Awareness of HIV testing and sexual health services

Engagement with black communities in Buckinghamshire

March 2023

What we did

Working in partnership with Buckinghamshire Council and Terrance Higgins Trust, we engaged with black African and Caribbean communities and gathered feedback on:

- attitudes to HIV

- awareness of PrEP (pre-exposure prophylaxis) - helps to prevent HIV infection prior to exposure

- awareness of PEP (post-exposure prophylaxis) – helps to treat patients who have been exposed to HIV

- awareness and knowledge in relation to how to access HIV tests and sexual health services

- barriers to accessing sexual health services

- preferred delivery of sexual health services (e.g., face--face/online)

- current sexual health promotion

Healthwatch Bucks engaged with barbershops and beauty salons, a Nigerian coffee shop, multicultural organisations, and local voluntary sector community groups to gather data. We collected survey responses in January and February 2023. It was completed by almost 50 people.

Key findings

+ Above half, 53%, of survey participants were aware that they could get free HIV tests at walk-in health centres. However, over two-thirds of them (70%) did not know that HIV tests could be posted to their home address.

+ Almost none of the respondents had heard of PrEP (pre-exposure prophylaxis) or PeP (post-exposure prophylaxis) for HIV prevention.

+ People from the black Caribbean group, more than those from the black African group, said that they would seek advice about PrEP and PeP from their local General Practitioner (GP).

+ 58% of respondents had considered visiting a sexual health clinic in the past.

+ "Fear of being judged by health professionals" was more of a concern for women (than men) and those that were married (than other partnership status).

+ People that were married were also less likely to visit a sexual health clinic than those reporting another partnership status.

+ Interpersonal communication i.e., face-to-face or by telephone was preferred for contacting sexual health services. Only one third of respondents said that they would prefer online contact.

+ Just under half of the respondents (42%) were undecided if black communities experience difficulties when accessing local sexual health services. However, our evidence suggests that women, more than men, believe they might experience difficulties.

+ Of those that had been tested for HIV, exactly half (50%) were taken for routine purposes i.e., pregnancy and travelling outside the UK.

Our recommendations

Based on the results of our survey, we recommend that Buckinghamshire Council and Terrence Higgins Trust develop an **integrated communications strategy** to:

☑ Signpost information about HIV testing and sexual health services on social media platforms, local media outlets i.e., community radio and local newspapers/newsletters.

☑ Work in partnership with local faith leaders and peer support networks including multicultural centres and heritage organisations. Also, raise awareness through local councillors with links to black communities.

☑ Create an 'infrastructure' for black communities by sharing sexual health information with existing multicultural community networks.

☑ Work with volunteers to raise awareness of HIV testing and prevention medicines such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through community outreach services.

☑ Engage with members of the public at community events and markets e.g., pop-up sexual health information stalls.

☑ Focus on sexual health: HIV testing in Buckinghamshire Council's programme of events during Black History Month

As part of this communications strategy, we recommend that sexual health promotion is targeted to black communities in a non-discriminatory way.

Sexual health promotion should:

☑ include all members of the community e.g., young, old, married, single, LGBTQ+ etc.

☑ be available in languages spoken within local communities.

☑ contain information about how to access free HIV tests and prevention medicines.

☑ highlight confidentiality and data protection rights.

☑ target information sharing (leaflets, posters, digital signage) in primary care health settings i.e., GP waiting rooms and in walk-in clinics as well as local settings i.e., coffee shops, barbers and hairdressers, nail salons and libraries.

We also recommend, the development of local social media toolkits to share HIV facts and advice on prevention. Using local businesses (e.g., barbers / hairdressers) to share information on their social media handles can help to reduce HIV stigma.

Social Media Toolkits should include:

☑ Information about free HIV tests and how to access them.

☑ Information about HIV prevention treatments (PrEP and PeP).

☑ Sexual health clinic services and availability, including out of hours assistance.

☑ HIV campaigns hashtags. (#)

What was the project about?

In January 2019, the government announced that it is committed to achieving zero new HIV infections, AIDS and HIV-related deaths in England by 2030.

In 2021, 2,955 people were newly diagnosed with HIV in the UK (includes people previously diagnosed abroad), of whom 90% (2,692) were diagnosed in England.

UK Health Security Agency annual official statistics data release (data to end of December 2021).

Public Health England (2019) identifies black African communities as a key population living with HIV, with 38 per 1000 living with the virus. Current research shows that despite health promotion efforts and advances in therapy people from black African communities are accessing HIV care late.

Healthwatch Bucks wanted to hear from black African and Caribbean communities about their experience and views on HIV health services. In so doing, we aimed to gather feedback on awareness of HIV testing and preventative treatments - *pre-exposure prophylaxis (PrEP)* and *post-exposure prophylaxis (PEP)*.

Who completed our survey

We heard from 49 people; however, we removed two responses from our analysis as they were not Buckinghamshire residents. A further two responses were incomplete and so not usable. We analysed feedback from 45 responses.

Our survey participants were:

- Mostly from black African heritage (56% 25/45)

- fairly evenly split between men and women

- aged between 18 and 65. The estimated median age was 43.

- mostly unmarried/not in a civil partnership (56% 25/45)

More detail can be found in Appendix 2.

What we heard

Sexual health services

Have you ever considered visiting a sexual health clinic?

We wanted to find out how many people had visited a sexual health clinic in the past. Equally, we were keen to find out how many people had 'considered' visiting a sexual health clinic. This would allow us to get a fuller picture of the need for sexual health services regardless of whether people contacted their local clinic.

Over half of the respondents, 58% (26/45), reported that they had considered visiting a sexual health clinic in the past.
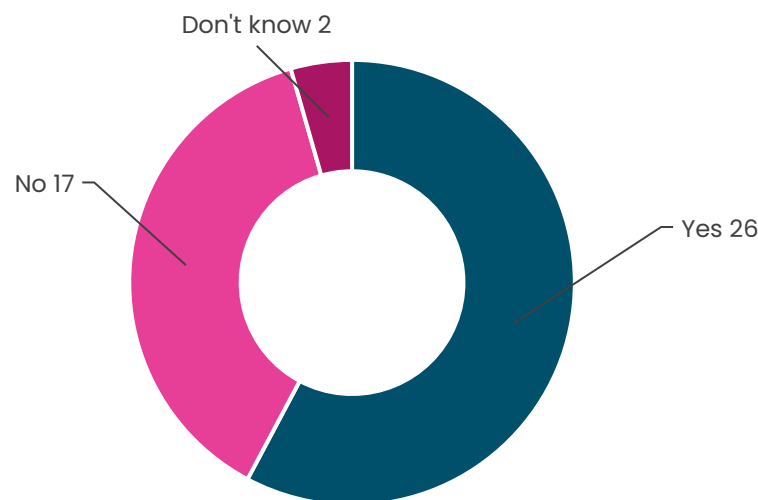
When we looked more closely, we found **very strong** evidence that the respondent's Age Group (45 and under vs. 46 and over) and Partnership Status (Married vs. Not Married/In a Civil Partnership) was linked to their answer for this question.

This finding suggests that people "45 and under" considered visiting a sexual health clinic more than those "46 and over". And those that are "Not Married/In a

Civil Partnership" considered visiting a sexual health clinic more than those that were "Married".

The people that responded both "No" and "Don't know" were then asked to give reasons for their response. More than one reason could be selected. We asked this so we could confirm that, in most cases, the answer would be "No need".

Responses	Count
No need	16
Used a different service	2
Don't know what they are	0

As expected, the majority had simply not had a need to visit a sexual health clinic. Others chose to go elsewhere. They did not specify which other service they visited.

Did you then attend a sexual health clinic?

We wanted to find out if the number of people that considered visiting a sexual health clinic matched the number of people that had used one. This was not the case. We found that 73% (19/26) of those who had considered visiting a clinic had done so.

Response	Count
Yes	19
No	7
Grand Total	26

If not, why?

As shown in the table above, seven respondents considered using a sexual health clinic but had not gone. Figure 1 below shows the reasons they gave (more than one choice was allowed).
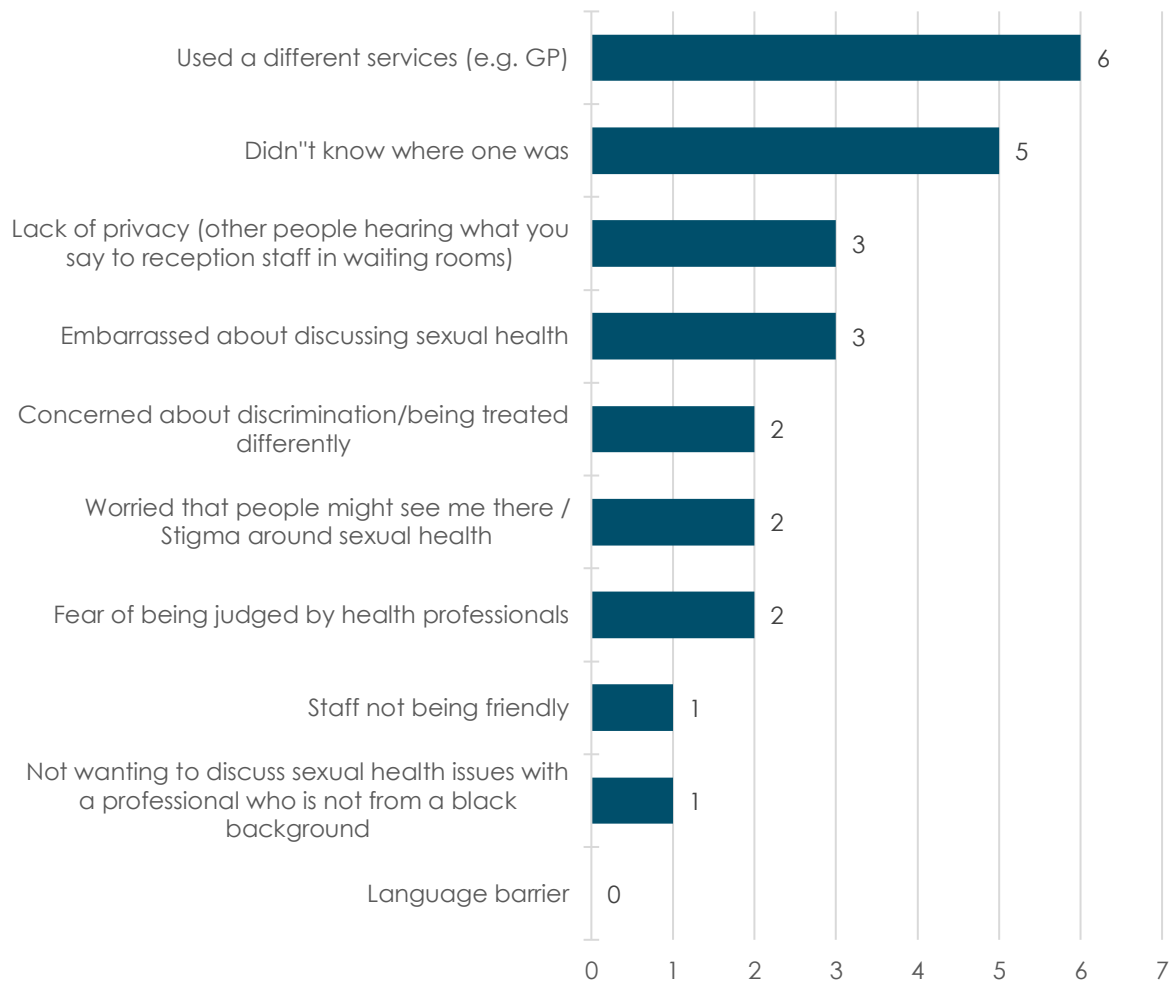
Figure 1 – reasons for not visiting a sexual health clinic

We can see that using a different service was the most common reason. This was chosen by 86% (6/7) who answered this question. This was followed by not knowing the location of a sexual health clinic. None of the seven respondents felt that language barriers had stopped them from visiting a clinic.

Barriers to accessing sexual health services

We wanted to gather feedback on user experience, in particular service-related barriers.

For those who had visited sexual health clinics, three experienced barriers to getting support. Two of those left comments:

> Being limited to certain days or times in regards to accessing a sexual health services.

> Location and times was an issue

Both comments relate to availability of service.

We asked people about their preferred method of communication with sexual health services. Almost everyone, 43 people, answered this question. Of which, 65% stated that they would prefer interpersonal communication i.e., in person or over the phone.
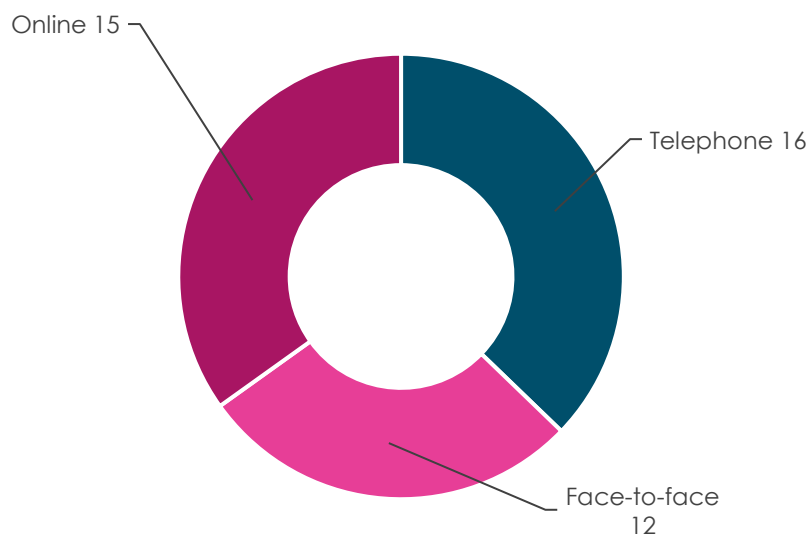
We also had two comments on this question, one related to contact with a GP surgery:

> Telephone and face to face

> Through the doctor's surgery as it is discreet.

Do you think that black communities might experience difficulties accessing local sexual health services?

Whilst 40% (18/45) of respondents thought that black communities might experience difficulties accessing local health services, 42% (19/45) remained unsure. Less than one fifth thought that black communities are **not** likely to experience difficulties accessing local sexual health services.

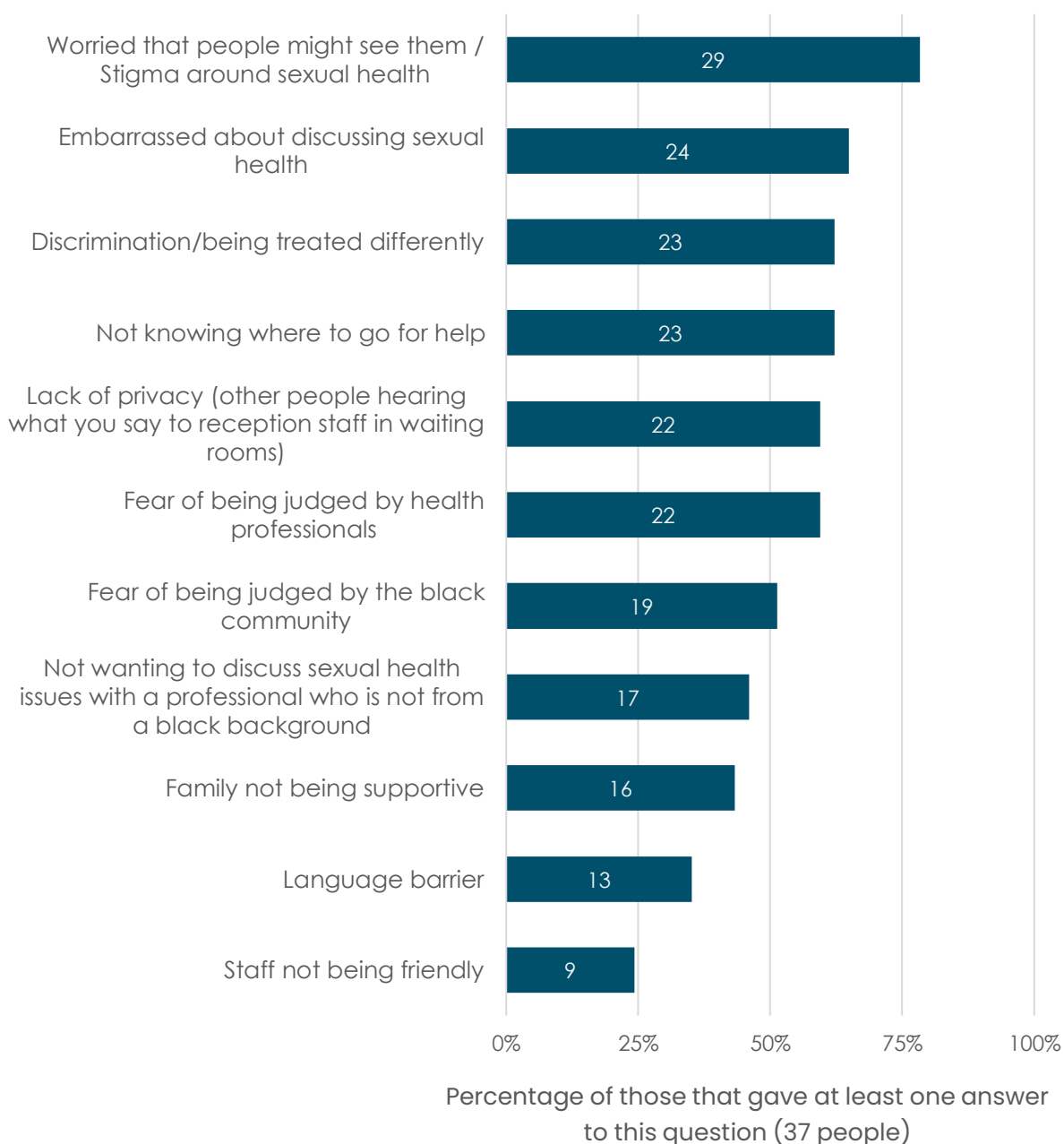| Response	Count
Yes	18
No	8
Not sure	19
Grand Total	**45**

When we looked more closely, we found **strong** evidence that the respondent's Gender (Man vs. Woman) was linked to their answer for this question.

This finding suggests that women, more than men, believe black communities might experience difficulties.

What do you think might stop black communities from accessing sexual health services?

We wanted to get a better understanding of how people viewed accessibility to local sexual health services. In so doing, we listed potential reasons that might stop people from black communities from accessing these services.

37 people chose at least one answer to this question. More than one answer was allowed. Responses are shown in Figure 2 below.

Response	Count
Worried that people might see them / Stigma around sexual health	29
Embarrassed about discussing sexual health	24
Discrimination/being treated differently	23
Not knowing where to go for help	23
Lack of privacy (other people hearing what you say to reception staff in waiting rooms)	22
Fear of being judged by health professionals	22
Fear of being judged by the black community	19
Not wanting to discuss sexual health issues with a professional who is not from a black background	17
Family not being supportive	16
Language barrier	13
Staff not being friendly	9

Percentage of those that gave at least one answer to this question (37 people)

Figure 2 – What do you think might stop black communities from accessing sexual health services?

We looked this data more closely to see if there were any differences, based on demographics, in the answers people chose.

We found **strong** evidence that:

+ Choosing "fear of being judged by health professionals" (or not) was linked to Gender, and Partnership Status

+ Choosing "discrimination/being treated differently" (or not) was linked to Partnership Status

In each case, being "a woman" or being "married" was the key difference.

We found weak evidence that choosing "Fear of being judged by health professionals "was linked to Age Groups (45 and under vs. 46 and over). The younger group chose this option less than expected. More research would be needed to confirm this finding.

Sexual health promotion

We asked people if they had seen any information about sexual health and wellbeing services in their local areas. 62% had not seen any– either printed or online.

Response	Count
Yes	15
No	28
(blank)	2
Grand Total	**45**

Almost everyone said that they would like to see more sexual health promotion in community-based settings. Nobody responded "No" to this question, however ten people were not decided.

Response	Count
Yes	32
Not sure	10
Grand Total	**45**

One person suggested the following additional locations for sexual health promotion:

> churches, community centres, hairdresser, food shops regularly visited by these community groups

Another didn't see a strong need for this information in community settings as it could be accessed digitally:

> Not bothered about any information, I can find any information online

HIV testing

There was an overall awareness of access to free HIV testing in local services with over half of the service respondents (23/45) knowing about this provision.

Response	Count
Yes	23
No	20
(blank)	2
Grand Total	**45**

However, 69% (31/45) did not know that a HIV test could be posted directly to their home address.

Response	Count
Yes	13
No	31
(blank)	1
Grand Total	**45**

We looked at this data more closely to see if there were any differences, based on demographics, in the answers people chose.

We found weak evidence that answering "Yes" was linked to Age Groups (45 and under vs. 46 and over). The younger group chose this option more than expected, and the older group less than expected. More research would be needed to confirm this finding.

Would you be happy to order a HIV test in the post to your home address?

We asked if people would use the option of getting a HIV by post. Most people answered "No" or "Not sure". However, 44% would be happy to use this option.

Response	Count
Yes	20
No	14
Not sure	10
(blank)	1
Grand Total	45

We again found weak evidence that answering "Yes" was linked to Age Groups (45 and under vs. 46 and over). The younger group chose this option more than expected, and the older group less than expected. More research would be needed to confirm this finding.

Have you ever had a HIV test?

Over one third of respondents, (35%), confirmed that they had taken a HIV test in the past.

Response	Count
Yes	16
No	22
Not sure	6
(blank)	1
Grand Total	45

Why did you have the test(s)?

We asked why people had taken HIV tests. More than one option from the table below could be selected.

Responses	Count
Exposure at work (e.g., needle stick)	0
Injected drugs	0
Before travelling outside the UK	1
Routine testing (e.g., pregnancy, employment reasons)	8
Sexual Health	8

Almost half of HIV tests taken (8/17) were done for routine purposes, all related to pregnancy. Of the 8 people that had HIV tests for sexual health purposes; 4 were male, 2 female and 2 preferred not to say.

Preventative treatments for HIV

We wanted to check what people knew about treatments that reduce the risk of getting HIV.

We gave a brief definition of PrEP (pre-exposure prophylaxis) and asked people if they had heard of this medication. Almost everyone, (82%) had not heard of it.

Response	Count
Yes	7
No	37
(blank)	1
Grand Total	**45**

We checked to see if being a member of any particular group affected answer to this question, but we couldn't find any evidence of this.

As with the previous question, we gave a definition of another HIV prevention medicine PEP (post-exposure prophylaxis) and asked people if they had heard of it. Similarly, almost everyone had not heard of this treatment.

Response	Count
Yes	8
No	36
(blank)	1
Grand Total	45

Here we again found weak evidence that answering "Yes" was linked to Age Groups (45 and under vs. 46 and over). The younger group chose this option more than expected, and the older group less than expected. More research would be needed to confirm this finding.

Getting more information about these treatments

We asked respondents where they would go if they wanted more information about PrEP and PEP. They were given a list of potential places with the option to choose **more than one** answer.

44 people responded to this question, as shown in Figure 3 below. The option to search for information on the internet was most preferred, followed by GPs and Sexual Health Clinics.
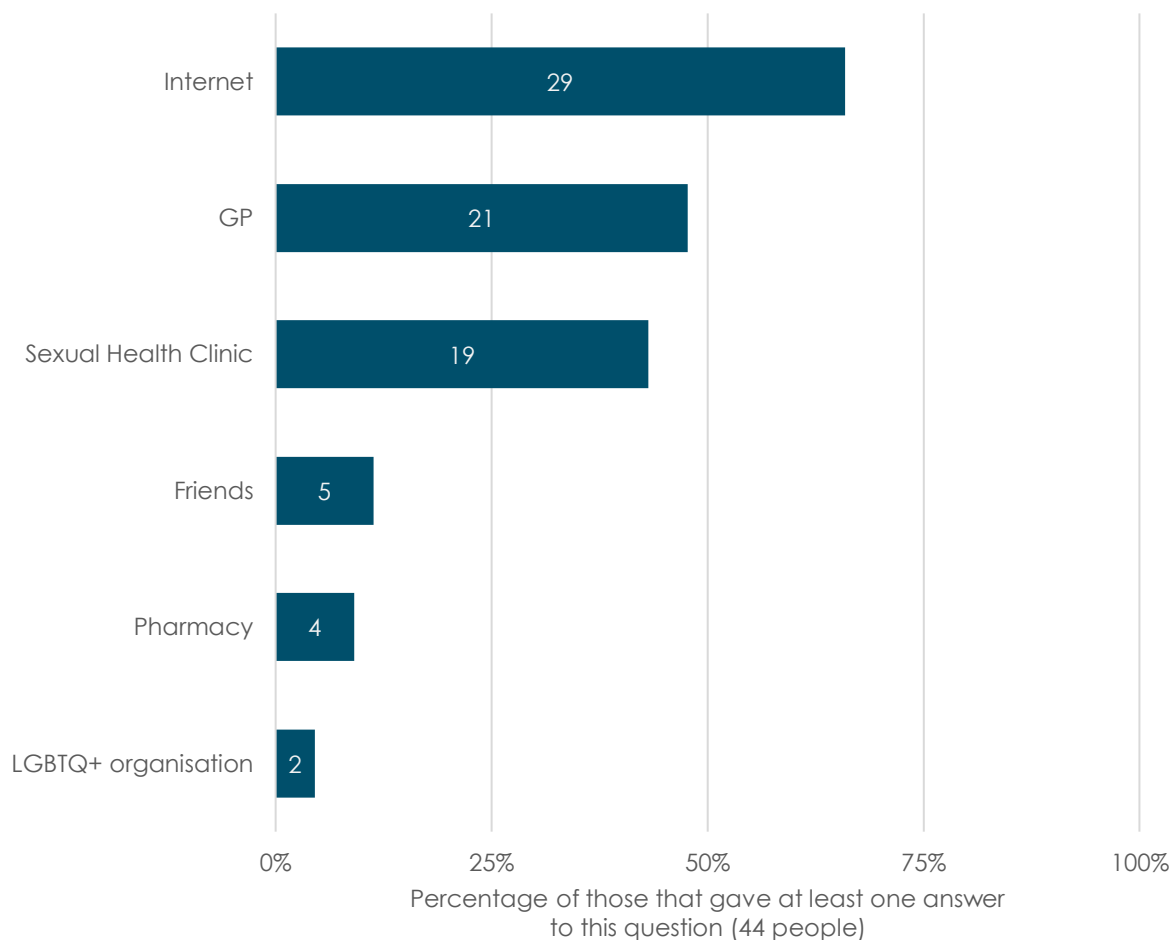
Figure 3 – Where would you go if you wanted more information on PrEP and PEP?

We looked at this data more closely to see if there were any differences, based on demographics, in the answers people chose.

We found **very strong** evidence that choosing "GP" (or not) was linked to Ethnic Group (African vs Caribbean) and Age Groups (45 and under vs. 46 and over).

+ The Caribbean group chose this option more than expected, and the African group less than expected.

+ The older group chose this option more than expected, and the younger group less than expected.

We also found weak evidence that choosing "Sexual Health Clinic" (or not) was linked to Ethnic Group (African vs Caribbean). The Caribbean group chose this option more than expected, and the African group less than expected. More research would be needed to confirm this finding.

Attitudes to HIV

Our final survey question was open-ended to capture more information about general attitudes to HIV in black communities. We wanted to learn more about general attitudes to HIV in your community. We asked:

"Is there anything that you could tell us about how HIV is viewed? Is it spoken about?"

We had comments from 31 people. Common themes emerged in relation to:

- stigma
- sexual orientation
- HIV information

Stigma

Responses to this question show that HIV is viewed negatively in black communities due to fear of being judged:

> HIV is definitely more talked about then it was many years ago and the stigma about it has lessened due to more knowledge about it. Still it is viewed negatively in our community due to feelings of being judged by peers and family and it is not talked about enough.

> It's not something commonly spoken about, there is an awareness and still like a taboo within the Black communities.

More than one third (12/31) said that HIV is not a topic of conversation:

> It is not spoken about in any serious capacity

> My friends and I are very educated, university level, it's not something we talk about.

As one response suggests, it is not spoken about as promotion of sexual health could encourage deviant behaviour:

> Not spoken about and some people think that it's a lifestyle choice and promotion related to sexual health could be encouraging bad behaviour

Another response implies that HIV is viewed with an element of shame and disgust:

> Seen as dirty

Sexual orientation

There were 4 comments in relation to HIV being a 'gay' disease:

> Not spoken about as felt that it is a disease as a result of promiscuous activity and or sexual orientation i.e., " being gay"

> HIV is seen as a disease of gay people. It's also seen as a disease that is no longer around as it is not commonly spoken about.

> I have a son who is gay and ensure that he looks after himself

> Not spoken about openly. A disease that is associated with people from the LGBT community.

HIV information

Some people believed that there is a lack of information about HIV in black communities:

> It's a virus that people are scared of and have a lack of information about

Another states that there is a lack of awareness across the board, amongst younger and older generations:

> Just in general I don't think young people or most adults don't know enough about HIV.

Conclusion

We found that HIV is not generally spoken about in black African and Caribbean communities with stigma directed at homosexuality. There was little awareness of treatment advances to reduce HIV transmission e.g., PrEP (pre-exposure prophylaxis) and PeP (post-exposure prophylaxis).

Buckinghamshire Council and Terrence Higgins Trust should promote HIV testing in community settings such as barbers, hair salons, food store, markets and church halls.

Awareness campaigns for routine HIV testing should also be promoted via Buckinghamshire Multicultural Organisations in Wycombe and Aylesbury, and SV2G (St Vincent and the 2nd Generation) African and Caribbean Arts & Heritage organisation.

Sexual health should be 'spoken about' at wider community events organised by Buckinghamshire Council and partnership organisations e.g., Black History Month.

Acknowledgements

We would like to thank all the people who took the time to complete our questionnaires. We would also like to thank our principal host survey providers: Vibez Mobile Barbering and La-Koco Nigerian Coffee Shop.

Disclaimer

Please note this report summarises responses to our online questionnaire. It is not known if any of the participants were living with HIV at the time of collection.

Appendix 1

More about our approach

Who we included

Our online survey was promoted in community-based settings.

We engaged with black African-Caribbean barbershops and hair salons to gather feedback. Barbershops have long been seen as excellent venues for handing out health information and increasing community awareness. They have already been used in the UK to promote HIV awareness.

Another host venue included a Nigerian Coffee Shop. A poster with a QR code and weblink to the survey was displayed in the Coffee Shop throughout the period of data collection, January and February 2023.

In addition to community-based settings, we used digital platforms to raise awareness about the survey through Healthwatch Bucks communication channels.

Who we will share our findings with

We will share our findings with Buckinghamshire Council, Buckinghamshire Sexual Health and Wellbeing (bSHaW) and Terrence Higgins Trust; HIV and sexual health charity.

We will also share our share our findings with Buckinghamshire Healthcare NHS Trust.

Statistical analysis

The findings from this survey are based on a **sample** of those who received information, who live in Bucks or use Bucks services. This means all findings are subject to sampling tolerances.

To get an overall idea of where variations between groups may occur in the results, we used pivot tables and charts. For example, we looked to see if there were different responses by demographic group. Where we suspected there may be a statistically significant difference, we applied a chi-squared test based on the following assumptions:

- each observation is independent of all the others (i.e., one observation per subject)

- all expected counts should be 5 or greater (two-by-two tables).

We tested at the 90%, 95% and 99% confidence levels. Only those at the 95% or above level have been reported as significant. This means the difference is likely to be real rather than be due to chance. Where no real difference is indicated there may still be a variation in the responses being compared but the difference is more likely to be due to chance.

All the statistical analysis is shown in full in Appendix 3 - Testing.

Appendix 2

Who did we hear from?

What age group are you in?

18 to 25 years	4
26 to 35 years	10
36 to 45 years	9
46 to 55 years	11
56 to 65 years	8
Prefer not to say	1
(blank)	2
Grand Total	**45**

Are you a:

A man	18
A woman	21
Prefer not to say	4
(blank)	2
Grand Total	**45**

Is your gender identity the same as your sex recorded at birth?

No	1
Prefer not to say	3
Yes	39
(blank)	2
Grand Total	**45**

What is your sexual orientation?

Asexual	1
Bisexual	3
Heterosexual / Straight	33
Prefer not to say	6
(blank)	2
Grand Total	**45**

How would you describe your marital or partnership status?

Cohabiting	2
Divorced / Dissolved civil partnership	1
Married	17
Prefer not to say	4
Separated	3
Single	15
(blank)	3
Grand Total	**45**

How would you describe your pregnancy or maternity status? (Tick all that apply)

Given birth in the last 26 weeks	0
Currently pregnant	1
Currently breastfeeding	1
Prefer not to say	2
Not applicable	39

What is your religion or belief?

Buddhist	2
Christian	27
Muslim	1
No religion	4
Prefer not to say	8
(blank)	3
Grand Total	**45**

How would you describe your ethnic group?

Black / Black British: African	25
Black / Black British: Caribbean	16
Mixed / Multiple ethnic groups: Black Caribbean and White	2
Mixed / Multiple ethnic groups: Any other Mixed / Multiple ethnic groups background (please tell us below)	1
Asian / Asian British	1
Grand Total	**45**

Deprivation (IMD2019 based on postcode sector)

Scale	Category	Explainer	Count
Least deprived	A	95% or more of the postcodes in this sector are in IMD2019 Quintile 1	0
	B	95% or more of the postcodes in this sector are in IMD2019 Quintile 1 and 2	0
	C	Other	14
	D	95% or more of the postcodes in this sector are in IMD2019 Quintile 4 and 5	2
Most deprived	E	95% or more of the postcodes in this sector are in IMD2019 Quintile 5	0

This is our own measure of levels of deprivation, based on postcode **sector**.

For example, if a postcode is in category E, there is a 95% chance that postcode is in the lowest quintile, i.e., the most deprived 20% of households in the UK.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/853811/IoD2019_FAQ_v4.pdf

Do you consider yourself to be a carer?

No	32
Prefer not to say	2
Yes	8
(blank)	3
Grand Total	**45**

Do you have a disability?

No	39
Prefer not to say	2
Yes	1
(blank)	3
Grand Total	**45**

Which of the following disabilities apply to you? (Tick all that apply)

Sensory impairment	0
Prefer not to say	0
Physical or mobility impairment	1
Neurodevelopmental condition (ADHD, ASD, learning disability or difficulties)	1
Mental health condition	1
Long term condition	1

Do you have a long-term health condition?

No	31
Prefer not to say	6
Yes	4
(blank)	4
Grand Total	**45**

Which of the following long-term conditions? (Tick all that apply)

Asthma, COPD or respiratory condition	2
Blindness or severe visual impairment	0
Cancer	0
Cardiovascular condition (including stroke)	0
Chronic kidney disease	0

Deafness or severe hearing impairment	0
Dementia	0
Diabetes	0
Epilepsy	0
Hypertension (high blood pressure)	0
Learning disability	0
Mental health condition	1
Musculoskeletal condition	1
Prefer not to say	0

Neurodevelopmental conditions - Have you been diagnosed with any of the following? (Tick all that apply)

Autism (ASD)	0
Dyspraxia	0
Dyscalculia	0
Dyslexia	0
Dysgraphia	0
ADHD/ADD (attention deficit hyperactivity disorder, attention deficit disorder)	1
Tourette's	0
Prefer not to say	0
Other	0

Appendix 3 – Testing

Null Hypothesis			
There is no difference in responses to 'Q3' between '45 and under' and '46 and over' 'Age Group'			

Observed Frequencies			
	Age Group		
Q3	45 and under	46 and over	Total
No / Don't Know	5	18	23
Yes	12	7	19
Total	17	25	42

Expected Frequencies			
	Age Group		
Q3	45 and under	46 and over	Total
No / Don't Know	9.3095	13.6905	23
Yes	7.6905	11.3095	19
Total	17	25	42

Parameters			
Level of Significance	0.01	0.05	0.1
Number of Rows	2	2	2
Number of Columns	2	2	2
Degrees of Freedom	1	1	1

Results			
Critical Value	6.6349	3.8415	2.7055
Chi-Square Test Statistic	7.4086	7.4086	7.4086
p-Value	0.0065	0.0065	0.0065
	Significant difference at 1% level	Significant difference at 5% level	Significant difference at 10% level

Assumptions

Each observation is independent of all the others (i.e., one observation per subject)*

All expected counts should be 5 or greater in 2x2 table.

Expected frequency assumption   is met.

Null Hypothesis

There is no difference in responses to 'Q3' between 'Married' and 'Not Married/In a Civil Partnership' 'Marital Status'

Observed Frequencies

Q3	Marital Status		Total
	Married	Not Married/In a Civil Partnership	
No / Don't Know	11	6	17
Yes	6	19	25
Total	17	25	42

Expected Frequencies

Q3	Marital Status		Total
	Married	Not Married/In a Civil Partnership	
No / Don't Know	6.8810	10.1190	17
Yes	10.1190	14.8810	25
Total	17	25	42

Parameters

Level of Significance	0.01	0.05	0.1
Number of Rows	2	2	2
Number of Columns	2	2	2
Degrees of Freedom	1	1	1

Results

Critical Value	6.6349	3.8415	2.7055
Chi-Square Test Statistic	6.9593	6.9593	6.9593
p-Value	0.0083	0.0083	0.0083
	Significant difference at 1% level	Significant difference at 5% level	Significant difference at 10% level

Assumptions

Each observation is independent of all the others (i.e., one observation per subject)*

All expected counts should be 5 or greater in 2x2 table.
Expected frequency
assumption   is met.

Null Hypothesis

There is no difference in responses to 'Q9' between 'A man' and 'A woman' 'Gender'

Observed Frequencies

Q9	Gender		
	A man	A woman	Total
No/Not Sure	14	8	22
Yes	4	13	17
Total	18	21	39

Expected Frequencies

Q9	Gender		
	A man	A woman	Total
No/Not Sure	10.1538	11.8462	22
Yes	7.8462	9.1538	17
Total	18	21	39

Parameters

Level of Significance	0.01	0.05	0.1
Number of Rows	2	2	2
Number of Columns	2	2	2
Degrees of Freedom	1	1	1

Results

Critical Value	6.6349	3.8415	2.7055
Chi-Square Test Statistic	6.2070	6.2070	6.2070
p-Value	0.0127	0.0127	0.0127
	No significant difference	Significant difference at 5% level	Significant difference at 10% level

Assumptions

Each observation is independent of all the others (i.e., one observation per subject)*

All expected counts should be 5 or greater in 2x2 table.

Expected frequency assumption   is met.

Null Hypothesis

There is no difference in responses to 'Fear of being judged by health professionals' between 'A man' and 'A woman' 'Gender'

Observed Frequencies

Fear of being judged by health professionals	Gender		
	A man	A woman	Total
Yes	6	14	20
Not yes	12	7	19
Total	18	21	39

Expected Frequencies

Fear of being judged by health professionals	Gender		
	A man	A woman	Total
Yes	9.2308	10.7692	20
Not yes	8.7692	10.2308	19
Total	18	21	39

Parameters

Level of Significance	0.01	0.05	0.1
Number of Rows	2	2	2
Number of Columns	2	2	2
Degrees of Freedom	1	1	1

Results

Critical Value	6.6349	3.8415	2.7055
Chi-Square Test Statistic	4.3105	4.3105	4.3105
p-Value	0.0379	0.0379	0.0379
	No significant difference	Significant difference at 5% level	Significant difference at 10% level

Assumptions

Each observation is independent of all the others (i.e., one observation per subject)*

All expected counts should be 5 or greater in 2x2 table.
Expected frequency assumption   is met.

Null Hypothesis

There is no difference in responses to 'Fear of being judged by health professionals' between 'Married' and 'Not Married/In a Civil Partnership' 'Partnership Status'

Observed Frequencies

Fear of being judged by health professionals	Partnership Status		Total
	Married	Not Married/In a Civil Partnership	
Yes	11	9	20
Not yes	2	12	14
Total	13	21	34

Expected Frequencies

Fear of being judged by health professionals	Partnership Status		Total
	Married	Not Married/In a Civil Partnership	
Yes	7.6471	12.3529	20
Not yes	5.3529	8.6471	14
Total	13	21	34

Parameters

Level of Significance	0.01	0.05	0.1
Number of Rows	2	2	2
Number of Columns	2	2	2
Degrees of Freedom	1	1	1

Results

Critical Value	6.6349	3.8415	2.7055
Chi-Square Test Statistic	5.7805	5.7805	5.7805
p-Value	0.0162	0.0162	0.0162
	No significant difference	Significant difference at 5% level	Significant difference at 10% level

Assumptions

Each observation is independent of all the others (i.e., one observation per subject)*

All expected counts should be 5 or greater in 2x2 table.
Expected frequency assumption   is met.

Null Hypothesis

There is no difference in responses to 'Discrimination/being treated differently' between 'Married' and 'Not Married/In a Civil Partnership' 'Partnership Status'

Observed Frequencies

Discrimination/being treated differently	Partnership Status		Total
	Married	Not Married/In a Civil Partnership	Total
No	11	11	22
Yes	2	10	12
Total	13	21	34

Expected Frequencies

Discrimination/being treated differently	Partnership Status		Total
	Married	Not Married/In a Civil Partnership	Total
No	8.4118	13.5882	22
Yes	4.5882	7.4118	12
Total	13	21	34

Parameters

Level of Significance	0.01	0.05	0.1
Number of Rows	2	2	2
Number of Columns	2	2	2
Degrees of Freedom	1	1	1

Results

Critical Value	6.6349	3.8415	2.7055
Chi-Square Test Statistic	3.8873	3.8873	3.8873
p-Value	0.0487	0.0487	0.0487
	No significant difference	Significant difference at 5% level	Significant difference at 10% level

Assumptions

Each observation is independent of all the others (i.e., one observation per subject)*

All expected counts should be 5 or greater in 2x2 table.
Expected frequency assumption   is violated.
Yates' Correction has been applied.

Null Hypothesis

There is no difference in responses to 'Q20 - GP' between 'African' and 'Caribbean' 'Ethnic Group'

Observed Frequencies

Q20 - GP	Ethnic Group		Total
	African	Caribbean	
Yes	7	12	19
Other	18	3	21
Total	25	15	40

Expected Frequencies

Q20 - GP	Ethnic Group		Total
	African	Caribbean	
Yes	11.8750	7.1250	19
Other	13.1250	7.8750	21
Total	25	15	40

Parameters

Level of Significance	0.01	0.05	0.1
Number of Rows	2	2	2
Number of Columns	2	2	2
Degrees of Freedom	1	1	1

Results

Critical Value	6.6349	3.8415	2.7055
Chi-Square Test Statistic	10.1654	10.1654	10.1654
p-Value	0.0014	0.0014	0.0014
	Significant difference at 1% level	Significant difference at 5% level	Significant difference at 10% level

Assumptions

Each observation is independent of all the others (i.e., one observation per subject)*

All expected counts should be 5 or greater in 2x2 table.

Expected frequency assumption   is met.

Null Hypothesis

There is no difference in responses to 'Q20 - GP' between '45 and under' and '46 and over' 'Age Group'

Observed Frequencies

Q20 - GP	Age Group 45 and under	46 and over	Total
Yes	6	14	20
Not Yes	17	5	22
Total	23	19	42

Expected Frequencies

Q20 - GP	Age Group 45 and under	46 and over	Total
Yes	10.9524	9.0476	20
Not Yes	12.0476	9.9524	22
Total	23	19	42

Parameters

Level of Significance	0.01	0.05	0.1
Number of Rows	2	2	2
Number of Columns	2	2	2
Degrees of Freedom	1	1	1

Results

Critical Value	6.6349	3.8415	2.7055
Chi-Square Test Statistic	9.4502	9.4502	9.4502
p-Value	0.0021	0.0021	0.0021
	Significant difference at 1% level	Significant difference at 5% level	Significant difference at 10% level

Assumptions

Each observation is independent of all the others (i.e., one observation per subject)*

All expected counts should be 5 or greater in 2x2 table.

Expected frequency assumption   is met.