultations within the Brazilian health system. Strict 10 minute appointments in the NHS made some participants feel rushed.

Some interviewees also complained of different treatment for migrant patients, perceiving friendly greetings from GP surgery staff for native English-speakers, but not for themselves. On the other hand, those participants who had access to NHS hospitals, sexual health clinics, as well as family planning clinics, were very happy with the service they received, rating these services as excellent, even better than the equivalent service they used back in Brazil, or in other European countries. GP practices require registration – once migrants have overcome this initial hurdle, they then face the challenge of persuading the GP to refer them to specialist services. However, if they do manage to gain access to these services, their experiences are often positive. Aside from the fact that, post-registration, no documents need to be provided in order to access specialist services, often these services are more likely to provide interpreting services such as Language Line. This could be due to lesser time constraints or greater flexibility in funding.

Some participants' unhappiness with GP services, however, was too strong to ignore. Some of them stated that when they get sick in England, they prefer to wait to be seen by their doctors either in Brazil or other European countries, to have a "proper" medical examination, rather than be seen by a GP here in England, who will not resolve their problems. Some others said if they cannot wait to go to Brazil, they will pay a private doctor from the Portuguese-speaking clinics. Even if visiting their GP initially, the perceived 'paracetamol culture', means that they feel dismissed and then will seek a second opinion from a doctor abroad or a private Portuguese-speaking clinic. When they compare results with those obtained from their GPs, often there is a disparity. This behaviour shows a massive distrust of GP services by many members of this community, in England.

Those who had to access established private clinics, often because they could not access the NHS, complained of having to pay £60 for an initial consultation, plus costs of any treatment needed. However, they thought the medical staff were always friendly, and they had the extra bonus of been seen by Portuguese-speaking doctors.

Below are a few examples of participants' experiences of accessing the health system in England:

Only in the last month I registered with a GP in England, after 11 years residing here. I registered now because of my illness. Although I also use the HIV clinic (Dean Street), and the private clinics where most Brazilians go. I had no choice. My liver was so badly affected by the combination of having HIV and hepatitis C. I was in pain. However, the GP refused to refer me for the tests I requested. I asked for a liver scan to see how my liver was. I ended up going private. It was a lot quicker. The GP simply told me it was unnecessary. I much prefer the health services in Brazil than here. In Brazil we focus a lot more on prevention than here. In England it's the opposite, they treat you after you get sick. I feel bad about it because I've paid tax here since I arrived in this country, and when I needed a medical service, I did not receive it. This was also the case at the Dean Street GUM clinic that I attend for my HIV care. I got very sick because of the hepatitis C infection, on top of my HIV. I couldn't even walk. It affected my head too. I was told by the doctors at Dean Street about a new drug for hepatitis C called Harvoni. This medication came out in 2013. They informed me that they could not give me this medication because it was too expensive and they were only using it for patients with cancer or cirrhosis of the liver. They offered me the second-best option which could take much longer to work. However, because of my health condition, I could not take that medication either because of the strong side-effects. I felt I was dying everyday a little. But then, looking on the internet, I found Harvoni on sale in India and Egypt for a fraction of the price. A relative of mine went to Egypt and brought over the medication. The total cost of the whole treatment in Egypt was £400. A month later, my liver was tested at the Dean Street clinic and it was already back to normal levels. I lost trust in the doctors in England.

Tiago (43 y.o. White MSM, sex worker, HIV+)

Even after residing in England for 2 years and 3 months, I haven't yet registered with a GP. The problem is that the GP practices now require proof of address, and also immigration status, such as a Home Office letter. I don't have either. I got sick with HPV and panicked. I went to the Brazilian clinic. I had to pay £50 for a consultation, and £70 for the examination. Too expensive! It was only later that I was helped by a community organisation to register with a GUM clinic, and then I

was able to receive free medical attention. In fact, the GUM clinic service in London is excellent. I received specialised treatment in every sense. I was treated with respect and dignity too. I was included in decision making in every aspect of my treatment. However, I still think the medical services in Brazil are better than here. They are more thorough in their examinations. The majority of Brazilians in London go to private Brazilian or Portuguese doctors, even though they are registered with GPs. This is because they don't really trust the doctors here. Although, this could also be because of the language barrier. Even in my family here this happens. They go to their GPs, and then to the Brazilian doctors, and then they compare both diagnoses, to see if they match.

Renata (32 y.o. Black undocumented heterosexual woman)

I am loving the HIV clinic where I go for treatment here in London. Before I was referred to this clinic, I was only able to go to the private doctors that Brazilians go to. Even the contraceptive pills I had to buy from this clinic, because I didn't have a GP, and they wouldn't give them to me at A&E. Now I get them free from the HIV clinic. I learned about the Brazilian doctors when I was illegal, through other Brazilians. It's easy to access. You go there and register yourself. They don't ask for any papers. You only have to pay a fee, and then you can use their services. Either in Portuguese or Spanish. The biggest difference I see between the health system in England and in Brazil is that in Brazil they have a more preventative approach to health. My experience of the health system here in England is that they will only pay attention to you once you are very ill.

Diana (27 y.o. White heterosexual woman, HIV+)

When I first arrived in England, for my first four years I was illegal, and could not register with a GP. I could only use the private clinic with the Brazilian doctor, where most Brazilians go. I once got very sick with a urine infection and my friend took me to the Free Hospital [Ana thinks the NHS' Royal Free London hospital is a free-of-charge hospital because of its name]. I was there for four days. Because the hospital is free, they took care of me without creating any problems. They actually opened their doors for me. I went to A&E. It was a Brazilian friend who told me about this free hospital.

Ana (37 y.o. White lesbian)

Because we don't have a GP, we had to pay the NHS hospital when they looked after my sick husband. In fact, we first went to the Brazilian clinic when my husband got sick, but he didn't get better. As my husband's health got worse, we took him straight to A&E in Epsom. We paid £80 at the Brazilian clinic, and then £712 for two days at the NHS hospital.

Mônica (23 y.o. White undocumented heterosexual woman)

I managed to register with a GP in England without problems because I have a Spanish passport. Although my experience using the service was not always the best. I once had a doctor that I thought wanted me dead. I needed help because of my high blood pressure. I believe the doctor had problems with me because I am transgender. As much as I explained my problems, she didn't get it. I ended up going to Brazil for treatment. I stayed in Brazil for two months. I saw a cardiologist there who simply added a small pill to my prescription and my high blood pressure dropped straight away to a normal level. On my return to England, I decided never to be seen by that same GP again.

Janaína (48 y.o. Black transgender, sex worker)

The main conclusion of this section is that many participants who had access to the NHS were unhappy with the GP structure, whilst feeling positive about other National Health services. This dissatisfaction came from several elements including language barriers and social concerns such as Janaina's belief that her GP had a problem with her being trans.

Several participants felt discriminated against because they did not speak English. As well as perceiving a lack of welcome from English-speaking staff in GP surgeries, they also experienced problems with GPs who were reluctant to use interpreters. Trying to organise interpreting services often took up the majority of the consultation, leading to limited time being available to discuss the patient's condition. The positive experiences participants recounted concerning Portuguese-speaking private doctors and clinics could also relate to shared culture as well as language – usually Portuguese-speaking doctors were trained abroad, meaning they would potentially have had the same cultural background as participants. However visiting these doctors is not a viable alternative, due to high costs excluding many Brazilians in London from accessing this kind of healthcare. This could lead,

as mentioned above, to Brazilians trying home remedies recommended in WhatsApp groups by strangers.

One of the most widely discussed reasons for dissatisfaction was the belief that “you only get help if you are very severely ill – anything less and the GP will prescribe paracetamol and send you away”. Several participants mentioned the Brazilian healthcare system’s emphasis on prevention rather than cure. They felt that GPs as gatekeepers contribute to a healthcare culture that leaves solutions to the last minute, often too late.

Although in the main, participants were positive about non-GP services, in Tiago’s experience, he also perceived his HIV clinic to be too restrictive in allowing access to further treatment. Tiago went abroad for the Hepatitis C medication ‘Harvoni’ because he was told he did not meet the NHS criteria for prescription at that time. The HIV clinic communicated effectively the NHS policy on this drug – it would only be given to people with cancer or cirrhosis of the liver due to cost-effectiveness, showing a high standard of information dissemination. In this instance, communication by NHS workers was not the problem. However we do see evidence of the point raised by other participants of the focus on treatment rather than prevention. Tiago went outside the NHS to buy the Harvoni from an unverified source in Egypt. Although this was a very risky strategy, and not to be recommended, monitoring by the NHS Dean Street HIV clinic showed complete liver recovery within a short period of time.

As delineated throughout this thesis, prevention is key to tackling the HIV epidemic – there is no cure. The conceptual framework’s building blocks of prevention are: information and education, health and social services, and a supportive social environment. In Brazil, as mentioned before, there are many wide-reaching campaigns concerning sexual health and HIV. This is not possible in the same way in England, where a campaign in Portuguese would be too expensive. Targeted information dissemination is more feasible, for example, by distributing leaflets in Portuguese – or through direct communication with GPs. This may involve an interpreter or a longer consultation. Although GPs’ main focus is not HIV, participants stated that one of their preferred sources of information is medical professionals. Therefore, if they do not build a relationship of trust with their first point of medical contact, that creates a problem concerning the dissemination of information about HIV. Not only are participants less likely to get that information in the first place, they are also less likely to trust the reliability of the medical recommendations.

4.2.8 Insights & Recommendations from participants regarding the best ways to pass HIV/STI information on to the Brazilian population in England

In this section, I wanted to gather the opinion of participants in this research regarding what they thought would be the best way to pass HIV and STI information on to the Brazilian expatriate population in England.

In general, the majority of participants mentioned that they never saw any HIV/STI campaigns in England. Although some blame themselves, for being too busy working or for not speaking enough English to understand messages. Although, even those participants who were fluent English speakers also mentioned not seeing sexual health campaigns like those they saw regularly in Brazil.

A few participants mentioned that their experience of England is that here they spend fewer resources on prevention and more on treatment. That “doctors will spend time treating you, but will have no time to educate you on how to prevent disease”. They suggest that more educational initiatives to make Brazilians aware of the risks of HIV and STIs in England are needed. This could be a combination of using the Brazilian media in England, such as online publications, social media (particularly Facebook and WhatsApp), newspapers and magazines, community-based organisations, outreach work in bars, restaurants and clubs where the Brazilian community goes, as well as GP practices where sexual health literature in Brazilian Portuguese can be disseminated. One participant also suggests that a good way to attract Brazilians to attend health services in England is by having Portuguese speakers on the staff with whom they can communicate. Whilst this would be very expensive, it might still be practical if there were a surgery which had a high number of Portuguese-speaking patients registered.

Below are examples of suggestions given by some of the 30 participants:

Everything I know about sexual health I learned in Brazil. Here in England I've never seen any sexual health information or campaigns. In my opinion, the best way to pass on information regarding the risks of HIV infection to the Brazilian community in England is through their GPs. If it is possible for GPs to try to educate their Brazilian patients. Try to find out what their patients know. After all, HIV and STIs are related to health. They should also have leaflets in various languages available in their practices.

Amélia (46 y.o. White lesbian)

I believe the best way to pass HIV/STIs information on to the Brazilian community in England is through the NHS. This is because Brazilians are scattered in different areas, and there are NHS services everywhere you go. They could start with educational leaflets, for instance.

Fátima (38y.o. White lesbian)

In my opinion, the best way to communicate about sexual health and HIV to the Brazilian community in England is through Facebook. 96% of Brazilians are connected through Facebook. There you will find advisements for fast-food business, jobs, hairdressers, etc. They create groups with more than 2000 people each. WhatsApp also have them. It is through these groups that I believe the Brazilian community should be targeted.

Dolores (30 y.o. White undocumented heterosexual woman, sex worker)

There are many people who believe they are immune to disease. They don't take adequate precautions to avoid infection. In my opinion, the Brazilian community needs ongoing sexual health education. On the Brazilian TV channels, Radio, etc. If it is aimed at Brazilians, it has to be in Brazilian Portuguese. Many Brazilians in England still don't speak English.

Juliana (58 y.o. Black heterosexual woman, HIV+)

I've never seen in England a HIV/STIs campaign. I believe the best way to inform Brazilians about the risks of HIV infection in England is through the Brazilian community organisations, like LondonHelp4U. Also, through the Brazilian media, newspapers, magazines for the Brazilian community. Also, it would be ideal if a campaign was created aimed at the Brazilian population in England.

Nunes (41 y.o. White bisexual man, sex worker, HIV+)

Well, I believe the best way to educate the Brazilian community in England is through the Brazilian churches. A sexual health campaign aimed at Brazilian churches. Because many Brazilians feel isolated and they tend to meet in Brazilian churches. Here, because of the language barrier, we don't really know what is happening in terms of risks of getting disease, like we know in Brazil. There in Brazil, we get informed through the TV news. Here, even if they inform people in English, we cannot follow because we don't speak the language. This is why I think it would work to target the churches.

Denise (27 y.o. White undocumented heterosexual woman)

I believe the best way to educate Brazilians in England is through leaflets and newspapers, in Portuguese. The Brazilian community newspapers, for instance. 'Leros' magazine too.

Mônica (23 y.o. White undocumented heterosexual woman)

Recommendations from within community are key to preventing HIV. As stated in this thesis' introduction, this approach is in line with the UNAIDS model. Individual citizens must be included in the policymaking that affects them and their communities.

The most widely mentioned recommendation from the participants of this research was to disseminate information in Portuguese. This information should relate to the facts about HIV and STIs along with where to access services, whether they are free and to whom they are available. The information might be distributed face-to-face by outreach workers who speak Portuguese or in leaflets in GP surgeries or on social media.

One key element is ease of information intake. As Clara says, "everybody in London is busy and doesn't have the time to go searching for this information." Other participants talk about posters being visually engaging or outreach workers having quick conversations – the information needs to be fast and easy to process.

Another factor in this is where the information is available. Many interviewees mentioned social spaces where Brazilians already go, such as bars or churches. Others spoke of specific events being organised for the community that focus on health such as a fundraiser like a barbecue or a talk in the evening. They also discussed social media, such as Facebook and WhatsApp, which, according to some participants is particularly accessible to undocumented Brazilian migrants.

They also mentioned more permanent spaces such as GP surgeries hiring Portuguese speakers if there was a large Portuguese-speaking community for them to serve. There was also discussion of Brazilian-run health organisations being set up, or creating health services within existing Brazilian-run, community-based organisations with an established platform.

As well as leaflets in GP surgeries and Portuguese-speakers on staff, there was also an emphasis on using GPs themselves as a source of information. This is important because GPs are the point of contact between the community and the system at large. These 'gatekeepers' could be used to address the request from within the community for prevention by education on sexual health and HIV. All of these recommendations fall within the conceptual framework with their focus on education and information, health services

and a supportive social environment. This demonstrates that including a community in decision-making on policy supports best public health practice concerning HIV prevention.

4.3 Discussion

This chapter has shown that the 30 participants in these in-depth interviews knew little about HIV and STIs, and even less about PrEP and PEP. In general, most of the 30 interviewees' attitudes towards HIV/AIDS showed they are somewhat comfortable relating to HIV positive people but are afraid of having sex with them. This shows a need for better knowledge through sexual health education in this community, including current information that HIV Undetectable = HIV Untransmittable (U=U), i.e., that HIV positive people who are successfully taking HIV medication and are undetectable for at least 6 months are not infectious, even if having unprotected sex. This was corroborated by evidence from chapter 3 (quantitative data), where the 1018 Brazilian participants in the KAP survey knew less about HIV/STIs than the sample from the Brazilian population in Brazil, regardless of the fact that the research done in England was carried out three years later.

Through these in-depth interviews, the 30 participants in England were able to explain some of the reasons why they are not getting the sexual health information they need. The interviews also explored why certain participants engaged in practices that increased risk of HIV/STIs, such as alcohol and drug use, sex work and unprotected sex.

Participants had limited access to health services in England, because of language barriers, immigration issues and because they do not yet know much about how the NHS and other health services work. Although, as discussed in Chapter 1, large-scale immigration started in the 1990s, the bulk of Brazilians in England started arriving around the turn of the millennium, with arrivals continuing up to the present day. Brazilians are often not integrated, because many do not speak the language, and tend to remain almost exclusively within their own communities. This is often to do with being undocumented and therefore unwilling to expose themselves to outside observers who may report them – including health services and GPs. Many undocumented migrants have no access to any NHS services whatsoever. Any newcomers who do enter this community, often paralysed by fear of immigration and a mistrust of the system, are therefore likely to inherit this predisposition not to integrate. This means that they will be less able and less willing to learn about how the NHS and other health services work.

Even for those Brazilians who do have access to health services, the language barrier was often mentioned in terms of not being able to communicate with their doctors in the NHS during consultation, which is one of the preferred places where they would like to receive HIV/STI information/education from. Communication was often still a problem even with the presence of an interpreter, as some participants said that the interaction with GPs often focussed negatively on the interpreting process rather than on a discussion of the patient's health needs.

Whilst language barriers limit access to health services in England and therefore information concerning HIV/STIs, they also indirectly impact vulnerability to HIV by influencing behaviour that increases risk. For example, many Brazilian migrants who do not speak good English, discover that they cannot find adequate work, and many of them therefore resort to sex work instead.

One example of how information, education and behaviour interact to impact vulnerability to HIV is the story of interviewee Francisco, the heterosexual man who sold sex to other men. He had never sold sex before he arrived in London and it was not part of his plans, but financial pressure plus encouragement from his Brazilian social network led him to start working in a gay brothel. He would not have been exposed to targeted campaigns in Brazil because, before migrating, he was not part of the MSM or sex work communities. In England, he had access to the outreach workers at the brothel, but they did not speak Portuguese. England cannot rely on Brazil to educate Brazilians before they arrive, because their migrant status increases their vulnerability.

4.4 Conclusions

According to the conceptual framework from AIDS in the World (1992), *Vulnerability to HIV Infection*, which I discussed in the introduction to this thesis, vulnerability should be considered on the following three interdependent levels: **personal**, **programmatic**, and **societal**.

By focussing the in-depth interviews on personal vulnerability, which involves both cognitive and behavioural factors, including 'informational needs' in terms of HIV/AIDS, it has become clear that the Brazilian population in England is having difficulties in keeping up-to-date with information which they need to protect themselves from HIV infection.

The language barrier, so often mentioned during interviews, for instance, makes it almost impossible for them to learn about HIV/STIs in England. Lack of knowledge on how the

health system in England works, including the NHS, is also a major vulnerability, as many participants do not know where they can go for HIV counselling and testing, or where to obtain free condoms and lubricants.

The Brazilian expatriate population in England needs public health support to counteract the level of vulnerability to HIV infection that currently exists in this population.

As discussed above, the most widely-mentioned recommendation from participants was the dissemination of information in Portuguese. I would also suggest free or low-cost English language classes, education that has been given to other migrant communities in England to assist with better integration. This would tackle the language barrier problem.

Another aspect of information and education is the method of dissemination as well as the language. Outreach workers from within the community could have face-to-face discussions in Portuguese. These could take place in social spaces frequented by the Brazilian expatriate population in England, both physical and online – social media especially is accessible to undocumented migrants. Two ways that the Brazilian migrant community want to be contacted in particular are through WhatsApp and Facebook. These approaches were not only recommended by participants themselves but also recommended by Grieb et al (2015) as an effective strategy to improve access to HIV testing and prevention services, as was seen among Latin Americans in Baltimore.

Along with information and education being disseminated by and within the community, it should also be distributed by and within health and social services such as GP surgeries. As well as the recommendations in leaflets in GP surgeries and Portuguese-speakers on staff (although I know that having a Portuguese speaker in GP surgeries are not economically feasible, language line might be a good alternative), there was also an emphasis from participants on using GPs themselves as a source of information. This is important because GPs can potentially address the request from within the community for prevention by education on sexual health and HIV. As well as improving the standard of information being given out by National Health services, actual access to these services must also be improved. Although the law in England has changed to allow all migrants independently of immigration status to register with a GP, in practice, many NHS workers will still prevent registration without proof of address or a valid ID. There has to be the political determination to ensure that a change to the law must be followed by a change to the culture, especially when dealing with vulnerable migrants.

These recommendations concerning the programmatic vulnerabilities regarding lack of education and information and lack of access to health and social services also feed into a wider consideration of how to create a supportive social environment. Improving migrants' access to information resources both in their own language and in English would allow a greater freedom of conversation and discussion surrounding HIV and STIs. If they could be supported to learn the English language it would also enable better access to jobs and therefore reduce the need to rely on sources of income such as sex work. Improving access to health services would help to reduce the climate of fear and mistrust of the system within the Brazilian expatriate community in England.

CHAPTER 5 Thesis Conclusions

My aim in this research was to discover if the HIV/AIDS-related knowledge, attitudes and practices of the Brazilian expatriate population in England are impacting on their vulnerability to HIV infection. My hypothesis is that if a migrant community has a good level of HIV/AIDS-related KAP then their HIV prevalence would be low. I wanted to investigate if the high levels of HIV prevalence in the Brazilian expatriate population in England was due to inadequate HIV/AIDS-related KAP.

According to the literature review, acculturation, machismo/gender roles/gender norms, alcohol and drug use and sex work were factors that had an impact on increasing the risks of HIV infection among migrants. It was also clear that the migration process itself, from Low and Middle to High Income Countries, puts some migrants in a vulnerable position that facilitates HIV infection (Selik et al., 1988; Singer et al., 1990; Cochran, 1989; Albarrán et al., 2011). One of the main conclusions was that to be effective, HIV programmes with vulnerable populations must therefore be tailored to respond to the specific contexts within which HIV risk behaviour occurs. Future initiatives to lower the risk of HIV transmission must include multidimensional, theory-based interventions that address individual and contextual variables as well as socio-cultural variables such as gender, class and ethnicity, and their influence on sexual behaviour. Numerous cultural and socioeconomic factors unique to migrants from Low and Middle Income Countries, must be given consideration while developing HIV/AIDS interventions. Adaptation might be required, preferably using a Community-Based Participatory Research approach (Knipper et al., 2007; Rhodes et al., 2010; Hacker et al., 2011; Rhodes et al., 2011; Gilbert & Rhodes, 2013; Rhodes et al., 2013; Sanchez et al., 2016). This is particularly important for new communities that don't yet speak the language of the host country, or understand the local culture and systems.

Following on from the literature review, I conducted a validated cross-sectional survey of HIV/AIDS-related KAP with 1,000 members of the Brazilian expatriate population in England to assess their levels of knowledge, attitudes and practices regarding HIV transmission and compared results from this research with those from the latest HIV/AIDS-related KAP (PCAP 2013) of the Brazilian population in Brazil in order to determine levels of access to health services of the Brazilian population in England.

Results show that the participants from the Brazilian expatriate population in England who took part in this study have, in general, a moderate to good level of knowledge of how HIV is transmitted, and of the way in which their behaviour can increase or decrease their risk of HIV acquisition. However, when results from this research were compared with those of the latest research in Brazil, a slightly lower level of knowledge in the sample in England (2016) was observed in six out of the eight indicators of knowledge, compared to those observed in Brazil (2013).

This indicates that the Brazilian population living in England knows relatively less about how HIV is transmitted and how to prevent it than those Brazilians living in Brazil. I am aware, however, that the difference in sample size, and other characteristics, might have played a role in the differences I found. One example, is the fact that the Brazilian research did not determine the HIV status of their participants.

Although findings show a moderate to good level of knowledge of how HIV is transmitted in this population, and of the ways in which their behaviour can increase or decrease their risk of HIV acquisition, there was evidence that Brazilians in England are not getting the required level of information to keep up-to-date on how to use all methods of HIV prevention, including PEP and PrEP.

In future, Brazilians in England should know as much about PEP and PrEP and U=U as they do about condom use. This is particularly important given the high level of engagement with sex work, alcohol and drugs within this community.

Increased knowledge must be combined with improvements to attitudes and practices regarding HIV transmission. For instance, Brazilians should be encouraged to use condoms more – they are not doing this even though they know it is the most effective way to prevent the transmission of HIV. The data suggests this could be in part due to the fact that they do not have access to free condoms. HIV testing should also become more frequent amongst the Brazilian expatriate community in England. Information about where to access free testing and free condoms should be distributed in Portuguese.

These findings are also in line with those from the in-depth interviews which showed that the 30 participants knew relatively little about HIV and STIs, and even less about PrEP and PEP. This was a contrast from results of the survey which showed knowledge in this population to be moderate to good. Furthermore, most of the 30 interviewees' attitudes towards HIV/AIDS showed a need for better knowledge through sexual health education in

this community, including current information that HIV Undetectable = HIV Untransmittable (U=U).

The interviews showed that participants had limited access to health services in England, because of language barriers, immigration issues and because they do not yet know much about how the NHS and other health services work. Brazilians are often not integrated, because many do not speak the language, and tend to remain almost exclusively within their own communities. This is often to do with being undocumented and therefore unwilling to expose themselves with fear of deportation. Many undocumented migrants have no access to any NHS services whatsoever. Any newcomers who do enter this community, often paralysed by fear of immigration and a mistrust of the system, are therefore likely to inherit this predisposition to not integrate. This means that they will be less able and less willing to learn about how the NHS and other health services work.

Even for those Brazilians who do have access to health services, the language barrier was often mentioned in terms of not being able to communicate with their doctors on the NHS services, during consultation, which is one of the preferred places where they would like to receive HIV/STI information/education from. Communication was often still a problem even with the presence of an interpreter, as some participants said that the interaction with GPs often focussed negatively on the interpreting process rather than on a discussion of the patient's health needs.

Whilst language barriers limit access to health services in England and therefore information concerning HIV/STIs, they also indirectly impact vulnerability to HIV by influencing behaviour that increases risk. For example, many Brazilian migrants who do not speak good English, discover that they cannot find adequate work, and many of them therefore resort to sex work instead.

This research has clearly shown that the Brazilian population in England is having difficulties in keeping up-to-date with vital information which they need to protect themselves from HIV infection.

The language barrier, so often mentioned during interviews, for instance, makes it almost impossible for them to learn about HIV/STIs in England. Lack of knowledge on how the health system in England works, including the NHS, is also a major vulnerability, as many participants do not know where they can go for HIV counselling and testing, or where to obtain free condoms and lubricants.

The Brazilian expatriate population in England needs public health support to counteract the level of vulnerability to HIV infection that currently exists in this population, and in order to replicate the progress, reported by PHE in 2017 and mentioned throughout this thesis, reached in other communities in England.

As discussed above, the most widely-mentioned recommendation from participants was the dissemination of information in Portuguese. I would also suggest free or low-cost English language classes, education that has been given to other migrant communities in England in the past. This would tackle the language barrier problem.

Another aspect of information and education is the method of dissemination as well as the language. Outreach workers from within the community could have face-to-face discussions in Portuguese. These could take place in social spaces frequented by the Brazilian expatriate population in England, both physical and online – social media especially is accessible to undocumented migrants. Two ways that the Brazilian migrant community want to be contacted in particular is through WhatsApp and Facebook. These approaches were not only recommended by participants themselves but also by other research studies discussed in the literature review.

England has a vibrant Brazilian population, with very proactive community leaders (e.g., Consulado do Brasil, NAZ, SASH, Leros Magazine, Casa do Brasil, London Help 4U, ABRAS, Queen Mary University, among others). Researchers and programme managers should try to make use of these existing resources when outreaching Brazilians in England.

According to the Vulnerability to HIV Infection framework, vulnerability should be considered on the following three interdependent levels, **personal**, **programmatic**, and **societal**. The framework concludes that after taking in consideration all the factors that increase an individual's vulnerability to HIV infection, including their own behaviours and other programmatic and societal dimensions, that **Personal empowerment is the antithesis of vulnerability**. Key to the success of reducing vulnerability to HIV infection and of promoting personal empowerment is the access to information/education and health and social services. This is exactly what the Brazilian participants of this research are saying they are not having access to.

The framework further explains that the success of decreasing vulnerability to HIV infection greatly depends on the quality and nature of the community or national sexual health programmes; and the broad societal influences that increase, sustain, or reduce personal empowerment. A weak national sexual health programme that lacks commitment and has a

fragile and moving structure, with limited resources and a growing sense of complacency, won't serve its purpose. Meanwhile, more people will become infected because they do not have sufficient access to information and services. This is exactly what is happening with some members of the Brazilian expatriate population in England, right now. They need access to free English lessons to facilitate integration into the British society, as well as access to health services, and sexual health information, in order to know how to protect themselves from HIV or STIs. They also need access to free condoms, HIV counselling and testing, without fear of immigration or deportation.

If England is to accomplish UNAIDS' 90-90-90 target to end the AIDS epidemic by 2030, specific Public Health efforts need to be developed and implemented, targeting the Brazilian expatriate Population. This needs to be incorporated into a sexual health campaign, and using the Vulnerability to HIV Infection Framework (AIDS in the World, 1992), discussed above. Preferably using a community-based participatory initiative, involving leaders of the Brazilian community in England, HIV NGOs, researchers, funders, and Public Health practitioners.

5.1 Thesis Limitations

A possible research limitation of this thesis is the fact that I am a migrant from Brazil, and working for a sexual health non-governmental organisation in London, supporting Portuguese speakers, including Brazilians. This could have added some bias to the interpretation of the data. Although I used a self-reflective approach throughout the research process, and discussed this in supervision, to limit the possibility of researcher bias occurring.

Despite this limitation, this study presents important information on a population which has previously been neglected in the public health literature. Triangulated methodology incorporating qualitative in-depth interviews and quantitative data constitutes a major strength of this study. The mixed-method approach also helped to enhance the study's validity. To further enhance validity, I enlisted support, endorsements, and direct involvement of highly respected community leaders, Community-based Organizations, local religious leaders and the Department of Health of both Brazil and England (PHE).

5.2 Areas for future research

Future research regarding risk of HIV infection among the Brazilian population in England should include a detailed focus on acculturation, to see if the risk of contracting HIV

increases or decreases depending on length of time that Brazilian migrants spend in England. This would help prevention initiatives better focus resources where it is mostly needed.

Also, an accurate estimation of the size of the Brazilian population in England would be important for statistical purpose, such as for quantitative research.

5.3 Thesis Recommendations/Policy implications

1. A sexual health campaign is needed to educate the Brazilian population about HIV and STIs in general, PrEP and PEP, and the concept of U=U. This sexual health campaign should aim to offer free HIV counselling and testing for targeted community members with increased risk of HIV infection. This campaign should be in Brazilian Portuguese; and as suggested by participants, it should include supply of free condoms, and educational sexual health leaflets, in Brazilian Portuguese. These should be available in community-based organisations, clubs, bars, and social events, where the Brazilian community assembles. A specific sexual health campaign aimed at Brazilian churches should also be explored, as many Brazilians attend churches in England, and it would be an easy way to outreach them. Including offering rapid HIV tests.
2. An educational initiative with the intent to make the Brazilian expatriate population in England aware of how the NHS operates is needed, to inform them how the NHS works, and to inform them that they can have access to free GPs, GUM clinics and family planning clinics, as per current legislation, regardless of their immigration status. This information should explain where they can have access to free sexual health screenings, PrEP and PEP if needed, as well as contraceptives, free HIV/STIs treatment if required, free counselling, and free condom and lubricants. Ideally, some of these health facilities would have Portuguese speakers among their members of staff, to attract more Brazilians to their services.
3. Free English language classes initiatives for Brazilian migrants in England are needed, to alleviate the difficulties faced by this population, in terms of integration into the British society.
4. A recommendation for the Brazilian Ministry of Health: An awareness campaign in Brazil is needed to make Brazilians migrating to High Income Countries aware of the risks of financial difficulties, getting involved in drug use, sex work, and HIV/STIs infection during migration.

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Appendices

Appendix 1 – Ethical approval

Faculty of Arts Ethics Approval Form

Researcher	José Henrique Resinente
School/Division	Faculty of Arts, School of Cultures, Languages and Area Studies
Project title	Brazilians, the new Black: Their experiences of accessing sexual health services in London
Date	27/04/2015
E-mail	asxjhr@nottingham.ac.uk

(1) Researcher Information. Please tick as appropriate.

YES ☐ NO ☒ Member of staff conducting research project

If ticked YES above, is the research funded by a RC that needs proof of ethics approval? And what is the funding body?

YES ☐ funding body _____ NO ☐

YES ☒ NO ☐ Postgraduate Researcher

If ticked YES above, indicate level of studies and supervisor.

PhD ☒ MA ☐ Supervisor _ Dr Jean Andrews_____

YES ☐ NO ☒ Member of staff obtaining approval for data collected by students on a module.

If ticked YES above, indicate level of studies.

PhD ☐ MA ☐ UG ☐

Module Code and Module Name

If obtaining approval for a module, in the sections below provide an overview of the type of projects the students will do. Attached with your paperwork the guidelines given to the students about the type of data they will collect, as well as the information about the relevant areas of the ethics protocol that they will need to follow. Students need to provide signed informed consent forms from ALL participants with their submitted work, as well as the tick sheet signed by them.

(2) Provide a brief summary of the research aims/questions [max 500 characters & spaces].

I am a PhD student at the School of Languages, Cultures and Area Studies, University of Nottingham, and my research using qualitative and quantitative methods is looking into the lived experiences of Brazilian immigrants accessing sexual health services in London.

For this research, I intend to use a survey to collect data from about 2000 Brazilians living in London regarding their experiences of accessing sexual health services here, as well as in-depth interviews with 15 members of the community, collecting and examining their testimonies.

There will be four categories of clients in this research, i.e. the general Brazilian community who access sexual health services; Brazilians who are living with HIV; Brazilian sex workers and Brazilian transgender.

The thesis will employ the tools of critical and cultural analysis to make sense of the text. The thesis will also contain a distinct self-referential and self-reflexive strand, as I will, in some cases, be dealing with people known personally or professionally through my work as one of the coordinators at the Naz Project.

The results of the survey will be shared with Public Health England and the NAZ project.

(3) Methods – tick as appropriate and provide an explanation as indicated below.

Part A YES ☐ NO ☒ psychophysiological measures (e.g. response times, eyetracking, ERP, etc.)

YES ☐ NO ☒ prolonged visual and/or auditory stimuli

YES ☒ NO ☐ interviews (focus groups)

YES ☒ NO ☐ questionnaires

YES ☒ NO ☐ other

____Survey_____
—

Part B YES ☐ NO ☒ using data produced by students (e.g. their essays)

YES ☒ NO ☐ using data freely available on-line

YES ☐ NO ☒ using data available on-line only available to members of the group

YES ☒ NO ☐ were the participants aware that work would be used for research purposes

Part C YES ☒ NO ☐ procedures likely to change participants' mood, be aversive or stressful

YES ☐ NO ☒ misleading participants about an experiment or withholding information

YES ☒ NO ☐ information-gathering on sensitive issues (e.g. sexual, racial, religious or political attitudes, etc.)

YES ☒ NO ☐ procedures which might be harmful or distressing to people in a specially vulnerable state (e.g. depressed, anxious, bereaved, etc.)

YES ☒ NO ☐ discussion or investigation of personal topics (e.g. relationships, feelings of success and failure) or any other procedure in which participants may have an emotional investment

For anything ticked YES, please provide more detailed information. Indicate any potential risks to participants and justify this risk. For interviews, please be clear whether the interviews are being recorded, how the identities' of participants are being protected, and who will have access to the data (e.g. will participants' recordings be presented at conference presentations). For Part B, for any data not publically available, indicate how you will obtain permission from participants to use their data.

Part A

Interviews:

Interviews will be recorded and fully transcribed (transcription/translation will be done by recruited UoN language students, who will be required to have had UoN ethics training and bound to confidentiality). The recordings will be stored in a secure location and only the researcher and his two supervisors will have access. People's names or job titles will not be included in reports. Participants will be offered a copy of their interview transcript and provided with the opportunity to take out or amend any part of it that they do not wish reported in the findings. Participants should also be aware that the researcher has a legal obligation to disclose information relating to unethical or criminal behaviour.

No risk to participants is anticipated in this project.

Questionnaires:

Questionnaires will be devised and tested by researcher in consultation with UoN supervisors. It will then be tested with colleagues before being piloted with prospective research participants. Amendments would follow if needed.

Survey:

A survey will be conducted in partnership with Public Health England (PHE) using a combination of already tested surveys, such as NATSAL, aMASE and Positive Voices. Authorization to use such Surveys was obtained. The Survey will be done using PHE software and analysis of the data will be done in conjunction with them.

The survey will have to be translated into Portuguese and a focus group with an average of 6 participants will be conducted to expand the questions from the client's perspective and needs. Later, a cognitive interviewing group of four participants will be undertaken to test the final survey; and finally, the survey can then be pre-tested with 10 service users before sending it electronically to at least 2000 members of the Brazilian community in the UK.

As with any means of data collected online and stored on servers, such as with survey software, I am aware that there is a small risk that the data could be hacked into. This information will also be passed to prospective participants via the Information Sheet.

I intend to use my position as one of the leaders in the Brazilian community in the UK to disseminate the survey, with the support of the Brazilian Consulate in London. I am in the process of organizing a meeting with Krishna Monteiro, one of the Ministers at the Brazilian Consulate, to discuss how they can support this initiative.

I am aware I am in a position of power as the coordinator of Naz Vidas, and hence, the gatekeeper to resources, and I would never use this position to pressure participants to take part in this project.

Part B

Using data freely available on-line:

I will only be using data that are freely available on-line or through databases. All data would be referenced in the final thesis.

Were the participants aware that work would be used for research purposes?

An Information Sheet has been created and will be distributed to prospective research participants prior to research taking place, with full explanation as to why research is being conducted and the importance of their contribution to this research.

Part C

Information-gathering on sensitive issues (e.g. sexual, racial, religious or political attitudes, etc.):

I have gained extensive training through a MSc in Public Health at the London School of Hygiene & Tropical Medicine, where modules such as Sexual Health, Family Planning, Control of Reproductive Tract Infections, Sexually Transmitted Infections and Principles of Social Research were undertaken. Ethical issues in sexual health and research were widely covered in these modules. I also have been working for the Naz Project (sexual health charity) for the last 14 years and am well aware of the importance of confidentiality and creating a safe atmosphere where clients can open up about intimate and sensitive issues.

I am aware I am in a position of power as the coordinator of Naz Vidas, and hence, the gatekeeper to resources, and I would never use this position to pressure participants to take part in this project.

(4) Location of data collection.

YES ☒ NO ☐ Will the task be performed outside of campus.

If data collection is occurring on campus please give the location. If data collection is occurring off campus, please provide information about the location.

Data collection will occur online (Survey) and at the Naz Project (In-depth Interviews), where clients access sexual health services.

(5) Participants, access, and inducements.

YES ☐ NO ☒ participants under 16 (if so, you may need to undergo a CRB check)

YES ☒ NO ☐ participants recruited from special sources (e.g. prisons, hospitals, schools. etc.)

YES ☐ NO ☒ participants whose capacity to give consent may be in doubt (e.g. learning disability, confusion, etc.)

YES ☐ NO ☒ participants who have received medical, psychiatric, clinical psychological or other similar attention

YES ☐ NO ☒ participants being investigated in connection with a performance deficit (e.g. dyslexia)

For anything ticked YES, please provide more detailed information and justification.

Participants will be recruited from the Naz Project, a London wide sexual health charity in which I work as a coordinator. Authorization has been granted by the charity management (signed form attached). Prospective clients will be contacted via email, text or phone calls and will receive an information sheet and detailed explanation about the research, as well as its relevance and impact for

the Brazilian community in London. Many of this client group has participated in various similar research from other researchers in the past and were able to decide for themselves if they wanted to take part or not, never been pressurized to do so by our charity. I will explain clearly that there is no pressure for them to take part and will go through the information sheet individually with them, exercising their autonomy to refuse if they like. A signed consent form giving authorization will be required from each participant.

I am aware I am in a position of power as the coordinator of Naz Vidas, and hence, the gatekeeper to resources, and I would never use this position to pressure participants to take part in this project.

YES ☐ NO ☒ are there any inducements for taking part

If YES, please provide more detailed information and justification.

(6) Data storage and anonymity.

YES ☐ NO ☒ is there a possibility of disclosure of confidential information (e.g. to other participants)

YES ☐ NO ☒ is there a possibility of identification of participants (e.g. when reporting results)

If YES, please provide more detailed information and justification.

Survey data will be collected and processed using PHE software and facilities, and PHE storage and anonymity protocols will be observed. Interviews and translations of interviews will be kept according to the same protocols where hard copies will be kept in locked cabinets and software will have passwords. Participant names will be coded to ensure anonymity.

The data collected for this research will be safely and securely kept for seven years from any publication and will then be safely destroyed, as per university policy requirements.

Public Health England (PHE) has an established role in monitoring HIV nationally. Its predecessors (Health Protection Agency and the Public Health Laboratory Service) monitored HIV infection nationally since the epidemic began in the early 1980s.

PHE are legally covered to collect confidential HIV data from NHS services through National Information Governance Board (NIGB) approval under section 251, including patient identifiable information without consent.

Statutory Instrument 2002 No. 1438 in The Health Service (Control of Patient Information) Regulations 2002 provides the legal basis for this data handling. Details of this can be found at: <http://www.legislation.hms.gov.uk/si/si2002/20021438.htm>

PHE is registered under the Data Protection Act 1998 (registration number Z7749250) to handle data for diagnostic, public health and other purposes.

As with any means of data collected online and stored on servers, such as with survey software, I am aware that there is a small risk that the data could be hacked into. This information will also be passed to prospective participants via the Information Sheet.

(7) Awareness of ethical behavior when collecting data.

Researchers must indicate awareness of ethical behavior when collecting data

from human participants by submitting the completed *Awareness of Ethical Behavior for Data Collection* (next pg) with this application. For students on a module, this form must be submitted with their work.

(8) Informed Consent Form

Provide an informed consent form for approval. The final page gives guidelines for producing one.

For Office Use Only

YES ☒ The form Awareness of Ethical Behavior for Data Collection has been included and ticked appropriately.

YES ☒ An appropriate consent form has been provided.

Approved By: Jen Birks Date: 28/05/15 Agreed By: Liz Evans Date: 28/05/2015

Awareness of Ethical Behavior for Data Collection

- ☒ Data gathering activities involving schools and other organizations will be carried out only with the agreement of the head of school/organization, or an authorised representative, and after adequate notice has been given.
- ☒ The purpose and procedures of the project, and the potential benefits and costs of participating (e.g. the amount of their time involved), will be fully explained to prospective participants at the outset.
- ☒ My full identity will be revealed to potential participants.
- ☒ Prospective participants will be informed that data collected will be treated in the strictest confidence and will only be reported in anonymised form, but that I will be forced to consider disclosure of certain information where there are strong grounds for believing that not doing so will result in harm to research participants or others, or (the continuation of) illegal activity.
- ☒ All potential participants will be asked to give their explicit, normally written consent to participating in the research, and, where consent is given, separate copies of this will be retained by both researcher and participant. These consent forms should be submitted as an Appendix, along with this form.
- ☒ In addition to the consent of the individuals concerned, the signed consent of a parent, guardian or 'responsible other' will be required to sanction the participation of minors (i.e. persons under 16 years of age) or those whose 'intellectual capability or other vulnerable circumstance may limit the extent to which they can be expected to understand or agree voluntarily'.
- ☒ Undue pressure will not be placed on individuals or institutions to participate in project activities.
- ☒ The treatment of potential research participants will in no way be prejudiced if they choose not to participate in the project.
- ☒ I will provide participants with my contact details (and details of the module convenor) in order that they are able to make contact in relation to any aspect of the project, should they wish to do so.
- ☒ Participants will be made aware that they may freely withdraw from the project at any time without risk or prejudice.
- ☒ Research will be carried out with regard for mutually convenient times and negotiated in a way that seeks to minimise disruption to schedules and burdens on participants.
- ☒ At all times during the conduct of the research I will behave in an appropriate, professional manner and take steps to ensure that neither myself nor research participants are placed at risk.
- ☒ The dignity and interests of research participants will be respected at all times, and steps will be taken to ensure that no harm will result from participating in the research.
- ☒ The views of all participants in the research will be respected and special efforts will be made to be sensitive to differences relating to age, culture,

disability, race, sex, religion and sexual orientation, amongst research participants, when planning, conducting and reporting on the research.

✓ Data generated by the research will be kept in a safe and secure location and will be used purely for the purposes of the project (including dissemination of findings). No-one other than markers and examiners will have access to any of the data collected.

✓ Research participants will have the right of access to any data kept on them.

✓ All necessary steps will be taken to protect the privacy and ensure the anonymity and non-traceability of participants – e.g. by the use of pseudonyms, for both individual and institutional participants.

✓ Where possible, participants will be provided with a summary of research findings and an opportunity for debriefing after taking part in the research.

✓ If working with children 16 and under for a prolonged period of time, I have received Advanced Criminal Records Bureau (CRB) disclosure.

Signed: __José H Resinente__

Date: __25/01/2015__

Appendix 2

Data Abstraction Form

Literature Review Studies

Vulnerability to HIV Infection: An Investigation of HIV/AIDS-related Knowledge, Attitude and Practices of the Brazilian Expatriate Population in England

Country, Author, Journal, Year, (Language)	Title	Topic	Methodology	Key findings (vulnerability or/and framework for prevention)	Limitations
USA, Mikawa et al, Hispanic Journal of Behavioral Sciences, 1992 (English)	Cultural Practices of Hispanics: Implication for the Prevention of AIDS	- Hispanics - HIV-related KAP - Condom use - Acculturation	Survey questionnaire	- The least educated among the Hispanics, especially recent immigrants, should be targeted for HIV prevention - Condom use was associated with “the one who buys the condoms”, mostly men - Also, machismo practices such as “protecting the women” could be used for reinforcing condom use messages	- Sample not randomly selected on a representative basis - The findings were based on self-reports
USA, McQuiston et al, Clinical Nursing Research, 1998 (English)	After-The-Fact Strategies Mexican Americans Use to Prevent HIV and STDs	- Mexicans - HIV-related KAP - Culture specific prevention	Focus Group	- Respondents used an “after exposure” as method of disease prevention, in line with lay model of illness - HIV prevention needs to be targeted differently for male Mexican Americans and females	- Small sample - Qualitative research might not be generalisable
USA, Organista et al, Health and Social Work, 1998 (English)	Exploring AIDS-Related Knowledge, Attitudes and Behaviours of Female Mexican Migrant Workers	- Mexicans - HIV-related KAP - Acculturation	- HIV-related KAP survey - Hispanic Condom Questionnaire	- Need for HIV education which is cultural and linguistically appropriate for each specific community - Problematic knowledge of how condoms should be used - Low use of condoms in this community group	Small sample, might not be generalisable

USA, McQuiston et al, Health Care for Women International, 2000 (English)	The Timing Is Never Right: Mexican Views of Condom Use	• Mexicans • HIV-related KAP • Condom use	• Focus group	• Men and women had different views on what safe sex meant. For men it was trust, for women it was communication. The women needed to communicate to trust, the men needed to trust to communicate • Might not have open discussion about safe sex • Need for interventions that puts people on the same timeline by addressing the need to use condoms early in the relationship (gender norms, skill building, etc.)	• All volunteers recruited from the same centre • Focus group about sex can introduce participant bias
USA, Raj et al, Public Health Reports, 2001 (English)	Is a General Women's Health Promotion Programme as Effective as an HIV-Intensive Prevention Programme in Reducing HIV Risk Among Hispanic Women?	• Hispanic women • Elements of HIV-related KAP • Condom use • HIV testing • HIV risk reduction	• Interventions: A 12-week general women's health promotion programme (WHP) X A 12-week HIV-intensive prevention programme (HIV-IP) • HIV-related self-administered KAP Survey before, after and 3 months following intervention	• Both WHP and HIV-IP interventions increased condom use • HIV-IP prevention programme appeared to be more effective in promoting safer sex negotiation • WHP appeared more effective in promoting HIV testing • Importance of risk-reduction programmes to be tailored to Hispanic women	• No randomisation of participants • All participants recruited through community service programme, clinics and community outreach at housing projects. Sample might not be representative
USA, Loue et al, Health Care for the Poor and Underserved, 2003 (English)	HIV Risk Among a Sample of Mexican and Puerto Rican Men and Women	• Mexican and Puerto Rican men and women • HIV-related KAP • HIV Risk behaviour (Perceived and actual risk, and predictors of risk)	• Interview-based study of HIV knowledge, risk behaviours and protective behaviours	• Individuals (Mexican and Puerto Ricans) who have been in the US for longer periods of time and who are younger in age are at an increased risk of HIV infection • Increased perceived risk may also be predictive of increased actual risk in this population	• May not be representative (sample not randomly selected) • Only two study sites were used for the research • Cross-sectional studies does not allow for causality

USA & Mexico, Villarruel et al, Transcultural Nursing, 2003 (English)	La Uniendo de Fronteras: Collaboration to Develop HIV Prevention Strategies for Mexican and Latino Youth	• Mexican and Latino youth • HIV-related KAP • HIV Risk-reduction	• Theoretical culturally based behavioural intervention designed to reduce HIV sexual risk behaviour among Latino adolescents	• This paper is about replicating a HIV prevention strategy developed in US for Latino youth in Mexico. The paper does not present any findings because it was written in the beginning of the collaboration. It is ongoing	• No findings or conclusions about the research was presented
USA, Shedlin et al, Urban Health, 2006 (English)	Immigration and HIV/AIDS in the New York Metropolitan Area	• Latinos, Caribbean and South Asians • Elements of HIV-related KAP • Vulnerability to HIV • HIV Risk	• Collaborative analysis of data from three studies of immigrant groups	• The need to understand and include immigrants in HIV prevention strategies planning and practices: "One size does not fit everyone"	• Participants of studies not randomly selected
Australia, Korner H, AIDS Care, 2007 (English)	Late HIV Diagnosis of People from Cultural and Linguistically Diverse Background in Sydney: The Role of Culture and Community	• Perspective of PLWH • Late HIV Diagnosis • Elements of HIV-related KAP	• Semi-structured in-depth interviews	• BAME communities need tailored education about HIV risk, treatment and discrimination awareness towards PLWH, in a culturally and linguistically appropriate way	• Participants were recruited from a multicultural HIV/AIDS and Hep C service and from a sexual health clinic. They might not be representative • Not randomly selected
USA, Hovey et al, Immigrant Health, 2007 (English)	Using Theatrical Presentations as a Means of Disseminating Knowledge of HIV/AIDS Risk Factors to Immigrant Farm Workers: An Evaluation of the Effectiveness of the <i>Infórmate</i> Programme	• Mexican Farmworkers • HIV-related KAP • HIV Risk • Theatrical Presentations	• HIV/AIDS intervention (<i>Infórmate</i>): Theatrical Presentation Evaluation • Before and after self-administered questionnaire	• Theatrical presentations can be an effective medium for increasing HIV/AIDS-related knowledge among migrant farmworkers in USA, but should be used with other educational methods to increase learning • Some farmworkers still hold false beliefs regarding modes of HIV transmission after the intervention	• No control group • Only Mexicans in sample • Only short term impact of intervention was measured
USA, Knipper et al, AIDS Education and Prevention, 2007 (English)	Condom Use Among Heterosexual Immigrant Latino Men in the Southeastern United States	• Latino Men • HIV-related KAP	• Cross-sectional survey • Community-based Participatory	• The need for innovative and targeted HIV/STIs prevention programmes among the emerging Latino communities. This	• Might not be generalisable to other Latinos

			Research (CBPR) approach used	need to be culturally and linguistically appropriate for each community	• Did not assess if condom use was correct • Assessment tool: survey was too long • Cross-sectional data: no causality • Might have desirability bias, or “faking good”
Spain, Rios et al, GAC Sanitario, 2009 (Spanish)	Knowledge of HIV and Sexually-Transmitted Diseases in Latin American and Maghrebi Immigrants in Catalonia (Spain)	• Latin Americans and Maghrebi • HIV-related KAP	• Semi-structured HIV-related KAP survey questionnaire through personal interview	• Low levels of HIV-related KAP • Interventions to educate immigrants is paramount in order to control the epidemic • Interventions need to be culturally and linguistically adequate to the immigrants	• Participants were only recruited in medical centres • Only Spanish speaker immigrants included on the research
USA, Bauer et al, DIS Mon, 2010 (English)	Improving Access to Primary Care and Health Outcomes for Migrant Farm Worker Populations: Challenges and Opportunities	• Mainly Latino Farm Workers • Access to Primary Care	• Methodology not discussed on the paper	• Migrant farmworkers need better access to health services that are culturally appropriate to their needs	• No explanation on methodology
Curacao (Netherlands), Hammer et al, Fam Community Health, 2010 (English)	How Much Do They Know About Sexual Health?	• Spanish Speaking Adolescents • HIV-related KAP • Sexual health education and prevention	• Baseline HIV-related KAP questionnaire • Focus Group Discussion using semi-structured question guide • Cross-sectional qualitative study	• Need for interventions that assist parents and adolescents to talk openly about interpersonal aspects of sexuality, as well as increase general communication • Need for further research on indication that early sexual initiation was due to force/coercion by older family member, such as stepfathers	• Response desirability bias (School settings) • Research about sex among classmates might add respondent bias • Interviewer bias (female interviewers only) • Sample not representative, as not randomly selected from all

					adolescents residing in Curacao
Europe, Brussa et al, HIV/AIDS Policy & Law Review, 2010 (English)	Vulnerabilities and Rights of Migrant Sex Workers in Europe	• Migrant Sex Workers (65 countries) • Vulnerability to HIV/STIs • Human Rights • Access to Health Services	• Article based on presentations from AIDS 2010 (International AIDS Conference)	• TAMPED estimates that only 30% of sex workers in Europe are covered by sexual health prevention activities • Access to health and social care services are needed to reduce vulnerability of sex workers to HIV/STIs	• No explanation of methodology was given • No bibliography
USA, Rhodes et al, American Journal of Industrial Medicine, 2010 (English)	HIV and Sexually Transmitted Disease Risk Among Male Hispanic/Latino Migrant Farmworkers in the Southeast: Findings From a Pilot CBPR Study	• Hispanic/Latino Migrant Farmworkers • HIV-related KAP • HIV/STIs Risk	• Community-based Participatory Research (CBPR) used • HIV/STIs-related Interviewer-administered questionnaire • Venous blood sample (syphilis)	• High intake of alcohol among Latino farmworkers • Low knowledge of HIV/STIs prevention and transmission • Low use of condoms • High use of sex workers	• Small sample size • Not assessed if migrants knew how to use condoms correctly • Cross-sectional data: no causality
Portugal, Dias et al, International Journal of Public Health, 2011 (English)	Factors Associated with HIV Testing Among Immigrants in Portugal	• Immigrants including Brazilians • Elements of HIV-related KAP • HIV Testing • HIV Information Seeking • HIV Stigma	• Quantitative study Survey questionnaire	• Adopting a more innovative approach to HIV testing is needed to improve efficacy of HIV prevention strategies among BAME communities. This need to be linguistically and culturally relevant	• Selection procedure might have biased results: only at National Immigrant Support Centre • Only English and Portuguese questionnaires might have excluded others
USA, Albarran et al, Association of Nurses in AIDS Care, 2011 (English)	HIV and Mexican Migrant Workers in the United States: A Review Applying the Vulnerable Populations Conceptual Model	• Mexicans • Vulnerable Populations Conceptual Model (VPCM)	• Literature Review	• Testing for migrants must be incorporated into routine care • Clinicians should be sensitive to the plight of migrants and not ask about their immigration status, not to scare them from accessing services	• Many of the studies included on this review do not make distinction between farm workers and day labourers (in the city)

				Cultural sensitivity is particularly important for health professionals caring for migrants	The study does not present a methodology
USA, Hacker et al, Social Science & Medicine, 2011 (English)	The Impact of Immigration and Customs Enforcement on Immigrant Health: Perceptions of Immigrants in Everett, Massachusetts, USA	- Various immigrants, including 18 Brazilians - Immigration and health - Access to Health	- Focus group - Community-based Participatory Research (CBPR) - Short survey for demographics and about prior use of health services	Fear of deportation increased migrants levels of stress, affected their emotional wellbeing, and limited their access to health care services	- Small sample - Only recruited in one community centre - Participants not measured for mental health conditions in relation to stress and depression - Focus group not recorded
USA, Rhodes et al, AIDS Behaviour, 2011 (English)	A Randomized Control Trial of a Culturally Congruent Intervention to Increase Condom Use and HIV Testing Among Heterosexually Active Immigrant Latino Men	- Latino men - HIV-related KAP - Condom use - HIV testing	- Randomised Control Trial (RCT) - Community-based Participatory Research (CBPR) - HIV Prevention Intervention x Cancer Education Intervention - Interviewer-administered baseline data collection (start + 3 months later)	Community-based interventions for immigrant Latino men that are developed in partnership with community members can greatly enhance preventive behaviours and may reduce HIV infection	- Study conducted with Latino men in North Carolina only. Might not be generalisable - Relied on self-reported sexual behaviour - Short follow-up period (3 months) - The comparison intervention was not equivalent in length - Data were not blinded - Six participants attended a different study arm from which they were randomly assigned
USA, Shedlin et al, Immigration	Research Participant Recruitment in Hispanic	- Hispanic Immigrants - Elements of HIV-related KAP	- Qualitative methods - Research Participant Recruitment (RPR)	Importance of using sensitivity, such as immigration issues, which causes immigrants to become hard-to-reach	Limitations of Paper not discussed

Minority Health, 2011 (English)	Communities: Lessons Learned	• Behavioural Research	• Semi-structured interviews • Focus groups (Informants and providers) • Ethnographic observations	• Community-based and faith organisations are key to aid in reaching hard-to-reach communities	• Participants only recruited in the New York metropolitan area. Might not be generalisable to other areas
USA, Chen et al, Immigrant Minority Health, 2012 (English)	HIV Testing Behaviours Among Latinos in Baltimore City	• Latinos • Migration History • Acculturation Level • HIV Risk Perception • HIV Risk Behaviour • HIV Knowledge	• Cross-sectional survey	• The need for HIV education in the Latino community in Baltimore City • The need for targeted sexual health services for Latinos, must be culturally and linguistically appropriate	• Participants only recruited at one health centre (BCHD), and hence might not be generalisable to all Latinos in Baltimore • The ARSMA II acculturation scale instrument used was developed for Mexicans, not all Latinos • Self-reported HIV risk and testing, might have misclassification
USA, Chavez L, Social Science & Medicine, 2012 (English)	Undocumented Immigrants and Their Use of Medical Services in Orange County, California	• Documented x undocumented Latinos x non-Latino white citizens • Access to Health	• Telephone survey (Randomly selected)	• Undocumented immigrants had relatively low income and were less likely to have medical insurance; experience a number of stresses in their lives; and underutilised medical services when compared to legal immigrants and citizens	• The research was done in only one county, might not be generalisable • Limited by telephone-based survey (excluded families without telephone) • Limited ethnographic depth

USA, Calabrese et al, AIDS Patient Care and STDs, 2012 (English)	The Pleasure Principle: The Effect of Perceived Pleasure Loss Associated with Condoms on Unprotected Anal Intercourse Among Immigrant Latino Men Who Have Sex With Men	• Latino MSM, including Brazilians • HIV-related KAP • Condom Use	• Computer assisted self-interviewing technology with audio enhancement KAP survey	• Pleasure needs to be prioritised in the development of condoms and other sexual safety measures as well as in the promotion of their use	• Causality could not be established (Cross-sectional study) • Condoms not specified in the research (Male or female)
USA, Castillo-Mancilla et al, Immigrant Minority Health, 2012 (English)	Differences in Sexual Risk Behaviour and HIV/AIDS Risk Factors Among Foreign-Born and US-Born Hispanic Women	• Foreign-Born and US-Born Hispanic Women • HIV Risk Factors • HIV-related KAP	• Self-administered survey questionnaire	• Foreign born Latinas were more likely to not having had a HIV test or access to health services • Prevention strategies should consider the different needs of the community depending on their levels of acculturation	• Self-administered sexual health survey can present reporting bias • Small sample in a single metropolitan area with suspected low risk of HIV • Non-representative sample (Recruited at STI clinics)
USA & Mexico, Holmes S, Social Science and Medicine, 2012 (English)	The Clinical Gaze in the Practice of Migrant Health: Mexican Migrants in the United States	• Triqui Mexicans Farm Workers • Structural Barriers to Health Care	• Long-term participant observation with practitioners & migrants (Ethnography) • In-depth Interviews • Grounded Theory	• This paper challenges the focus of mainstream cultural competence training by showing that it is not the culture of the patient, but rather the structure and culture of biomedicine that form the primary barriers to effective multicultural health care	• Limitations not discussed in paper • Small sample
Switzerland, Darling et al, Posgrad Med Journal, 2013 (English)	Suboptimal Access to Primary Healthcare Among Street-Based Sex Workers in Southwest Switzerland	• Sex Workers (including Brazilians) • Access to Health Care • Access to HIV Testing	• Cross-sectional survey questionnaire	• 56% of sex workers had no health insurance • 70% unaware of health services • HIV prevalence not known (untested) • Public health issue: HIV testing need to be available for migrant sex workers	• Recruitment bias (only outreach van) • Only permitted areas were visited. Some sex workers might work in non-permitted areas, therefore, sample might not be representative

Spain, Hoyos et al, International AIDS Society, 2013 (English)	Never Tested for HIV in Latin-American Migrants and Spaniards: Prevalence and Perceived Barriers	• Latin-Americans & Spaniards • Elements of HIV-related KAP • HIV Prevention • HIV Testing	• Anonymous self-administered questionnaires, that were code-linked to participants' HIV test results	• Higher prevalence of HIV testing among Latino immigrants than Spaniards • Same barriers to HIV testing identified for Latino immigrants and Spaniards: low perceived risk of HIV infection	• Self-reported risk behaviour could have responder or desirability bias • Sample not representative from either population: migrant or general population
USA, Gilbert et al, AIDS Patient Care and STDs, 2013 (English)	HIV Testing Among Immigrant Sexual and Gender Minority Latinos in a US Region with Little Historical Latino Presence	• Latinos • HIV-related KAP • HIV Testing • HIV Prevention	• Cross-sectional face-to-face KAP Interviews • Community-based Participatory Research (CBPR) • Respondent Driven Sample (RDS)	• Majority of immigrants had HIV test in last year, however incidence remains high • Prevention strategies should ensure adequate safeguards for undocumented Latinos, providing culturally and linguistically congruent services	• RDS as a recruitment method could bias the sample (homophily), and hence might not be generalisable • Cross-sectional survey: no causality • Modest sample size, may have reduced statistical power of regression model
USA, Rhodes et al, Health Promotion Practice, 2013 (English)	A Systematic Community-Based Participatory Approach to Refining an Evidence-Based Community-Level Intervention: The HOLA Intervention for Latino Men Who Have Sex With Men	• MSM Latinos • HIV-related KAP • Health Promotion • Lay Health Advisors (LHA)	• Community-based Participatory Research (CBPR) • Respondent Driven Sample (RDS) • Intervention using Lay Health Advisors (LHA), the "Navegantes"	• Successful sexual health interventions for Latino MSM should use a similar model as the "HOLA" intervention, using both CBPR and RDS	• RDS as a recruitment method could bias the sample (homophily), and hence might not be generalisable
Spain, Rodrigues-Alvarez et al, Immigrant Minority Health, 2013 (English)	Social Factors Associated with the Knowledge About HIV of the Immigrants From China, Latin America, the Maghreb and Senegal in the Basque Country (Spain)	• Chinese, Latin-Americans, Maghreb and Senegalese • Access to Health • HIV Vulnerability • HIV Prevention	• Cross-sectional survey	• Needs of different migrant communities need to be taken into consideration if health inequality is to be addressed, including details of gender issues	• Selection bias due to non-random sampling • Small sample size could have weakened the

					strength of the association
Canada, Ochoa et al, Culture, Health & Sexuality, 2014 (English)	Risk Perception and Vulnerability to STIs and HIV/AIDS Among Immigrant Latin-American Women in Canada	- Latino Women - HIV-related KAP - Migration and HIV/STI Risk - Access to Health Services - Vulnerability Framework	- In-depth Interviews - Ethnographic Approach (Observations)	The provision of health services to the Latino-American women must focus on sexual and reproductive health needs and should do so from a multicultural perspective that takes into account the changes associated with the migration process	- Self-reported risk behaviour questionnaire might have responder or desirability bias - Small sample - Women recruited from two health and social service centres, might not be generalisable
USA, Grieb et al, Immigrant Minority Health, 2015 (English)	Qualitative Assessment of HIV Prevention Challenges and Opportunities Among Latino Immigrant Men in a New Receiving City	- Latino Men - Barriers to HIV Testing - Barriers to HIV Prevention - ICT	- Qualitative Research - Focus Group - Thematic analysis	- Information and Communication Technology (ICT) is good for prevention in this community (mHealth) - Community-based Organisations (CBOs) are a good way to offer HIV testing - This community need extra HIV education	- Small sample, might not be generalisable - May have social desirability bias - May have limited discussion of stigmatised behaviours because of peers
USA, Rhodes et al, AIDS Education and Prevention, 2015 (English)	Condom Use Among Immigrant Latino Sexual Minorities: Multilevel Analysis After Respondent-Driven Sampling	- Latino Sexual Minorities - HIV-related KAP - Homophobia - Condom Use - HIV Prevention	- Respondent Driven Sample (RDS) - Interviewer-administered survey	- Good HIV-related KAP increase condom use - Homophobia decreased consistent condom use	- Interviewer-administered (desirability bias) - Sample from North Carolina might not be generalisable to other Latino communities - Medium sample size - Cross-sectional data: no causality
USA, Sanchez et al, World Medical and	Evaluating a Culturally Tailored HIV Risk Reduction Intervention Among Latina	Undocumented Latinas	Intervention: Salud, Educación,	The SEPA intervention was effective in increasing HIV knowledge and decreasing HIV risk behaviours. However, no changes	Data was self-reported (could have

Health Policy, 2016 (English)	Immigrants in the Farmworker Community	• Elements of HIV-related KAP • HIV Risk Reduction	Prevención et Autocuidado (SEPA) • Community-based Participatory Research (CBPR) • Individual interviews • Focus groups	in self-efficacy were found in the present sample	poor recall or social desirability bias) • No comparison group • Small non-clinical sample
KAP = Knowledge, Attitudes and Practices; CBPR = Community-based Participatory Research; PLWH = People Living With HIV; RCT = Randomized Control Trial; RPR = Research Participant Recruitment; RDS = Respondent Driven Sample; LHA = Lay Health Advisors; ICT = Information Communication Technology; SEPA = <i>Salud, Educacion, Prevención, Autocuidado</i> (Health, Education, Prevention, Self-Care)					

Appendix 3 – PCAP England Survey Questionnaire (Portuguese)

Apoio:



PCAP - Inglaterra - 2016

Esta pesquisa é sobre a saúde sexual e planejamento familiar de brasileiros que moram na Inglaterra. **A sua participação é indispensável, e irá nos ajudar a entender as necessidades de nossa comunidade neste país, e a criar serviços adequados a estas necessidades.** Vamos perguntar sobre seus conhecimentos, atitudes e práticas em relação a saúde sexual. Favor observar que as mesmas perguntas são feitas, com muito respeito, para todos, sem discriminação. O questionário é completamente SIGILOSO (NÃO PRECISA NEM NOME, NEM ENDEREÇO), e você tem o direito de interromper e parar de preencher quando quiser.

Este questionário pode levar entre 20 a 45 minutos para ser preenchido, e devido sua natureza, sugerimos responder em privacidade, e quando tiver tempo disponível. Todas perguntas devem ser respondidas para se passar de uma página a outra. Uma mensagem em vermelho aparece caso a página esteja incompleta. Ao terminar cada página, favor descer ao final da mesma e clicar na tecla [PRÓXIMO], para continuar. Na última página, quando terminar o questionário, favor clicar na tecla [ENVIAR/TERMINAR].

Obrigado por ajudar a nossa comunidade a crescer! Boa sorte!

Em que país você nasceu?

- ☐ Brasil
- ☐ Outro

Sexo

- ☐ Masculino
- ☐ Feminino
- ☐ Transgender

Qual a sua orientação sexual?

- ☐ Homem heterossexual
- ☐ Mulher heterossexual
- ☐ Homem gay/homossexual
- ☐ Lésbica/homossexual
- ☐ Homem bissexual
- ☐ Mulher bissexual
- ☐ Prefiro não responder

Qual a sua idade?

Qual o seu estado conjugal?

- ☐ Nunca foi casado(a) ou viveu com companheiro(a) (solteiro(a))
- ☐ Casado(a) atualmente
- ☐ Vive com companheiro(a) atualmente
- ☐ Já viveu com companheiro(a) e não vive mais
- ☐ Separado(a) ou divorciado(a)
- ☐ Viúvo(a)

Qual o seu grau de escolaridade?

- ☐ Analfabeto(a)
- ☐ Ensino fundamental
- ☐ Ensino médio
- ☐ Universidade (incompleto)
- ☐ Universidade (completo)
- ☐ pós-graduado (incompleto)
- ☐ pós-graduado (completo)

Você está estudando atualmente?

- ☐ Sim
- ☐ Não

Qual foi o curso mais elevado que o/a chefe de sua família completou?

- ☐ Analfabeto(a)
- ☐ Ensino fundamental
- ☐ Ensino médio
- ☐ Universidade (incompleto)
- ☐ Universidade (completo)
- ☐ pós-graduado (incompleto)
- ☐ pós-graduado (completo)

Como você se classifica em relação a sua cor ou raça?

- ☐ Branca
- ☐ Preta
- ☐ Amarela
- ☐ Parda
- ☐ Indígena
- ☐ Outra

Em que estado do Brasil você nasceu?

- ☐ Acre
- ☐ Alagoas
- ☐ Amapá
- ☐ Amazonas
- ☐ Bahia
- ☐ Ceará
- ☐ Distrito Federal
- ☐ Espírito Santo
- ☐ Goiás
- ☐ Maranhão
- ☐ Mato Grosso
- ☐ Mato Grosso do Sul
- ☐ Minas Gerais
- ☐ Paraíba
- ☐ Pará
- ☐ Paraná
- ☐ Pernambuco

- ☐ Piauí
- ☐ Rio de Janeiro
- ☐ Rio Grande do Norte
- ☐ Rio Grande do Sul
- ☐ Rondônia
- ☐ Roraima
- ☐ Santa Catarina
- ☐ São Paulo
- ☐ Sergipe
- ☐ Tocantins

Em que ano você se mudou para o Reino Unido (Inglaterra, Escócia, Irlanda do Norte e País de Gales)? Por exemplo: 2015

Quando você deixou o Brasil, qual país/países você morou antes de se mudar para o Reino Unido? Várias opções

- ☐ Espanha
- ☐ Portugal
- ☐ França
- ☐ Itália
- ☐ Alemanha
- ☐ Irlanda
- ☐ Outro país europeu
- ☐ América do Norte
- ☐ América Central
- ☐ América do Sul
- ☐ África
- ☐ Ásia
- ☐ Oceania
- ☐ Nenhum, eu vim do Brasil direto para o Reino Unido

Você tem outra nacionalidade além da brasileira?

- ☐ Sim
- ☐ Não

Qual outra nacionalidade você tem?

- ☐ Britânica
- ☐ Espanhola

- ☐ Portuguesa
- ☐ Francesa
- ☐ Italiana
- ☐ Alemã
- ☐ Irlandesa
- ☐ Outra nacionalidade europeia
- ☐ Outra nacionalidade

Qual a sua situação de imigração no Reino Unido?

- ☐ Visto de Permanência
- ☐ Visto de turista
- ☐ Passaporte europeu/Dupla nacionalidade
- ☐ Visto de casamento
- ☐ Visto de estudante
- ☐ Asilo
- ☐ Ilegal/Visto vencido

Favor escrever a primeira parte do código postal de onde você mora. Por exemplo, Se seu código for SE24 0JT, Favor escrever "SE24"

Você se considera religioso(a)?

- ☐ Sim
- ☐ Não

Qual a sua religião?

- ☐ Católica
- ☐ Evangélica
- ☐ Budista
- ☐ Muçulmana
- ☐ Espírita
- ☐ Umbanda/Candomblé
- ☐ Outras religiões

Qual é a sua situação de trabalho atual?

- ☐ Servidor(a) público(a)
- ☐ Empregado(a) (pagando taxas)
- ☐ Empregado(a) (dinheiro na mão, sem pagar taxas)

- ☐ Trabalha por conta própria e não tem empregados
- ☐ Empregador(a)
- ☐ Não trabalha atualmente

Qual a principal razão para você não estar trabalhando atualmente?

- ☐ Dona de casa / cuidando da família
- ☐ Procurou, mas não conseguiu encontrar trabalho
- ☐ Trabalhos não remunerados
- ☐ Estudos / treinamento
- ☐ Aposentado / incapacitado para o trabalho
- ☐ Doença
- ☐ Outro

Nos últimos 12 meses, qual foi sua principal ocupação?

- ☐ Altos funcionáRíos do governo, dirigentes, gerentes ou altos funcionáRíos de empresa
- ☐ Profissionais do nível superior
- ☐ Profissionais das artes
- ☐ Profissionais ou técnicos de nível médio
- ☐ Trabalhadores de serviços administrativos
- ☐ Trabalhadores da prestação de serviços e comerciáRíos
- ☐ Trabalhadores de serviços domésticos (exemplo: cleaners)
- ☐ Trabalhadores agropecuáRíos, florestais de caça e pesca
- ☐ Trabalhadores manuais (produção de bens e serviços industriais)
- ☐ Construção / Pedreiro
- ☐ Trabalhadores manuais de reparação e manutenção
- ☐ Membros das forças armadas, policiais e bombeiros militares
- ☐ Ocupações mal especificadas do trabalho informal (ambulante, manobrista, guardador de carro, etc)
- ☐ Profissionais do sexo/Escort/Adult Worker
- ☐ Desempregado

Qual o nível de inglês que você fala?

- ☐ Não falo Inglês
- ☐ Falo o básico
- ☐ Escrevo o básico

- ☐ Falo fluentemente
- ☐ Falo e escrevo fluentemente
- ☐ Proficiente

Agora, por favor, responda as seguintes perguntas da melhor maneira possível:

Gostaria de saber qual ou quais doenças uma pessoa pode ser infectada por meio de alimentos ou de água contaminada? Várias opções

- ☐ Aids
- ☐ Sífilis
- ☐ Hepatite A
- ☐ Hepatite B
- ☐ Hepatite C
- ☐ Hepatite D
- ☐ Dengue
- ☐ Malária
- ☐ Gonorréia
- ☐ Nenhuma destas

E, qual ou quais das doenças uma pessoa pode ser infectada ao usar banheiros públicos? Várias opções

- ☐ Aids
- ☐ Sífilis
- ☐ Hepatite A
- ☐ Hepatite B
- ☐ Hepatite C
- ☐ Hepatite D
- ☐ Dengue
- ☐ Malária
- ☐ Gonorréia
- ☐ Nenhuma destas

E, para qual ou quais doenças uma pessoa pode ser infectada compartilhando escova de dente? Várias opções

- ☐ Aids
- ☐ Sífilis
- ☐ Hepatite A
- ☐ Hepatite B
- ☐ Hepatite C
- ☐ Hepatite D

- ☐ Dengue
- ☐ Malária
- ☐ Gonorréia
- ☐ Nenhuma destas

E, qual ou quais das doenças uma pessoa pode ser infectada ao compartilhar com outras pessoas instrumentos para o uso de drogas, tais como seringa, agulha, cachimbo, latinha, canudo, etc.? Várias opções

- ☐ Aids
- ☐ Sífilis
- ☐ Hepatite A
- ☐ Hepatite B
- ☐ Hepatite C
- ☐ Hepatite D
- ☐ Dengue
- ☐ Malária
- ☐ Gonorréia
- ☐ Nenhuma destas

E, qual ou quais doenças uma pessoa pode ser infectada ao não usar preservativos em relações sexuais? Várias opções

- ☐ Aids
- ☐ Sífilis
- ☐ Hepatite A
- ☐ Hepatite B
- ☐ Hepatite C
- ☐ Hepatite D
- ☐ Dengue
- ☐ Malária
- ☐ Gonorréia
- ☐ Nenhuma destas

E, qual ou quais doenças uma pessoa pode ser infectada compartilhando os instrumentos de manicure/pedicure (alicate de unha, lixa, espátula, etc)? Várias opções

- ☐ Aids
- ☐ Sífilis
- ☐ Hepatite A
- ☐ Hepatite B
- ☐ Hepatite C

- ☐ Hepatite D
- ☐ Dengue
- ☐ Malária
- ☐ Gonorréia
- ☐ Nenhuma destas

E, para qual ou quais doenças uma pessoa pode ser infectada fazendo tratamento dentário, endoscopia ou hemodiálise? Várias opções

- ☐ Aids
- ☐ Sífilis
- ☐ Hepatite A
- ☐ Hepatite B
- ☐ Hepatite C
- ☐ Hepatite D
- ☐ Dengue
- ☐ Malária
- ☐ Gonorréia
- ☐ Nenhuma destas

E, para qual ou quais doenças uma pessoa pode ser infectada fazendo tatuagem ou colocando piercieng? Várias opções

- ☐ Aids
- ☐ Sífilis
- ☐ Hepatite A
- ☐ Hepatite B
- ☐ Hepatite C
- ☐ Hepatite D
- ☐ Dengue
- ☐ Malária
- ☐ Gonorréia
- ☐ Nenhuma destas

Agora, para cada frase que eu citar, gostaria de saber se você concorda ou discorda.

Uma pessoa pode ser infectada pelo vírus da hepatite B, C ou D compartilhando lâminas de barbear ou de depilar.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

Uma pessoa pode ser infectada pelo vírus da hepatite B, C ou D ao realizar qualquer cirurgia.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

O risco de transmissão do vírus da aids pode ser reduzido, se uma pessoa tiver relações sexuais somente com parceiro fiel e não infectado.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

Uma pessoa com aparência saudável pode estar infectada pelo vírus da aids.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

Usar preservativo é a melhor maneira de evitar que o vírus da aids seja transmitido durante a relação sexual.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

Uma pessoa pode ser infectada com o vírus da aids compartilhando talheres, copos, ou refeições.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

Uma mulher grávida que esteja com o vírus da aids e recebe um tratamento específico durante a gravidez e no momento do parto, diminui o risco de passar o vírus da aids para o seu filho.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

Existe cura para a aids.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

Uma pessoa que está tomando medicamento para aids tem menos risco de transmitir o vírus da aids para outra pessoa.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

Aids é uma doença crônica, possível de ser controlada.

- ☐ Concorda
- ☐ Discorda
- ☐ Não sabe

A mulher tem o direito de terminar uma gravidez (aborto).

- ☐ Concorda
- ☐ Discorda
- ☐ Depende da situação
- ☐ Prefiro não responder

Agora vou fazer perguntas sobre o atendimento do serviço de saúde e sobre algumas doenças sexualmente transmissíveis.

Qual foi a última vez que você precisou ir a um médico?

- ☐ Há menos de 2 semanas
- ☐ Entre 15 dias e um mês
- ☐ Entre um mês e 3 meses atrás
- ☐ Entre três meses e um ano
- ☐ Há mais de um ano atrás

Qual foi a razão de precisar ir ao médico?

- ☐ Acidente ou lesão
- ☐ Continuação de tratamento ou terapia
- ☐ Pílulas anticoncepcionais
- ☐ Consulta pré-natal
- ☐ Exame médico periódico
- ☐ Outro exame médico (admissional, para carteira de motorista, etc.)

- ☐ Doença sexualmente transmissível
- ☐ Outro problema de saúde

Foi aqui no Reino Unido?

- ☐ Sim
- ☐ Não

Onde procurou o primeiro atendimento médico por este motivo?

- ☐ Médico de bairro (GP)
- ☐ Hospital
- ☐ Clínica de saúde sexual
- ☐ Ambulância
- ☐ Pronto socorro de um hospital do 'NHS'
- ☐ Hospital particular
- ☐ Dentista do 'NHS'
- ☐ Dentista particular
- ☐ Clínica particular
- ☐ Em casa, com enfermeiros do 'NHS'
- ☐ Hospital particular
- ☐ NAZ Vidas
- ☐ Outra organização (Casa do Brasil, ABRAS, LH4U, etc)
- ☐ Consulado do Brasil
- ☐ Outro lugar

Você sabe onde conseguir pílulas anticoncepcionais de graça no Reino Unido?

- ☐ Sim
- ☐ Não

Quando foi a última vez que fez um exame ginecológico?

- ☐ Nos últimos 3 anos
- ☐ 4-5 anos atrás
- ☐ Mais de 5 anos atrás
- ☐ Nunca fez
- ☐ Não sabe

Pensando nessa última vez que você fez o exame ginecológico, você fez o exame preventivo (Papanicolau)?

- ☐ Sim
- ☐ Não
- ☐ Não lembra

Você tem ou já teve relações sexuais com parceiro que tem ou já teve corrimento pelo canal da urina?

- ☐ Sim
- ☐ Não
- ☐ Não lembra / não sabe

Você já teve, alguma vez na vida, algum dos seguintes sintomas:

Feridas na genitália? (vulva, vagina, partes íntimas, etc)

- ☐ Sim
- ☐ Não
- ☐ Irrelevante

Quantos anos você tinha no último episódio:

Corrimento pelo canal da urina?

- ☐ Sim
- ☐ Não
- ☐ Irrelevante

Quantos anos você tinha no último episódio:

Feridas no pênis?

- ☐ Sim
- ☐ Não
- ☐ Irrelevante

Quantos anos você tinha no último episódio:

Pequenas bolhas no pênis?

- ☐ Sim
☐ Não
☐ Irrelevante

Quantos anos você tinha no último episódio:

Verrugas (berrugas) no pênis?

- ☐ Sim
☐ Não
☐ Irrelevante

Quantos anos você tinha no último episódio:

Você já foi alguma vez em sua vida diagnosticado(a) com alguma das seguintes doenças? (varias opções)

	Sim	Não	Prefiro não responder
Clamídia	☐	☐	☐
Você foi diagnosticado(a) nos últimos 12 meses?	☐	☐	☐
Gonorréia	☐	☐	☐
Você foi diagnosticado(a) nos últimos 12 meses?	☐	☐	☐
Sífilis	☐	☐	☐
Você foi diagnosticado(a) nos últimos 12 meses?	☐	☐	☐

E, na última vez em que você teve algum desses sintomas, você fez algum tipo de tratamento?

- ☐ Sim
☐ Não
☐ Não lembra

Na última vez que você teve um desses sintomas, recebeu alguma dessas orientações? (Favor responder todas):

	Sim	Não
Usar regularmente preservativo	☐	☐
Informar aos (às) parceiros (as)	☐	☐
Fazer o teste de HIV	☐	☐
Fazer o teste de sífilis	☐	☐
Fazer os testes para as hepatites B e C	☐	☐

Quem foi o primeiro profissional que você procurou na última vez que teve algum desses sintomas?

- ☐ Médico
- ☐ Farmacêutico
- ☐ Outra pessoa
- ☐ Não procurou atendimento

Você já operou de fimose ou fez circuncisão?

- ☐ Sim
- ☐ Não

Você já foi em alguma clínica de doença sexualmente transmissível (DST) aqui no Reino Unido?

- ☐ Sim
- ☐ Não

Você achou que os médicos que cuidaram de você eram de confiança e seguros?

- ☐ Sim
- ☐ Não

Os médicos lhe deram oportunidades de decidir o tipo de tratamento que você recebeu?

- ☐ Sim
- ☐ Não

Você recebeu informação suficiente sobre sua enfermidade e tratamento?

- ☐ Sim, a informação que recebi foi suficiente
- ☐ Recebi um pouco só de informação
- ☐ Recebi o suficiente de informação
- ☐ Recebi informação mas não falo inglês
- ☐ Não recebi nenhuma informação

Você acha que sua privacidade foi respeitada em todo momento quando sendo examinado(a) e tratado(a) pelo médico(a)?

- ☐ Sim
- ☐ Não

Em geral, o que você achou da sua experiência com o serviço médico que você recebeu?

- ☐ Minha experiência foi muito ruim
- ☐ Minha experiência foi ruim
- ☐ Minha experiência foi boa
- ☐ Minha experiência foi excelente

Você já fez o teste para aids alguma vez na vida?

- ☐ Sim
- ☐ Não
- ☐ Não lembra

Você fez o teste para aids nos últimos 12 meses?

- ☐ Sim
- ☐ Não
- ☐ Não lembra

Quantas vezes você fez o teste para aids nos últimos 12 meses?

- ☐ Sim

- ☐ Não
- ☐ Não lembra

Você já fez um teste rápido de aids cujo resultado sai na hora?

- ☐ Sim
- ☐ Não
- ☐ Não lembra

Em que local você fez o último teste para aids?

- ☐ Hospital público no Brasil (SUS)
- ☐ Hospital particular (Brasil)
- ☐ Clínica de saúde sexual grátis (outro país da Europa)
- ☐ Clínica de saúde sexual no Reino Unido (NHS)
- ☐ Médico de bairro (GP)
- ☐ Hospital público (Reino Unido - NHS)
- ☐ Hospital particular (Reino Unido)
- ☐ Hospital particular (outro país da Europa)
- ☐ NAZ Vidas
- ☐ Outra organização (e.g.: Casa do Brasil, ABRAS, LH4U, etc)
- ☐ Não lembro

Qual foi o principal motivo para você ter feito o último teste para aids?

- ☐ Por solicitação do empregador
- ☐ Doou sangue somente para se testar
- ☐ Doou sangue porque precisou ou quis
- ☐ Pré-natal
- ☐ Algum comportamento de risco
- ☐ Curiosidade
- ☐ Parceira (o) pediu
- ☐ Parceira (o) está infectada (o) pelo vírus da aids
- ☐ Indicação médica
- ☐ Outro motivo
- ☐ Não lembra

Quanto tempo o resultado do último teste para aids demorou para ficar pronto?

- ☐ No mesmo dia
- ☐ Menos de uma semana
- ☐ Mais de uma semana e menos de um mês

- ☐ De 1 a 2 meses
- ☐ Mais de dois meses

Ainda com relação ao seu último teste para aids, você sabe o resultado?

- ☐ Sim
- ☐ Não
- ☐ Não lembra

Se você não se importa em me informar, qual foi o resultado de seu último teste?

- ☐ Positivo
- ☐ Negativo
- ☐ Não lembro

Em qual país você foi diagnosticado primeiro com o vírus do HIV/aids?

- ☐ Brasil
- ☐ Reino Unido
- ☐ Espanha
- ☐ Portugal
- ☐ França
- ☐ Alemanha
- ☐ Itália
- ☐ Irlanda
- ☐ Outro país europeu
- ☐ América do Norte
- ☐ América Central
- ☐ América do Sul
- ☐ África
- ☐ Ásia
- ☐ Oceania

Depois que você soube do resultado positivo do teste de aids, você foi encaminhado para médico especialista ou algum serviço de saúde?

- ☐ Sim, para o serviço público
- ☐ Sim, para o serviço particular
- ☐ Não fui encaminhado
- ☐ Prefiro não dizer

Você foi ao médico especialista ou ao serviço de saúde quanto tempo depois de ter recebido o resultado positivo do teste de aids?

- ☐ Em até uma semana
- ☐ Entre 7 dias e um mês
- ☐ Entre um mês e 3 meses
- ☐ Mais de três meses
- ☐ Ainda não fui

Como você avalia o seu risco de se infectar com o vírus da aids?

- ☐ Nenhum
- ☐ Baixo
- ☐ Médio
- ☐ Alto

Você sabe de algum serviço de saúde no Reino Unido onde o teste de aids é feito gratuitamente?

- ☐ Sim
- ☐ Não

Você já ouviu falar sobre a Profilaxia Pós-Exposição do HIV (PEP)?

- ☐ Sim
- ☐ Não

Você sabe onde obter a Profilaxia Pós-Exposição do HIV (PEP) de graça, no Reino Unido?

- ☐ Sim
- ☐ Não

Você já ouviu falar sobre a Profilaxia Pré-Exposição (PrEP) do HIV?

- ☐ Sim
- ☐ Não

Você já fez o teste de hepatite alguma vez na vida?

- ☐ Sim
- ☐ Não
- ☐ Não lembra

Para qual ou quais tipos de hepatites você fez o teste? Pode responder mais de uma.

- ☐ Hepatite B
- ☐ Hepatite C
- ☐ Hepatite D
- ☐ Não lembra / Não sabe

Você fez teste de hepatite nos últimos 12 meses?

- ☐ Sim
- ☐ Não
- ☐ Não lembra / Não sabe

Em que local você fez o último teste de hepatite?

- ☐ Hospital público no Brasil (SUS)
- ☐ Hospital particular (Brasil)
- ☐ Clínica de saúde sexual grátis (outro país da Europa)
- ☐ Clínica de saúde sexual no Reino Unido (NHS)
- ☐ Médico de bairro (GP)
- ☐ Hospital público (Reino Unido - NHS)
- ☐ Hospital particular (Reino Unido)
- ☐ Hospital particular (outro país da Europa)
- ☐ NAZ Vidas
- ☐ Outra organização (Casa do Brasil, ABRAS, LH4U, etc)
- ☐ Não lembro

Qual foi o principal motivo para você ter feito o último o teste de hepatite?

- ☐ Por solicitação do empregador
- ☐ Doou sangue somente para se testar para hepatite
- ☐ Doou sangue porque precisou ou quis
- ☐ Pré-natal
- ☐ Algum comportamento de risco
- ☐ Curiosidade
- ☐ Parceira (o) pediu
- ☐ Parceira (o) está infectada (o) pelo vírus da hepatite
- ☐ Indicação médica
- ☐ Outro motivo
- ☐ Não lembra

Quanto tempo o resultado do último teste demorou para ficar pronto?

- ☐ No mesmo dia
- ☐ Menos de uma semana
- ☐ Mais de uma semana e menos de um mês
- ☐ De 1 a 2 meses
- ☐ Mais de dois meses

Ainda com relação ao seu último teste de hepatite, você sabe o resultado?

- ☐ Sim
- ☐ Não
- ☐ Não lembra

Você se importa em me dizer o resultado do seu último(s) teste(s)?

- ☐ Positivo
- ☐ Negativo
- ☐ Não sabe/Prefere não responder

Você sabe de algum serviço de saúde no Reino Unido onde os testes de hepatites B e/ou C são feitos gratuitamente?

- ☐ Sim
- ☐ Não

Você já se vacinou para hepatite B?

- ☐ Sim, e tomei uma dose
- ☐ Sim, e tomei duas doses
- ☐ Sim, e tomei três doses
- ☐ Sim, mas não lembro quantas doses
- ☐ Não
- ☐ Não lembro/ Não sei informar

Você já recebeu transfusão de sangue alguma vez na vida?

- ☐ Sim, nos últimos 12 meses
- ☐ Sim, entre um ano e 20 anos atrás
- ☐ Sim, à mais de 20 anos atrás
- ☐ Não, nunca!

Você já doou sangue alguma vez na vida?

- ☐ Sim, nos últimos 12 meses
- ☐ Sim, entre um ano e 20 anos atrás

- ☐ Sim, há mais de 20 anos atrás
- ☐ Não

Você já tomou vacina para o HPV?

- ☐ Sim
- ☐ Não
- ☐ Não lembro / não sei informar

Agora, gostaria de saber a sua opinião sobre os seguintes temas:

Em relação à afirmação “um casal gay tem direito a adotar uma criança”, você:

- ☐ Concorda
- ☐ Discorda

Em relação a ter amigos gays, você:

- ☐ Nunca teria amigos gays
- ☐ Talvez teria amigos gays
- ☐ Teria amigos gays sem problema

Gostaria de saber se você concorda com as seguintes afirmações:

Concorda

Discorda

“Se você soubesse que há uma criança com aids na escola de seu filho, você continuaria a mandar seu filho a esta escola”.

“Se você soubesse que alguém que trabalha vendendo legumes e verduras está com o vírus da aids, você continuaria comprando esses alimentos dessa pessoa”.

“Se uma professora tem o vírus da aids, mas não está doente, ela pode continuar

a dar aulas em qualquer escola.

Nos últimos 12 meses, como você teve acesso à camisinha:

- ☐ De graça dos postos de saúde do 'NHS'
- ☐ De graça (NAZ Vidas)
- ☐ De graça através de outra organização brasileira (e.g.: Casa do Brasil, ABRAS, LH4U, etc)
- ☐ Comprei na farmácia
- ☐ Comprei em supermercado
- ☐ Comprei em outro lugar
- ☐ Não consegui camisinha em lugar nenhum
- ☐ Não sei onde conseguir camisinha de graça
- ☐ Não preciso de camisinha

Nos últimos 12 meses, você recebeu ou pegou camisinha de graça na escola?

- ☐ Sim
- ☐ Não

Você conhece o preservativo feminino, mesmo que só de ouvir falar?

- ☐ Sim
- ☐ Não

Nos últimos 12 meses, você recebeu ou pegou preservativo feminino de graça?

- ☐ Sim, através do NHS
- ☐ Sim, através das ONGs
- ☐ Sim, de outro lugar
- ☐ Não

Agora, gostaria que você respondesse algumas perguntas sobre sua vida sexual:

Você já teve relações sexuais alguma vez na sua vida?

- ☐ Sim
- ☐ Não

Com quantos anos de idade você teve a sua primeira relação sexual?

Você já teve mais do que um parceiro(a) sexual em toda sua vida?

- ☐ Sim
- ☐ Não
- ☐ Não quero responder

Quantos parceiros(as) sexuais você teve em toda sua vida?

Você já teve relação sexual com pessoa do mesmo sexo que o seu alguma vez na vida?

- ☐ Sim
- ☐ Não
- ☐ Não quero responder

Atualmente, de uma maneira geral, com quem você mantém relações sexuais?

- ☐ Somente com homens
- ☐ Somente com mulheres
- ☐ Tanto com homens quanto com mulheres
- ☐ Prefiro não responder

Agora, favor falar de suas experiências sexuais somente nos últimos 12 meses.

Você teve relações sexuais nos últimos 12 meses?

- ☐ Sim
- ☐ Não
- ☐ Prefiro não responder

Você teve relações sexuais no último mês?

- ☐ Sim
- ☐ Não
- ☐ Prefiro não responder

Quantos parceiros(as) sexuais você teve nos últimos 12 meses?

Pensando na sua última relação sexual vocês usaram camisinha?

- ☐ Sim
- ☐ Não
- ☐ Não sei / prefiro não responder

Você teve relação sexual com parceiros (as) fixos (as), ou seja, namorado (a), noivo (a), esposo (a), companheiro (a), etc., nos últimos 12 meses?

- ☐ Sim
- ☐ Não
- ☐ Prefiro não responder

Nas relações sexuais que você teve com esses parceiros (as) fixos (as), vocês usaram camisinha?

- ☐ Sim
- ☐ Não
- ☐ Não sei / prefiro não responder

Vocês usaram camisinha em todas as vezes?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Você teve relação sexual com parceiros (as) casuais, ou seja, paqueras, “ficantes”, rolos, etc., nos últimos 12 meses?

- ☐ Sim
- ☐ Não
- ☐ Não quero responder

Nas relações sexuais que você teve com estes parceiros (as) casuais, ou seja, paqueras, “ficantes”, rolos, etc. vocês usaram camisinha?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Vocês usaram camisinha em todas as vezes?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Pensando somente na última relação sexual com parceiro (a) casual, nos últimos 12 meses, você usou camisinha?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Desses parceiros(as) casuais, nos últimos 12 meses, você recebeu dinheiro em troca de sexo de algum deles?

- ☐ Sim
- ☐ Não
- ☐ Não quero responder

Vocês usaram camisinha nas relações sexuais em que você recebeu dinheiro em troca de sexo, nos últimos 12 meses?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Vocês usaram camisinha em todas as vezes que você recebeu dinheiro em troca de sexo?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Ainda pensando nos últimos 12 meses, você pagou alguma pessoa para ter sexo?

- ☐ Sim
- ☐ Não
- ☐ Não quero responder

Você usou camisinha nas relações sexuais que você teve com esses parceiros (as) que você pagou para ter sexo?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Vocês usaram camisinha em todas as vezes que você teve relações sexuais com parceiros(as) que você pagou para ter sexo?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Você teve relações sexuais com parceiro(a) fixo e com parceiros(as) casuais no mesmo período de tempo?

- ☐ Sim
- ☐ Não
- ☐ Não quero responder

Você já teve relações sexuais com pessoas que conheceu pela internet?

- ☐ Sim
- ☐ Não
- ☐ Não quero responder

Na última relação sexual que teve com essas pessoas que conheceu pela internet você usou camisinha?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Agora, gostaria de falar sobre preservativos e lubrificantes íntimos.

Você já teve relação sexual com mulher usando preservativo feminino?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Você já teve relação sexual usando preservativo feminino?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Você já teve relação sexual usando preservativo feminino?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Você conhece lubrificantes íntimos, mesmo que só de ouvir falar?

- ☐ Sim
- ☐ Não

Nas relações sexuais, para uma lubrificação extra, você usa lubrificantes íntimos:

- ☐ Sim
- ☐ Não

Agora vamos falar um pouco sobre hábitos e costumes.

Você concorda com a seguinte afirmação: “o uso de álcool ou drogas pode fazer com que as pessoas transem sem usar camisinha”?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Isso já aconteceu com você?

- ☐ Sim
- ☐ Não
- ☐ Não sei / não quero responder

Favor indicar se você já usou alguma vez:

	Sim	Não	Não quero responder
álcool			
Você bebe atualmente?	☐	☐	☐
maconha	☐	☐	☐
Você fuma maconha atualmente?	☐	☐	☐
anfetamina (são drogas estimulantes como bolinhas, rebites, medicamentos para emagrecer, ritalina, modafinil, ecstasy, etc)	☐	☐	☐
Você usa anfetamina (são drogas estimulantes como bolinhas, rebites, medicamentos para emagrecer, ritalina, modafinil, ecstasy, etc) atualmente?	☐	☐	☐
cocaína	☐	☐	☐
Você cheira cocaína atualmente?	☐		☐
cocaína injetada	☐	☐	
Você já se injetou com seringa/agulha que havia sido usada antes por outra pessoa?	☐	☐	☐

Parabéns, você chegou ao final do questionário.
 Obrigado pela sua participação! Visite agora a website
["snapsurvey.phe.org.uk/nazpcap"](https://snapsurvey.phe.org.uk/nazpcap) caso queira participar
 de um sorteio para um 'Apple Watch'."

Appendix 4 – Table 3.1 Sociodemographic Characteristics – PCAP England

Sociodemographic Characteristics - PCAP England (Collected from 11/11/15 to 13/04/16)							
Variables	N	%					
Total	1,018	100					
Gender							
Male	487	47.8					
Female	529	52					
Transgender	2	0.2					
Sexual orientation							
Heterosexual man	361	35.5					
Heterosexual woman	487	47.8					
Gay man/homosexual	107	10.5					
Lesbian	17	1.67					
Bisexual man	13	1.28					
Bisexual woman	17	1.67					
Prefer not to say	16	1.57					
	Total		Male		Female		p-value
	N	%	N	%	N	%	
Total	1,018	100	487	100	529	100	-
Region of birth (Brazil)							
North	33	3.24	16	3.3	16	3	0.429
Northeast	97	9.53	41	8.4	55	10	
Southeast	559	54.9	264	54	295	56	
South	170	16.7	80	16	90	17	
West	136	13.4	76	16	60	11	
Missing data	23	2.26	10	2.1	13	2.5	
Age range							
14 - 24 years	184	18.1	99	20	85	16	0.009
25 - 34 years	374	36.7	190	39	183	35	
35 - 49 years	385	37.8	173	36	211	40	
50 - 81 years	75	7.37	25	5.1	50	9.5	
Marital status							
Never married or cohabited	248	24.4	155	32	93	18	
Married	455	44.7	191	39	264	50	

Cohabiting	152	14.9	68	14	84	16	<0.001
Cohabited before but not now	63	6.19	36	7.4	26	4.9	
Separated or divorced	96	9.43	36	7.4	59	11	
Widowed	4	0.39	1	0.2	3	0.6	
Currently studying							
Yes	285	28	410	84	377	71	<0.001
No	733	72	77	16	152	29	
Education							
GCSE	46	4.52	24	4.9	22	4.2	0.005
A-level	324	31.8	171	35	152	29	
University (incomplete)	248	24.4	131	27	116	22	
University (complete)	227	22.3	91	19	136	26	
Postgraduate (incomplete)	30	2.95	15	3.1	15	2.8	
Postgraduate (complete)	143	14	55	11	88	17	
Ethnicity (in Brazil defined by skin colour)							
White	650	63.9	309	63	341	64	0.002
Black	71	6.97	47	9.7	24	4.5	
Yellow	28	2.75	9	1.8	19	3.6	
Mixed	164	16.1	82	17	81	15	
Indigenous	20	1.96	11	2.3	9	1.7	
Other	85	8.35	29	6	55	10	
Double nationality							
Yes, British	120	11.8	45	9.2	74	14	0.003
Yes, European	417	41	227	47	190	36	
Yes, another non-European	15	1.47	6	1.2	9	1.7	
No, only Brazilian	466	45.8	209	43	256	48	
Immigration status							
Leave to Remain	251	24.7	106	22	145	27	0.01
Tourist Visa	55	5.4	26	5.3	29	5.5	
European passport/Double Nationality	491	48.2	256	53	234	44	
Spouse Visa	123	12.1	45	9.2	77	15	
Student Visa	54	5.3	29	6	25	4.7	
Over stayer	44	4.32	25	5.1	19	3.6	
Follow any religion							
Yes	626	61.5	288	59	336	64	0.152
No	392	38.5	199	41	193	36	
Which religion (1)							

Catholic	295	47.1	124	43	170	51	0.162
Evangelical	221	35.3	108	38	112	33	
Other religion	110	17.6	56	19	54	16	
Employment							
Civil servant	24	2.36	13	2.7	11	2.1	<0.001
Employed (paying tax)	511	50.2	268	55	243	46	
Employed (cash in hand, not paying tax)	83	8.15	48	9.9	35	6.6	
Self-employed with no employees	144	14.1	64	13	78	15	
Employer	27	2.65	17	3.5	10	1.9	
Out of work	229	22.5	77	16	152	29	
English language							
Do not speak	31	3.05	13	2.7	18	3.4	0.002
Basic only spoken	208	20.4	82	17	126	24	
Basic only written	59	5.8	40	8.2	19	3.6	
Speaks fluently	158	15.5	86	18	72	14	
Speak and write fluently	338	33.2	163	33	174	33	
Proficiency level	224	22	103	21	120	23	

Source: PCAP England

Note (1): Percentage of those who have a religion

Appendix 5 – Table 3.4

Distribution of Total Participants with correct Knowledge regarding HIV Transmission and Prevention. Comparison between two samples.

Agree with the following statements:	%	%	p-value
	(N = 1,018) Brazilians in England* (PCAP England)	(N = 12,000) Brazilians in Brazil** (PCAP 2013)	
Having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection	74.3	78.5	<0.001
A person living with HIV can look healthy	90.5	90.8	0.375
Using condom during penetrative sex is the best way to avoid HIV infection	91.7	94.0	0.002
A person cannot contract HIV through sharing cutlery, foods or drinks	77.4	73.8	0.006
A pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth	70.9	66.6	0.003
There is no cure for HIV	72.8	80.4	<0.001
A HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person	23.3	33.1	<0.001
HIV is a chronic illness that can be medically controlled	59.2	78.4	<0.001

*Source: PCAP England

**Source: PCAP 2013 (Brazilian Ministry of Health)

Appendix 6 - Table 3.5

Distribution of Total Participants with Correct Knowledge regarding HIV Transmission and Prevention by Gender, in England

Agree with the following statements:	Total (N = 1.018)		Male (N = 487)		Female (N = 529)		p-value
	N	%	N	%	N	%	-
Having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection	756	74.3	376	77.2	379	71.6	<0.001
A person living with HIV can look healthy	921	90.5	440	90.4	479	90.6	0.614
Using condom during penetrative sex is the best way to avoid HIV infection	933	91.7	443	91.0	488	92.3	0.496
A person cannot contract HIV through sharing cutlery, foods or drinks	788	77.4	362	74.3	424	80.2	0.081
A pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth	722	70.9	344	70.6	377	71.3	0.511
There is no cure for HIV	741	72.8	357	73.3	383	72.4	0.633
A HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person	237	23.3	134	27.5	102	19.3	0.008
HIV is a chronic illness that can be medically controlled	603	59.2	279	57.3	322	60.9	0.149

Source: PCAP England

Appendix 7 - Table 3.6

Distribution of Total Participants with Correct Knowledge regarding HIV Transmission and Prevention by Age Groups (14 to 81 y.o.)

Agree with the following statements:	Total (N = 1.018)		14 to 24 years (N = 184)		25 to 34 years (N = 374)		35 to 49 years (N = 385)		50 to 81 years (N = 75)		p-value
	N	%	N	%	N	%	N	%	N	%	-
Having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection	756	74.3	137	74.5	262	70.1	300	77.9	57	76.0	0.001
A person living with HIV can look healthy	921	90.5	150	81.5	338	90.4	365	94.8	68	90.7	<0.001
Using condom during penetrative sex is the best way to avoid HIV infection	933	91.7	156	84.8	350	93.6	363	94.3	64	85.3	<0.001
A person cannot contract HIV through sharing cutlery, foods or drinks	788	77.4	112	60.9	288	77.0	327	84.9	61	81.3	<0.001
A pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth	722	70.9	114	62.0	273	73.0	290	75.3	45	60.0	0.002
There is no cure for HIV	741	72.8	131	71.2	270	72.2	290	75.3	50	66.7	0.669
A HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person	237	23.3	41	22.3	84	22.5	100	26.0	12	16.0	0.037
HIV is a chronic illness that can be medically controlled	603	59.2	77	41.9	207	55.4	274	71.2	45	60.0	<0.001

Source: PCAP England

Appendix 8 - Table 3.7

Distribution of Total Participants with Correct Knowledge regarding HIV Transmission and Prevention by Marital Status

Agree with the following statements	Living with a partner						p-value
	Total (N = 1.018)		Yes (N = 607)		No (N = 411)		
	N	%	N	%	N	%	
Having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection	756	74.3	448	73.8	308	74.9	0.458
A person living with HIV can look healthy	921	90.5	561	92.4	360	87.6	0.033
Using condom during penetrative sex is the best way to avoid HIV infection	933	91.7	565	93.1	368	89.5	0.128
A person cannot contract HIV through sharing cutlery, foods or drinks	788	77.4	494	81.4	294	71.5	<0.001
A pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth	722	70.9	441	72.7	281	68.4	0.328
There is no cure for HIV	741	72.8	437	72.0	304	74.0	0.767
A HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person	237	23.3	126	20.8	111	27.0	<0.001
HIV is a chronic illness that can be medically controlled	603	59.2	388	63.9	215	52.3	0.001

Source: PCAP England

Appendix 9 - Table 3.8

Distribution of Total Participants with Correct Knowledge regarding HIV Transmission and Prevention by Education Level

Agree with the following statements:	Total (N = 1.018)		Basic Education (N = 618)		Higher Education (N = 400)		p-value
	N	%	N	%	N	%	
Having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection	756	74.3	442	71.5	314	78.5	0.016
A person living with HIV can look healthy	921	90.5	550	89.0	371	92.8	0.014
Using condom during penetrative sex is the best way to avoid HIV infection	933	91.7	553	89.5	380	95.0	0.003
A person cannot contract HIV through sharing cutlery, foods or drinks	788	77.4	439	71.0	349	87.3	<0.001
A pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth	722	70.9	414	67.0	308	77.0	0.002
There is no cure for HIV	741	72.8	403	65.2	338	84.5	<0.001
A HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person	237	23.3	129	20.9	108	27.0	0.024
HIV is a chronic illness that can be medically controlled	603	59.2	333	53.9	270	67.5	<0.001

Source: PCAP England

Appendix 10 - Table 3.9

Distribution of Total Participants with Correct Knowledge regarding HIV Transmission and Prevention by Ethnicity

Agree with the following statements:	Total (N = 1.018)		White (N = 650)		Black and mixed (N = 235)		Other skin colours (N = 133)		p-value
	N	%	N	%	N	%	N	%	
Having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection	756	74.3	500	76.9	172	73.2	84	63.2	0.001
A person living with HIV can look healthy	921	90.5	600	92.3	215	91.5	106	79.7	<0.001
Using condom during penetrative sex is the best way to avoid HIV infection	933	91.7	613	94.3	213	90.6	107	80.5	<0.001
A person cannot contract HIV through sharing cutlery, foods or drinks	788	77.4	505	77.7	181	77.0	102	76.7	0.512
A pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth	722	70.9	472	72.6	174	74.0	76	57.1	0.002
There is no cure for HIV	741	72.8	498	76.6	159	67.7	84	63.2	0.006
A HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person	237	23.3	149	22.9	56	23.8	32	24.1	0.872
HIV is a chronic illness that can be medically controlled	603	59.2	377	58.0	145	61.7	81	60.9	0.013

Source: PCAP England

Appendix 11 - Table 3.10

Distribution of Total Participants with Correct Knowledge regarding HIV Transmission and Prevention by Religion

Agree with the following statements:	Total (N = 1.018)		Religious:				
			Yes (N = 626)		No (N = 392)		p-value
	nº	%	nº	%	nº	%	
Having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection	756	74.3	470	75.1	286	73.0	0.686
A person living with HIV can look healthy	921	90.5	567	90.6	354	90.3	0.307
Using condom during penetrative sex is the best way to avoid HIV infection	933	91.7	575	91.9	358	91.3	0.849
A person cannot contract HIV through sharing cutlery, foods or drinks	788	77.4	473	75.6	315	80.4	0.200
A pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth	722	70.9	429	68.5	293	74.7	0.095
There is no cure for HIV	741	72.8	427	68.2	314	80.1	<0.001
A HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person	237	23.3	123	19.7	114	29.1	0.002
HIV is a chronic illness that can be medically controlled	603	59.2	349	55.8	254	64.8	0.005

Source: PCAP England

Appendix 12 - Table 3.11

Distribution of Total Participants with Correct Knowledge regarding HIV Transmission and Prevention by Employment

Agree with the following statements:	Total (N = 1.018)		Currently working				
			Yes (N = 789)		No (N = 229)		
	N	%	N	%	N	%	p-value
Having a monogamous relationship with a HIV negative partner decreases the risk of HIV infection	756	74.3	596	75.5	160	69.9	0.225
A person living with HIV can look healthy	921	90.5	717	90.9	204	89.1	0.697
Using condom during penetrative sex is the best way to avoid HIV infection	933	91.7	730	92.5	203	88.7	0.164
A person cannot contract HIV through sharing cutlery, foods or drinks	788	77.4	616	78.1	172	75.1	0.310
A pregnant woman who has HIV but takes appropriate medication diminishes the risks of passing the virus to the baby during pregnancy and birth	722	70.9	568	72.0	154	67.3	0.342
There is no cure for HIV	741	72.8	580	73.5	161	70.3	0.423
A HIV positive person who is successfully taking HIV medication has less risk of passing on the virus to another person	237	23.3	177	22.4	60	26.2	0.390
HIV is a chronic illness that can be medically controlled	603	59.2	463	58.7	140	61.1	0.142

Source: PCAP England

Appendix 13 - Table 3.12

Distribution of individuals in relation to access to health services by gender
(anywhere in the world)

Variables:	Total (N = 1.018)		Male (N = 487)		Female (N = 529)		
	N	%	N	%	N	%	p-value
Last time visited a doctor							
Less than 2 weeks ago	157	15.4	65	13.3	92	17.4	<0.001
Last 15 to 30 days	79	7.8	29	6.0	50	9.5	
Last 30 days to 3 months	211	20.7	82	16.8	128	24.2	
Last 3 months to a year	237	23.3	112	23.0	125	23.6	
Over a year ago	334	32.8	199	40.9	134	25.3	
Reason of your visit							
Accident & emergency	158	15.5	126	25.9	31	5.9	<0.001
Treatment or therapy	88	8.6	47	9.7	41	7.8	0.282
Contraception	89	8.7	1	0.2	88	16.6	<0.001
prenatal examination	37	3.6	5	1.0	32	6.1	<0.001
Routine examination	272	26.7	106	21.8	165	31.2	0.001
Other medical condition	23	2.3	15	3.1	8	1.5	0.093
STI	34	3.3	24	4.9	10	1.9	0.007
Another health problem	372	36.5	187	38.4	185	35.0	0.257
Had access to a doctor in England	817	80.3	377	77.4	438	82.8	0.031
Knows where to get free contraception methods in England¹	376	71.1	-	-	376	71.1	-
Last time had a gynaecological examination¹							
In the last 3 years	428	80.9	-	-	428	80.9	-
4-5 years ago	29	5.5	-	-	29	5.5	
More than 5 years ago	11	2.1	-	-	11	2.1	
Never	37	7.0	-	-	37	7.0	
Does not know	24	4.5	-	-	24	4.5	
Had Pap smear done (Papanicolaou)²	398	93.0	-	-	398	93.0	-

Source: PCAP England

Notes: (1) Only among women

(2) Only among women who had a gynaecological examination in the last 3 years

Appendix 14 - Table 3.13

Distribution of ever having an STI according to epidemiological variables (Sores, blisters and warts)

Variables:	Total	Sores		Blisters		Warts	
	N	N	%	N	%	N	%
Total	1,018	66	6.5	61	6.0	53	5.2
Gender							
Male	487	29	6.0	30	6.2	21	4.3
Female	529	37	7.0	31	5.9	32	6.1
p-value	-	-	0.502	-	0.041	-	0.214
Age range							
14 - 24 years	184	5	7.6	10	16.4	7	0.0
25 - 34 years	374	24	6.4	20	5.4	23	6.2
35 - 49 years	285	33	8.6	29	7.5	21	5.5
50 - 81 years	75	4	5.3	2	2.7	2	2.7
p-value	-	-	0.065	-	0.325	-	0.487
Sexual orientation⁽¹⁾							
Heterosexual	848	53	6.3	50	5.9	48	5.7
Homosexual	124	8	6.5	8	6.5	2	1.6
Bisexual	30	2	6.7	3	10.0	3	10.0
p-value	-	-	0.993	-	0.642	-	0.086

Source: PCAP England

Notes: (1) Only among those who disclosed their sexual orientation

Appendix 15 - Table 3.14

Distribution of having at least once an STI according to epidemiological variables (Chlamydia, gonorrhoea and syphilis)

Variables:	At least once					
	Chlamydia (N=996)		Gonorrhoea (N = 993)		Syphilis (N = 982)	
	N	%	N	%	N	%
Total	72	7.2	44	4.4	22	2.2
Gender						
Male	40	8.5	40	8.4	20	4.3
Female	32	6.1	4	0.8	2	0.4
p-value	-	0.060	-	<0.001	-	<0.001
Age range						
14 to 24 years	4	2.2	3	1.7	0	0.0
25 to 34 years	26	7.1	18	4.9	3	0.8
35 to 49 years	39	10.4	21	5.7	17	4.6
50 to 81 years	3	3.0	2	2.8	2	2.7
p-value	-	0.007	-	0.357	-	0.007
Sexual orientation⁽¹⁾						
Heterosexual	43	5.1	17	2.1	3	0.4
Homosexual	26	22.2	24	20.2	17	14.7
Bisexual	2	7.4	3	10.3	2	7.1
p-value	-	<0.001	-	<0.001	-	<0.001

Source: PCAP England

Appendix 16 - Table 3.15

Distribution of having an STI in the last 12 months, according to epidemiological variables (Chlamydia, gonorrhoea and syphilis)

Variables:	In the last 12 months					
	Chlamydia (N = 72)		Gonorrhoea (N = 44)		Syphilis (N = 22)	
	N	%	N	%	N	%
Total	17	23.6	7	15.9	9	40.9
Gender						
Male	12	30.0	7	17.5	8	40.0
Female	5	15.6	0	0.0	1	50.0
p-value	-	0.269	-	0.648	-	0.204
Age range						
14 to 24 years	2	50.0	2	66.7	0	0.0
25 to 34 years	4	15.4	1	5.6	1	33.3
35 to 49 years	11	28.2	4	19.1	7	41.2
50 to 81 years	0	0.0	0	0.0	1	50.0
p-value	-	0.063	-	0.158	-	0.855
Sexual orientation⁽¹⁾						
Heterosexual	11	25.6	4	23.5	1	33.3
Homosexual	6	23.1	3	12.5	7	41.2
Bisexual	0	0.0	0	0.0	1	50.0
p-value	-	0.841	-	0.544	-	0.064

Source: PCAP England

Notes: (1) Only among those who disclosed their sexual orientation

Appendix 17 - Table 3.17

Distribution of individuals in relation to access to health services (anywhere in the world) following an STI occurrence, according to gender

Access to health services after STI diagnosis (Anywhere in the world)	Total (N = 104)		Male (N = 67)		Female (N = 37)		p-value
	N	%	N	%	N	%	
Received treatment	98	94.2	64	95.5	34	91.9	0.521
Orientations received:							
Use condoms regularly	86	82.7	59	88.1	27	73.0	0.141
Inform sexual partners	82	78.9	56	83.6	26	70.3	0.282
Take a HIV test	75	71.1	54	80.6	21	56.8	0.033
Take a syphilis test	70	67.3	54	80.6	16	43.2	<0,001
Take a Hep B and C test	69	66.4	54	80.6	15	40.5	<0,001
First professional contact							
Doctor	48	46.2	35	52.2	13	35.1	0.147
Pharmacy	3	2.9	3	4.5	0	0.0	
Another person	2	1.9	1	1.5	1	2.7	
No professional contact	51	49.0	28	41.8	23	62.2	

Source: PCAP England

Appendix 18 - Table 3.18

Distribution of individuals who have ever been to an STI clinic in England and their experience of the service, according to gender

Access to STI clinic in England	Total (N = 1.007)		Male (N = 486)		Female (N = 519)		p-value
	N	%	N	%	N	%	
Have ever been to an STI clinic in England	205	20.4	111	22.8	92	17.7	0.003
Found the doctors trustworthy and safe	196	95.6	108	97.3	86	93.5	0.536
Doctors gave an opportunity to discuss treatment options	177	86.3	95	85.6	80	87.0	0.750
Received enough information about illness and treatment							
Yes, the information was enough	182	88.8	98	88.3	82	89.1	0.838
Not enough information	15	7.3	8	7.2	7	7.6	
Information was given but I do not speak English	3	1.5	3	2.7	0	0.0	
No information was given	2	0.98	1	0.9	1	1.09	
Missing data	3	1.5	1	0.9	2	2.2	
My privacy was respected	200	97.6	109	98.2	89	96.7	0.908
What was your experience of the health service							
Very bad	3	1.5	0	0.0	3	3.3	0.186
Bad	7	3.4	3	2.7	4	4.3	
Good	103	50.2	63	56.8	40	43.5	
Excellent	90	43.9	45	40.5	43	46.7	
Missing data	2	1.0	0	0.0	2	2.2	

Source: PCAP England

Appendix 19 - Table 3.20 - Distribution of women who received HPV vaccination, according to sociodemographic information

Variables	Received HPV Vaccination	
	N	%
Total	90	17.0
Gender:		
Male	-	-
Female	90	17.0
Transgender	-	-
p-value	-	-
Age range:		
14 to 24 years	32	37.7
25 to 34 years	42	23.0
35 to 49 years	16	7.6
50 to 81 years	0	0.0
p-value	-	<0.001
Sexual orientation:		
Heterosexual	80	16.5
Homosexual	7	41.2
Bisexual	3	17.7
p-value	-	0.030
Marital status:		
Is in a relationship	53	15.2
Is not in a relationship	37	20.4
p-value	-	0.130
Education:		
Basic education	57	19.7
Higher education	33	13.8
p-value	-	0.075
Ethnicity (skin colour):		
White	61	17.9
Black or Mixed	16	15.2
Others	13	15.7
p-value	-	0.768
Religious belief:		
Yes	49	14.6
No	41	21.2
p-value	-	0.050
Has a job:		
Yes	61	16.2
No	29	19.1
p-value	-	0.422

Source: PCAP England

Appendix 20 - Table 3.21

Distribution of the number of HIV tests in the last 12 months, according to sociodemographic information

Variables	Total	Only once		Twice		Three times or more		p-value
	N	N	%	N	%	N	%	
Total	225	154	68.4	47	20.9	24	10.7	-
Gender:								
Male	103	60	58.3	29	28.2	14	13.6	0.004
Female	120	94	78.3	17	14.2	9	7.5	
Transgender	2	0	0.0	1	50.0	1	50.0	
Age range:								
14 to 24 years	16	10	62.5	3	18.8	3	18.8	0.822
25 to 34 years	99	66	66.7	24	24.2	9	9.09	
35 to 49 years	100	70	70.0	19	19.0	11	11.0	
50 to 81 years	10	8	80.0	1	10.0	1	10.0	
Sexual orientation:								
Heterosexual	161	120	74.5	30	18.6	11	6.8	0.011
Homosexual	51	28	54.9	13	25.5	10	19.6	
Bisexual	11	5	45.5	3	27.3	3	27.3	
Marital status:								
Is in a relationship	133	98	73.7	27	20.3	8	6.0	0.019
Is not in a relationship	92	56	60.9	20	21.7	16	17.4	
Education:								
Basic education	117	77	65.8	24	20.5	16	13.7	0.312
Higher education	108	77	71.3	23	21.3	8	7.4	
Ethnicity (skin colour):								
White	138	102	73.9	25	18.1	11	8.0	0.085
Black or Mixed	54	29	53.7	15	27.8	10	18.5	
Other	33	23	69.7	7	21.2	3	9.1	
Religious belief	123	83	67.5	27	22.0	13	10.6	0.911
Has a job	173	117	67.6	37	21.4	19	11.0	0.312

Source: PCAP England

Appendix 21 - Table 3.22

Distribution of HIV testing in the last 12 months in relation to location and reason of test, according to gender

HIV testing in the last 12 months	Total		Male		Female		p-value
	N	%	N	%	N	%	
Total	551	100	241	100	308	100	-
Location of HIV test:							
Public hospital in Brazil (SUS)	57	10.3	33	13.7	24	7.8	0.034
Private hospital (Brazil)	118	21.4	45	18.7	73	23.7	
Free STI clinic (Another European country)	30	5.4	16	6.6	14	4.5	
Free STI clinic in the UK (NHS)	143	26.0	74	30.7	67	21.8	
GP (NHS)	52	9.4	19	7.9	33	10.7	
Hospital (NHS)	87	15.8	28	11.6	59	19.2	
Private hospital (England)	12	2.2	4	1.7	8	2.6	
Private hospital (Another European country)	12	2.2	6	2.5	6	1.9	
NAZ Vidas (NGO)	4	0.7	1	0.4	3	1.0	
Another organisation	15	2.7	5	2.1	10	3.2	
Can't remember	21	3.8	10	4.1	11	3.6	
Reason for having the HIV test:							
Employer requested	17	3.1	10	4.1	7	2.3	<0.001
Donate blood to have a free HIV test	15	2.7	9	3.7	6	1.9	
Had a HIV test because of blood donation	31	5.6	20	8.3	11	3.6	
Prenatal examination	90	16.3	1	0.4	89	28.9	
Sexual risk behaviour	46	8.3	31	12.9	15	4.9	
CuRíosity	149	27.0	77	32.0	70	22.7	
Partner requested	24	4.4	13	5.4	11	3.6	
My partner is HIV +Ve	3	0.5	3	1.2	0	0.0	
Doctor suggested	53	9.6	15	6.2	38	12.3	
Another reason	95	17.2	50	20.7	45	14.6	
Can't remember	28	5.1	12	5.0	16	5.2	

Source: PCAP England

Appendix 22 - Table 3.23

Distribution of HIV testing logistic data (at least once), according to gender

HIV test results	Total		Male		Female		p-value
	N	%	N	%	N	%	
Total	551	100	241	100	308	100	-
How long it took to get the result:							
Same day	111	20.1	62	25.7	48	15.6	0.024
Less than a week	232	42.1	89	36.9	142	46.1	
More than a week, less than a month	173	31.4	78	32.4	95	30.8	
Between one and two months	25	4.5	8	3.3	17	5.5	
More than two months	10	1.8	4	1.7	6	1.9	
Know HIV status	533	96.7	232	96.3	299	97.1	0.550
HIV positive results⁽¹⁾	43	8.1	36	15.5	7	2.3	<0.001
Country where HIV was first diagnosed⁽²⁾:							
Brazil	12	27.9	8	22.2	4	57.1	0.148
UK	25	58.1	23	63.9	2	28.6	
Other	6	14.0	5	13.9	1	14.3	
Had appointment with a doctor following HIV diagnosis⁽²⁾	42	97.7	36	100	6	85.7	0.022
How long after HIV diagnosis had first appointment with HIV doctor ⁽²⁾:							
Within a week	23	53.5	18	50.0	5	71.4	0.043
Between a week and a month	13	30.2	13	36.1	0	0.0	
Between a month and three months	6	14.0	5	13.9	1	14.3	
After three months	1	2.3	0	0.0	1	14.3	

Source: PCAP England

Notes: (1) Only among those who know their HIV test result

(2) Only among those who know their HIV test result, and the result was positive

Appendix 23 - Table 3.26

Distribution of the HIV testing logistic data (at least once), according to sexuality

Data regarding HIV test results	Total		Heterosexual		Homosexual		Bisexual		p-value
	N	%	N	%	N	%	N	%	
Total	551	100	431	100	95	100	19	100	-
How long it took to get the result:									
Same day	111	20.1	75	17.4	33	34.7	2	10.5	0.003
Less than a week	232	42.1	195	45.2	28	29.5	7	36.8	
More than a week, less than a month	173	31.4	132	30.6	30	31.6	10	52.6	
Between one and two months	25	4.5	20	4.6	4	4.2	0	0.0	
More than two months	10	1.8	9	2.1	0	0.0	0	0.0	
Know HIV result	533	96.7	415	96.3	94	98.9	19	100	0.601
HIV positive results⁽¹⁾	43	8.1	9	2.2	32	34.0	2	10.5	<0.001
Country where HIV was first diagnosed⁽²⁾:									
Brazil	12	27.9	5	55.6	5	15.6	2	100	0.026
UK	25	58.1	3	33.3	22	68.8	0	0.0	
Others	6	14.0	1	11.1	5	15.6	0	0.0	
Had appointment with a doctor following HIV diagnosis⁽²⁾	42	97.7	8	88.9	32	100	2	100	0.145
How long after HIV diagnosis had first appointment with HIV doctor⁽²⁾:									
Within a week	23	53.5	6	66.7	16	50.0	1	50.0	0.207
Between a week and a month	13	30.2	0	0.0	12	37.5	1	50.0	
Between a month and three months	6	14.0	2	22.2	4	12.5	0	0.0	
After three months	1	2.3	1	11.1	0	0.0	0	0.0	

Source: PCAP England

Notes: (1) Only among those who know their HIV test result

(2) Only among those who know their HIV test result, and the result was positive

Appendix 24 - Table 3.28

Distribution of individuals who received or donated blood, according to sociodemographic information

Variables	Received blood						Donated blood			
	Total	At least once		In the last 12 months ⁽¹⁾			At least once		In the last 12 months ⁽²⁾	
	N	N	%	N	%		N	%	N	%
Total	1,018	62	6.1	9	14.5		288	28.3	43	14.9
Gender:										
Male	487	29	6.0	5	17.2		154	31.6	26	16.9
Female	529	33	6.2	4	12.1		134	25.3	17	12.7
Transgender	2	0	0.0	-	-		0	0.0	-	-
p-value	-	-	0.921	-	0.722		-	0.057	-	0.319
Age range:										
14 to 24 years	184	11	6.0	0	0.0		30	16.3	9	30.0
25 to 34 years	374	19	5.1	1	5.3		101	27.0	20	19.8
35 to 49 years	385	24	6.2	6	25.0		132	34.3	11	8.3
50 to 81 years	75	8	10.7	2	25.0		25	33.3	3	12.0
p-value	-	-	0.330	-	0.101		-	<0.001	-	0.008
Sexual orientation:										
Heterosexual	848	48	5.7	4	8.3		242	28.5	37	15.3
Homosexual	124	10	8.1	3	30.0		35	28.2	2	5.7
Bisexual	30	3	10.0	1	33.3		9	30.0	3	33.3
p-value	-	-	0.383	-	0.086		-	0.981	-	0.090
Marital status:										
Is in a relationship	607	34	5.6	4	11.8		193	31.8	24	12.4
Is not in a relationship	411	28	6.8	5	17.9		95	23.1	19	20.0
p-value	-	-	0.428	-	0.374		-	0.003	-	0.090
Education:										

Basic education	618	36	5.8	6	16.7	147	23.8	23	15.6
Higher education	400	26	6.5	3	11.5	141	35.3	20	14.2
p-value	-	-	0.660	-	0.427	-	<0.001	-	0.728
Ethnicity (skin colour):									
White	650	37	5.7	4	10.8	178	27.4	22	12.4
Black or Mixed	235	18	7.7	3	16.7	73	31.1	9	12.3
Other	133	7	5.3	2	28.6	37	27.8	12	32.4
p-value	-	-	0.509	-	0.315	-	0.558	-	0.006
Religious belief:									
Yes	626	38	6.1	6	15.8	164	26.2	19	11.6
No	392	24	6.1	3	12.5	124	31.6	24	19.4
p-value	-	-	0.973	-	1.000	-	0.061	-	0.067
Has a job:									
Yes	789	48	6.1	7	14.6	225	28.5	29	12.9
No	229	14	6.1	2	14.3	63	27.5	14	22.2
p-value	-	-	0.987	-	1.000	-	0.766	-	0.066

Source: PCAP England

Notes: (1) Percentage calculated only among those who have received blood at least once

(2) Percentage calculated only among those who have donated blood at least once

Appendix 25 - Table 3.29

Distribution of individuals' sexual practice/behaviour indicators in relation to HIV transmission, according to age groups

Population	Sexual practices/activities	Total (N = 1.018)		14 to 24 years (N = 184)		25 to 34 years (N = 374)		35 to 49 years (N = 385)		50 to 81 years (N = 75)		p-value
		N	%	N	%	N	%	N	%	N	%	
Total population	Had sex at least once	938	92.1	143	77.7	351	93.9	370	96.1	74	98.7	<0.001
	Had sex in the last 12 months	836	89.1	126	88.1	331	94.3	331	89.5	48	64.9	<0.001
	Had sex in the last month	736	88	107	84.9	306	92.5	287	86.7	36	75	0.008
Sexually active population	Had sex before age 15 years	235	25.1	57	39.9	104	29.6	69	18.7	5	6.76	<0.001
	Had more than one sexual partner	783	83.5	112	78.3	307	87.5	304	82.2	60	81.1	0.056
	Had more than 10 sexual partners(1)	279	35.6	29	25.9	116	37.8	121	39.8	13	21.7	0.005
	Had same gender sex	244	26	58	40.6	88	25.1	88	23.8	10	13.5	<0.001
Sexually active population (last 12 months)	Had more than one sexual partner	233	27.9	65	51.6	82	24.8	77	23.3	9	18.8	<0.001
	Had more than five sexual partners	90	10.8	21	16.7	29	8.76	37	11.2	3	6.25	0.071
	Had sex with fixed partners only	703	84.1	84	66.7	289	87.3	288	87	42	87.5	<0.001
	Had sex with casual partners	225	26.9	50	39.7	83	25.1	85	25.7	7	14.6	0.002
	Paid someone for sex(2)	33	14.7	4	8	10	12.1	16	18.8	3	42.9	0.049
	Had sex with people met on the internet (2)	114	50.7	16	32	42	50.6	53	62.4	3	42.9	0.008

Source: PCAP England

Notes: (1) Percentage calculated only among those who had sex at least once

(2) Percentage calculated only among those who had sex with casual partners in the last 12 months

Appendix 26 - Table 3.30

Distribution of individuals' sexual practice/behaviour indicators in relation to HIV transmission, according to sexuality ⁽¹⁾

Population	Sexual practices/activities	Total (N = 1.018)		Heterosexual (N = 848)		Homosexual (N = 124)		Bisexual (N = 30)		p-value
		N	%	N	%	N	%	N	%	
Total population	Had sex at least once	938	92.1	779	91.9	121	97.6	29	96.7	0.051
	Had sex in the last 12 months	836	89.1	697	89.5	110	90.9	25	86.2	0.550
	Had sex in the last month	736	88	618	88.7	94	85.5	20	80	0.023
Sexually active population	Had sex before age 15 years	235	25.1	168	21.6	58	47.9	7	24.1	<0.001
	Had more than one sexual partner	783	83.5	644	82.7	111	91.7	24	82.8	0.041
	Had more than 10 sexual partners ⁽²⁾	279	35.6	182	28.3	85	76.6	9	37.5	<0.001
	Had same gender sex	244	26	102	13.1	117	96.7	22	75.9	<0.001
Sexually active population (last 12 months)	Had more than one sexual partner	233	27.9	138	19.8	79	71.8	14	56	<0.001
	Had more than five sexual partners	90	10.8	31	4.45	54	49.1	4	16	<0.001
	Had sex with fixed partners only	703	84.1	607	87.1	72	65.5	20	80	<0.001
	Had sex with casual partners	225	26.9	144	20.7	70	63.6	9	36	<0.001
	Paid someone for sex ⁽³⁾	33	14.7	17	11.8	16	22.9	0	0	0.045
	Had sex with people met on the internet ⁽³⁾	114	50.7	49	34.0	58	82.9	6	66.7	<0.001

Source: PCAP England

Notes: (1) This table has 16 missing data

(2) Percentage calculated only among those who had sex at least once

(3) Percentage calculated only among those who had sex with casual partners in the last 12 months

Appendix 27 - Table 3.32

Distribution of individuals' sexual practice/behaviour indicators in relation to HIV transmission, according to marital status (is/is not in a relationship)

Population	Sexual practices/activities	Total (N = 1.018)		Is in a relationship				p-value
				Yes (N = 607)		No (N = 411)		
		N	%	N	%	N	%	
Total population	Had sex at least once	938	92.14	579	95.4	359	87.4	<0.001
	Had sex in the last 12 months	836	89.13	550	95.0	286	69.7	<0.001
	Had sex in the last month	736	88.04	513	93.3	223	78.0	<0.001
Sexually active population	Had sex before age 15 years	235	25.05	127	21.9	108	30.1	0.005
	Had more than one sexual partner	783	83.48	473	81.7	310	86.4	0.062
	Had more than 10 sexual partners(1)	279	35.63	139	29.4	140	45.2	<0.001
	Had same gender sex	244	26.0	102	17.6	142	39.6	<0.001
Sexually active population (last 12 months)	Had more than one sexual partner	233	27.87	67	12.2	166	58.0	<0.001
	Had more than five sexual partners	90	10.77	24	4.36	66	23.1	<0.001
	Had sex with fixed partners only	703	84.09	506	92.0	197	68.9	<0.001
	Had sex with casual partners	225	26.91	72	13.1	153	53.5	<0.001
	Paid someone for sex(2)	33	14.67	12	16.7	21	13.7	0.561
	Had sex with people met on the internet(2)	114	50.67	31	43.1	83	54.3	0.117

Source: PCAP England

Notes: (1) Percentage calculated only among those who had sex at least once

(2) Percentage calculated only among those who had sex with casual partners in the last 12 months

Appendix 28 - Table 3.33

Distribution of individuals' sexual practice/behaviour indicators in relation to Condom use, according to age group

Condom use	Total (N = 836)		14 to 24 years (N = 126)		25 to 34 years (N = 331)		35 to 49 years (N = 331)		50 to 81 years (N = 48)		p-value
	N	%	N	%	N	%	N	%	N	%	
On the last sexual intercourse	282	33.7	49	38.9	96	29.0	118	35.7	19	39.6	0.266
On sexual intercourse with fixed partner	311	37.2	47	37.3	102	30.8	118	35.7	15	31.3	0.448
On sexual intercourse with casual partner ⁽¹⁾	152	67.6	31	62.0	60	72.3	57	67.1	4	57.1	0.592
On the last sexual intercourse with casual partner ⁽¹⁾	135	60.0	24	48.0	49	59.0	57	67.1	5	71.4	0.159
On all sexual intercourse with fixed partner (last 12 months)	185	22.1	26	20.6	67	20.2	81	24.5	11	22.9	0.589
On all sexual intercourse with casual partner (last 12 months) ⁽¹⁾	111	49.3	20	40.0	40	48.2	48	56.5	3	42.9	0.304
On all sexual intercourse with any partner (last 12 months)	239	25.5	38	26.6	86	24.5	102	27.6	13	17.6	0.314

Source: PCAP England

Notes: (1) Percentage calculated only among those who had sex with casual partners

Appendix 29 - Table 3.35

Distribution of individuals' sexual practice/behaviour indicators in relation to Condom use, according to education level

Condom use	Total (N = 836)		Basic education		Higher education		p- value
	N	%	N	%	N	%	
On the last sexual intercourse	282	33.7	154	31.2	128	37.3	0.067
On sexual intercourse with fixed partner	311	37.2	162	32.9	120	35.0	0.523
On sexual intercourse with casual partner ⁽¹⁾	152	67.6	88	62.0	64	77.1	0.019
On the last sexual intercourse with casual partner ⁽¹⁾	135	60.0	76	53.5	59	71.1	0.009
On all sexual intercourse with fixed partner (last 12 months)	185	22.1	102	20.7	83	24.2	0.229
On all sexual intercourse with casual partner (last 12 months) ⁽¹⁾	111	49.3	65	45.8	46	55.4	0.163
On all sexual intercourse with any partner (last 12 months)	239	25.5	134	24.2	105	27.3	0.293

Source: PCAP England

Notes: (1) Percentage calculated only among those who had sex with casual partners

Appendix 30 - Table 3.36 - Distribution of individuals who knows about and have used female condoms, according to sociodemographic information

Variables	Total		Knows female condoms		Used female condoms	
	N		N	%	N	%
Total	938		756	80.6	82	10.8
Gender						
Male	449		334	74.4	41	12.3
Female	487		420	86.2	40	9.5
Transgender	2		2	100	1	50.0
p-value	-		-	<0.001	-	0.098
Age range						
14 to 24 years	143		115	80.4	12	10.4
25 to 34 years	351		290	82.6	27	9.3
35 to 49 years	370		287	77.6	36	12.5
50 to 81 years	74		64	86.5	7	10.9
p-value	-		-	0.192	-	0.663
Sexual orientation						
Heterosexual	779		636	81.6	77	12.1
Homosexual	121		90	74.4	0	0.0
Bisexual	29		24	82.8	4	16.7
p-value	-		-	0.163	-	0
Marital status						
Is in a relationship	579		466	80.5	46	9.9
Is not in a relationship	359		290	80.8	36	12.4
p-value	-		-	0.911	-	0.274
Education						
Basic education	553		417	75.4	47	11.3
Higher education	385		339	88.1	35	10.3
p-value	-		-	<0.001	-	0.677
Ethnicity (Skin colour)						
White	607		491	80.9	45	9.2
Black or Mixed	218		176	80.7	20	11.4
Other	113		89	78.8	17	19.1
p-value	-		-	0.870	-	0.021
Religious						
Yes	573		453	79.1	54	11.9
No	365		303	83.0	28	9.2
p-value	-		-	0.135	-	0.246
Has a job						
Yes	742		595	80.2	60	10.1
No	196		161	82.1	22	13.7
p-value	-		-	0.538	-	0.195

Source: PCAP England

Appendix 31 - Table 3.37 - Distribution of individuals who know about intimate lubricants and those who have already used them, according to sociodemographic information

Variables	Total		Knows about lubricants		Have already used lubricants	
	N		N	%	N	%
Total	938		828	88.3	432	52.2
Gender						
Male	449		395	88.0	242	61.3
Female	487		431	88.5	189	43.9
Transgender	2		2	100	1	50.0
p-value	-		-	0.848	-	<0.001
Age range						
14 to 24 years	143		131	91.6	62	47.3
25 to 34 years	351		317	90.3	176	55.5
35 to 49 years	370		317	85.7	163	51.4
50 to 81 years	74		63	85.1	31	49.2
p-value	-		-	0.109	-	0.399
Sexual orientation						
Heterosexual	779		681	87.4	328	48.2
Homosexual	121		114	94.2	80	70.2
Bisexual	29		27	93.1	20	74.1
p-value	-		-	0.068	-	<0.001
Marital status						
Is in a relationship	579		503	86.9	259	51.5
Is not in a relationship	359		325	90.5	173	53.2
p-value	-		-	0.910	-	0.625
Education						
Basic education	553		469	84.8	235	50.1
Higher education	385		359	93.2	197	54.9
p-value	-		-	<0.001	-	0.173
Ethnicity (Skin colour)						
White	607		544	89.6	284	52.2
Black or Mixed	218		186	85.3	92	49.5
Other	113		98	86.7	56	57.1
p-value	-		-	0.206	-	0.468
Religious						
Yes	573		491	85.7	256	44.7
No	365		337	92.3	176	48.2
p-value	-		-	0.002	-	0.980
Has a job						
Yes	742		653	88.0	342	46.1
No	196		175	89.3	90	45.9
p-value	-		-	0.620	-	0.824

Source: PCAP England

Appendix 32 - Table 3.38 - Distribution of participants' opinion if alcohol or drugs can impair a person's decision to use condoms, and if it ever happened to them

Variables	Total	Alcohol or drugs can impair a person's decision to use condoms			
		Agree		Happened to me	
		N	%	N	%
Total	938	807	86.0	327	34.9
Gender					
Male	449	390	86.9	205	45.7
Female	487	415	85.2	121	24.8
Transgender	2	2	100	1	50.0
p-value	-	0.653	0.907	-	<0.001
Age range					
14 to 24 years	143	120	83.9	58	40.6
25 to 34 years	351	303	86.3	129	36.8
35 to 49 years	370	326	88.1	132	35.7
50 to 81 years	74	58	78.4	8	10.8
p-value	-	0.139	0.003	-	<0.001
Sexual orientation					
Heterosexual	779	672	86.3	257	33.0
Homosexual	121	112	92.6	60	49.6
Bisexual	29	20	69.0	9	31.0
p-value	-	-	0.003	-	0.002
Marital status					
Is in a relationship	579	506	87.4	180	31.1
Is not in a relationship	359	301	83.8	147	40.9
p-value	-	-	0.128	-	0.002
Education					
Basic education	553	476	86.1	198	35.8
Higher education	385	331	86.0	129	33.5
p-value	-	-	0.965	-	0.467
Ethnicity (Skin colour)					
White	607	530	87.3	219	36.1
Black and Mixed	218	184	84.4	79	36.2
Other	113	93	82.3	29	25.7
p-value	-	-	0.270	-	0.091
Religious					
Yes	573	505	88.1	186	32.5
No	365	302	82.7	141	38.6
p-value	-	-	0.020	-	0.053
Has a job					
Yes	742	647	87.2	269	36.3
No	196	160	81.6	58	29.6
p-value	-	-	0.046	-	0.082

Source: PCAP England

Appendix 33 - Table 3.39

Distribution of individuals' alcohol and drug use, according to gender

Type of drugs	Use	Total (N = 1.018)		Male (N = 487)		Female (N = 529)		p-value
		N	%	N	%	N	%	
Alcohol	Past	828	81.3	416	85.4	410	77.5	0.001
	Present ⁽¹⁾	515	62.2	277	66.6	237	57.8	0.009
Cannabis	Past	366	36.0	219	45.0	145	27.4	<0.001
	Present ⁽¹⁾	121	33.1	84	38.4	36	24.8	0.007
Amphetamine	Past	150	14.7	91	18.7	59	11.2	0.001
	Present ⁽¹⁾	42	28.0	33	36.3	9	15.3	0.005
Cocaine	Past	147	14.4	100	20.5	46	8.7	<0.001
	Present ⁽¹⁾	28	19.1	10	19.0	9	19.6	0.936
Heroin	Past	7	0.7	4	0.8	3	0.6	0.716
	Present ⁽¹⁾	2	28.6	1	25.0	1	33.3	1.000
	Shared objects ⁽¹⁾	4	57.1	1	25.0	3	100	0.143

Source: PCAP England

Note: (1) Percentage calculated only among those who have used before (Past)

Appendix 34 - Table 3.40

Distribution of individual's alcohol and drug use, according to age groups

Type of drugs	Use	Total (N = 1.018)		14 to 24 years (N = 184)		25 to 34 years (N = 374)		35 to 49 years (N = 385)		50 to 81 years (N = 75)		p-value
		N	%	N	%	N	%	N	%	N	%	
Alcohol	Past	828	81.3	141	76.6	310	82.9	325	84.4	52	69.3	0.005
	Present(1)	515	62.2	97	68.8	198	63.9	192	59.1	28	53.9	0.118
Cannabis	Past	366	36.0	77	41.9	163	43.6	113	29.4	13	17.3	<0.001
	Present(1)	121	33.1	44	57.1	49	30.1	24	21.2	4	30.8	<0.001
Amphetamine	Past	150	14.7	24	13.0	66	17.7	57	14.8	3	4.0	0.020
	Present(1)	42	28.0	9	37.5	18	27.3	14	24.6	1	33.3	0.690
Cocaine	Past	147	14.4	22	11.4	63	16.8	59	15.3	4	5.3	0.039
	Present(1)	28	19.1	6	28.6	10	15.9	11	18.6	1	25.0	0.627
Heroin	Past	7	0.7	1	0.5	2	0.5	3	0.8	1	1.3	0.731
	Present(1)	2	28.6	0	0.0	0	0.0	1	33.3	1	100	0.714
	Shared objects(1)	4	57.1	1	100	0	0.0	2	66.7	1	100	0.486

Source: PCAP England

Note: (1) Percentage calculated only among those who have used before (Past)

Appendix 35 - Table 3.41

Distribution of individual's alcohol and drug use, according to sexual orientation

Type of drugs	Use	Total (N = 1.018)		Heterosexual (N = 848)		Homosexual (N = 124)		Bisexual (N = 30)		p-value
		N	%	N	%	N	%	N	%	
Alcohol	Past	828	81.3	674	79.5	120	96.8	27	90.0	<0.001
	Present(1)	515	62.2	405	60.1	90	75.0	17	63.0	0.008
Cannabis	Past	366	36.0	275	32.4	74	59.7	12	40.0	<0.001
	Present(1)	121	33.1	75	27.3	38	51.4	6	50.0	<0.001
Amphetamine	Past	150	14.7	89	10.5	47	37.9	11	36.7	<0.001
	Present(1)	42	28.0	14	15.7	24	51.1	3	27.3	<0.001
Cocaine	Past	147	14.4	82	9.7	52	41.9	9	30.0	<0.001
	Present(1)	28	19.1	9	11.0	16	30.8	2	22.2	0.016
Heroin	Past	7	0.7	3	0.4	1	0.8	2	6.7	0.011
	Present(1)	2	28.6	0	0.0	0	0.0	1	50.0	0.500
	Shared objects(1)	4	57.1	1	33.3	0	0.0	2	100	0.400

Source: PCAP England

Note: (1) Percentage calculated only among those who have used before (Past)

Appendix 36 - Table 3.42

Distribution of individuals' alcohol and drug use, according to marital status

Type of drugs	Use	Total (N = 1.018)		Is in a relationship (N = 607)		Is not in a relationship (N= 411)		p-value
		N	%	N	%	N	%	
Alcohol	Past	828	81.3	488	80.4	340	82.7	0.349
	Present ⁽¹⁾	515	62.2	278	57.0	237	69.7	<0.001
Cannabis	Past	366	36.0	199	32.8	167	40.6	0.010
	Present ⁽¹⁾	121	33.1	39	19.6	82	49.1	<0.001
Amphetamine	Past	150	14.7	73	12.0	77	18.7	0.003
	Present ⁽¹⁾	42	28.0	9	12.3	33	42.9	<0.001
Cocaine	Past	147	14.4	72	11.9	75	18.3	0.004
	Present ⁽¹⁾	28	19.1	8	11.1	20	26.7	0.016
Heroin	Past	7	0.7	4	0.7	3	0.7	1.000
	Present ⁽¹⁾	2	28.6	1	25.0	1	33.3	1.000
	Shared objects ⁽¹⁾	4	57.1	2	50.0	2	66.7	1.000

Source: PCAP England

Note: (1) Percentage calculated only among those who have used before (Past)

Appendix 37 - Table 3.43

Distribution of individuals' alcohol and drug use, according to education level

Type of drugs	Use	Total (N = 1.018)		Basic education (N = 618)		Higher education (N = 400)		p-value
		N	%	N	%	N	%	
Alcohol	Past	828	81.3	476	77.0	352	88.0	<0.001
	Present ⁽¹⁾	515	62.2	267	56.1	248	70.5	<0.001
Cannabis	Past	366	36.0	197	31.9	169	42.3	0.001
	Present ⁽¹⁾	121	33.1	78	39.6	43	25.4	0.004
Amphetamine	Past	150	14.7	79	12.8	71	17.8	0.029
	Present ⁽¹⁾	42	28.0	25	31.7	17	23.9	0.294
Cocaine	Past	147	14.4	84	13.6	63	15.8	0.339
	Present ⁽¹⁾	28	19.1	17	20.2	11	17.5	0.671
Heroin	Past	7	0.7	3	0.5	4	1.0	0.443
	Present ⁽¹⁾	2	28.6	0	0.0	2	50.0	0.429
	Shared objects ⁽¹⁾	4	57.1	1	33.3	3	75.0	0.486

Source: PCAP England

Note: (1) Percentage calculated only among those who have used before (Past)

Appendix 38 - Table 3.44

Distribution of individuals' alcohol and drug use, according to religiosity

Type of drugs	Use	Total (N = 1.018)		Religious (N = 626)		Non-religious (N = 392)		p-value
		N	%	N	%	N	%	
Alcohol	Past	828	81.3	481	76.8	347	88.5	<0.001
	Present ⁽¹⁾	515	62.2	269	55.9	246	70.9	<0.001
Cannabis	Past	366	36.0	169	27.0	197	50.3	<0.001
	Present ⁽¹⁾	121	33.1	51	30.2	70	35.5	0.278
Amphetamine	Past	150	14.7	60	9.6	90	23.0	<0.001
	Present ⁽¹⁾	42	28.0	17	28.3	25	27.8	0.941
Cocaine	Past	147	14.4	61	9.7	86	21.9	<0.001
	Present ⁽¹⁾	28	19.1	9	14.8	19	22.1	0.264
Heroin	Past	7	0.7	2	0.3	5	1.3	0.115
	Present ⁽¹⁾	2	28.6	1	50.0	1	20.0	1.000
	Shared objects ⁽¹⁾	4	57.1	1	50.0	3	60.0	1.000

Source: PCAP England

Note: (1) Percentage calculated only among those who have used alcohol and/or drugs before (Past)

Appendix 39 - Table 3.47

Distribution of individual's opinion regarding abortion, according to sociodemographic information

Variables							
	N	Agree (%)	Disagree (%)	Depends (%)	Prefer not to say (%)	p-value	
Total	1,018	35.7	21.7	29.9	12.8	-	
Gender							
Male	487	34.5	26.9	26.7	11.9	0.002	
Female	529	36.7	17.0	32.7	13.6		
Age range							
14 to 24 years	184	40.8	40.0	40.0	0.0	0.029	
25 to 34 years	374	36.6	21.1	31.0	11.2		
35 to 49 years	385	32.5	22.3	32.7	12.5		
50 to 81 years	75	34.7	12.0	34.7	18.7		
Sexual orientation							
Heterosexual	848	32.7	23.9	30.8	12.6	<0.001	
Homosexual	124	54.8	11.3	25.8	8.1		
Bisexual	30	40.0	13.3	30.0	16.7		
Marital status							
Is in a relationship	607	33.1	22.6	32.4	12.0	0.076	
Is not in a relationship	411	39.4	20.4	26.3	13.9		
Education							
Basic education	618	27.5	27.5	31.6	13.4	<0.001	
Higher education	400	48.3	12.8	27.3	11.8		
Ethnicity (Skin colour)							
White	650	38.9	20.9	30.3	9.9	<0.001	
Black or Mixed	235	29.8	27.2	27.2	15.7		
Other	133	30.1	15.8	32.3	21.8		
Religiosity	626	23.2	29.1	33.4	14.4	<0.001	
Has a job	789	36.1	22.9	28.9	12.0	0.157	

Source: PCAP England

Appendix 40 - Table 3.48

Distribution of male circumcision, according to sociodemographic information

Variables	Total	Was		p-value
	N	N	%	
Total	487	84	17.2	-
Age range				
14 to 24 years	99	10	10.1	0.051
25 to 34 years	190	33	17.4	
35 to 49 years	173	33	19.1	
50 to 81 years	25	8	32.0	
Sexual orientation				
Heterosexual	361	56	15.5	0.244
Homosexual	107	24	22.4	
Bisexual	13	2	15.4	
Marital status				
Is in a relationship	259	42	16.2	0.520
Is not in a relationship	228	42	18.4	
Education				
Basic education	326	47	14.4	0.019
Higher education	161	37	23.0	
Ethnicity (Skin colour)				
White	309	54	17.5	0.595
Black or Mixed	129	24	18.6	
Other	49	6	12.2	
Religious				
Yes	288	52	18.1	0.571
No	199	32	16.1	
Has a job				
Yes	410	73	17.8	0.453
No	77	11	14.3	

Source: PCAP England

Appendix 41 - Table 3.49

Distribution of individuals who agreed that gay couples have the rights to adopt a child, according to sociodemographic information

Variables	Total	Affirmation 1	
	N	N	%
Total	1,018	746	73.3
Gender			
Male	487	333	68.4
Female	529	411	77.7
Transgender	2	2	100
p-value	-	-	0.003
Age range			
14 to 24 years	184	131	71.2
25 to 34 years	374	273	73.0
35 to 49 years	385	282	73.2
50 to 81 years	75	60	80.0
p-value	-	-	0.541
Sexual orientation			
Heterosexual	848	590	69.6
Homosexual	124	119	96.0
Bisexual	30	29	96.7
p-value	-	-	<0.001
Marital status			
Is in a relationship	607	435	71.7
Is not in a relationship	411	311	75.7
p-value	-	-	0.156
Education			
Basic education	618	401	64.9
Higher education	400	345	86.3
p-value	-	-	<0.001
Ethnicity (Skin colour)			
White	650	495	76.2
Black or Mixed	235	156	66.4
Other	133	95	71.4
p-value	-	-	0.013
Religious			
Yes	626	413	66.0
No	392	333	84.9
p-value	-	-	<0.001
Has a job			
Yes	789	581	73.6
No	229	165	72.1
p-value	-	-	0.663

Source: PCAP England

Affirmation 1: A gay couple have the rights to adopt a child

Appendix 42 - Table 3.50

Distribution of individuals in relation to the question if “they would have gay friends”, according to sociodemographic information

Variables	Total	Never		Maybe		Yes		p-value
	N	N	%	N	%	N	%	
Total	1,018	13	1.3	57	5.6	948	93.1	-
Gender								
Male	487	9	1.8	34	7.0	444	91.2	0.197
Female	529	4	0.8	23	4.3	502	94.9	
Transgender	2	0	0.0	0	0.0	2	100	
Age group								
14 to 24 years	184	5	2.7	12	6.5	167	90.8	0.174
24 to 34 years	374	3	0.8	14	3.7	357	95.5	
35 to 49 years	385	4	1.0	24	6.2	357	92.7	
50 to 81 years	75	1	1.3	7	9.3	67	89.3	
Sexual orientation								
Heterosexual	848	12	1.4	51	6.0	785	92.6	0.137
Homosexual	124	0	0.0	2	1.6	122	98.4	
Bisexual	30	1	3.3	2	6.7	27	90.0	
Marital status								
Is in a relationship	607	7	1.2	33	5.4	567	93.4	0.876
Is not in a relationship	411	6	1.5	24	5.8	381	92.7	
Education								
Basic education	618	11	1.8	44	7.1	563	91.1	0.006
Higher education	400	2	0.5	13	3.3	385	96.3	
Ethnicity (Skin colour)								
White	650	6	0.9	30	4.6	614	94.5	0.097
Black or Mixed	235	3	1.3	19	8.1	213	90.6	
Other	133	4	3.0	8	6.0	121	91.0	
Religious								
Yes	626	10	1.6	45	7.2	571	91.2	0.010
No	392	3	0.8	12	3.1	377	96.2	
Has a job								
Yes	789	10	1.3	42	5.3	737	93.4	0.775
No	229	3	1.3	15	6.6	211	92.1	

Source: PCAP England

Appendix 43 - Table 3.51 - Distribution of individuals who agreed with the following 3 HIV/AIDS affirmations (see foot of the table), according to sociodemographic information

Variables	Total	Affirmation 1		Affirmation 2		Affirmation 3	
	N	N	%	N	%	N	%
Total	1,018	903	88.7	747	73.4	898	88.2
Gender							
Male	487	437	89.7	352	72.3	428	87.9
Female	529	464	87.7	393	74.3	468	88.5
Transgender	2	2	100	2	100	2	100
p-value	-	-	0.525	-	0.535	-	0.839
Age groups							
14 to 24 years	184	157	85.3	109	59.2	146	79.3
25 to 34 years	374	330	88.2	267	71.4	334	89.3
35 to 49 years	385	349	90.6	309	80.3	350	90.9
50 to 81 years	75	67	89.3	62	82.7	68	90.7
p-value	-	-	0.300	-	<0.001	-	0.001
Sexual orientation							
Heterosexual	848	744	87.7	596	70.3	739	87.1
Homosexual	124	122	98.4	118	95.2	121	97.6
Bisexual	30	27	90.0	23	76.7	27	90.0
p-value	-	-	0.002	-	<0.001	-	0.003
Marital status							
Is in a relationship	607	534	88.0	457	75.3	540	89.0
Is not in a relationship	411	369	89.8	290	70.6	358	87.1
p-value	-	-	0.371	-	0.094	-	0.367
Education							
Basic education	618	535	86.6	409	66.2	524	84.8
Higher education	400	368	92.0	338	84.5	374	93.5
p-value	-	-	0.008	-	<0.001	-	<0.001
Ethnicity (Skin colour)							
White	650	584	89.8	486	74.8	577	88.8
Black or Mixed	235	204	86.8	166	70.6	208	88.5
Other	133	115	86.5	95	71.4	113	85.0
p-value	-	-	0.308	-	0.405	-	0.457
Religious							
Yes	626	546	87.2	431	68.8	540	86.3
No	392	357	91.1	316	80.6	358	91.3
p-value	-	-	0.059	-	<0.001	-	0.015
Has a job							
Yes	789	706	89.5	579	73.4	705	89.4
No	229	197	86	168	73.4	193	84.3
p-value	-	-	0.146	-	0.995	-	0.036

Source: PCAP England - **Affirmation 1:** If there was a HIV positive child in the same class of your children you would still allow them to attend that school

Affirmation 2: If you knew that the person selling fruit and vegetables in the corner shop was HIV positive you would still buy their products

Affirmation 3: If a teacher is HIV positive but is not sick she/he can still carry on teaching in any school

Appendix 44 - Table 3.52

Distribution of individuals who received money from casual sex partners in the last 12 months, and their condom use, according to sociodemographic information

Variables	Total	Received money for sex		Used condoms some of the time(1)		Used condoms every time(1)	
		N	N	%	N	%	N
Total	225	29	12.9	24	82.8	22	75.9
Gender							
Male	160	20	12.5	16	80.0	14	70.0
Female	63	8	12.7	7	87.5	7	87.5
p-value	-	-	0.789	-	0.640	-	0.334
Age range							
14 to 24 years	50	6	12.0	3	50.0	3	50.0
25 to 34 years	83	16	19.3	14	87.5	12	75.0
35 to 49 years	85	7	8.2	7	100	7	100
50 to 81 years	7	0	0.0	0	-	0	-
p-value	-	-	0.374	-	0.045	-	0.109
Sexual orientation							
Heterosexual	144	21	14.6	17	81.0	15	71.4
Homosexual	70	6	8.6	5	83.3	5	83.3
Bisexual	9	2	22.2	2	100	2	100
p-value	-	-	0.494	-	0.792	-	0.593
Marital status							
Is in a relationship	72	7	9.7	5	71.4	5	71.4
Is not in a relationship	153	22	14.4	19	86.4	17	77.3
p-value	-	-	0.078	-	0.362	-	0.753
Education							
Basic education	142	24	16.9	19	79.2	17	70.8
Higher education	83	5	6.0	5	100	5	100
p-value	-	-	0.032	-	0.262	-	0.166
Ethnicity (Skin colour)							
White	146	15	10.3	14	93.3	13	86.7
Black and Mixed	54	10	18.5	7	70.0	6	60.0
Other	25	4	16.0	3	75.0	3	75.0
p-value	-	-	0.462	-	0.289	-	0.312
Religious							
Yes	123	18	14.6	14	77.8	13	72.2
No	102	11	10.8	10	90.9	9	81.8
p-value	-	-	0.287	-	0.364	-	0.558
Has a job							
Yes	184	28	15.2	25	89.3	21	75.0
No	41	1	2.4	1	100	1	100
p-value	-	-	0.048	-	0.642	-	0.566

Source: PCAP England

Notes: (1) Percentage calculated only among those who exchanged money with casual partners

Appendix 45 – Interview Schedule



The University of
Nottingham

Topic Guide for in-depth interview into the lived experiences of Brazilian immigrants accessing sexual health and HIV services in London

By José Resinente – PhD Researcher

Background to the study:

This research is regarding the Brazilian community access to sexual health and HIV services in London: Has it been positive or negative? Are there any cultural differences? Are there any barriers to access? Are there ways that it can be improved?

I intend to collect 1000 survey data, and examine 20 testimonies of Brazilians who are currently residing or have resided in London.

What if I do not want to take part in the research?

Your participation in the study is entirely voluntary and you are free to withdraw from the study at any point without giving an explanation.

What will happen if I take part in the research?

Before starting the interview proper, I will clarify any questions you may have. When you are completely sure that you wish to take part in the study I will ask you to sign a consent form. I will ask you questions regarding the subject area using a pre-designed interview topic guide. So that I can study your answers fully, I will be using a Dictaphone to record the interview. Most interviews will take about 45 minutes.

What about confidentiality?

Interviews will be recorded and fully transcribed. The recordings will be stored in a secure location and only myself and my supervisors will have access. People's names or job titles will not be included in reports. Participants will be offered a copy of their interview transcript and provided with the opportunity to take out or amend any part of it that they do not wish reported in the findings.

What else do I need to know?

This research has been approved by the University of Nottingham Ethics Committee. Also, as with any means of data collected online and stored on servers, such as with survey software, there is a very small risk that the data could be hacked into. Participants should also be aware that the researcher has a legal obligation to disclose information relating to unethical or criminal behaviour.

How will the results be used?

The data from this research will be used for the PhD thesis, for academic research papers and presentations, and a summary report will be circulated to all interested participants or participating organisations.

Topic Guide

Can you tell me a little about yourself?

	✓ Age ✓ Occupation ✓ Marital status ✓ Education ✓ Children
	✓ Where in Brazil were you born? ✓ Where did you grow up? ✓ Family background: occupation of mother/father, relationship with siblings

Story of migration:

	✓ How long have you been in London? ✓ How old were you when you left Brazil? ✓ Have you been in other countries before coming to London? (which/why/how long?) ✓ Would you tell me about the first time you left Brazil? (<i>reasons to migrate/ stories of migration in family, or social context/ family/education/employment</i>) ✓ Why did you choose London?
	✓ What happened when you arrived in London? (<i>experiences about visa, language, education, employment culture/socio-economic boundaries/work experience</i>) ✓ Was it easy to adapt? If not, what were the difficulties that you experienced at that time? How long did that go on? ✓ What made you stay in London? ✓ Accommodation arrangements ✓ How fluent is your English? (spoken/written)

Selling or Buying Sex:

	✓ Have you ever sold/bought sex? (<i>explore what was happening in his/her life at that time/who told him/her about it</i>) ✓ Would you tell me the story of your first client? (<i>explore preparation, first time negotiating</i>) What happened after that? ✓ Have you ever exchanged sex for money or goods in Brazil? ✓ Do you always use condoms with clients?
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NHS

Knowledge about the NHS	✓ Knowledge about the NHS (what is free/Not free) ✓ Other insurance cover ✓ Sources of information ✓ Private doctors ✓ Medication
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Health & Illness, Care seeking behaviour

Care seeking behavior (General Health)	✓ What do you generally do when you get sick? How this affects your daily life? Do you ask anyone for help? ✓ What have been your main health needs (General Health) since you arrived in London? How did you cope with that? (testing, treatment, contraceptive pills, condoms, smear test, etc) ✓ Do you know health services in London where you can get support? How did you get this information? Is it easy to access these services? Why? What language? Which service have you attended? ✓ Have you ever felt discriminated in these health services because your sexual preferences/sex work/HIV Status/ethnicity? ✓ How do you compare these services with the same services back in Brasil?
HIV & STI Testing	✓ Have you heard about STI or HIV? What did you hear? Are you worried about them? Why? ✓ Have you ever been to a Sexual Health Clinic in London? Which one? Would you tell me your experience? Was it easy to access this clinic? (<i>explore about language barriers/ culture/ costs</i>) Did they provide you the service that you needed? Why? Were you involved in the decision making about your care and treatment? What can be improved in these clinics? ✓ Have you ever had a sexual health screening? When/Which/ Why/ would you tell me what was your result? What happened after? ✓ Have you ever had a HIV test? When/Why/would you tell me what was your result? ✓ Did you disclose to your GP your work as a sex worker/HIV status? Why? Do you think this is important? Why? ✓ Have you ever felt discriminated because of your sexual orientation/HIV status/sex work/race in London or in Brazil?

<i>Living with HIV</i>	<i>Now, I want to ask you about living with HIV:</i> ✓ Where you were firstly diagnosed? ✓ When? ✓ Would you tell me how were you informed that you were HIV positive? (reaction/feelings) What happened after that? ✓ There have been situations where you haven't used condoms? What happened? Was it intentionally? ✓ Are you receiving treatment? In London/Brazil/Another country? ✓ What is your opinion about treatment? Benefits to self/Partners/Public? ✓ What is it like to take pills? (how many? Side effects? Positive effects? Missed pills? Adherence?) ✓ How do you find the HIV service in London? ✓ Have you disclosed your health status to someone? (Sex Partners/Family/friends/GP/at work/clients) Why? ✓ Are you receiving support from your family/friends/partner? How do you feel now? ✓ Has your life changed since been diagnosed with HIV? In what ways? ✓ How would you compare the HIV services in London with those in Brazil, or where you received treatment before? ✓ Is there another way you use to cope with your HIV diagnoses? (Religion, massage, Chinese medicine? Meditation, Exercise?)
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Safe sex, condoms, PreP and PEP (TasP):

<i>Safe sex/Condoms</i>	✓ Do you have access to free condoms/lubricants? ✓ Where do you get these?
<i>PreP/PEP</i>	✓ Do you know what PreP is? What do you think about it? ✓ Do you know what PEP is? What do you think about it?

	✓ Do you know where to access either of them in London? ✓ Have you ever told someone to go and get either? ✓ What does it mean for you that these are available to the public? ✓ What do you consider to be risky sex now? (Concerns about other STIs?)
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Illicit drugs:

Drug use	✓ Have you ever used illicit drugs/alcohol? ✓ Which ones?
Drug use and sex	✓ Have you ever had sex under the influence of drugs/alcohol? ✓ Has it ever influenced your use of condoms/safe sex? ✓ Have you ever been invited to a sex party? How was it?

Living in London:

Social Networks	✓ Do you have friends in London? Who are they? What do you do to have fun? ✓ Do you participate in any club or organization? If so, please tell me what are they?
Romantic & Sexual life	✓ Do you have a partner? Can you tell me about him/her? Would you tell me how your relationship is? (<i>explore violence/sexual or physical abuse</i>) ✓ Does your partner know about sex work/HIV? Have you ever been in a relationship with a man/woman?

Closing and thoughts for the future:

Future	✓ What are your plans for the future? Do you plan to go back to Brazil? Do you plan to stay in London? Do you plan to move to another country?
Comments	✓ Is there anything that you would like to say that we haven't talked about?

Fieldwork notes:

Place of interview: _____

Date of interview: _____

Interviewee's ID No: _____

Key ideas/themes of the interview in bullets points
(e.g. the interviewee feels more free in the London):

Context of the interview:
What types of things happened during the interview?

Personal notes:
How did I feel during the interview?



Research participant information sheet

Access to sexual health and HIV services: The lived experiences of Brazilian immigrants in London

Background to the study

I am a PhD student at the School of Languages, Cultures and Area Studies, at the University of Nottingham, and my research question is regarding the Brazilian community access to sexual health and HIV services in London: Has it been positive or negative? Are there any cultural differences? Are there any barriers to access? Are there ways that it can be improved?

I intend to collect 1000 survey data, and examine 20 testimonies of Brazilians who are currently residing or have resided in London and who access sexual health/family planning services in London.

What if I do not want to take part in the research?

Your participation in the study is entirely voluntary and you are free to withdraw from the study at any point without giving an explanation.

What will happen if I take part in the research?

If you decide to take part in the research, I will arrange a convenient time and place for us to meet. Before starting the interview proper, I will clarify any questions you may have after reading this leaflet. When you are completely sure that you wish to take part in the study I will ask you to sign a consent form. I will ask you questions regarding the subject area using a pre-designed interview topic guide. So that I can study your answers fully, I will be using a Dictaphone to record the interview. Most interviews will take about 45 minutes.

What are the risks/ discomforts involved in taking part in the study?

Your participation involves approximately 45 minutes being interviewed about your experiences accessing sexual health services in London so I do not anticipate any discomforts/ risks to yourself.

What about confidentiality?

Interviews will be recorded and fully transcribed. The recordings will be stored in a secure location and only the researcher and his two supervisors will have access. People's names or job titles will not be included in reports. Participants will be offered a copy of their interview transcript and provided with the opportunity to take out or amend any part of it that they do not wish reported in the findings. Participants should also be aware that the researcher has a legal obligation to disclose information relating to unethical or criminal behaviour.

What else do I need to know?

This research has been approved by the University of Nottingham Ethics Committee. Also, as with any means of data collected online and stored on servers, such as with survey software, there is a very small risk that the data could be hacked into.

How will the results be used?

The data from this research will be used for:

1. PhD thesis
2. Academic research papers and presentations
3. A summary report to be circulated to all interested participants or participating organisations.

We hope you will be able to help with this important area of research. If you agree to take part please complete the consent form. You are still free to withdraw at any time and without giving a reason.

Please indicate on the consent form if you would like to receive a summary of the results.

Please get in touch if you would like further information:

José Resinente – 07788 952 808; asxjhr@nottingham.ac.uk

Thank you.



PARTICIPANT CONSENT FORM

Project title:

Access to sexual health and HIV services: The lived experiences of Brazilian Immigrants in London

Researcher's name: José Henrique Resinente

Supervisor's name: Jean Andrews

- I have read the Participant Information Sheet, and the nature and purpose of the research project has been explained to me.

☐ Yes ☐ No

- I understand the purpose of the research project and my possible involvement in it, if I decide to take part.

☐ Yes ☐ No

- I understand that if I take part I may withdraw from the research project at any stage and that this will not affect my status now or in the future.

☐ Yes ☐ No

- I understand that while information gained during the study may be published and shared with NAZ and PHE, I will not be identified and my personal results will remain confidential.

☐ Yes ☐ No

- I accept to be audiotaped during the interview.

☐ Yes ☐ No

- I understand that data will be stored in audiotapes, hard copies of transcripts and electronically, and will be kept in a safe and secure location and will be used purely for the purposes of the research project (including dissemination of findings). No-one other than research colleagues, supervisors or examiners will have access to any of the data collected. The data will be destroyed after seven years as per University guidelines.

☐ Yes ☐ No

- I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the

Research Ethics Coordinator of the School of Cultures, Languages and Area Studies, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.

☐ Yes ☐ No

Name:..... (Research participant)

Sign: **Date**

Researcher contact details:

Researcher: *José Henrique Resinente*
NAZ, 30 Blacks Road, London, W6 9DT
Mobile: 07788 952 808

Supervisor: Dr J.M. Andrews
Department of Spanish, Portuguese and Latin American Studies, School of Languages,
Cultures and Area Studies, University of Nottingham, Nottingham, NG7 2RD
Tel: 0115 8466359

Thank you!