MAKING IT COUNT

A collaborative planning framework to reduce the incidence of HIV infection during sex between men
The HIV epidemic continues apace among gay and bisexual men in England, with about 1,300 men becoming infected each year. This third edition of Making It Count serves the same purpose as its predecessor: it is both a planning framework for collaboration in HIV prevention and a framework for local and national action. It has been developed in collaboration with a wide range of stakeholders (see Acknowledgements).

It describes where we are now, the directions we want to be moving in and what needs to change to get there. Understanding these staging posts requires understanding of the social context of the epidemic. Making It Count therefore also presents a succinct social commentary on the HIV epidemic among gay and bisexual men.

The chapters outline a wide number of actions that can be taken by a wide range of key players at both national and local level. The challenge to the authors has been to describe these actions with sufficient specificity for people to act on them but with enough generality that they are not almost immediately out of date. In most cases we have described the direction of change rather than a (utopian) endpoint.

For this third edition, the framework has been updated in the context of advances in health promotion theory (eg. Nutbeam, 2000). Other significant changes include:

- the addition of reducing HIV positive to HIV negative semen transfer as a strategic aim for homosexually active men;
- the addition of increasing post-exposure prophylaxis as a strategic aim for men sexually exposed to HIV;
- the addition of reducing the time between infection and diagnosis as a strategic aim for men who acquire HIV;
- an expansion of the description of the roles of communities, services and policy makers in meeting the HIV prevention needs of homosexually active men, and the adoption of key strategic aims for each of these three constituencies.

The agencies and authorities involved in HIV prevention in the UK have diverse histories, structures and purposes. The first edition of Making It Count fostered an unprecedented sense of common purpose among this extremely diverse group. The second edition continued to contribute to this developing consensus and has been recommended by the Department of Health as the framework for local HIV prevention commissioning.

We hope this third edition will continue to build on this consensus, as well as reaching out to more people concerned with HIV incidence and opening up more avenues through which to influence it.

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(On behalf of the Making It Count Development Group)
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SUMMARY

Strategic goal of Making it Count
To contribute to the national goal of reducing by 25% the annual incidence of HIV infection during sex between men, from approximately 1,300 infections per year to approximately 975 infections per year, by 2007.

Strategic aims for homosexually active men

Strategic HAM aim 1: Reduce the average time between HIV infection and HIV diagnosis in men who become infected.

Strategic HAM aim 2: Reduce HIV sero-discordant unprotected anal intercourse, condom failure and HIV positive to HIV negative semen transfer.

Strategic HAM aim 3: Reduce the average length of time men have undiagnosed STIs (specifically gonorrhoea, NSU, syphilis and herpes).

Strategic HAM aim 4: Increase the proportion of HIV uninfected men who are sexually exposed to HIV who take post-exposure prophylaxis within 72 hours of exposure.

Strategic aims for communities, the media and businesses

Strategic community aim 1: Members of the general public reduce the frequency with which they verbally abuse and physically assault gay and bisexual men.

Strategic community aim 2: Gay and bisexual men increase activity with their peers and sexual partners that reduces HIV prevention need, including talking and passing on written resources, condoms and lubricant.

Strategic community aim 3: Parents, families and friends of young gay and bisexual men decrease the frequency with which they reject them and increase activities which reduce their HIV prevention needs, including talking and passing on written resources, condoms and lubricant.

Strategic community aim 4: Gay and bisexual community organisations (helplines, support groups, community centres etc.) exist and increase activities which reduce HIV prevention need in homosexually active men.

Strategic community aim 5: Editors and journalists of gay press titles increase editorial and copy that reduce the HIV prevention needs of their readers.

Strategic community aim 6: Gay web-site managers increase features of their sites that reduce the HIV prevention needs of their users.

Strategic community aim 7: Managers of gay bars, pubs and clubs increase the features of venues that reduce the HIV prevention needs of their users (eg, availability of education leaflets, awareness posters, condoms and lubricant).

Strategic community aim 8: Managers of saunas and other commercial premises that facilitate sex on the premises increase the features of venues that reduce the HIV prevention needs of their users (eg, availability of condoms and lubricant).

Strategic community aim 9: Mainstream media reflects the variety of contemporary gay and bisexual life in all aspects of the public sphere: media, community settings, education, etc.

Strategic community aim 10: Providers and owners of mainstream businesses and services decrease discrimination against gay men or bisexual men.

Strategic community aim 11: Gay and bisexual men increase their non-sexual social interaction.

Strategic community aim 12: Religious leaders reduce their verbal abuse of gay and bisexual men, including members of their own organisations who come out, and increase their active contribution to reducing men’s HIV prevention needs.

Strategic community aim 13: Gay and bisexual men increase reporting of unacceptable services received in the public sector.

Strategic community aim 14: Gay and bisexual men increase their lay involvement in Primary Care Trusts (PCTs) and other planning and consultation structures.
Strategic aims for education, health and social services

Strategic service aim 1: All service providers include homosexually active men in their service planning.

Strategic service aim 2: All service providers increase their delivery of culturally appropriate HIV prevention interventions to homosexually active men.

Strategic service aim 3: All NHS providers increase the equity of their generic services to homosexually active men.

Strategic service aim 4: All GP and primary care staff increase actions that reduce HIV prevention need among homosexually active men and stop actions which make them worse.

Strategic service aim 5: Clinical sexual health services prioritise homosexually active men as a client group.

Strategic service aim 6: All GUM staff increase offers of HIV tests to homosexually active men attending for STI screening and seek informed consent for testing.

Strategic service aim 7: An increase at NHS services in the availability of post-exposure prophylaxis (PEP) to men sexually exposed to HIV.

Strategic service aim 8: An increase in sexual health promotion interventions by HIV care and treatment providers.

Strategic service aim 9: All school boards develop and review policies to address homophobic bullying by pupils and teachers and that promotes gay and bisexual social inclusion.

Strategic service aim 10: Secondary schools increase the frequency with which they employ people able to teach pupils about sexual diversity, including homosexuality, in line with statutory sex and relationship guidance.

Strategic service aim 11: Police officers increase the equity of their generic services to homosexually active men.

Strategic service aim 12: Prison officers increase the frequency with which they make condoms and lubricant freely and confidentially available to inmates.

Strategic service aim 13: An increase by local health promoters in community development for HIV prevention.

Strategic service aim 14: Service providers increase leadership of collaborative planning fora and Local Strategic Partnerships for education, health and social services.

Strategic service aim 15: All teachers and trainers of education, health and social services staff increase coverage (and quality) of sexuality and HIV awareness.

Strategic service aim 16: Education, health and social services staff increase their input to the design and implementation of research investigations about HIV prevention.

Strategic service aim 17: Education, health and social services staff increase their input to local commissioning plans for sexual health and HIV.

Strategic service aim 18: Lobbying and policy charities increase their advocacy and lobbying to policy makers for gay and bisexual men’s HIV prevention work.

Strategic aims for policy makers, researchers and commissioners

Strategic policy aim 1: The Government finds a way to increase the priority given to HIV prevention activity within the NHS.

Strategic policy aim 2: All policy makers and commissioners increase their contribution to the national sexual health and HIV evidence base by collecting and making available transparent data for evaluating policy change, including the surveillance and publication of resource allocations.

Strategic policy aim 3: The Government increase its actions to ensure faster global progress towards the development of a safe and effective preventative vaccine against HIV.

Strategic policy aim 4: The Home Office increases its actions to enable Prisons Services to meet the (sexual) HIV prevention needs of inmates of prisons and young offenders institutes.

Strategic policy aim 5: An increase in the proportion of Strategic Health Authorities that include HIV and sexual health promotion with homosexually active men in Local Delivery Plans and performance monitoring mechanisms.

Strategic policy aim 6: PCTs increase HIV prevention programmes for homosexually active men and ensure they are adequately resourced.

Strategic policy aim 7: PCT commissioners increase consortia commissioning arrangements for programmes of HIV prevention for homosexually active men across PCT and Local Authority boundaries.

Strategic policy aim 8: PCTs (which have prisons within their area) engage with local prisons to jointly develop Health Improvement Plans for prisoners that include policies for access to condoms, sexual assaults and care of prisoners with HIV.

Strategic policy aim 9: Local authorities increase commissioning of services which reduce the HIV prevention needs of homosexually active men.

Strategic policy aim 10: An increase in the proportion of local authorities which explicitly recognise gay and bisexual men as a community group with extensive unmet social need, including young men leaving care.

Strategic policy aim 11: Researchers increase the applicability of the national evidence base to services, the community and policy makers.

Strategic policy aim 12: Police authorities develop and make known clear policies on the ways in which they support gay and bisexual victims of crime, including domestic violence, sexual assault, homophobic hate crime and street sensitivity issues.

Strategic policy aim 13: Police authorities develop and make known clear policies on the ways in which they respond to public complaints about gay and bisexual men, ‘gross indecency’ and ‘outrage to public morals’.

Strategic policy aim 14: An increase in leadership from MPs of the response to the gay and bisexual HIV epidemic that rejects homophobia and places civil action, human rights and respect at its centre.

Strategic policy aim 15: The Government introduce an amendment to the Employment Equality (Sexual Orientation) Regulations 2003 that makes religious organisations subject to its provision.

Strategic policy aim 16: The Government instigates legislation which provides the condition of legal equality of same-sex partnerships with mixed-sex partnerships.

Strategic policy aim 17: The Government repeals the gross indecency laws.

Strategic policy aim 18: The Government follows through on its stated intention to act on the recommendations of the Disability Rights Task Force and extends the cover of the 1995 Disability Discrimination Act (DDA) to people with HIV from the point of diagnosis.
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This document describes a framework for planning national and local activity intended to contribute to a reduction in the incidence of HIV infection during sex between men. It is intended as a reference for all people with a stake in doing this, including:

- men who have sex with men
- education, health and social services
- policy makers, commissioners and researchers
- media, businesses and the wider community

The document is a formal statement of the aspirations of a range of organisations who are engaged in HIV prevention with homosexually active men across England. It does not encompass all the concerns or all the activities of those agencies but articulates our common purpose in reducing HIV incidence. The document aims to increase our collective capacity to reduce HIV incidence by describing:

- a model of the HIV epidemic among homosexually active men in England;
- an explicit and acceptable approach to influencing HIV incidence in that population;
- the range of players who impact on those men’s HIV prevention needs and actions they can take to mitigate the epidemic;
- a system of prioritisation of need (and hence resources), which attends to both equity and impact on HIV incidence;
- a strategic planning framework for building collaborative HIV prevention programmes at national, local and agency levels.

The central body of the document provides an overview of the HIV prevention needs of the nation, starting with those of homosexually active men and moving out to the many stakeholder groups who have influence over them. This means describing:

- The needs of both HIV positive and HIV negative homosexually active men to have control over HIV diagnosis, sexual HIV exposure, condom failure, semen transfer, STI diagnosis and treatment and benefiting from post-exposure prophylaxis.

- Homosexually active men’s needs to reduce their own HIV prevention needs and those of their sexual partners and peers.

- The needs of friends and families of homosexually active men to reduce (or at least not exacerbate) the HIV prevention needs of those men they know.

- Community groups and business owners’ needs to provide aspects of community infrastructure that support a reduction in (or do not exacerbate) the HIV prevention needs of homosexually active men.

- Education, health and social service providers’ needs to provide accessible, acceptable, effective and efficient services to homosexually active men to reduce their HIV prevention needs.

- The needs of the boards of Primary Care Trusts to allocate resources, commission services and create a policy environment that has the greatest impact on HIV incidence with the greatest degree of equity within their local area.

- The needs of Strategic Health Authorities to develop strategy and to facilitate cross-PCT collaboration on programmes of HIV prevention for homosexually active men.

- National policy makers’ and commissioners’ needs to allocate resources, commission services and create a policy environment that has the greatest impact on HIV incidence with the greatest degree of equity across England.

All of these groups are targets of interventions outlined in the framework.
1.2 SCOPE AND EQUITY

The framework is concerned with all homosexually active men (and those who wish to become so) living in England, including men across the ranges of perceived, actual or diagnosed HIV status, sexual identity, ethnic group, age, social class, educational qualifications, area of residence, disability, religious or cultural affiliation.

The framework does not address HIV infections occurring through routes other than sex between men, or other health concerns of homosexually active men except as they relate to HIV. We focus on reducing the rate at which HIV negative men are becoming infected with HIV, events in which men with HIV are necessarily involved. The framework is therefore concerned with the sexual health of both HIV infected and uninfected men but not the other health concerns of either group.

For men with HIV infection, having little or no control over exposing their infection to others probably means having little or no control over being exposed to further sexually transmitted infections themselves. In other words, many of the unmet needs in positive men that contribute to HIV exposure also contribute to their poor sexual health more generally. Increasing the control men with HIV have over their involvement in sexual HIV exposure will contribute both to a lower incidence of HIV and to the improved sexual health of men with HIV.

How far away any single homosexually active man is from having his psycho-social needs met (as described in Chapter 3) is viewed as a marker of his needs. Unmet need suggests the potential to benefit from an intervention or programme of work. Rather than equality of input (each group getting the same resources regardless of need) we call for equality of need (that all men are educated, aware, empowered and equipped about HIV and other STIs). Given finite resources and extensive unmet need effective targeting is needed to reduce both health inequalities and HIV incidence.

The framework is concerned with programmes of interventions (particularly across organisations) for populations of men. Homosexually active men do not form a homogenous or discrete group. Even if all men were equally in need, individuals (and groups) may differentially benefit from intervention to meet those needs. No single intervention can meet all HIV prevention need for all men. This is a call for a plurality of interventions, emanating from a variety of sources, each contributing towards the overall goal of reduced HIV incidence.

Many homosexually active men live with stigma and discrimination including homophobia, HIV prejudice and racism. As well as attending to prioritisation based on differences in HIV incidence and/or need, all organisations should consider equity of access to their interventions. This means expecting interventions to be equally accessible to all groups unless stated otherwise and where this is not so, to instigate interventions specifically targeted at those groups. In practice, different groups of men require varying degrees of intervention depending on their personal and collective capacities to engage with available service provision.

1.3 VALUES, ETHICS, THEORY AND EVIDENCE

This is a framework for planning HIV health promotion. Health promotion is “the process of enabling people to increase control over, and to improve, their health” (WHO, 1986). The two broad categories of activity by which this process occurs are health education (for example, of gay men or medical practitioners) and healthy public policy making (for example, about education in schools) (Tones & Tilford, 1994).

A central principle of health promotion is that the promotion of one person’s health must not be at the expense of another’s. Strategic aims, needs and possible interventions are not advocated solely on the basis that they might ‘work’. They are also judged on how they might work. So, not all activities that could prevent HIV infection can be considered HIV health promotion. For example, discouraging men with diagnosed HIV from having any sex may reduce the number of exposures that occur in the population, yet it cannot be considered health promotion because it involves removing some men’s right to a satisfying and fulfilling sex life.

The framework is a product of the ethics and values of those agencies and individuals involved in its development. Even when an outcome is universally
regarded as desirable, influencing social processes to achieve that outcome must be guided by ethical principles. We recognise that the way in which we attempt to change the factors contributing to incidence is as important as successfully altering them.

The following values underpin the decisions taken in the framework. Taken together these principles can be seen as the ethical context in which the framework is situated.

- All people, whether they have HIV infection or not, are entitled to a satisfying and fulfilling sex life.
- All people, whatever their sexual preference or identity, their consensual sexual behaviour or their HIV status, are entitled to the same rights and respect as all other people.

The primary audience for the framework is those agencies undertaking and commissioning health services for and with gay men and other homosexually active men, including the treatment and care of men with diagnosed HIV. However, we also recognise that many external factors affect men’s sexual choices. Since these factors are often outside the scope of specialist HIV prevention agencies, this document is also a call for communication, cooperation and collaboration between agencies and across specialisms.

The framework is evidence based. We consider as evidence any information used for decision making that is systematically and transparently gathered and reported. We have used published research evidence in decisions about its strategic aims and intervention aims along with other sources of information. As most of the questions raised by, and directions taken in the framework would benefit from further evidence, this document also outlines a research agenda for HIV health promotion and the reduction of primary HIV infection.

Although based in available evidence, our decisions have not been driven by it. All information or data, in the process of becoming evidence, must be used within a theory, which in turn is tested by practice. So this is also a theory-based framework, rooted in known good practice. We recognise that endorsement of particular theories over others, and the decisions we take about acting on theories, are strongly influenced by our values. The recognition of a shared value base is important, given that fundamental decisions are based implicitly or explicitly on them.

We believe that educating and empowering men about sex and HIV, and increasing the control they have over their own lives, is a more effective approach to the sexual health of the population than making choices for them, telling them what to do or influencing their behaviour by indoctrination, misinformation or the removal of options. HIV prevention approaches which directly influence behaviour by removing or reducing people’s control may, in the short-term, be effective but will undermine the basis on which HIV prevention will be successful in the long-term.

We also recognise that even when all their HIV prevention needs are met, some men decide to engage in sexual HIV exposure (including both infected and uninfected men). Since men make their own sexual choices, and have the right to do so, this must necessarily be the case. This is not a framework for controlling men’s sexual behaviour. This is deemed both unfeasible (given the interventions available for control and the numbers of men involved) and undesirable (given our values). We are not assuming that avoiding involvement in HIV transmission is the single most important concern in men’s lives, nor are we attempting to make it so. We recognise that health promoters are not and cannot be responsible for men’s sexual behaviour. That must remain the responsibility of men themselves.

1.4 CONCURRENT EPIDEMICS

The HIV/AIDS epidemic in England is made up of a number of distinct and inter-related epidemics. There is the epidemic of on-going infection, the epidemic of ill-health among those infected (including those moving into the country with HIV) and the epidemic of negative social, political and economic consequences of these. The National Strategy for Sexual Health and HIV (Department of Health, 2001) considered all three of these epidemics.

The epidemic of on-going infections is itself composed of different epidemics. The largest and longest standing
is that among homosexually active men and it is the epidemic this framework is concerned with.

In addition, there is a fast growing HIV epidemic among African people resident in the UK. The driver for this epidemic has been migration from countries with a high prevalence of heterosexually acquired HIV infection as well as homosexually acquired infection. Every commentator stresses that the African epidemic is predominantly heterosexual, as if it means there is no homosexual epidemic in Africa. But while HIV prevalence is high among male and female heterosexually active Africans – and therefore the majority of Africans with HIV are heterosexual – it is still higher among male homosexually active Africans. African men are over-represented in diagnoses of homosexually acquired infection (Macdonald, personal communication) and homosexual activity is over-represented in samples of African men with HIV (Chinouya & Davidson, 2003). Whatever the driver for high HIV prevalence among Africans in the UK, there is a substantial, growing, HIV infected (both diagnosed and undiagnosed), relatively young, heterosexually active African population in the UK. Heterosexual HIV exposure and transmission involving Africans living in the UK is certainly increasing.

The UK epidemic is often expressed in terms of proportion of infections that occur through different routes, changes in these proportions being taken as evidence that the epidemic is changing. However, the changes do not reflect a shift in the epidemic but its diversification. Gay communities and African communities in Britain are not in competition for a finite number of infections. The number of diagnoses of heterosexually acquired HIV has outstripped the number of homosexually acquired infections because the former has grown, not because the latter has fallen. The gay epidemic has not gone away but has been gradually increasing. The UK epidemic is too often portrayed as a competition between these communities for an amount of resources that has not increased in line with the growing epidemic. We resist this implied competition and call for more resources to address both the large on-going gay epidemic and the growing UK-based African epidemic.

This observation makes it all the more necessary to identify national HIV prevention needs that transcend routes of transmission such as political leadership against stigma and discrimination, progress toward an effective preventative vaccine and the availability of post-exposure prophylaxis (PEP) for sexual exposure.

1.5 DISCRIMINATION FUELS THE EPIDEMIC

Social justice and equity are fundamental prerequisites for health (WHO, 1986) and social exclusion has been identified as a key cause of ill health (Townsend & Davidson, 1982; Wilkinson & Marmot, 1998; Department of Health, 2001). HIV does not occur at random in the entire population, nor in the population of homosexually active men. While the factors that lead to HIV exposure and infection are behavioural and biological, they involve people and are determined by social processes. Therefore, influencing the behavioural and biological factors requires influencing the social processes that lead to them and which determine their distribution through the population.

There exist many barriers to the HIV health promotion aims being met. Central are the social taboo of homosexuality generally, discrimination against gay men in particular, discrimination against people with diagnosed HIV infection, and the isolation these social exclusions create and maintain. Stigma and discrimination not only reduces the control people have over their own lives; it also reduces access to services and compromises the effectiveness of services when they are used.

All HIV prevention work exists within a national and local context of heterosexism and discrimination against people with HIV. Not only does this make all of our work to achieve these aims more difficult (Piot & Aggleton, 1997) but it also directly and negatively impacts on the mental health of many people (Otis & Skinner, 1996; Cole et al., 1996). Although significant change has been achieved in recent years, inequality between sexual minorities and the sexual majority exist in every area of life and HIV continues to be a very stigmatised disease.
Such policy and practice exist both on a national basis, enshrined within the law and on a local basis as part of the policy and practice of key local organisations (such as local authorities or the Police). For an effective HIV prevention response we need gay men and other men who have sex with men and people with HIV to be explicitly included in policies that promote social equality and undermine discrimination.

On the other hand, legislation that promotes discrimination and make sexual health and HIV prevention interventions less possible needs to be removed. Central government should promote policies which support this framework, challenge discrimination and champion equality for homosexually active men and for people with HIV.

Addressing inequalities in all communities, across the range of geography, social class and ethnic groups, will make meeting our subsequent health promotion aims more feasible and more likely. We assert that without the above inequalities being addressed, the effectiveness and efficacy of all HIV prevention interventions will be compromised.

Health literacy and healthy environments: HIV prevention needs

HIV related behaviours are determined by the extent to which the HIV prevention needs of the population are met. These are represented by the ring encircling the HIV related behaviours. In order to reduce HIV-related risk behaviours men require choices, self-worth, knowledge, abilities (including skills and efficacy), material resources, and access to diagnoses and treatments for STIs (including HIV). These are the HIV prevention needs of homosexually active men and the extent to which they are met determine the extent of HIV-related risk behaviours.

Intervening

HIV prevention needs are influenced by the actions of three very broad constituencies, for convenience labelled ‘community’, ‘services’ and ‘policy’. The actions of these constituencies both aggravate and relieve the HIV prevention needs of homosexually active men. HIV prevention actions can emanate from each of the three constituencies, as can negative actions which increase incidence by increasing HIV prevention needs. For example, while policy actions can facilitate a supportive and anti-discriminatory environment, they can also result in discrimination (eg. the current law on marriage and pensions) and can foster and support intolerance (eg. the recently removed Section 28). Similarly, while services’ actions can reduce prevention need through, for example, information giving, screening and treatment or running youth groups, they can also exacerbate HIV prevention needs by devaluing or belittling sex between men, not respecting patients’ rights or colluding with the homophobic of other clients. Lastly, while the community at large (including the homosexually active men within it) has been the greatest source of interventions which reduce need (such as peer education, political lobbying and service advocacy) it has also been the greatest source of harmful interventions which undermine needs (such as homophobic abuse and assault, misinformation and stigma).
Each constituency can also act towards the needs of the other two constituencies, as well towards its own needs. Therefore each can also be the target of the preventative activity of the others, with the intention of increasing their positive actions or reducing negative ones. Whether or not a constituency acts (toward homosexually active men, toward the other two constituencies or toward itself) will be determined by whether or not its needs for action are met. The needs of the community, services and policy makers are modifiable determinants of homosexually active men’s HIV prevention needs.

**Community, business and media**

In order to act in its own interests, a community requires knowledge and awareness of its problems, empowerment, leadership, social norms (public opinion), a supportive legal framework, meeting spaces and resources. The needs of the community are outlined in Chapter 5. Extensive influence on HIV prevention needs also comes from the mass media (television, newspapers, etc.) and businesses.

Community, business and media actions can be directed toward homosexually active men’s HIV prevention needs (eg. peer education, workplace anti-homophobia policies, media inclusion), toward the capacity of services (eg. public involvement in service planning) or towards policy makers (eg. advocacy and lobbying). Community action can also be toward other community members to meet their needs for positive action (eg. community mobilisation,) or to limit their potential for negative actions (eg. challenging homophobia).

**Health, education and social services**

The needs for positive action by services include the make-up of the workforce, its skills and abilities, the environments it works in (estates), its resource costs and policies, information and research, as well as accountability and public involvement. The needs of health, education and social services are outlined in Chapter 6.

Actions by services can be directed toward homosexually active men’s HIV prevention needs (eg. education, vaccination, social support groups), toward needs for community action (eg. community development, group facilitation) and toward needs of policy makers (eg. advocacy, political organising). Services also act toward other services in order to meet their needs to act (eg. staff training, policy collaboration).

**Healthy public policy, research and resource allocation**

In order to make healthy public policies and to allocate resources effectively and equitably, policy making needs people with skills and time, they need power to act, awareness, knowledge and information about the needs of communities and services, resources to allocate and mechanisms for allocating them. The needs of policy makers, commissioners and researchers are outlined in Chapter 7.

Policy actions can be directed towards homosexually active men’s prevention needs directly (eg. statements of values and intent), towards the community (eg. anti-homophobic equality legislation), or services (eg. regulation and resource allocation). Policy actions can also be made toward other policy makers and commissioners (eg. until recently the ring fence around HIV monies).
Figure 1.6: Overview of the framework: a bio-pyscho-social model of HIV incidence

Community, businesses & media

Education, health & social services

Policy, commissioning & research

HIV related behaviours

HIV incidence

HIV prevention needs

action

influence

requirements for action
Since the second edition of *Making It Count* (summer 2000) several substantial changes have occurred. These changes include a major re-organisation of the NHS and a range of governmental policy documents concerning HIV and sexual health. The Government had been in the process of developing a strategic response to HIV for some time before it was merged with the strategy to reduce all sexually transmitted infections and unwanted conceptions / births. Before describing the changes in the policy environment it is worth highlighting that some things have not changed.

First, in England, new HIV infections continue to disproportionately affect gay men in comparison to any other group in the population (see Chapter 2).

Second, there remain many barriers to the HIV prevention needs of homosexually active men being met. Central are the social taboo of homosexuality, discrimination against gay men and against people with diagnosed HIV infection, and the isolation these social exclusions create and maintain. Discrimination not only reduces the control people have over their own lives; it also reduces their access to interventions and compromises the effectiveness of interventions when they are used.

Third, the ‘evidence-base’ for HIV health promotion remains dispersed and unsystematic (Ellis et al., 2003). Although there is increasing consensus on the meaning of success in HIV health promotion, what counts as acceptable, equitable, effective and efficient interventions remains to be agreed. This problem is magnified when we consider the interaction of interventions in a programme.

On a more positive note, advances in effective anti-HIV therapy (Alcorn, 2002) continue to offer improvements to the health and well-being of many people with diagnosed HIV (Anderson & Weatherburn 1998; Anderson et al., 2000). Improved treatments have also substantially reduced the death rate associated with HIV. However, HIV infection remains a life-long and life-threatening infection. Despite treatment advances, prevention of primary HIV infection remains a central pillar of a comprehensive national response to HIV.

Progress is also being made in exploiting the potential of post-exposure prophylaxis (PEP) for sexual exposure. We assume that although the proportion of exposures in which uninfected men know they are being exposed to HIV is low, sufficient numbers of uninfected men are aware of their exposure to warrant making PEP more widely available. The Department of Health’s updated guidelines for the use of PEP (UK Chief Medical Officer’s Expert Advisory Group on AIDS, 2000) acknowledged the potential value of PEP for sexual exposure, although at the time of their writing little evidence was available on which to base recommendations for or against its use. Since then further positive evidence has been generated and specific guidelines for the use of PEP following sexual exposure are being developed jointly by the Association of Genitourinary Medicine and the Medical Society for the Study of Venereal Disease (Fisher, Benn, Davidson et al., 2003).

Section 28 of the Local Government Act 1988 has been repealed. It was introduced by Margaret Thatcher’s Conservative Government at the height of the HIV hysteria in the UK. It stated that no local authority shall “promote homosexuality” nor promote “the acceptability of homosexuality as a pretended family relationship”. Implicitly a move to protect the nation from HIV by attempting to suppress homosexuality, Section 28 has protected no one but instead has done untold damage to the HIV prevention response in England over the last fifteen years. As well as directly damaging the social capital of lesbians and gay men, it has obstructed the development of adequate sex education in schools and has sapped time and energy of community members from more productive activities.

In terms of this framework the most important governmental action in the last few years has been the publication of the first *National Strategy for Sexual Health and HIV* (Department of Health, 2001), launched for consultation in July 2001. In has been followed by an Implementation Action Plan (Department of Health, 2002), a ‘commissioning toolkit’ (Department of Health, 2003a) and a ‘health promotion toolkit’ (Department of Health, 2003b). Further documents include a ‘Manual for health advising practice’ (forthcoming Autumn 2003), a ‘Stigma and discrimination action plan’ (planned for...
As part of the strategy implementation process the Department of Health have also endorsed a set of Recommended standards for NHS HIV services, developed by the Medical Foundation for AIDS & Sexual Health (MedFASH, 2003). They have also commissioned a Framework for prevention and services for people in African communities from the National AIDS Trust (due 2003).

All these strategic documents should be viewed in the context of other governmental guidance on the modernisation of the NHS. Each add detail and means of achieving the five goals of the original strategy document. These were to:

- reduce the transmission of HIV and STIs;
- reduce the prevalence of undiagnosed HIV and STIs;
- reduce unwanted pregnancy;
- improve health and social care for people living with HIV; and
- reduce the stigma associated with HIV and STIs.

Consensus has emerged that targeted HIV prevention is necessary (UK Chief Medical Officer, 2002), that gay men and African people are the two primary targets (Department of Health 2001, 2002, 2003a) and that within those groups HIV positive people are a priority.

In April 2002, the National Health Service underwent substantial reorganisation. Previously England was divided into eight Regional Health Authorities between them containing 95 Health Authorities. Following re-organisation, England now has four Directorates of Health & Social Service (North, Midlands & Eastern, South and London), which together cover 28 Strategic Health Authorities (SHAs), which contain 302 Primary Care Trusts (PCTs). Most PCTs are co-terminus with local authority areas. Commissioning of all NHS services now occurs at the PCT level. It remains to be seen if this arrangement increases the relationship between need and response in the HIV epidemic. The changes do, however, increase the need for health commissioners to work together in consortia to make the most of limited resources.

At the same time as this devolution of commissioning decisions, the ring-fence around HIV prevention monies was removed. This means that resources previously earmarked for (if not always spent on) HIV prevention can now be spent on any health issue. In the planning arena, the HIV prevention needs of gay men have always competed with the sexual health needs of heterosexually active young people and adults. All these sexual health needs are now in competition with all other health issues in the general population.

This third edition of the Making It Count framework is therefore launched into a fast changing and uncertain field. The challenge has been to describe the problem, current responses and potential future solutions in sufficient detail to be useful but with sufficient generality to not be immediately out of date.
2.1 HIV PREVALENCE AND HIV INCIDENCE

HIV prevalence is the proportion of the entire population who currently have HIV, whether their infection has been diagnosed or not. Prevalence goes up as people with HIV join the population (when people with diagnosed or undiagnosed infection migrate to a country or area) and as uninfected people become infected (incidence of infection).

If HIV infection could be cured, prevalence could be reduced by diagnosis and treatment. As HIV infection remains incurable, prevalence only decreases as people with HIV die (or move away). The introduction and uptake effective anti-HIV therapy has extended the life of many people with HIV and precipitated a corresponding increase in HIV prevalence. That is, the very desirable change that fewer people are dying with HIV disease is reflected in an overall increase in prevalence.

Figure 2.1 illustrates HIV prevalence and HIV incidence in a population. The whole triangle represents the entire population of concern. The smaller triangle at the top represents those who have HIV infection. Those with HIV are split into people who have had their infection diagnosed, and those who have not (‘HIV infected: undiagnosed’, the smallest triangle). The remainder of the triangle represents those who do not have HIV (uninfected).

HIV incidence is the rate at which people in a population become infected with HIV. In Figure 2.1 it is represented by movement of people from the ‘HIV negative’ section into the ‘undiagnosed positive’ section. All infections must be acquired before they are diagnosed so all people who have their HIV infection diagnosed must have spent some time with undiagnosed infection.

HIV incidence is a rate. It is the proportion of HIV negative men who become infected in a given period. Incidence refers only to the number of uninfected men becoming infected (during a specific time, usually a year) and not the number of men those infections come from.

HIV incidence should not be confused with HIV diagnoses, which is represented by movement from ‘undiagnosed positive’ to ‘diagnosed positive’. Reports of diagnoses of infections present a partial picture of new HIV infections because of the variable time between infection and diagnosis, and undiagnosed infection. However, over time, almost all HIV infections will eventually be diagnosed, giving a partial picture of recent incidence.
2.2 HIV PREVALENCE AND HIV INCIDENCE AMONG HOMOSEXUALLY ACTIVE MEN IN ENGLAND

The population of concern of this framework is men aged 16 years and over who live in England and who will have sex with a man in the future.

In 2001 there were 18,861,816 males aged 16 years and over living in England (ONS, 2002). If we take the proportion of adult males who are homosexually active in a five year period to be 2.6% (range 2.2%–3.1%; Johnson et al., 2001) then:

- there were 490,407 homosexually active men living in England in 2001 (range 414,960–584,716).

In 2001 there were an estimated 14,500 men living in England with diagnosed homosexually acquired HIV infection and in touch with services (Health Protection Agency, personal communication, based on SOPHID adjusted for under-reporting and non-attendance at services). Therefore:

- the prevalence of diagnosed HIV infection among all homosexually active men in England in 2001 was 14,500/490,407, or 3.0% (range 2.5%–3.5%).

A direct measurement of the prevalence of diagnosed infection among a large national sample of homosexually active men recruited in 2001 was 2.5% suggesting this estimate is correct (Sigma Research, National Gay Men’s Sex Survey 2001, England-resident men recruited on the internet, weighted for gender of sexual partners).

Diagnosed infection is very unevenly distributed among homosexually active men. In the above survey prevalence was 0.8% among behaviourally bisexual men but 4.1% among exclusively homosexually active men. Among the latter it was 3.0% outside London but 6.5% in London. Among community and GUM (rather than internet) recruited samples of gay men in London, the prevalence of diagnosed infection was higher again (at 7.4% in Dodds & Mercey, 2002).

At the end of 2001 there were estimated to be another 3,800 homosexually active men with HIV infection who had not yet had it diagnosed (Health Protection Agency, personal communication, 2003). This suggests in 2001 there were 18,300 homosexually active men with HIV infection in England, 21% of which had not had their infection diagnosed. This means:

- the prevalence of all HIV infection (both diagnosed and undiagnosed) among all homosexually active men in England in 2001 was 18,300/490,407, or 3.7% (range 3.1%–4.4%).

In 2001 this left 472,107 homosexually active men without HIV (range 396,660–566,416).

The number of men currently acquiring HIV is difficult to determine. Our best guess is based on diagnoses in recent years. In 2001 between 1,200 and 1,400 new homosexually acquired infections were diagnosed in men living in England. This would suggest that:

- the annual incidence of HIV infection among all homosexually active men in England in 2001 was 0.21%–0.35%.

Direct measurement of recent HIV acquisition among homosexually active men receiving a syphilis tests during GUM clinic attendance has found an incidence ten times higher than this (Murphy et al., 2003). National incidence in this group was 2.4% per year (3.1% in London and 1.0% elsewhere). The large difference between incidence estimated from the total population and that measured in clinical studies is because clinics draw men from a population much more likely to seroconvert to HIV than the general homosexually active population. HIV is very unevenly distributed among the population of homosexually active men across a number of characteristics and behaviours (including GUM attendance). Taking account of these inequalities is discussed in Section 8.3.

2.3 THE NATIONAL GOAL: REDUCING HIV INCIDENCE

This framework is concerned with the incidence of HIV infection. The shared goal of those planning with this framework is to slow the flow of men from the negative into the undiagnosed positive section of Figure 2.1. Our overall goal is to minimise the number of men becoming infected each year.

The Government has set a national goal of reducing HIV incidence by 25% by the year 2007 (Department of Health, 2001). This should not be confused with the number of diagnoses of HIV made each year. Figure 2.3a
shows the number of diagnoses made each year grouped by how people are thought to have acquired the virus: sex with men (swm, males and females separately), sex with women (sww, all of whom are male), intravenous drug use (idu), mother-to-child (vertical) and other/undetermined (the last three include both males and females). As the overall height of the column shows, the past five years has seen major increases in the number of people being diagnosed with HIV in the UK.

However, it is not possible to use HIV diagnoses in the UK as a surrogate marker for HIV incidence in the UK because new diagnoses include both people living in the UK who have acquired HIV (reflecting incidence in the UK) and people who have moved to the UK with HIV infection (reflecting migration to the UK with HIV).

Ignoring this crucial difference has resulted in the data in Figure 2.3a being interpreted as showing "a 25% increase in the number of British people infected with HIV over the past year" (BBC News on-line, 30 November 2002). This widespread misunderstanding is being used as an justification to reduce resources for interventions targeting gay and bisexual men.

The Health Protection Agency’s diagnoses surveillance system does not record where people were living when they acquired their infection. Since the beginning of the epidemic it has sought to establish where in the world heterosexually acquired infections were probably acquired, an indicator which conflates UK residents who acquire their infection on a visit abroad and people with HIV moving to the UK from elsewhere. Since 2000 the HPA has also sought data on where homosexually active men probably acquired their infection.

If we separate out those infections thought to have been heterosexually acquired abroad (Figure 2.3b) from the rest (Figure 2.3c) we see that the rise in HIV diagnoses in the UK over the last few years is almost entirely due to increases in the number of people with infections heterosexually acquired abroad. Studies of people with diagnosed HIV living in the UK suggest these are people moving to the UK with HIV, rather than people in the UK becoming infected while visiting abroad. It is possible that in 2001 more people moved into the UK with HIV infection than people living in Britain became infected.
If we consider only those infections not known to have been acquired abroad (ie. those in Figure 2.3c) and look at the proportions accounted for by each infection route (Figure 2.3d) we see that sex between men accounts for approximately 80% of infections, and that this has not fundamentally changed in the last five years.

This means we could prevent every HIV infection occurring in the UK through heterosexual sex, mother-to-child and injecting drug use, and we would still not have achieved the government’s goal of a 25% reduction. Homosexually active men, and in particular gay men living in London, are central to tackling HIV infection in England.

The strategic goal of Making It Count is that of the National Strategy for Sexual Health and HIV.

**Strategic goal**

To contribute to the national goal of reducing by 25% the annual incidence of HIV infection during sex between men, from approximately 1,300 infections per year to approximately 975 infections per year, by 2007.

HIV is a virus. During sex it is passed from one person to another through a very limited number of specific behaviours aided or obstructed by a number of biological facilitators, the volume and pattern of which will result in the singular and specific number of infections in the population.

An HIV health promotion programme whose goal is to slow the rate of HIV infection must take account of factors contributing to incidence it is unable or unwilling to change while influencing those it can. The factors we are attempting to change are called ‘strategic aims’.

The next chapter describes the behaviours of homosexually active men that may be contributing to HIV incidence and considers their potential as ‘strategic aims’. For each factor, we ask: is it possible to reduce its contribution to incidence; is it ethical to do so; and is it practically feasible to do so.

The same questions are asked about the HIV-related behaviours of policy makers, commissioners and researchers (Chapter 7), health, education and social services (Chapter 6) and the wider community (Chapter 5).
HAM NEEDS

3 The actions and needs of homosexually active men
3.1 THE ROLE OF HOMOSEXUALLY ACTIVE MEN

Homosexually active men are the front-line of the HIV epidemic. They are the bodies through which HIV is moving and it is their actions that constitute the first set of strategic aims outlined in this framework. The level of each strategic aim in the population will be determined by the personal and collective capacities of homosexually active men, which in turn will be determined by the actions of service providers, policy makers and the rest of the population.

Five conditions are necessary for primary HIV infection to occur during sex between men (referred to as source, exposure route, medium, loading and susceptibility):

(i) an infected man and an uninfected man must have sex together [source];

(ii) they must engage in sexual acts which provide an exposure route for HIV to pass from the infected to the uninfected man (the uninfected partner being receptive in anal or oral intercourse, either without a condom or with a condom that fails; the uninfected partner being insertive in anal intercourse, again either without a condom or with a condom that fails) [route];

(iii) a sufficient quantity of body fluid (semen, pre-ejaculate or blood) containing HIV must be transferred from the infected to the uninfected partner [medium];

(iv) the body fluid must contain a sufficient concentration of viral particles [loading];

(v) the uninfected partner must be susceptible to infection [susceptibility].

Not all of these are amenable to intervention at the population level. However, it is clear that if incidence is to be reduced, the behaviours and biological co-factors facilitating it will have to change.

3.2 INFLUENCING BEHAVIOURS

Reducing the factors contributing to incidence requires influencing what men do. Activities to influence what people do vary in several ways, not least of which is whether they are effective or not (ie. do they actually influence what people do?). However, our choices of activity are not solely based on evidence of their effectiveness, nor should they be. They are also political and ethical decisions.

Approaches to influencing what people do can be thought of as sitting somewhere on a We Decide / You Decide axis. This axis concerns who decides what people do, the people doing the influencing or the people they are attempting to influence. We can imagine the axis starting with ‘You will do what we say’ through ‘Well, you should do this really’, to ‘Do what you think best’. Figure 4.2 illustrates a number of approaches to influencing what people do. The behaviour could be, for example, a sexual act, having blood taken for an HIV test, the use of lubricant with a condom, having asymptomatic gonorrhoea diagnosed, or seeking and taking post-exposure prophylaxis. We can think about using any (or each) approach to making that behaviour more likely. We can also think about each approach for making the behaviour less likely.
3.3 THE AIM OF INTERVENTIONS IS REDUCING NEEDS

This chapter also introduces the needs of homosexually active men to contribute to a reduction in incidence by reducing (or in some cases increasing) their involvement in HIV-related behaviours. By definition, the HIV prevention needs of homosexually active men are the aims of health promotion interventions whose targets are homosexually active men and their HIV prevention needs.

The aims described here are ambitious. They concern the information men have, the meaning of that information to their lives, their personal and social resources and their interpersonal skills. They also concern the control men have over condom failure, what they know about services and how to access them.

We aspire to meet the needs of all homosexually active men and recognise that the extent to which they are met varies greatly across different groups (Hickson et al., 1999; Weatherburn et al., 2000; Hickson et al., 2001; Reid et al., 2002). We also recognise that all these needs will never all be met for all homosexually active men, not least because there are (predominantly younger) men joining the population all the time. It is, however, the situation we are working towards.

Different people want different things out of sex and relationships. Our aim is not to promote or deprecate any particular sexual act or sexual lifestyle. It is to ensure men know about HIV and its implications and are able to pursue their own desires and choices with minimum harm to themselves and others.

The ‘HIV risk behaviours’ of homosexually active men we are seeking to address are not unitary and men’s needs with regard to these actions are complex and multiple. Needs for control over one of the behaviours are often the same as for other behaviours. For example, being knowledgeable about HIV will be related to having undiagnosed HIV infection diagnosed, involvement in sexual HIV exposure and seeking PEP if exposure occurs. We have grouped the HIV-related behaviours into those which share a set of similar needs.
3.4 SWIFTER DIAGNOSES OF HIV: INCREASING AWARENESS OF THE PRESENCE OF HIV INFECTION

3.4.1 Opportunities for sexual HIV exposure

The number of times HIV infected and uninfected men have sex together is rising. This is due to changes in at least three parameters.

First, the size of the male homosexually active population is increasing. The proportion of men in Britain who had sex with a man in the last five years rose from 1.5% to 2.6% between 1990 and 2000 (Johnson et al., 2001). We consider this to be primarily due to a decrease in discrimination toward gay men in the general population and welcome such an increase.

Secondly, thanks to anti-HIV treatments the average time homosexually active men have HIV has been considerably extended by preventing their deaths (CDSC, 2002). This means the prevalence of HIV in the homosexually active population is increasing. The number of men living with HIV infection is rising each year (see Figure 3.4.1) as men continue to become infected but fewer men die.

A cure for HIV infection (and a subsequent reduction in HIV prevalence) would greatly assist a reduction in HIV incidence. This framework is congruent with that goal but does not expand on it further.

Thirdly, as many men with HIV infection are also enjoying better health and well-being the frequency with which they have sex with men without HIV has also increased (accompanying an overall increase in the volume of sexual partners of all homosexually active men; Mercer, 2003). These are the outcomes of successful medical interventions.

Together, these parameters define the number of HIV sero-discordant sexual sessions occurring. All three parameters are increasing and none is useful as a strategic aim for interventions. Hence, our attempts to reduce incidence are hampered by rise in the size of the population, the prevalence of HIV within it and by the increasing health and vitality of those infected.

3.4.2 The benefits of having HIV diagnosed

With regard to HIV testing, there are a number of benefits to knowledge of the presence of infection.

The person with HIV knowing they have HIV

Studies suggest couples who know they are HIV sero-discordant (i.e., one is HIV positive the other is not) are less likely to have unprotected intercourse than those who know they are sero-concordant (Crepaz & Marks, 2002; Crawford et al., 2003). This suggests men who know they have HIV may reduce the frequency with which they engage in sex which exposes their infection to uninfected men. However, we recognise that having HIV diagnosed does not automatically give men the skills and abilities, nor the power, to ensure that their subsequent sexual behaviour never exposes their infection to others.

The person with HIV’s healthcare provider knowing they have HIV

Diagnosis of HIV is the gateway to clinical care. Although an HIV diagnosis can be psychologically traumatic, postponing diagnosis does not make it go away. Anti-viral therapy, preventative medication and prompt responses to health problems can preserve the health and well-being of people with HIV. Doctors and their patients make the best healthcare decisions when they know what they are dealing with. Strict adherence by health
care professionals to codes of confidentiality are not only a prerequisite of acceptable testing services but also increases the effectiveness of care. In addition, drugs may also reduce their infectivity which could contribute to fewer onward infections (see Section 3.5.1 below).

**Public health surveillance knowing about HIV positive diagnoses**

Public testing services allow for national surveillance, a vital part of our national response. The UK is fortunate to have one of the best HIV public health surveillance systems in the world, in the form of a number of data gathering systems of the Health Protection Agency. The preceding sections of this document would not have been possible without these efforts.

**The National Strategy for Sexual Health and HIV**

The National Strategy (Department of Health, 2001) identifies a reduction in undiagnosed HIV infection as one of its central goals. This framework supports this goal. We estimate that in 2001 approximately 21% of all infections were undiagnosed (about 3,800 men living in England). As the number of men with diagnosed HIV infection grows, the proportion of all infections that are undiagnosed will inevitably get smaller. A more precise strategic aim is the time between HIV infection and HIV diagnosis. As CD4 count is an (inverse) surrogate marker for this length of time, an indicator for this parameter is the average (mean) CD4 at diagnosis. Currently this is 340 cells/mm³ (mean in 2000; Macdonald, 2002) so an increase in this value would be evidence of change in this population parameter.

### 3.4.3 The needs associated with swift diagnosis of HIV infection

The approach advocated by this framework for ensuring the shortest time between infection and diagnosis is that of ensuring human rights, open access to HIV testing services, education and empowerment. It is clear that discrimination of people with HIV, poor or inaccessible testing services, ignorance about HIV, HIV testing or HIV treatment and disenfranchisement all extend the time people spend with undiagnosed HIV infection.

The needs associated with swift HIV diagnosis described below are also congruent with the needs associated with safer sex, swifter STI diagnosis and treatment and greater post-exposure prophylaxis described in the following sections.

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**Homosexually active men – strategic aim 1**

**Reduce the average time between HIV infection and HIV diagnosis in men who become infected.**

Needs include:

- Freedom from psychological and emotional barriers to HIV testing.
- Freedom from discrimination for testing for HIV.
- Freedom from discrimination if the result is positive.
- Access to a trusted HIV testing service.
- Freedom to choose whether and when to test for HIV.
- Knowledge about HIV testing and the meaning of HIV test results.
- Knowing that a medical test exists which can determine whether they are infected with HIV or not.
- Knowing that the HIV antibody test has a window period when their recent infection may not be detected, and understand what that means for them.
- Knowing that a test result applies only to the person taking the test and not to any of their sexual partners.
- Understanding that a negative test result, if the person has not been exposed to HIV during the window period, means a person is almost certainly not infected with HIV, and does not mean a person is immune, even if they know they have been exposed to HIV.
- Understanding that a positive test result means a person is infected with HIV and can pass their infection on.
- Knowing that a positive test result means a person may benefit from health monitoring, medical treatment and support services that would be unavailable if their infection remained undiagnosed.

We stress that advocating this change is not a pro-testing stance but a pro-diagnosis stance. We are not advocating the widespread 'promotion' of HIV testing among homosexually active men per se. Nor are we advocating men rejecting sexual partners on the basis of perceived HIV status or promoting disclosure of perceived status to sexual partners. The required actions and needs of services, policy makers and surveillance with regard to diagnosis are outlined in Chapters 6 and 7.
3.5 SAFER SEX: REDUCING EXPOSURES AND SEMEN TRANSFER

3.5.1 Sexual acts transmitting HIV

The proportion of HIV sero-discordant sexual sessions that provide an exposure route for HIV is probably increasing. Three sexual acts are known to provide an exposure route for a fluid carrying HIV to pass from an infected to an uninfected partner:

- the infected partner being insertive in anal intercourse;
- the uninfected partner being insertive in anal intercourse;
- the infected partner being insertive in oral intercourse.

Oral and anal intercourse are widespread activities among homosexually active men. In the last year 97% engaged in receptive oral intercourse, 97% engaged in insertive oral intercourse, 74% engaged in insertive anal intercourse and 68% engaged in receptive anal intercourse (Reid et al., 2002). However, the proportion of sero-discordant sexual sessions that feature each of these acts is unknown, and therefore the number of each of these sero-discordant acts occurring is unknown.

This framework does not seek to reduce the proportion of sero-discordant sexual sessions which feature each of these acts, although this may occur as a secondary consequence of the strategic aims adopted below. It does pursue the use of condoms for all occasions of anal intercourse where the partners are not confident they have the same HIV status.

A condom can be used during each of these three acts, which if it remains intact, provides substantial protection against HIV being transmitted (Pinkerton & Abramson, 1997). Although uncommon during oral intercourse, condom use during anal intercourse is common among homosexually active men, with 82% of those engaging in insertive intercourse having worn one in the last year (Reid et al., 2002). However, the proportion of each of these individual sero-discordant sexual acts that feature condoms is unknown.

We do know that the proportion of men who engage in any unprotected anal intercourse (either receptive or insertive) within a year period has increased since 1996 (see Figure 3.5.1). This is not because the proportion of men who engage in anal intercourse has increased, but because the proportion who always use a condom when they have AI has decreased.

The increase in the proportion of men having UAI includes an increase in UAI between men who know themselves to be HIV sero-concordant (Hickson et al., 2001). This component does not contribute to HIV incidence. However, it also includes an increase in UAI between partners who do not know each other’s HIV status (Dodds et al., 2002), an increasing proportion of whom will be HIV sero-discordant because HIV prevalence is increasing. The proportion of men who engage in known sero-discordant UAI in a year period appears constant, although it is not necessarily the same men each year.

We have evidence that sufficient UAI is currently occurring both between pairs of men who know they are sero-discordant for HIV and between those who do not know their sero-concordancy (Hickson et al., 1999; Elford et al., 1999; Weatherburn et al., 2000) for it to be feasible to reduce the contribution sdUAI is making towards incidence.
3.5.2 HIV sero-discordant unprotected anal intercourse (sdUAI) where the infected partner is insertive

HIV transmission is much more likely if the infected man is insertive and the uninfected man is receptive (Caceres & van Griesven, 1994). Our first strategic aim for exposures is the sexual act most commonly resulting in HIV transmission: to reduce the number of occasions of sero-discordant UAI where the infected partner is insertive.

Specifically, among men who have tested HIV positive, we seek a reduction in the proportion who have insertive UAI with men whose HIV status they do not (down know from 24%) and a reduction in the proportion who have insertive UAI with men they know to be HIV negative (down from 10%). Similarly, among men who have not tested HIV positive we seek reductions in the proportion who have receptive UAI with men whose HIV status they do not know (down from 18%) and in the proportion who have receptive UAI with men they know to be HIV positive (down from 1%).

3.5.3 HIV sero-discordant unprotected anal intercourse (sdUAI) where the uninfected partner is insertive

Since HIV infection also occurs when uninfected partners are insertive during anal intercourse, this act is a second part of this strategic aim: to reduce the number of occasions of sero-discordant UAI where the uninfected partner is insertive.

Specifically, among men who have tested HIV positive we seek reductions in the proportion who have receptive UAI with men whose HIV status they do not know (down know from 32%) and in the proportion who have receptive UAI with men they know to be HIV negative (down from 14%). Similarly among men who have not tested HIV positive we seek a reduction in the proportion who have IUAI with men whose HIV status they do not down know (down from 19%) and in the proportion who have IUAI with men they know to be HIV positive (down from 1%).

These strategic aims may be achieved by reducing the proportion of men engaging in each sero-discordant act, or by increasing the proportion of those acts which feature condoms, or by a combination of the two.

3.5.4 HIV sero-discordant unprotected oral intercourse (sdUOI) where the infected partner is insertive

No man has picked up HIV having oral sex performed on them (ie. when an HIV negative partner is insertive in oral sex). HIV transmission does occur during sero-discordant oral intercourse where the infected partner is insertive (Keet et al., 1992). However, attributable risk is “especially low” (Page-Shafer et al., 2002). A recently completed study of HIV sero-discordant couples documented 96 women who between them had performed unprotected fellatio an estimated 8,965 times on HIV positive male partners (with ejaculation occurring in the mouth on an estimated 3,060 occasions) but without observing one sero-conversion (Romero et al., 2002).

Documented cases of orally acquired HIV suggest that ejaculation into an uninfected man’s mouth is the key behaviour and possibly requires another co-factor, such as throat infection, oral ulceration or recent dental work (UK Chief Medical Officers’ Expert Advisory Group on AIDS, 2000). This framework does not seek to reduce the number of times infected men are insertive in oral intercourse with uninfected men, but does seek to reduce ejaculation into the mouth.

3.5.5 Condom failure

In addition to non-condom use during intercourse, condom failure also contributes to the number of transmission routes HIV is given during sex between men. A recent trial (Golombok, Harding & Sheldon, 2001) measured a condom breakage rate during anal intercourse of 3.3%, with an additional 3.2% slipping off. This trial identified a number of behaviours contributing to failure which have subsequently been measured in the population of condom users (Reid et al., 2002).

We seek to reduce the proportion of condoms that fail during sero-discordant anal intercourse by reducing the proportion that fail during all uses. Surveys among gay and bisexual men suggest the most common condom-failure related behaviours are not changing the condom during long duration of intercourse, and using saliva as a
lubricant (Reid et al., 2002). Specifically, we seek to reduce the proportion of condom wearers who (in the preceding year) engaged in protected anal intercourse for over half an hour without changing the condom (down from 15%) and to reduce the proportion of condom wearers who (in the preceding year) used saliva as a lubricant (down from 15%).

3.5.6 Exposure is not the whole story

Not all HIV exposures during anal and oral intercourse between infected and uninfected partners result in a new infection. Incidence is not simply a function of the number of exposures. The proportion of all anal intercourse exposures that result in transmission is relatively small and have been estimated at (Mastro & de Vicenz, 1996; Royce, Sena, Cates et al., 1997):

- 0.03%–0.1% for all exposures where the uninfected partner is insertive and the infected partner is receptive (ie. between 1 in 3,333 and 1 in 1,000).
- 0.1%–3.0% for all exposures where the infected partner is insertive and the uninfected partner is receptive (ie. between 1 in 1,000 and 1 in 33).

No estimate for the proportion of oral intercourse exposures is available. The probability of a man who is sexually exposed to HIV becoming infected is determined by many factors and the complex interrelationships between them. These can be grouped into factors influencing the quantity of medium transferred, the viral loading in that medium and the susceptibility of uninfected partners.

3.5.7 Reducing infected semen transfer

When infected partners are insertive the body fluid carrying HIV is semen but ejaculation is not necessary for transmission to occur because HIV is present in pre-seminal fluid (Ilaria et al., 1992; Pudney et al., 1992). However, transmission is more likely if ejaculation in the rectum occurs than if it does not as the quantity of the viral medium is increased. The amount will be decreased if fewer infected partners ejaculate into the body of their uninfected partners. We seek to reduce the number of times HIV infected men ejaculate into uninfected men’s rectums without condoms.

Specifically, among men who have tested HIV positive this includes reducing the proportion who ejaculate into the rectum of men whose HIV status they do not know and of men they know to be HIV negative, although we have no estimates for how common these activities are. Similarly, among men who have not tested HIV positive this change includes reducing the proportion who take ejaculate in their rectum from men whose HIV status they do not know and from men they know to be HIV positive.

In the absence of ejaculation into the mouth, HIV transmission during oral intercourse appears very unlikely and we have not adopted the number of times uninfected men take infected men’s penises in their mouths as a strategic aim. However, since all oral transmissions appear to be a subset of those where ejaculation in the mouth occurred, reducing this medium transfer may influence the number of infections occurring though this route. We therefore seek to reduce the number of times HIV infected men ejaculate into uninfected men’s mouths without condoms.

Specifically, among men who have tested HIV positive we seek to reduce the proportion who ejaculate into the mouths of men whose HIV status they do not know, down from 38%, and to reduce the proportion who ejaculate into the mouths of men they know to be HIV negative, down from 15%. Among men who have not tested HIV positive the change includes reducing the proportion who take ejaculate in their mouth from men whose HIV status they do not, down from 37% and reducing the proportion who take ejaculate in their mouth from men they know to be HIV positive, down from 2%.

3.5.8 The needs associated with reducing sexual HIV exposure and medium transfer

Men engage in sUAI for multiple and complex reasons. The reasons may differ markedly for the same couples at different times, between different pairs of men, and between the infected and uninfected men involved (Henderson et al., 1998; Keogh et al., 1999). Many factors differentiate those men more likely to be involved in sUAI from those who are less likely to. The first explanatory factor is opportunity. For example:
where men live; whether they have HIV infection or not; how many different men they have sex with; whether they regularly have sex with someone who is HIV sero-discordant to themselves.

All these factors dictate whether men have the opportunity to engage in sdUAI. As groups, those who live in the larger cities, those with HIV infection, those who have more sexual partners and those who regularly have sex with someone who is HIV sero-discordant are more likely to engage in sdUAI than those living in rural areas, those without HIV infection, those with fewer sexual partners and those who do not regularly have sex with an HIV sero-discordant partner. We recognise that altering these is feasible. However, these are human rights, so we are not trying to:

- stop men having sex;
- change where men live;
- change who they have sex with; or
- change how many people they have sex with, or how often.

Men may make these changes as consequence of having their HIV prevention needs met but change in these areas is not what we are attempting to achieve and they are not part of our meaning of success.

Another evidence-based set of reasons that predict whether men are involved in sdUAI or not concern characteristics of individuals in the context of that sexual situation. Predominant among these are:

- the control men have over the sexual situation;
- the confidence and interpersonal skills involved in negotiating different kinds of sex with that partner (including the availability of condoms and lubricant);
- what men know and believe about HIV;
- what men know and believe about the HIV sero-concordancy between themselves and their sexual partner.

After opportunity, all of these factors influence the extent to which men are involved in sdUAI. Men are more likely to have sdUAI if: they have little control over the sex they have; lack the confidence or interpersonal skills required to negotiate either no sex with that partner, some other kind of sex, or the use of a condom; are uninformed or misinformed about HIV; or are unaware that they and their partner are sero-discordant for HIV. Men are less likely to have sdUAI if they have confidence, interpersonal skills, access to condoms, are knowledgeable and aware that they and the person they are having sex with are, or might be sero-discordant for HIV.

As sdUAI and semen transfer requires two men, we are using the above approaches with both uninfected and infected men. The overall aims of interventions concerning sdUAI and semen transfer are that men have autonomy and are able, knowledgeable and aware. We aspire to this condition for both infected and uninfected men. This means that the aims of our interventions with men with HIV infection (either diagnosed or undiagnosed) are the same as those for HIV negative men. The extent to which the aims are true for these groups differ. However, we do not aspire to something less (or more) for one group of men over another.

We judge that men are less likely to engage in sdUAI if these aims are true than if they are not. We recognise that, because choice remains with men themselves, some men will still choose to engage in sdUAI even when they know what they are doing, they understand what the consequences may be, and they can do otherwise. To ensure men do not engage in sdUAI requires the removal of their autonomy, which the agencies collaborating on this framework deem unethical. However, the proportion of sdUAI where this is true appears small (Henderson et al., 1999; Keogh et al., 1999). We therefore judge it feasible to influence the number of sdUAI occasions by addressing these aims.
Homosexually active men – strategic aim 2

Reduce HIV sero-discordant unprotected anal intercourse, condom failure and HIV positive to HIV negative semen transfer.

Needs include:

Homosexually active men of all cultural and religious affiliations have control over the sex they have. Including:

- Men are able to invite and decline sexual contact, either verbally or non-verbally.
- Men are able to manage and where required to assert or protect their personal boundaries during sexual encounters.
- No man is raped or otherwise sexually assaulted.
- No man is sexually exploited.
- No man’s sexuality is a problem to him.
- No man’s sexual behaviour is a problem to him if his sexual behaviour is not a problem to his sexual partners.
- No man engages in sexual activity he does not want because he feels it is expected of him.
- Men can envisage a future for themselves and a means to achieve it.
- Men have opportunities for psycho-social change.

Homosexually active men of all cultural and religious affiliations are equipped and competent to negotiate sex. Including:

- Men have the self-confidence to negotiate sex.
- Men have the interpersonal skills to negotiate sex.
- Men have easy access to appropriate condoms and water-based lubricant.
- Men have the skills to use condoms and lubricant correctly.
- Men are free from internal conflicts and dilemmas about sex and sexuality, including conflicting beliefs, ideals, emotional responses and needs, desires and behaviours.

Homosexually active men are knowledgeable about HIV and STIs, their exposure, transmission and prevention. Including:

- Men know that HIV is a virus that can result in AIDS, a serious, incurable and often fatal disease.
- Men understand how HIV is and is not transmitted and the difference between exposure and transmission during sex.
- Men know that the use of a condom reduces the likelihood of infection with gonorrhoea, NSU, syphilis and herpes if they have intercourse with someone who is infected.
- Men know that anal intercourse is by far the most common and easiest route of HIV transmission and understand how the use of a condom prevents HIV exposure.
- Men know that HIV is carried in semen, pre-seminal fluid and blood and that one of these fluids must enter the body for infection to occur.
- Men know that an HIV positive man is still potentially infectious even if he has an undetectable viral load.
- Men know and understand the differences between condoms and between lubricants and their relationship to condom failure.

- Men know that incorrect use of condoms increases the rate at which they fail.
- Men know that condoms can fail, even if they are correctly used.

Homosexually active men are aware of the possible HIV related consequences of their sexual actions for themselves and their sexual partners. Including:

- Men know there are both HIV-uninfected and HIV-infected homosexually active men in all areas of Britain and in every country in the world.
- Men know that a man’s appearance, age, ethnic group, life experience and behaviour are neither accurate nor reliable ways of telling whether they are infected with HIV or not, and that men can have HIV without experiencing any symptoms.
- Men are aware that some men have undiagnosed HIV infection.
- Men are aware that some men believe their HIV status to be other than it actually is.
- Men are aware that some men who do not know their HIV status will engage in UAI without revealing that they do not know their status.
- Men are aware that some men who know they are not infected with HIV will engage in UAI without revealing their negative status.
- Men are aware that some men who know they have HIV will engage in UAI without revealing their positive status.
- Men are aware that the more men they engage in UAI with, the more likely it is that they will be involved in HIV exposure.
- Men understand that having HIV infection does not depend on whether that infection is diagnosed or not.
- Men know that HIV plasma viral load tests do not necessarily reflect seminal viral load and should not be used as a guide to infectiousness.
- Men know that an undetectable HIV plasma viral load does not mean an HIV positive man cannot transmit his infection.

Homosexually active men have maximum control over condom failure during anal intercourse. Including:

- Men have easy access to appropriate condoms and water-based lubricant.
- Men have the skills to use condoms and lubricant correctly.
- Men know that anal intercourse is by far the most common and easiest route of HIV and understand how the use of a condom prevents HIV exposure.
- Men know and understand the differences between condoms and between lubricants and their relationship to condom failure.
- Men know that incorrect use of condoms increases the rate at which they fail.
- Men know that condoms can fail, even if they are correctly used.
3.6 SWIFTER DIAGNOSIS AND TREATMENT OF STIS: REDUCING VIRAL LOADING AND SUSCEPTIBILITY

3.6.1 HIV infectivity

The concentration of viral particles in the body fluid transferred from an infected to uninfected man is a key determinant of HIV infection. Broadly speaking, the more viral particles in a body fluid the smaller the quantity of fluid required to cause infection. The body fluid in which HIV is transmitted during sex is seminal fluid (including pre-ejaculate) when the infected partner is insertive and blood when the infected partner is receptive.

The infectiousness of the body fluids of an infected men is mediated by viral load. A higher viral load indicates greater infectiousness. Plasma (blood) viral load can significantly differ from seminal viral load (Choudhury, Pillay, Taylor et al., 2002). Although seminal viral load is usually lower than plasma viral load in any one individual, seminal viral load can increase markedly with other sexually transmitted infections. It is possible to have a detectable genital viral load with an undetectable plasma viral load (Fisher, Benn, Davidson et al., 2003). For these reasons we do not advocate men with diagnosed HIV using (plasma) viral load results to inform sexual risk decisions.

Viral load is influenced by several factors, important among which are the use of anti-retroviral drugs (which reduces viral load in both plasma and semen (Vernazza et al., 1997; 2000) and genital infections (or trauma such as may result from sexual assault or perhaps first experience of anal intercourse).

Consequently, all people with HIV (a) being prescribed the anti-HIV treatment regime that is optimum for their health and (b) adhering to that regime, would contribute to a reduction in HIV incidence. This framework is congruent with these strategic aims but does not expand on them.

Another avenue currently being opened up are microbicides. A microbicide which could be applied locally (as a gel, foam, sponge or cream) which acts on HIV such as to kill it or make it less infectious, could assist in reducing incidence. No such product is currently available but action can be taken to move towards them by Government, researchers and HIV organisations. A plan for action in this area has been developed by the National AIDS Trust (Webb et al. 2003) and this framework concurs with that plan (see Section 7.4.1).

3.6.2 STIs and HIV infectivity

Viral load in semen has been shown to increase when men have a concurrent genital infection, such as gonorrhoea and NSU (Rottingen, Cameron, Garnett, 2001) and herpes (Celum et al., 2002). The incidence of these and other sexually transmitted infections has been increasing among homosexually active men in England (and elsewhere in the world) in the last five years. A review on the synergy between HIV and other STIs (Fleming & Wasserheit, 1999) claimed “available data leave little doubt that other STDs facilitate HIV transmission through direct, biological mechanisms and that [reducing the prevalence of STDs through] early STD treatment should be part of a high quality, comprehensive HIV prevention strategy” (see also Bonell et al., 2000). In order to reduce the prevalence of gonorrhoea and NSU during HIV sero-discordant UAI we seek to reduce them among all among homosexually active men.

Unlike HIV, both gonorrhoea and NSU can be cured and reducing the length of time men have infections is a key parameter in driving down prevalence. We therefore seek a reduction in the average length of time between infection and diagnosis / treatment of gonorrhoea and NSU among all homosexually active men. This goal also overlaps with a goal of the National Strategy.

3.6.3 STIs and susceptibility to HIV

The susceptibility to HIV infection of uninfected men exposed to HIV varies dependant on several factors including genetic factors (O’Brien & Dean, 1997) which remain constant throughout an individual’s life. It is likely that some people are genetically immune to HIV, although no way exists to tell who is and who is not. Also, men may be more susceptible to some strains of HIV than others, although the evidence for this is conflicting (Mastro et al., 1997) and we have no way of influencing the strains of HIV being passed around.
If the uninfected man is insertive in sdUAI, having a foreskin may increase the likelihood of transmission (and being circumcised appears to decrease it, Moses et al., 1994). However, among gay men in the UK the prevalence of circumcision is no lower among men with HIV infection than among those without (Reid et al., 2002), suggesting circumcision plays little or no role in incidence among homosexually active men.

Again, if the uninfected man is insertive in sdUAI, having an ulcerative or exudative urethral infection such as herpes or syphilis is likely to increase his susceptibility to infection (Dickerson et al., 1996). In England, the incidence of syphilis among homosexually active men increased 16.05% from 1996 to 2001 (from 20 cases in 1996 to 341 in 2001, House of Commons Health Committee, 2003, p17). In order to reduce the prevalence of syphilis and herpes during HIV serodiscordant UAI we seek to reduce them among all among homosexually active men.

### 3.6.4 The needs associated with swift diagnosis and treatment of STIs

The needs associated with diagnosis and treatment of STIs are not new. Even before HIV, homosexually active men were subject to more sexually transmitted infections than age comparable heterosexually active men. We would like to say this has wholly changed and that a healthy gay man is as valued as a healthy heterosexual man. However, while this may be true in many services, policy documents and research strategies, it is not the case in many others. As it is very rare to find gay health valued more highly than heterosexual health, virtually all those cases where there is inequality of value favour the heterosexual. Consequently, there is still a major societal imbalance in the value placed on the health of women and men, lesbians and gay men. The needs of services, policy makers and communities to act to change this situation are described in Chapters 5, 6 and 7. Here we outline the needs of homosexually active men themselves (both HIV positive and HIV negative) to swiftly address sexually transmitted infections.

### Homosexually active men – strategic aim 3

**Reduce the average length of time men have undiagnosed STIs (specifically gonorrhoea, NSU, syphilis and herpes).**

Needs include:

- Freedom from psychological and emotional barriers to STI testing.
- Prompt access to trusted STI diagnosis and treatment services.
- Knowledge about gonorrhoea, NSU, syphilis and herpes, and how to prevent them, including their transmission, detection and treatment.
- Knowing that sexual contact can transmit bacterial, viral and parasitic infections that can cause serious diseases as well as unpleasant and inconvenient ones.
- Knowing that gonorrhoea and NSU are more easily contracted than HIV.
- Knowing that the greater a man’s number of sexual partners, the greater his possible exposure to gonorrhoea, NSU, syphilis and herpes.
- Knowing that gonorrhoea, NSU and syphilis can be cured.
- Knowing that a man’s appearance, age, ethnic group, life experience and behaviour are neither accurate nor reliable ways of telling whether they are infected with gonorrhoea, NSU, syphilis and herpes, and that men can have gonorrhoea and NSU without experiencing any symptoms.
- Knowing that the longer gonorrhoea, NSU, syphilis and herpes remain untreated, the more physical damage and disease they cause to the person infected.
- Knowing which sexual health clinical services are available free and confidentially on the NHS.
- Ability to approach sexual health clinical services and talk honestly about their sexual behaviour with staff if they wish to do so.
- Understanding what happens when they visit a sexual health clinical service and why.

The term ‘clinical sexual health services’ here refers to diagnosis and treatment interventions irrespective of the nominal service they are delivered in. So, for example, HIV positive men may receive these services at an HIV care clinic and any man may receive them from a primary care service able to deliver Level 2 interventions in the National Strategy.
3.7 GREATER POST-EXPOSURE PROPHYLAXIS (PEP): REDUCING SUSCEPTIBILITY

The probability that a man who is sexually exposed to HIV becomes infected is also influenced by the presence or absence of pharmaceutical prophylaxis.

As with microbicides, the development of a successful preventative vaccine against HIV would greatly assist a reduction in HIV incidence. Again, no such product is currently in existence but action can be taken to move towards them by Government, researchers and HIV organisations (Webb et al., 2003).

There is, however, a technology in existence now which could be making a greater contribution to reducing HIV incidence among homosexually active men. Post-exposure prophylaxis (or PEP) involves taking anti-HIV drugs shortly after exposure. PEP decreases the likelihood of HIV infection by inhibiting viral replication following HIV exposure (Miller et al., 2000; Pinto et al., 1997; Spira et al., 1996). In England, PEP availability is very patchy and its use following sexual exposure is relatively rare.

A clear consensus is emerging as to utility of PEP and how to use it. The Clinical Effectiveness Group (Association of Genitourinary Medicine and the Medical Society for the Study of Venereal Disease) will soon be publishing United Kingdom guideline for the use of post-exposure prophylaxis for HIV following sexual intercourse (Fisher, Benn, Davidson et al., 2003). That document makes recommendations on the potential use of PEP, the circumstances in which it may be recommended and the appropriate use of subsequent diagnostic tests to measure individual outcomes.

Homosexually active men – strategic aim 4

Increase the proportion of HIV uninfected men who are sexually exposed to HIV who take post-exposure prophylaxis within 72 hours of exposure. Needs include:

- Safe access to PEP.
- Men know about and feel able to access PEP.
- Men know which clinical sexual health services provide PEP and how they can access them.
- Men feel able to approach sexual health clinical services and can talk honestly about their sexual behaviour with clinic staff if they wish to do so.
- Men understand what they need to do to maximise the effectiveness of PEP.
- Men understand that the sooner PEP is taken, the more likely it is to prevent infection and that it does not prevent infection for 100% of people exposed.

This is a new strategic aim for Making It Count and the most challenging for services, community and policy to influence. Lack of action in all three constituencies in the past five years has resulted in little change to the availability of PEP, community engagement with or knowledge of PEP, policy guidelines, resource identification or research. We are collectively failing gay and bisexual men by maintaining this inaction. We do not have enough routes through which to contribute to a reduction in HIV incidence to be able to afford continuing to ignore one.
HIV health promotion is the process of enabling people to increase their control over HIV in their everyday lives. It attempts to ensure that people have the necessary resources for everyday living with HIV, whether they are infected or not. Hence, our overall aim for gay men, bisexual men and other homosexually active men is that, with regard to HIV and STIs, they are educated, aware, empowered and equipped and that they have access to clear, accurate and credible information and quality services.

Each HIV related behaviour gives rise to a number of requirements for control over that behaviour. We understand the requirements for HIV prevention actions to be HIV prevention needs. All interventions work through HIV prevention needs. The HIV prevention needs of homosexually active men therefore become the aims of HIV prevention interventions targeted at homosexually active men and their HIV-related behaviours.

The extent to which these HIV prevention needs are met will be dependent on the actions of the communities gay and bisexual men live in, the extent and quality of services available to reduce them, the actions of policy makers and commissioners and the investigations of researchers. In order for these needs to be met a range of services must exist and operate within set standards. That is, homosexually active men must be able to access and understand interventions to reduce their HIV prevention needs, should they wish to do so, including: further information about HIV, its transmission and prevention; HIV testing; condoms and their use; other STIs, their transmission and prevention; and post-exposure prophylaxis.

This is what the agencies planning within this framework are aspiring to achieve to reduce HIV incidence. The aim has emerged from our collective work (including both research and interventions) with gay men, bisexual men and other homosexually active men over many years. We have taken into consideration both what we know and what we can currently achieve. We believe that if these needs are met, fewer men will be involved in sexual HIV exposure, less often, and fewer of those exposures will result in infection, than if the needs are not met.

While our assessment of what constitutes HIV prevention needs is an on-going debate, we next turn our attention to the harder task of ensuring the needs described above are met.
3.9 INTERIM SUMMARY

IN ORDER TO INFLUENCE:

STRATEGIC GOAL: Contribute to the national goal of reducing by 25% the annual incidence of HIV infection during sex between men.

WE WILL SEEK INFLUENCE:

<table>
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<tr>
<th>Increasing diagnosis</th>
<th>STRATEGIC AIM 1: Reduce the average time between HIV infection and HIV diagnosis in men who become infected.</th>
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<tr>
<td>Reducing exposures</td>
<td>STRATEGIC AIM 2a: Reduce the number of occasions of sero-discordant unprotected anal intercourse where the infected partner is insertive.</td>
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<td>STRATEGIC AIM 2b: Reduce the number of occasions of sero-discordant unprotected anal intercourse where the uninfected partner is insertive.</td>
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<td>STRATEGIC AIM 2c: Reduce the proportion of condoms that fail during anal intercourse.</td>
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<td>Reducing medium transfer</td>
<td>STRATEGIC AIM 2d: Reduce the number of times HIV infected men ejaculate into uninfected men’s rectums without condoms.</td>
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<td>STRATEGIC AIM 2e: Reduce the number of times HIV infected men ejaculate into uninfected men’s mouths without condoms.</td>
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<tr>
<td>Reducing infectivity</td>
<td>STRATEGIC AIM 3a: Reduce the average length of time between infection and diagnosis/treatment of gonorrhoea and NSU.</td>
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<td></td>
<td>STRATEGIC AIM 3b: Reduce the average length of time between infection and diagnosis/treatment of syphilis and resurgent genital herpes.</td>
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<td>Reducing susceptibility</td>
<td>STRATEGIC AIM 4: Increase in the proportion of men sexually exposed to HIV infection who take post-exposure prophylaxis within 72 hours of exposure.</td>
</tr>
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BY MEETING THE FOLLOWING INTERVENTION AIMS:

- Homosexually active men are knowledgeable about HIV testing and the meaning of HIV test results and are free to choose whether and when to test for HIV.
- Homosexually active men have control over the sex they have.
- Homosexually active men are equipped and competent to negotiate sex.
- Homosexually active men are knowledgeable about HIV, its exposure, transmission and prevention.
- Homosexually active men are aware of the possible HIV related consequences of their sexual actions for themselves and their sexual partners.
- Homosexually active men have maximum control over condom failure during anal intercourse.
- Homosexually active men are knowledgeable about gonorrhoea, NSU, syphilis and herpes, and how to prevent them, including their transmission, detection and treatment.
- Homosexually active men know about and feel able to access quality sexual health clinical services (including HIV testing services and PEP).

The strategic aims are aspirations for a collective, national HIV prevention response. Whether these strategic aims are achieved will depend on central and local government, health and social services, the media, gay community organisations, the general public and homosexually active men themselves. No one strategic aim is within the control of any one agency and neither is HIV incidence.

Chapters 5, 6 and 7 describe the actions each of these groups can make toward reducing HIV incidence.
INTERVENING

4 Intervening on the HIV prevention needs of homosexually active men

5 The actions and needs of communities and businesses

6 The actions and needs of education, health and social services

7 The actions and needs of policy makers, researchers and commissioners
Chapter 3 demonstrates the continuing HIV epidemic among gay and bisexual men. We have suggested that the size and nature of the national response to date has kept the epidemic ‘treading water’ (or, more optimistically, ‘reasonably controlled’). We have also suggested that without an increased or more focussed response our strategic goal of a 25% reduction in HIV incidence among homosexually active men is very unlikely to be realised. The Director of UNAIDS, Peter Piot (2001), has pointed out:

“The world faces two paths. Two possible futures. One path: the current situation: an epidemic that we are fighting but which is gradually defeating us...but the other path is collective responsibility...freed from the shackles of shame and fear. This is the path where we finally match the scale of the epidemic with the scale of our response. Where the fight against AIDS is truly embraced in every field of social action – by politicians, in the churches, mosques and temples, by unions and the women’s movement, by business alongside government.”

(6th International Congress on AIDS in Asia and the Pacific, 5th October 2001)

We believe this statement to be true for all aspects of the global epidemic, including (if not particularly) the on-going HIV epidemic among homosexually active men in England.

The success of this framework rests on the commitment of a diverse constituency of people and organisations. As such, it demands a multi-level approach to realise its goal. Moreover, there currently exists no one agency or institution with overall responsibility for reducing HIV incidence through sex between men nor any single group of organisations commanding sufficient expertise, resources and respect to ensure that it occurs. Hence our collective success will depend crucially on the degree and success of our collaboration.

There is a growing acknowledgement that HIV among gay and bisexual men in England has been an epidemic without a commensurate national response. Gay and bisexual men and HIV must be brought within mainstream social exclusion discourse in terms of both the inequalities between gay and bisexual men and the sexual majority, and the inequalities among gay and bisexual men that reflect social exclusion generally. There are few health inequalities in the UK as large as that between HIV in homosexually active men and HIV among other sexually active adults. These connections are slowly being made but this is only a beginning of a response. There is an urgent need to expand this at national and local levels. Understanding of the social determinants of HIV infection is advancing, effective preventative responses are known and the published evidence base for prevention is growing all the time.

Policy-makers and commissioners, service providers and the community share the need for a collective, coherent and co-ordinated response. There are increasing numbers and types of players engaged in the response to the HIV epidemic among gay and bisexual men, with concomitant need for partnerships, referrals and exchange of learning. These needs also require addressing.

There has been significant progress in generating new financial commitments to sexual health, yet it is not clear if this will increase a collective response to HIV among gay and bisexual men. This is coupled with concern about sustainability of the momentum of the national response over the next ten years. The National Strategy for Sexual Health and HIV signals a new national political commitment by the Department of Health to tackle HIV incidence but at many levels throughout the
country there remains complacency and homophobia which impede appropriate prevention policies and programmes.

We recognise the key role played by religious organisations and leaders in ensuring that a number of HIV prevention needs are unmet. The Roman Catholic, Evangelical Anglican and Muslim traditions in particular ensure many men experience their sexuality (and hence themselves) as a problem or of less worth and many men are in psychological conflict about having sex with men. Currently, all three of these religious movements are doing more to increase HIV incidence among gay and bisexual men than decrease it. If we expect gay and bisexual men to change, then these powerful institutions will need to change as well.

There are many groups whose influence on homosexually active men can be increased through health promotion activity. Below we identify the roles in which people will influence the HIV prevention needs of homosexually active men in the future. People may carry out more than one role and organisations may include a number of roles. In the following sections we outline the responsibilities of each of these roles with regard to HIV incidence. We have grouped the actions into service, policy and community levels (following Aggleton, 1999), reflecting the multi-layered response we think is necessary.

The state of future HIV incidence will be a measure of the collective success or failure of all these stakeholders. The behaviour of each group of stakeholders against their responsibilities will be an indicator of their contribution to the overall level of incidence.

4.2 A NETWORK OF HIV PREVENTION ACTION

Within this approach we recognise HIV prevention activity as any action whose purpose is to reduce unmet HIV prevention need (for one or more men) without aggravating any other (for the same or other men). As many stakeholders are involved in addressing or exacerbating men’s needs, HIV related actions involve many groups of people other than homosexually active men. Hence HIV prevention is affected by all policy areas, a vast array of human services and the common conduct of most of the population. To date, many of these actions have made HIV prevention needs worse as far as gay and bisexual men and other homosexually active men are concerned. The social epidemic of homophobia and discrimination associated with HIV has fed the epidemic since its inception. A vast amount of HIV prevention activity has been spent addressing these obstacles precisely among those people who could have been contributing to a reduction in HIV incidence, such as the medical and caring professions, religious bodies and the mass media. This framework seeks to encourage sufficient activity to stack the nation’s actions against HIV instead of in its favour.

Any action that contributes towards meeting any of the aims for any of the target groups of this framework are recognised as a valid HIV prevention activity. This means it is possible to have interventions that make a significant contribution to reducing HIV incidence without directly addressing homosexually active men or without mention of sexual practice, HIV or condom use. Chapters 5, 6 and 7 describe the variety of interventions that could be used to address the needs described in Chapter 4. We use the word intervention to refer to any finite, defined and purposeful action: in this context one intended to contribute to a reduction in HIV prevention need and hence a change in the HIV-related behaviours and hence to a reduction in HIV incidence. Therefore the term intervention includes actions directed towards, for example, MPs, religious leaders, newspaper editors, PCT boards, Local authority councillors as well as actions directed at homosexually active men.

From the preceding it should be clear that an ‘HIV prevention action’ can be carried out by:

- homosexually active men, community leaders and other members of the general public;
- policy makers, commissioners, researchers and charity funders;
- and education, health and social services personnel.

It should also be clear that an ‘HIV prevention intervention’ can be targeted at:
• homosexually active men’s requirements for sexual health behaviours;
• the needs of community members (including homosexually active men) to increase HIV prevention actions or to reduce damaging actions;
• policy makers, researchers and resource allocators’ requirements to increase HIV prevention actions or to reduce damaging actions;
• education, health and social services personnel’s requirements to increase HIV prevention actions or to reduce damaging actions.

The following table outlines the minimum, essential elements of a national response to the HIV prevention epidemic among homosexually active men. We believe it is paucity of many of these actions that accounts for the continuing HIV epidemic among gay and bisexual men.

<table>
<thead>
<tr>
<th>Constituency making the intervention</th>
<th>Target of the intervention</th>
<th>Minimum interventions of a national programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy makers, commissioners &amp; researchers</td>
<td>Policy makers, researchers &amp; resource allocators action needs</td>
<td>National evidence base, Public funds</td>
</tr>
<tr>
<td></td>
<td>Service providers’ action needs</td>
<td>National and local prevention strategies/plans, Development of HIV vaccines and microbicides, National and local HIV treatment &amp; care strategies/plans</td>
</tr>
<tr>
<td></td>
<td>Community action needs</td>
<td>Leadership against stigma and discrimination</td>
</tr>
<tr>
<td></td>
<td>Gay and bisexual men’s HIV prevention needs</td>
<td>Social equality &amp; justice legislation</td>
</tr>
<tr>
<td>Education health and social service providers</td>
<td>Policy makers, researchers &amp; resource allocators action needs</td>
<td>Professional associations and representation in policy making, research &amp; resource allocation</td>
</tr>
<tr>
<td></td>
<td>Service providers’ action needs</td>
<td>Training &amp; professional development, National and local collaborative planning fora</td>
</tr>
<tr>
<td></td>
<td>Community action needs</td>
<td>Community development</td>
</tr>
<tr>
<td></td>
<td>Gay and bisexual men’s HIV prevention needs</td>
<td>Equitable generic education, health and social services, HIV education, skills-building &amp; counselling, Condoms &amp; lubricant distribution, Access to HIV &amp; STI diagnosis &amp; treatment, inc. ARVs &amp; PEP</td>
</tr>
<tr>
<td>Community members</td>
<td>Policy makers, researchers &amp; resource allocators action needs</td>
<td>Political action and lobbying</td>
</tr>
<tr>
<td></td>
<td>Service providers’ action needs</td>
<td>Gay and bisexual public involvement in service planning</td>
</tr>
<tr>
<td></td>
<td>Community action needs</td>
<td>Voluntary associations and community mobilisation, Leadership of religious acceptance</td>
</tr>
<tr>
<td></td>
<td>Gay and bisexual men’s HIV prevention needs</td>
<td>Peer education</td>
</tr>
</tbody>
</table>

Figure 4.2: The network of actions that can contribute to a reduction in HIV incidence during sex between men
The vast majority of research into HIV prevention interventions in the UK (and globally) has concentrated on just one of these twelve possible routes to HIV prevention: that of service providers addressing homosexually active men’s HIV prevention needs (Ellis et al., 2003). While this evidence is valuable, it is woefully insufficient to make evidence based judgements about which approaches to prevention will pay the largest dividends or how to improve the performance of the other eleven types of intervention.

However, for all people acting to reduce HIV incidence, there are two broad principles to bear in mind when intervening. These are:

- to promote and protect human rights (All-Party Parliamentary Group on AIDS, 2001) and

- to counter stigmatisation, prejudice and discrimination (Aggleton, 1999).
The Actions and Needs of Communities and Businesses

5.1 Key Players

Everyone is a community member. All people delivering education, health and social services, those developing and implementing policy, carrying out and publishing research or allocating resources can also be involved in the community activities described in this chapter. However, here we are mainly concerned with people who do not have an occupational responsibility toward homosexually active men’s HIV prevention needs. These include:

- Gay men, bisexual men and other homosexually active men
- Friends and family of gay men and bisexual men
- Non-commercial infrastructure providers
  - Help-line boards & volunteers
  - Community group facilitators
- Businesses
  - Gay targeted
    - Press owners, editors and journalists
    - Bar, club, sauna, shop owners & managers
    - Web-site owners & managers
  - Not gay targeted
    - Employers
    - Newspaper owners, editors and journalists
    - TV broadcasters
    - Condom manufacturers and purveyors
- Rest of population
  - Religious community leaders
  - General population

5.2 Roles

Community members can make a number of actions that contribute to a reduction in homosexually active men’s HIV prevention needs and these can be targeted towards those men themselves, services, policy makers and other community members. These include:

- Political action and lobbying, informing, prompting and pressurising policy makers to act.
- Gay and bisexual public involvement in service planning and interacting with services and their planning to improve them.
- Forming voluntary associations and mobilising communities to act in their own interests.
- Informal education and support of homosexually active men to reduce their HIV prevention needs.

Increasing community actions such as these (and reducing negative actions by community members) is the second group of changes this framework advocates.

Summary Strategic Community Aim

Community members and businesses increase actions that contribute to a reduction in homosexually active men’s HIV prevention needs and desist from those which exacerbate them.

In order to act communities require knowledge and awareness of the problems, empowerment, leadership, social norms (public opinion), a supportive legal framework, meeting spaces and resources. Below we outline a number of different constituencies that make up the community and describe their actions, potential actions and requirements for action (needs) in more detail. All of the needs described can become the target of actions of others.
5.3 COMMUNITIES MEETING THE NEEDS OF HOMOSEXUALLY ACTIVE MEN

Gay men, bisexual men and other homosexually active men interact with and are addressed by every sector of society. They are exposed to all mainstream media, every television programme and film and every radio programme and recording. They are present in all public places, use every business and public service, every sports facility, shop, bar and restaurant. Every taxi, train and bus regularly has a gay man in it, as has every barbers, bookies and theatre.

The population of homosexually active men within any country will always be small in proportion to the overall population. The extent to which the needs described in Chapter 4 are true for a population of homosexually active men will depend on what meaning the majority population ascribe to sex between men and the way homosexually active men are regarded and treated. How homosexually active men are regarded will influence: how people develop social policy and allocate resources; how people deliver education, health and social services; whether and how people deliver or develop the infrastructure in which homosexually active men meet; how homosexually active men act with each other in public and in private.

All areas of the country have young men growing up in them who do or will have sex with men. The way the nation treats these young men today will influence the incidence of HIV in ten years time. Action is needed to tackle the wider social determinants of health for gay and bisexual men. The All-Party Parliamentary Group on AIDS (APPGA, 2001) made the broad recommendation that “the environment in which gay men grow up and live is addressed in order to affect the impact it has on self-esteem, assertiveness and, ultimately, health” (§85). We support this approach and specify below the people who make up that environment and what their actions might achieve.

5.3.1 The general public address gay men, bisexual men and other homosexually active men

Verbal abuse and physical assault are the most tangible indicators of homophobia in the general population. The National Gay Men’s Sex Survey 2002 (Sigma Research, 2002) found 34% of gay men had been verbally abused because of their sexuality in the last year, and 7% had been physically assaulted. The majority of the violence comes from strangers in public places.

STRATEGIC COMMUNITY AIM 1:
Members of the general public reduce the frequency with which they verbally abuse and physically assault gay and bisexual men.

Needs include:
- For homophobic hate crime to be illegal and for people to know they will be pursued and prosecuted for it.
- The public to recognise and respect that gay and bisexual men are as diverse as the general population in terms of their age, ethnicity, class, relationship status, occupation and in all the other characteristics in the country.
- For the public to know that homophobic hate crime is socially unacceptable.
- The general public feel equipped and able to challenge the homophobia of others in their everyday lives.
- Policing that is sensitive and responsive to complaints of homophobic hate crime.
5.3.2 Gay men address homosexually active men

Gay men have been HIV health promotion’s largest human resource and many needs can best be met by discussion between them. Our ideal is that men reduce each others HIV prevention needs via social and sexual interaction. Of course, not all prevention needs can be met this way. For example, determining their HIV status and access to antibiotics to treat bacterial STIs are needs which cannot normally be met by peers, but require qualified medical personnel. Similarly, peers may be able to give little practical assistance where men are experiencing clinical psychosexual problems. However, these needs are in the minority. Most of the needs in the preceding chapter are achievable by peers with resources and support. This can only occur in a broader social context that enables such actions. Although the majority of these interventions are informal, an indicator of need for action in this area may be the proportion of gay and bisexual men who have volunteered for a gay or HIV organisation in the last year. The National Gay Men’s Sex Survey found this figure to be 4.2% in 2001 (Sigma Research, 2001).

5.3.3 Friends and family of gay and bisexual men

Just as gay and bisexual men can act as health educators to their sexual partners and peers, so too can other people in the social networks of homosexually active men contribute to a reduction in their HIV prevention needs.

If there are 500,000 homosexually active men in England there are many million of friends and family members of gay men and bisexual men. Although gay men are often represented as a collection of individuals or a homogenous group, the majority live in social networks containing a range of people diverse in gender, age and sexuality. We estimate an additional three million people in England have close personal relationships with homosexually active men and another ten million socially know a gay man or bisexual man.

STRATEGIC COMMUNITY AIM 2:
Gay and bisexual men increase activity with their peers and sexual partners that reduces HIV prevention need, including talking and passing on written resources, condoms and lubricant.

Needs include:
- Men are able to bring up HIV and sexual risk in conversations, both before, during or after sex and with friends.
- Men are able to inform their sexual partners if they are diagnosed with an STI, including HIV.
- Men are able to talk to their sexual partners and friends about HIV and STIs and are able to support and refer them to reduce unmet needs.
- Men are able to identify what interventions they can make with other men.
- Men know about and are able to participate in local inter-agency planning fora for sexual health promotion.

STRATEGIC COMMUNITY AIM 3:
Parents, families and friends of young gay and bisexual men decrease the frequency with which they reject them and increase activities which reduce their HIV prevention needs, including talking and passing on written resources, condoms and lubricant.

Needs include:
- Parents are aware their son may be gay or bisexual.
- Parents and families of gay and bisexual men are able to be supportive if and when their son comes out to them.
- Friends and families of gay and bisexual men are able to identify what interventions they can make.
- Friends and families of gay and bisexual men can access information and support for themselves.
5.3.4 Non-commercial gay infrastructure providers address homosexually active men

Generally, speaking, the 35 years since the enactment of the 1967 Sexual Offences Act has seen a steady growth in the non-commercial gay community infrastructure. The main growth of the political or voluntary sector took place throughout the 1970s. With the advent of AIDS in the early 1980s, the community response became largely directed towards activities concerning HIV care and prevention. Today a lively (non-HIV) Lesbian, Gay, Bisexual and Transgender (LGBT) voluntary sector thrives in most of the major metropolitan areas of England.

HIV and other sexual health promotion activities are often only able to occur in places where men meet and socialise due to homophobic resistance to such work occurring in broader settings. As well as challenging such resistance, action can be taken to increase the settings in which interventions can occur. Men’s HIV prevention needs are more likely to be met if there exist places where men can encounter interventions and each other. The existence of a diverse non-commercial gay infrastructure strengthens public health by providing the social fabric which is a pre-requisite for health as well as the settings in which health promotion interventions can occur. This includes meeting places, social networks, social and interest groups, political groups and organisations, community centres and telephone helplines. People who build or maintain gay and bisexual community infrastructure and social networks without seeking a profit include help-lines, support group facilitators and interest group facilitators.

5.3.5 Gay targeted businesses address homosexually active men

The growth of the commercial gay scene over the last 20 years has been dramatic. In the UK, growth has been concentrated in certain cities (notably London, Manchester, Birmingham and Brighton). The largest such growth accompanied the economic boom years of the 1990’s during which time most towns and cities experienced a growth in their gay scene, and London and Manchester outstripped many European and North American cities to become two of the largest gay commercial centres in the world. The opportunities that such an active commercial centre offers for health promotion efforts for gay and bisexual men are manifold. However, by its nature, such commercial ‘scenes’ exacerbate existing problems of exclusion, based as they are around the tenets of capital investment and profit. Therefore, younger (and older) men, less well educated, less affluent men, disabled men and men from some ethnic minorities are likely to find themselves excluded from participating in the commercial gay scene. Moreover, concentrating interventions solely within such a sector is likely to result in greater exclusion for the groups with greater levels of unmet HIV prevention needs.

However, for the men who do use them, the gay business community provides a variety of services and products which relate to gay and bisexual men’s HIV prevention needs. The gay press has historically been the most important source of HIV/AIDS information for gay and bisexual men and continues to play an important role. Bars and clubs where men socialise and meet provide a key outlet for the gay press and HIV prevention resources. Commercial venues designed to facilitate casual sex (such as backrooms and saunas) can either maximise or minimise a risk taking environment by their design and services.
STRATEGIC COMMUNITY AIM 5:
Editors and journalists of gay press titles increase editorial and copy that reduce the HIV prevention needs of their readers.
Needs include:
- Recognition that gay and bisexual men are diverse as the nation in terms of their age, ethnicity, class, relationship status, occupation and in all the other characteristics that make up the country.
- Knowledge of current HIV prevention issues and interventions.

STRATEGIC COMMUNITY AIM 6:
Gay web-site managers increase features of their sites that reduce the HIV prevention needs of their users.
Needs include:
- Knowledge of current HIV prevention issues and interventions.
- Access to web useable resources.

STRATEGIC COMMUNITY AIM 7:
Managers of gay bars, pubs and clubs increase the features of venues that reduce the HIV prevention needs of their users (eg. availability of education leaflets, awareness posters, condoms and lubricant).
Needs include:
- Knowledge of what actions are feasible.
- Access to resources.

STRATEGIC COMMUNITY AIM 8:
Managers of saunas and other commercial premises that facilitate sex on the premises increase the features of venues that reduce the HIV prevention needs of their users (eg. availability of condoms and lubricant).
Needs include:
- Knowledge of what actions are feasible.
- Access to resources (eg. a regular supply of condoms and lubricant).
- Local authority licencing requirements that include supplying condoms.

5.3.6 The mainstream media addresses homosexually active men

Many people are exposed to health related information and opinion through television and newspapers, and the media has played a central role in the HIV epidemic in Britain. Clause 10 of the National Union of Journalists (NUJ, 2003) Code of Conduct states that “A journalist shall mention a person's age, sex, race, colour, creed, illegitimacy, disability, marital status, or sexual orientation only if this information is strictly relevant. A journalist shall neither originate nor process material which encourages discrimination, ridicule, prejudice or hatred on any of the above-mentioned grounds.” There is no published research on adherence to these guidelines. The NUJ and HEA (1993) has also issued guidelines for reporting on HIV and AIDS in the media.

STRATEGIC COMMUNITY AIM 9:
Mainstream media reflects the variety of contemporary gay and bisexual life in all aspects of the public sphere: media, community settings, education, etc.
Needs include:
- Journalists, editors and producers recognise that gay and bisexual men are diverse as the nation in terms of their age, ethnicity, class, relationship status, occupation and in all the other characteristics that make up the country.
- Journalists and editors are knowledgeable about HIV, its prevention, treatment and epidemiology.
- Publishers and broadcasters have clear and accountable processes for challenging homophobia within the media.
- Feedback from the community on how they are performing.
5.3.7 Other mainstream businesses and services address homosexually active men

Although it is mainly gay men who use gay services, all generic services and businesses have clients and customers who are gay or bisexual.

STRATEGIC COMMUNITY AIM 10:
Providers and owners of mainstream businesses and services decrease discrimination against gay men or bisexual men.

Needs include:
- An awareness that some of their customers will be gay or bisexual.
- Equality of Service legislation.
- Product specific market research with gay and bisexual populations.

5.4 COMMUNITIES MEETING THE NEEDS OF COMMUNITIES

The London HIV Strategy Group (2001) stated:

“Community attachment and support are important to health. Because of the discrimination and prejudice which still exists, many gay men miss out on informal community and family support which many people take for granted, and have to develop their own support structures. Supporting the development of such networks needs to be seen as a core component of gay men’s health promotion.” (§7.2)

One indicator of need in this area is the proportion of gay men who agree with “I sometimes feel lonely” (59% in 2000, Hickson et al., 2001). We therefore identify another strategic aim that is broadly concerned with the quality and quantity of men’s social networks. This aim being met will contribute not only to men’s HIV prevention needs but to many other health and social needs. As such it is shared by many other stakeholders.

STRATEGIC COMMUNITY AIM 11:
Gay and bisexual men increase their non-sexual social interaction.

Needs include:
- Legal equality and social justice.
- Opportunities for broad ranging community involvement.
- Places exist where men can encounter interventions and each other in a non-sexual environment.
- Men are knowledgeable about the existing community infrastructures.
- Men feel able to access any community infrastructure available including project centres and community meeting places.

The propensity of communities to accept and support or to reject and persecute gay and bisexual men is strongly influenced by the actions and speeches of religious leaders. Many gay and bisexual men have rejected organised religion because of their ideology of heterosexual superiority, cutting off a potential source of spiritual development and excluding them from potentially supportive social networks.

STRATEGIC COMMUNITY AIM 12:
Religious leaders reduce their verbal abuse of gay and bisexual men, including members of their own organisations who come out, and increase their active contribution to reducing men’s HIV prevention needs.

Needs include:
- An awareness that some members of their organisations are gay or bisexual.
- An ability to identify potential interventions they can make.
- Knowledge that public pronouncements about the unacceptability of sex between men may be prosecuted as a hate crime.
**5.5 COMMUNITIES MEETING THE NEEDS OF SERVICES**

Gay public involvement in service planning makes services better. It can occur either at a service or policy level. The simplest way in which the community can meet the information needs of service providers to deliver the best service possible is through informal and formal feedback, including but not limited to complaints.

**STRATEGIC COMMUNITY AIM 13:**
Gay and bisexual men increase reporting of unacceptable services received in the public sector.

Needs include:
- Recognition of unacceptable service.
- Knowledge of how to make an opinion known.
- Confidence that expressing the opinion will make a difference.
- Gay and bisexual lay involvement in service planning.
- Clear and known complaints procedures in public services.

**5.6 COMMUNITIES MEETING THE NEEDS OF POLICY MAKERS, RESEARCHERS AND COMMISSIONERS**

The devolution of the NHS to PCTs has increased both its responsibility towards and openness to influence by local community members. PCTs are able to fulfil their roles more effectively when they seek and accept input from lay persons. In the context of their contribution to HIV incidence, public involvement by gay and bisexual men is essential to this process.

**STRATEGIC COMMUNITY AIM 14:**
Gay and bisexual men increase their lay involvement in Primary Care Trusts (PCTs) and other planning and consultation structures.

Needs include:
- Knowledge about local HIV prevention services.
- Access to and ability to participate in local inter-agency planning fora for sexual health promotion.
- PCTs having inclusive and diverse mechanisms for public involvement.
HIV prevention needs are diverse and come within the realm of responsibility of a large collection of public services in both statutory and voluntary sectors. All services intended to address the education, health and social needs of the population can impact on the HIV prevention needs of homosexually active men. These include:

**National providers**
- Terrence Higgins Trust
- Sexual Health and national AIDS Helpline

**Local providers**
- Schools & colleges
- NHS managed services
  - GPs and primary care teams
  - GUM staff
  - Health promoters
  - HIV care & treatment services
- Local authority managed services
  - Social services
  - HIV care services
  - Youth services
  - Gay and bisexual men's services
- Voluntary sector services
  - Switchboard / Helplines
  - Gay and bisexual men's service providers
  - HIV care & self-help groups
- Police officers
- Prison, detention centre and probation staff

Historically in the UK, a relatively small amount of resources have been put into gay specific services and many other services have sloughed their responsibilities to their gay and bisexual clients. Those gay specific services are then shackled with the entire spectrum of education, health and social service needs of gay and bisexual men, a task such few resources have no hope of addressing. Often those services are then accused of failing when the national HIV incidence does not drop. This approach has not worked and a greater collective responsibility is required. All education, health and social services must take responsibility for the HIV prevention needs of the nation’s current and future gay and bisexual men.

**6.2 ROLES**

Services have a number of roles to play in reducing HIV prevention need, including:

- delivering both generic and dedicated services directly to gay men and other homosexually active men to reduce their HIV prevention needs;
- delivering services to communities to enable them to act to reduce the HIV prevention needs of homosexually active men;
- advocating for client groups, forming professional associations and having representation in policy making, research & resource allocation;
- delivering training and professional development to other services to do all the above.

Interventions that might realistically contribute to a reduction in the HIV prevention needs of gay men and other homosexually active men can be made by a wide range of organisations and institutions including very many whose primary goal is not reducing HIV incidence but who wish to contribute towards it. The London Strategy Group made an observation we believe to be true throughout the country:

“At a sector and local levels, stronger links should be established between HIV prevention programmes in different settings, such as sex education in schools, harm reduction in prisons; and primary care and GUM services.” (§7.5(15))
In this Chapter we outline the needs of the education, health and social services providers to contribute to a reduction in HIV incidence among homosexually active men.

6.3 SERVICES MEETING THE NEEDS OF HOMOSEXUALLY ACTIVE MEN

The most commonly regarded HIV prevention actions are those of services targeted directly at homosexually active men to reduce their HIV prevention needs. These can come from a range of agencies and take a wide variety of forms.

6.3.1 All education, health and social services

We recognise that HIV prevention initiatives need to be delivered in the broader context of gay and bisexual men’s lives. Rather than HIV prevention interventions broadening their aims in order to achieve this, we suggest increasing the element of HIV prevention and sexual health promotion in broader educative, health and social service interventions with gay and bisexual men. Rather than dedicated HIV prevention services addressing all education, health and social care needs of gay and bisexual men, we seek for all education, health and social services to increase their contribution to addressing homosexually active men’s HIV prevention needs.

Many organisations, institutions and services have responsibility for some aspect of the HIV prevention needs of homosexually active men. The activity of these organisations, institutions and services also affects our health promotion activities. Hence, this framework recognises that a man’s general health and his sexual health cannot be seen in isolation from other social, environment and cultural factors that may act as a barrier to choice.
6.3.2 Clinical services

The National Health Service provides a wide variety of services in a number of settings that contribute to a reduction in HIV prevention needs among gay and bisexual men. These include services specifically addressing HIV and those which can reduce needs in the course of other services being delivered. The first priority for the latter is that gay and bisexual men are not excluded from or receive a worse service from generic NHS services. In addition, all services should be able to respond, directly or by referral, to HIV prevention needs encountered during the course of their work.

STRATEGIC SERVICE AIM 3:
All NHS providers increase the equity of their generic services to homosexually active men.

Needs include:
- An awareness that some of their male clients will have sex with men.
- Awareness of the cultural diversity of homosexually active men.
- Policies of equality of service provision that includes sexuality.
- Equality of Service policies.
- An accessible evidence base about the performance qualities of interventions.
- Gay and bisexual public involvement in service planning.
- A reduction in institutional homophobia in the NHS.
- Freedom from media discrimination and ridicule for serving gay and bisexual men.

6.3.3 General practice services

Many gay men use GP and other primary care interventions though not necessarily in relation to sexual health matters. Surveys suggest many gay men consult their GP. Although the majority of these consultations will be unrelated to either HIV or having sex with men, many will also give rise to opportunities to address gay and bisexual men’s HIV prevention needs. To achieve this, GPs and primary care teams need knowledge, skills and awareness.

STRATEGIC SERVICE AIM 4:
All GP and primary care staff increase actions that reduce HIV prevention need among homosexually active men and stop actions which make them worse.

Needs include:
- Policies of equality of service provision that includes sexuality.
- Knowing some homosexually active men will access and use their services without disclosing sexuality or sexual practice.
- Awareness of the range of health and lifestyle issues for gay and bisexual men.
- Basic HIV awareness and knowledge and adherence to anti-discriminatory practice.
- Appreciation that most gay men’s health problems are not related to HIV or sex.
- An accessible evidence base about the performance qualities of interventions.
- Gay and bisexual public involvement in service planning.
- A reduction in institutional homophobia in the NHS.
- Freedom from media discrimination and ridicule for serving gay and bisexual men.

6.3.4 GUM out-patients services

For homosexually active men to be able to determine their HIV status and to get other STIs diagnosed and treated, there must be adequate and accessible clinical sexual health services. Homosexually active men are the single group most likely to acquire HIV and STIs and should be the number one priority group for men’s clinical sexual health services.

Community surveys suggest that the quality of GUM services to gay and bisexual men in England is high (Sigma Research, 1999). The majority of users feel respected, listened to and satisfied with the services they get. This forms an excellent base from which to increase the contribution of GUM services to meeting their HIV prevention needs. However, recent years have seen a large increase in demand for these services but no comparable increase in resources to address them. The recent Health Select Committee on sexual health concluded that under-resourcing of clinical STI services is a major obstacle to tackling infections.
STRATEGIC SERVICE AIM 5:
Clinical sexual health services prioritise homosexually active men as a client group.
Needs include:
- Resources.
- Awareness of the disproportionate impact of STIs on homosexually active men.
- An ability to provide acceptable and effective clinical sexual health services to homosexually active men.
- Knowledge of models of clinical sexual health service delivery for homosexually active men.
- An accessible evidence base about the performance qualities of interventions.
- Gay and bisexual public involvement in service planning.
- Freedom from media discrimination and ridicule for serving gay and bisexual men.

In Chapter 3 we discussed the importance of reducing the average length of time between HIV infections and their diagnoses. GUM services are the most common setting for HIV testing amongst gay and bisexual men and the majority of HIV diagnoses are made there. However, many men with undiagnosed infection attend and exit GUM services without having had their infection diagnosed. A vital opportunity to contribute to both their health and public health is being missed.

STRATEGIC SERVICE AIM 6:
All GUM staff increase offers of HIV tests to homosexually active men attending for STI screening and seek informed consent for testing.
Needs include:
- Policy on offering of HIV testing to clinic attenders.
- Ability to raise and talk about HIV testing without making men feel obliged to take a test.
- Ability to explore past and potential opportunities for infection and onward transmission with clients.
- Ability to educate men about the benefits and drawbacks of both a positive and negative test.
- An appreciation that some men will decline HIV testing without wishing to disclose a reason for declining.
- An agreed minimum standard for quality HIV testing services.

GUM services are also the settings in which PEP would be most usefully and easily made available.

STRATEGIC SERVICE AIM 7:
An increase at NHS services in the availability of post-exposure prophylaxis (PEP) to men sexually exposed to HIV.
Needs include:
- Central guidance on the use of PEP (from the Association of GUM Medicine and the Medical Society for the Study of Venereal Disease).
- Resources.
- Clinicians able to assess men’s needs for PEP.
- An accessible evidence base about the performance qualities of interventions.
- Community support and lobbying for making PEP available.

6.3.5 HIV care services
The vast majority of people with diagnosed HIV infection are in touch with treatment and care services, both those clinically and community based. These services are very well placed to address the HIV prevention needs of their users either directly or by referral to prevention and community services.

STRATEGIC SERVICE AIM 8:
An increase in sexual health promotion interventions by HIV care and treatment providers.
Needs include:
- An understanding of unmet HIV prevention need among users.
- Knowledge of interventions that reduce HIV prevention need.
- Knowledge of services to refer to.
6.3.6 Schools and colleges

The education and welfare of young gay and bisexual men is the responsibility of their schools. How young gay and bisexual men are treated at school, by staff and by other pupils, will determine their outlook on life and society and will determine the extent to which they wish to avoid HIV infection in the future and how able they are to do so. How teenagers are being treated in schools today will influence the rate at which, in ten years time, gay and bisexual men in their 20s acquire HIV.

HIV prevention and health promotion services cannot be expected to address the inadequacies of sex education in schools in the UK. While these services can often make a considerable contribution to school sex education they cannot do so alone. All of the sexual health needs of young people that can be addressed in schools should extend to the same needs for young gay and bisexual men. No sex education classes should assume all of the students are (or will be) heterosexual. Informing students of where they can go for advice, for example, should include local gay and bisexual men’s projects, helplines and gay youth groups.

For young gay and bisexual men, equality at school means both adequate and appropriate sex and personal development education as well as the absence of homophobic discrimination and prejudice. There is considerable evidence that homophobic bullying is both widespread in schools and has substantial long-term consequences for the victims (Rivers, 2000, 2001; Carragher & Rivers, 2002; Rivers & Duncan, 2002). The now-defunct Section 28 presented the biggest obstacle to teachers tackling this problem (Douglas et al., 1998). Increasing change in this area is more feasible than ever.

### STRATEGIC SERVICE AIM 9:

All school boards develop and review policies to address homophobic bullying by pupils and teachers and that promotes gay and bisexual social inclusion.

Needs include:

- Awareness of the size and scope of the problem including the need for equality of education and care for gay and bisexual pupils.
- Knowledge of policy options.
- An accessible evidence base about the performance qualities of interventions.
- Policy input from local health and social services, and Healthy School Partnerships.
- Policy input from gay and bisexual lay men.
- Freedom from media discrimination and ridicule for serving young gay and bisexual men.

The curriculum requirements are interpreted and further guidance is provided in Key Stages 1 to 4 of the National Curriculum. Personal, social and health education is an aspect of the requirement on the national curriculum to provide spiritual, moral and cultural education. At Key Stage 2 pupils should be taught “to realise the nature and consequences of racism, teasing, bullying and aggressive behaviours” and “that differences and similarities between people arise from a number of factors including cultural, ethnic, racial and religious diversity, gender and disability”. The absence of sexuality from this list, by far the most common means of teasing and bullying, is indicative of the invisibility of young gay and bisexual men in schools.

Sex and Relationship Education Guidance (Department for Education and Employment, 2000) continues to collude with bigotry and consequently provides contradictory guidance. It states that “young people, whatever their sexuality, need to feel that sex and relationship education is relevant to them and sensitive to their needs” and that “there should be no direct promotion of sexual orientation”. However, it is also unequivocal that sex and relationships education is about promoting heterosexuality: it is about “learning the value of family [ie. heterosexual] life, marriage and...relationships for the nurture of children”. Given
this clear bias and the overwhelming negative societal representations of gay and bisexual men, direct acknowledgement and valuing of homosexuality is exactly what young gay and bisexual men need. This contradictory stance is enabling schools to fail in their duties to gay and bisexual pupils.

The guidelines for Key Stage 3 suggest pupils should be taught: (in a context of the importance of relationships) about human reproduction, contraception, sexually transmitted infections, HIV and high-risk behaviours including early sexual activity; to recognise and manage risk and make safer choices about healthy lifestyles; to recognise when pressure from others threatens their personal safety and well-being and to develop effective ways of resisting pressures, including knowing when and where to get help; about the effects of all types of stereotyping, prejudice, bullying, racism and discrimination and how to challenge them assertively. This approach is also reflected in the Government’s new Healthy Schools Standard Initiative.

However, a recent audit of education about sex and relationships in schools by the Office for Standards in Education found that “Education about HIV/AIDS is receiving less attention than in the past, despite the fact that it remains a significant health problem”, that boys in particular felt unsupported by their schools and that “school programmes need to do more to develop values and attitudes and personal skills” (OFSTED, 2002). All these failings were in relation to students who are presumed to be heterosexual either currently or in the future. Standards are even worse for young gay and bisexual men. Current evidence suggests the extent and quality of education in schools about homosexuality is low (Douglas et al., 1998). This is due to several factors including teachers’ perceptions of parental disapproval and lack of training on and confidence to educate young people about diversity. Sex education is in the hands of the governors and overall responsibility for the curriculum resides with the Head Teacher.

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**STRATEGIC SERVICE AIM 10:**
Secondary schools increase the frequency with which they employ people able to teach pupils about sexual diversity, including homosexuality, in line with statutory sex and relationship guidance. Needs include:

- School policy for sex education that is inclusive of the needs of gay and bisexual pupils.
- Teachers aware of and able to deal with issues of sexual diversity, homophobic bullying, and the adverse effects of homophobia and inequality on the physical and mental health of (young) gay and bisexual men.
- Mechanisms for pupils to complain about homophobic teachers.
- On-going support and training for teachers to deal with diverse sexuality and homophobia in the classroom.
- Freedom from media discrimination and ridicule for serving gay and bisexual men.

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**6.3.7 Police authorities**
Police authorities can impact on the ability of other services to deliver intentions. More generally they can contribute to respect (or otherwise) for gay and bisexual men in the community. They also have considerable autonomy in the ways in which they pursue and prosecute “gross indecency”, especially in public sex environments (PSEs).

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**STRATEGIC SERVICE AIM 11:**
Police officers increase the equity of their generic services to homosexually active men. Needs include:

- Equal treatment policy for sexual minorities.
- Awareness of diversity and sensitivity to sexual minorities.
6.3.8 Prison governors and officers

There are 138 prisons in England and Wales detaining approximately 72,000 people at any given time. Both HIV prevalence and HIV incidence in the prison population is higher than in the community and infectious diseases including HIV are one of the main health risks to those incarcerated.

Despite injecting drugs in prison being illegal, tablets for sterilising injecting equipment have been available in prisons since 1998. On the other hand, although sex between men in prison is not illegal (prisons cells not being public places and prison officers not being members of the public when on duty), condoms and lubricant are still not easily available to prison inmates. Although there are no technical obstacles to prison medical officers issuing condoms, the absence of supportive higher level guidance is resulting in extreme local variation in conditions. Access to water based lubricant is equally important and is currently almost completely unavailable even to those who can get condoms.

6.3.9 Health promotion services

Interventions targeting homosexually active men to directly reduce their HIV prevention needs are the most common of all HIV prevention interventions and are the subject of the majority of evaluations carried out. Such interventions include information giving and education but also clinical interventions such as access to an HIV test. Some of these interventions can be done by anyone, others require considerable skill and resources.

In all settings the following two recommendations should be observed unless specified otherwise:

- ‘No HIV prevention interventions should implicitly assume that all of their targets are uninfected’ (London HIV Strategy Group, 2001).
- ‘In any programme of HIV prevention interventions, some interventions should aim to address the specific needs of those with HIV’ (London HIV Strategy Group, 2001).

Not only do many men with HIV share unmet needs with men without HIV, but our aims also include reducing the social exclusion engendered by marginalisation in the language of HIV prevention. If the target group for the intervention is men without diagnosed infection, or those who believe themselves uninfected, this should be explicit.

All PCTs contain some people with HIV. However, this does not mean each PCT should be delivering interventions as many will be better delivered collaboratively across larger areas and require specialist knowledge and skills.

The range and potential of health promotion interventions targeted directly to homosexually active men in order to meet their HIV prevention needs are described and explored in The Field Guide (Devlin et al., 2003), a companion document to Making It Count published simultaneously with the framework.
6.4 SERVICES MEETING THE NEEDS OF COMMUNITIES

In the context of HIV prevention, community development involves services which increase the capacity of populations of people to identify and address their own HIV prevention needs. Here, services work with community members to increase interventions such as those described in Chapter 5. For example, this includes increasing the capacity of community members to:

- organise and form voluntary associations;
- directly address the needs of homosexually active men in the community;
- reduce homophobia and discrimination;
- lobby policy makers, researchers and commissioners;
- input to service planning.

Some HIV health promotion intends to increase the competencies of members of social networks to address the HIV prevention needs of homosexually active men in those networks. These interventions target people in the social networks of homosexually active men (often though not always homosexually active men themselves). The interventions aim to increase those people’s abilities to make interventions with homosexually active men in their networks that reduce their HIV prevention need. One generic name for some such interventions is peer-led education. Other key means of social diffusion include critical consciousness raising and community mobilisation.

Such interventions usually occur in two stages. The first involves recruiting gay and bisexual men, addressing their HIV prevention needs and training them to make interventions with men in their social networks. Key objectives often involve facilitating community involvement which takes place in community meeting places and project centres. The second part of the intervention is carried out by the men recruited and involves them making interventions with other homosexually active men which decrease their HIV prevention needs, during everyday social interaction. These can be many of the interventions identified in The Field Guide (Devlin et al., 2003), the companion document to Making It Count.

Some interventions address the significant others of homosexually active men such as family and friends to increase the contribution they make as described in Chapter 5. Others target gay related businesses such as bars, saunas and shops to increase their contribution to meeting the HIV prevention needs of their customers and create safer environments in which men have sex.

STRATEGIC SERVICE AIM 13:
An increase by local health promoters in community development for HIV prevention.

Needs include:
- Resources.
- An accessible evidence base about the performance qualities of interventions that includes community development interventions.
- A workforce able to deliver community development interventions.

HIV prevention community development also seeks to bring into existence social networks and support pre-existing ones. This is beneficial in that it both increases social cohesion and creates settings in which services can occur. Much health promotion activity is only possible because of the existence of a gay community infrastructure including meeting places, gay media, social networks, organised and semi-organised groups. Conversely, the lack of a community infrastructure limits the range of settings in which direct contact activities occur.

The aim of community development is the existence of strong community infrastructures. As such, the target is not individuals, but the relationships between them. The objectives are less tangible and predetermined than those of services directly addressing homosexually active men’s prevention needs, and include establishing, facilitating or supporting the functioning of community groups. Community infrastructures are not an end in themselves, but desirable to the extent that they benefit their members.

Across the UK a huge variety of community groups exist for a variety of purposes and with a variety of relationships to HIV prevention. The development,
administration or support of community groups via the provision of funding, space, staff time or training, or advice and consultancy is one role taken by a range of health promotion agencies.

The most common type of community health promotion is probably the facilitated social group or peer-support group. These exist in many towns and cities and usually serves specific sub-groups of gay and bisexual men. For most social groups the target is younger gay and bisexual men but groups exist for a range of targets including men with diagnosed HIV, deaf men, black men, Latin American men, married men etc.

Some health promotion agencies also host or initiate special events – club nights, or trips to events for example – have mailing lists and provide volunteering opportunities. Such interventions are, at least partly intended to build community infrastructure.

Homosexually active men find out about the interventions targeting them in the gay and HIV press, on the gay commercial scene or via (other) community groups and in GUM and HIV clinics and from other providers of HIV health promotion and care services. Some interventions are advertised on the internet or through direct mailing to men who belong to a mailing list. The interventions occur in a range of settings including gay pubs, clubs, agency centres and other public spaces such as town halls or arts centres. Other public spaces such as libraries, sports centres and GP practices are also used to publicise some of these interventions, as are the listings of magazines like Time Out and What's On.

The direct aim of most community health promotion is the provision of space in which social networks can form or flourish. Some interventions also prescribe the nature of the space to be created, such as safe and supportive or free from prejudice and discrimination. While some community health promotion aspires to impart sexual and / or general health information, more commonly the aim is to improve men’s physical, social and mental well-being or their capacity to make choices and to express themselves. Many of these aims are assumed to be met by the contact between peers at community interventions.

6.5 SERVICES MEETING THE NEEDS OF SERVICES

Since the beginning of the HIV epidemic, education, health and social services have had to educate themselves about needs and issues as they have arisen. The main source of practical assistance in service delivery has usually come from learning from other services, rather than from research or through policy guidance. Interaction and learning between a diverse range of services is also essential for a collaborative response.

6.5.1 Collaborative planning fora

The impact of all services can be increased if they are aware of and complementary to all other services in a local area, and with national services. Ensuring this is the case can only occur with communication across services and with their active participation.

STRATEGIC SERVICE AIM 14:

Service providers increase leadership of collaborative planning fora and Local Strategic Partnerships for education, health and social services.

Needs include:

- Accessible fora facilitated by service providers.
- Human resources to attend meetings.
- Technical support to participate in discussions and decisions.

6.5.2 Trainers and educators in health, education and social services

Some service providers deliver a range of interventions to increase other services’ ability to contribute to a reduction in HIV incidence among their client group. While the range of organisations that touch on HIV prevention practice is enormous, a relatively small and finite set of interventions are possible with all of them. Interventions will include (professional) training, policy making, conferences and facilitating community involvement in service development. The aims of such interventions vary by the target organisation but include any that facilitate organisational or professional development.
However, the HIV training costs of the education, health and social service workforce can not indefinitely be devolved to specialist training units. The core training of these professions must include responding to sexual and HIV diversity and improving sexual health.

STRATEGIC SERVICE AIM 15:
All teachers and trainers of education, health and social services staff increase coverage (and quality) of sexuality and HIV awareness.

Needs include:
- An awareness of the disproportionate need for education, health and social services among homosexually active men.
- Ability to train trainees in sexual diversity and responding to homophobia.
- Gay and bisexual public involvement in education, health and social care services training.

6.6 SERVICES MEETING THE NEEDS OF POLICY MAKERS, RESEARCHERS AND COMMISSIONERS

Education, health and social services have a key role to play in meeting the needs of policy makers, researchers and commissioners. Not only do they hold extensive knowledge about their client groups and therefore assessments of need, but they are also the key to ensuring the research that is carried out is eventually useful in practice.

Much of the response of Government, health and local authorities to HIV in the last 20 years has been motivated and informed by actions of services, particularly voluntary sector services such as the Terrence Higgins Trust, Gay Men Fighting AIDS, the George House Trust and the National AIDS Trust. Change in policy makers often requires representation from services who are on the forefront of the epidemic. While we should be careful to distinguish these services from the communities they serve, that they continue to advocate for those communities is vital.

STRATEGIC SERVICE AIM 17:
Education, health and social services staff increase their input to local commissioning plans for sexual health and HIV.

Needs include:
- Accessible fora facilitated by policy makers.
- Human resources to attend meetings.
- Technical support to participate in discussions and decisions.

STRATEGIC SERVICE AIM 18:
Lobbying and policy charities increase their advocacy and lobbying to policy makers for gay and bisexual men’s HIV prevention work.

Needs include:
- Resources to develop workforce and support (technical and information) mechanisms.
- An understanding of the issues involved.
- Proximity and access to politicians and decision makers.
- Mechanisms to consult with other services and community members.
7 THE ACTIONS AND NEEDS OF POLICY MAKERS, RESEARCHERS AND COMMISSIONERS

7.1 KEY PLAYERS

All of the groups and agencies identified in Chapters 5 and 6 have roles to play in policy making, research and resource allocation, although these are not their primary purpose. This chapter considers the activity of the following key players (see box opposite) in the HIV epidemic. International research suggests that it is these players who have greatest influence on (and therefore greatest responsibility for) HIV incidence (Barnett & Whiteside, 2003; UNAIDS, 2002).

7.2 ROLES

Communities and the services designed to address them are both either confined and blocked or enabled and encouraged by the actions of local and national policy makers, researchers and commissioners. Globally, the most important factor in a nation’s response to HIV incidence is political leadership (Barnett & Whiteside, 2002). The actions of governments and their agents determine the level of HIV incidence in a country through their impact on social norms, the size and configuration of the service response and the abilities of communities to address their own needs. A recent poll among 77 gay men under the age of 25 found public policy change was what they felt was most needed to meet their HIV prevention needs (Warwick et al., 2001).

The actions of policy makers, commissioners and researchers can be directed towards services (education, health or social), communities (including businesses and the media), towards other policy makers, commissioners and researchers, or towards homosexually active men themselves. These actions impact on homosexually active men’s HIV prevention needs through a variety of routes. They include developing policy, allocating resources and doing research that:
• respects diversity and promotes human rights;
• enables services to maximise their contribution to reducing HIV prevention needs;
• empowers communities to address their own HIV prevention needs;
• fosters joined up policy, funding and research.

In the UK, it continues to be the case that only a small proportion of the activity done in the name of HIV prevention has gay and bisexual men’s HIV prevention needs as its target, and that small amount is expected to do the job alone. Very little HIV prevention supporting policy has been made. The APPGA (2001) recommended that:

“Spending priorities should be clearly directed by epidemiological evidence of transmission and not by historical tradition, prejudice or scarcity of funding.” (§60)

The epidemiological evidence is that new HIV infections among people living in Britain in the next few years will be overwhelmingly among gay and bisexual men. What is needed is for national and local policy makers and commissioners to act on this knowledge.

Policy makers, commissioners and researchers are as diverse as services or the community. They include national and local players, people in a wide variety of posts and with varying degrees of power. The following sections outline the major constituencies, the actions required of them and their needs for action.

### Summary strategic policy aim

**Policy makers, commissioners and researchers increase actions that enable services and communities to reduce the HIV prevention needs of homosexually active men, and stop actions that make them worse.**

This framework recognises and supports policy making which brings about social equality for all gay men, bisexual men and people infected with HIV and which facilitates HIV prevention interventions. Campaigning, lobbying and advocacy can be used to influence government policy both to ensure facilitative policies are in place and to remove policies which are obstacles. The same methods can be used on a local basis to ensure local organisations (for example, PCTs, police authorities and local authorities) have policies that support effective HIV prevention and sexual health promotion planning and implementation.

#### 7.3 Policy meeting the needs of policy makers, researchers and commissioners

Many actions of this constituency are concerned with its own needs to carry out tasks for the benefit of the population. These include public health surveillance, the development of a national prevention evidence base programme and strategies for national resource allocation.

There are a relatively small number of national players who determine the amount of money available for addressing HIV incidence and where those resources end up. They including MPs, the Medical and Economic & Social Research Councils and large charity funders who are involved in prevention (eg. CRUSAID). The activity of some services is specifically directed towards meeting the needs of this constituency to make the best decisions with resources (eg. the National AIDS Trust).

Sexual health in general and HIV prevention in particular must be given adequate attention within Government policy if the epidemics are to be brought under control. If the government is not seen to prioritise these issues, few commissioning authorities will and resources will go to other services. The incidence of HIV infection among homosexually active men is in the hands of Government legislators. However, sexual health and HIV were removed from the governments list of core NHS priorities in 1997, the year in which HIV infections began to rise.

The Health Select Committee report (2003) characterised the sexual health of the UK and the service infrastructure to address it as a ‘crisis’. It identified the absence of leadership as one of five key drivers of this crisis and calls for a National Service Framework for sexual health and HIV. We agree this would be one solution and focus on the generic purpose of such an action.
STRATEGIC POLICY AIM 1:
The Government finds a way to increase the priority given to HIV prevention activity within the NHS.
Needs include:
- Policy options.
- Evidence of the social, medical and economic impact of the HIV epidemic in the UK.
- Lobbying by services and community.

STRATEGIC POLICY AIM 2:
All policy makers and commissioners increase their contribution to the national sexual health and HIV evidence base by collecting and making available transparent data for evaluating policy change, including the surveillance and publication of resource allocations.
Needs include:
- Knowledge of which aspects of activity are useful to monitor.
- Practical tools for data collection and collation.
- Researchers able to accept and process data from a number of sources.

7.4 POLICY MEETING THE NEEDS OF SERVICES

The central actions of policy makers and commissioners in meeting the needs of services is the development of strategies for the distribution of public funds and the identification of useful interventions.

7.4.1 Central Government
Clinical sexual health service providers would be able to make a much larger contribution to reducing HIV incidence if they had a safe and effective preventative vaccine against HIV. A global movement for vaccines has been in operation for some years and a recent National AIDS Trust policy document outlines the greater contribution the British Government could be making to this goal. Making It Count concurs with this document and urges the Government to follow its recommendations.

7.4.2 NHS policy makers and commissioners
England is divided into 334 health authorities determining resource allocation and policy on NHS services used by homosexually active men and the regulation of clinical interventions.

STRATEGIC POLICY AIM 3:
The Government increase its actions to ensure faster global progress towards the development of a safe and effective preventative vaccine against HIV.
Needs include:
- Policy options.
- An action plan.
- Community and service involvement.

The National AIDS Trust’s strategy for New Pathways to HIV Prevention (Webb et al., 2003) provides a road-map for moving forward and this framework supports this plan.

Action is also needed now to meet the needs of Prison Officers to act to reduce HIV prevention needs of prisoners. However, the disbanding of the National AIDS & Prisons Forum in June 2003 further reduces our collective policy response to the HIV prevention needs of this extremely disempowered population.

STRATEGIC POLICY AIM 4:
The Home Office increases its actions to enable Prisons Services to meet the (sexual) HIV prevention needs of inmates of prisons and young offenders institutes.
Needs include:
- Knowledge of the level of HIV infection and HIV transmission risk within prisons and intervention which could reduce them.
- Knowledge of the issues involved.
- Knowledge of the possible range of policies.
- Community input to policy making.
- Lobbying by services and community.
- Political pressure.
4 Health & Social Services Directorates

28 Strategic Health Authorities, each with a Director of Public Health

302 Primary Care Trusts, each with a Sexual Health and HIV Lead

The Health Select Committee identified lack of involvement of public health at the Strategic Health Authority (SHA) level as being a key reason for the current crisis in sexual health in Britain. The role of SHAs is to develop local strategy and priorities and to oversee the development and delivery of services by PCTs. Their current involvement in HIV prevention at any level is, however, minimal.

**STRATEGIC POLICY AIM 5:**

An increase in the proportion of Strategic Health Authorities that include HIV and sexual health promotion with homosexually active men in Local Delivery Plans and performance monitoring mechanisms.

Needs include:

- Nominated lead for sexual health and HIV.
- Knowledge of local HIV epidemic, priority groups and prevention needs.
- Health promotion expertise.

The current failure of strategic direction from SHAs is being compensated for by extensive collaboration between PCTs, often over the entire SHA. Many PCTs collaborate on policy, resource allocation and commissioning but there is no centralised picture of who and how they do so.


**STRATEGIC POLICY AIM 6:**

PCTs increase HIV prevention programmes for homosexually active men and ensure they are adequately resourced.

Needs include:

- Resources to allocate.
- Knowledge of national priorities and local needs.
- Service provider organisations.
- A planning framework.
- Planning input from the community.
- Planning input from the practitioners (statutory & voluntary).
- An ability to access and use evidence of need.
- Freedom from media discrimination and ridicule for serving gay and bisexual men.

**STRATEGIC POLICY AIM 7:**

PCT commissioners increase consortia commissioning arrangements for programmes of HIV prevention for homosexually active men across PCT and local authority boundaries.

Needs include:

- A planning framework.
- Planning input from the community.
- Planning input from the practitioners (statutory & voluntary).
- A consensus between PCTs and HIV health promoters on the minimum standards for local HIV prevention programmes.

**STRATEGIC POLICY AIM 8:**

PCTs (which have prisons within their area) engage with local prisons to jointly develop Health Improvement Plans for prisoners that include policies for access to condoms, sexual assaults and care of prisoners with HIV.

Needs include:

- Awareness of responsibilities regarding prison health.
- Knowledge of local prisons and conditions.
- Knowledge of health and sexual health issues in prisons.
7.4.3 Local authority policy makers and commissioners

Many services and functions carried out by local government in England impact both on homosexually active men themselves and on activities intended to address their needs.

Local authority functions that impinge on HIV prevention needs include: education; housing; social services; libraries; environmental health; trading standards; leisure & recreation; and the police (not a direct function). Through their services local authorities can often play a major part in reaching vulnerable gay and bisexual men.

Some local authorities (such as Westminster, Manchester and Brighton & Hove) gain from the revenue from gay commercial centres and all local authorities are large scale employers with employment policies and practices. They should also have an important voice in Local Strategic Partnerships between, for example, voluntary organisations, the Police and the community.

In England there are 445 English authorities determining resource allocation and policy on local authority services used by homosexually active men and the regulation of community infrastructure. That is:

- 33 London borough councils (all services) – plus the Greater London Authority; London Regional Transport; Metropolitan Police; London Fire & Civil Defence Authority
- 36 metropolitan councils (all services in 6 major metropolitan areas) – plus each of those 6 areas has joint authorities for public transport, Police, Fire & waste
- 47 unitary councils (all services) – plus each of these 47 also have joint Police and Fire authorities
- 34 county councils (education and social services) – containing 238 district councils (local planning; housing; environmental health; refuse)

In addition there are several thousand Town, Parish and Community Councils in England controlling local amenities. All of the preceding make policies regarding the community and its amenities and services that have a direct impact on the lives of homosexually active men.

STRATEGIC POLICY AIM 9:
Local authorities increase commissioning of services which reduce the HIV prevention needs of homosexually active men.

Needs include:
- Resources to allocate.
- Knowledge of national priorities and local needs.
- Service provider organisations.
- A planning framework.
- Planning input from gay and bisexual lay men and other community members.
- Planning input from health promotion practitioners (statutory & voluntary).
- Freedom from media discrimination and ridicule for serving gay and bisexual men.

The Government's Neighbourhood Renewal Fund could also appropriately address social exclusion among gay and bisexual men. The Department of Health and the Neighbourhood Renewal Unit expressly recognise this as a possibility when they acknowledge that “neighbourhood renewal programmes can provide consistent health promotion messages regarding ‘safer sex’” (Department of Health & the Neighbourhood Renewal Unit, 2002). However, while recognising that sex between men remains the major route of transmission in the UK, the suggested elements of a local plan make no mention of gay and bisexual men but instead suggest services strive to be ‘young people friendly’. The sexual health needs of gay and bisexual men must be recognised at local as well as national levels and gay and bisexual men explicitly acknowledged as an appropriate group for regeneration. The new powers of local authorities to promote and improve social, economic and environmental well-being of communities are in important lever for the promotion of sexual health.
STRATEGIC POLICY AIM 10:
An increase in the proportion of local authorities which explicitly recognise gay and bisexual men as a community group with extensive unmet social need, including young men leaving care.

Needs include:
- Knowledge of the issues involved.
- Knowledge of the possible range of policies.
- Community input to policy making.

7.4.4 University and independent researchers

The systematic generation and collation of data to inform policy makers, services and communities about HIV and its prevention occurs in a wide variety of settings. Although a considerable amount of resources are spent on this activity, it is questionable the extent to which it provides the information needed to increase the contribution interventions make to reducing HIV prevention needs. Currently, the majority of research activity is directed towards other researchers and is rarely toward the constituencies the research is intended to serve (eg. services, policy makers, communities).

STRATEGIC POLICY AIM 11:
Researchers increase the applicability of the national evidence base to services, the community and policy makers.

Needs include:
- A research workforce and funding.
- Knowledge of unmet information need among services, community and policy makers.
- A strategy for prioritising unmet information needs.
- Development resources to evolve methods for evaluating interventions and whole programmes.
- Awareness of implicit and explicit causal pathways for interventions.
- Review mechanisms to consider different types of evidence about various qualitites of interventions.
- Input to research design from gay and bisexual lay men.
- Input to research design from policy makers.
- Mechanisms for getting their research to its target audiences.

7.5 POLICY MEETING THE NEEDS OF COMMUNITIES

Parliamentary legislation, central government policy and subsequent resource allocation set the parameters and limitations on all of the preceding activity. Government policy and behaviour also sets the tone of acceptance or stigma toward people with HIV.

The current Government recognises that it is necessary and appropriate “to support strong and active communities in which people of all races and backgrounds are valued and participate on equal terms” (Home Office Aim 7). Furthermore, it proposes to do this by “developing social policy to build a fair, prosperous and cohesive society in which everyone has a stake ... and to ensure that active citizenship contributes to the enhancement of democracy and the development of civil society” via the Home Office, Active Community Unit. The Unit is responsible for the achievement of the Government’s goal of increasing voluntary and community sector activity, including increasing community participation, by 5% by 2006.

7.5.1 Police Authorities

Engagement in civil society for gay and bisexual men is difficult when homophobic hate-crime is widespread and is not formally recognised in law. The Crown Prosecution Service has published policy (2002a) and guidance (2002b) on prosecuting cases with a homophobic element. Their policy (2002a) recognises:

“homophobic crimes as particularly serious because they undermine people’s right to feel safe about and be safe in their sexual orientation .... Such crimes are based on prejudice, discrimination and hate and they have no place in an open and democratic society”.

The CPS have committed to deter people from committing such crimes by making clear “that such behaviour is not acceptable”. They have also recognised the need to provide an environment in which people have the confidence to report such crime and prosecute such cases effectively.

In order to feel reporting a hate crime is worthwhile, gay and bisexual men must have confidence in the police to act on their complaint. Knowing about police policy in response to such reports is essential.
**STRATEGIC POLICY AIM 12:**

Police authorities develop and make known clear policies on the ways in which they support gay and bisexual victims of crime, including domestic violence, sexual assault, homophobic hate crime and street sensitivity issues.

Needs include:
- Knowledge of the issues involved.
- Knowledge of the possible range of policies.
- Community input to policy making.

Since much homophobic crime occurs where men meet other men for sex, one of the central obstacles to reporting of homophobic crime is the victims’ fears of prosecution themselves for sex offences. Clear and known policies for dealing with sex offences are also necessary.

**STRATEGIC POLICY AIM 13:**

Police authorities develop and make known clear policies on the ways in which they respond to public complaints about gay and bisexual men, ‘gross indecency’ and ‘outrage to public morals’.

Needs include:
- Knowledge of the issues involved.
- Knowledge of the possible range of policies.
- Community input to policy making.

**7.5.2 Members of Parliament**

The Active Community Unit “has a vision of a society where the voluntary and community sector flourishes and where all individuals and communities are enabled to play a full part in civil society. We want to ensure that the support, assistance and means exist to enable that vision to become a reality.” This vision is particularly necessary when facing the HIV epidemic among gay and bisexual men. The silence of MPs on the gay and bisexual epidemic contributes to the difficult climate in which communities and services are responding.

**STRATEGIC POLICY AIM 14:**

An increase in leadership from MPs of the response to the gay and bisexual HIV epidemic that rejects homophobia and places civil action, human rights and respect at its centre.

Needs include:
- An understanding of what is driving the epidemic.
- A platform for speaking out.
- An appreciation of the political gain to be had from supporting the diverse communities threatened by HIV.

**7.5.3 Government and religious exceptionalism in employment**

The 2002 Department for Trade and Industry proposals for implementing the EU Directive on Equal Treatment in Employment and Occupation also talks positively about the long-term need for one Equality Commission that would deal with all type of discrimination and we concur. This would not occur within this Parliament (ie. before the end of 2006) but in the meantime the paper calls for discussion on what should happen in the interim. One possibility is that the Equal Opportunities Commission could take on the responsibility for sexual orientation issues. Alternatively a variety of partners – the TUC, lesbian and gay groups, lawyers and Citizens Advice Bureaux, for example – might be asked to make provisions.

For gay and bisexual men, equality at work means being able to pursue a career without fear of harassment or discrimination, whether overt or indirect. It means having equality of opportunity in recruitment, promotion and training, being entitled to the same benefits as co-workers and being protected in law from unfair treatment on the grounds of sexual orientation. In 2003 a new law, the Employment Equality (Sexual Orientation) Regulations 2003 was agreed by parliament. The new legislation bans discrimination in the workplace on grounds of sexual orientation, except in cases of genuine occupational requirement (where a persons sexuality is important to the quality of the tasks involved in the job for example), where an employment benefit is limited to married partners and where the employer concerned is a religious organisation.
We believe provision of exceptions for genuine occupational requirement to be sound. Continuing discrimination on the excuse of continuing exclusion from marriage should be addressed by changing the exclusion of same-sex partners from marriage (see below). However, the on-going support of the state for discrimination by religious organisations is unacceptable. As the new law stands, a religious organisations (which include places of worship, schools, health care centres and many other social institutions) can wholly legally:

- sack an employee for being gay or bisexual;
- refuse to employ someone for being gay or bisexual;
- refuse access to training or promotion to a gay or bisexual man;
- give someone leaving an unfair reference for being gay;
- victimise or treat less favourably a gay employee.

It is ironic that precisely those institutions that (quite rightly) warrant protection for their members from discrimination on the basis of religious belief now have a charter for active bigotry toward another minority group in society. The exception gained by such organisations is an indicator of their willingness to damage the mental and physical health of gay and bisexual men in order to support their own gender ideology. Changing this religious exceptionalism in employment law is one of the future challenges of HIV prevention efforts as part of the larger changes required in religious organisations if they are to stop stoking the HIV epidemic.

**STRATEGIC POLICY AIM 15:**

The **Government introduce an amendment to the Employment Equality (Sexual Orientation) Regulations 2003 that makes religious organisations subject to its provision.**

Needs include:

- Evidence of the on-going harm caused by religious exceptionalism in employment legislation.
- Lobbying by services and community.
- Political pressure.

Under the new law, victims of discrimination (other than employers of religious organisations) are able to sue for damages if they can show that they have been treated differently because of their sexuality. Under the terms of the Directive, workplace benefits provided for unmarried heterosexual partners will also have to be provided for same-sex partners. However pension schemes, like those in the public sector which only provide survivors’ benefits to married couples, may be ruled as exempt from the Directive. Progress on this front requires legal recognition of same-sex couples.

**7.5.4 Government and equality of partnerships**

Both the European Convention and the Universal Declaration of Human Rights recognise the right to family life as a fundamental human right. While opinions differ about what form legal recognition of same-sex partnerships should take, there is a widespread desire for some legal recognition. Being equal as partners extends beyond being able to register and formalise relationships: it extends into areas of public law, intestacy, taxation, inheritance rights and family law. Because of the lack of legal recognition of same sex partnerships, men in relationships with men face a wide variety of discrimination including access to partners’ employers fringe benefits including health insurance, life insurance, and cheap or free use of the employer’s services; adoption; and tenancy rights in rented housing. In the event of illness, a same-sex partner is unlikely to be deemed to be next of kin. In the event of death a same-sex partner will have difficulty with the transfer of employers pension rights; payment of capital gains tax and other rules regarding inheritance in the absence of a will.

**STRATEGIC POLICY AIM 16:**

The **Government instigates legislation which provides the condition of legal equality of same-sex partnerships with mixed-sex partnerships.**

Needs include:

- Policy options.
- Evidence of the on-going harm caused by current exclusionary legislation.
- Lobbying by services and community.
- Political pressure.
Currently in English law there is neither sexual equality nor equality of sexuality. Men cannot enjoy sexual and emotional relationships with other men with the same rights and responsibilities as if their partner is a woman. A key impediment to equality is “gross indecency” legislation, under which homosexually active men may be fined, prosecuted or imprisoned for having consensual, adult sex. The APPGA (2001) specifically recommended:

“The Home office take forward the recommendations made in Setting the Boundaries and ensure that criminal law does not discriminate between homosexual and heterosexual acts.” (§32)

A recent Government White Paper Protecting the Public sets out an overhaul of the sex laws to make them equitable between heterosexual and homosexual acts. However, the actions of hetero-supremacist pressure groups (such as the Conservative Family Campaign, the Christian Institute and Reform, the evangelical wing of the Church of England) and weak community voices for justice are in danger of derailing this process. This is a good example of where community influence is proving vital to government action.

**STRATEGIC POLICY AIM 17:**
The Government repeals the gross indecency laws.

Needs include:
- An understanding of sexuality and human rights.
- Lobbying by services and community.
- Political pressure.

**7.5.5 Government and anti-HIV discrimination**

This framework is congruent with the aims of equality for people with HIV of The UK Declaration of the Rights of People with HIV and AIDS, launched by The UK Forum on HIV and Human Rights (UK Forum on HIV and Human Rights, 1992). Rights that we all enjoy under international law are:

- The right to liberty and security of person.
- The right to equal protection in the law and protection from discrimination.
- The right to privacy.
- The right to freedom of movement.
- The right to freedom from inhumane or degrading treatment.
- The right to housing, food, social security, medical assistance and welfare.
- The right to marry.
- The right to found a family.
- The right to education.

We assert that without the above HIV and human rights aim being met, the effectiveness and efficacy of all HIV prevention interventions will remain severely compromised. Meeting the above aim will make meeting the following HIV health promotion aims more likely.

The 1995 Disability Discrimination Act (DDA) makes it unlawful for people with a disability to be treated less favourably than other people for any reason related to their disability. It protects people in the areas of employment, access to goods, facilities and services, and buying or renting land or property. At present, people with AIDS are protected from being discriminated against but people with asymptomatic HIV are not.

**STRATEGIC POLICY AIM 18:**
The Government follows through on its stated intention to act on the recommendations of the Disability Rights Task Force and extends the cover of the 1995 Disability Discrimination Act (DDA) to people with HIV from the point of diagnosis.

Needs Include:
- Examples of the everyday discrimination experienced by people with HIV.
- Lobbying by services and community.
- Political pressure.
PLANNING

8 Needs assessment & evaluation
9 Development of Making it Count
NEEDS ASSESSMENT & EVALUATION

8.1 THE MEANING OF NEED WITHIN THE FRAMEWORK

Need describes areas where individuals or groups have the potential to benefit from an intervention or programme of work. An aim not being met for any target group is the meaning of HIV prevention need in this framework. Need is defined as an aim being unmet. Our aims arise out of descriptions of need and are constantly under review. In this framework:

- Homosexually active men (and those who wish to be so) have unmet HIV prevention needs if they are unaware of HIV or STIs, ignorant or misinformed about them, disempowered in sexual relationships or activity, or ill-equipped to take protective action, including but not limited to using condoms. As we are also attempting to increase the number and quality of peer-led interventions, men not being able to make interventions with their peers is also considered evidence of need within the framework.

- Friends and family of gay and bisexual men have unmet needs if they exacerbate the HIV prevention needs of the gay and bisexual men they know, or are unable to alleviate them.

- Media workers and businesses have unmet needs if they exacerbate the HIV prevention needs of their gay and bisexual customers or are unable to alleviate them. Since we require community infrastructures to do direct contact and social diffusion projects, the absence of community infrastructures is also considered as evidence of need within the framework.

- Organisations unable to contribute to a reduction in HIV incidence during the course of their work are in need. Education, health and social service providers have unmet needs if they are unable to provide quality services to gay and bisexual men. As health promoters and researchers require organisational structures, personnel, skills and planning data, the absence of these is also viewed as an HIV prevention need within the framework.

- Local policy makers and commissioners are in need if they are unable to commission programmes of intervention that use available resources with greatest impact and equity. The existence of policy and practices that unfairly discriminate against homosexually active men and people with HIV, and which make HIV prevention interventions less possible are in themselves evidence of need.

- National policy makers and commissioners are in need if they are unable to make policy and channel resources to address the HIV epidemic among gay and bisexual men.

An assessment of need for interventions to reduce HIV incidence during sex between men could cover any or all these areas of need.

8.2 WHOSE NEEDS FOR WHAT?

Needs assessment involves making informed judgements about the extent to which health promotion aims are unmet in their target groups. Resources are likely to be most efficiently used if they are employed in areas of greatest need. Alternatively health promotion activities may be inefficient simply because their aims are already well met for the target audience. An assessment of need may consider:

- the extent to which a specific aim(s) is met for an entire population; for example,
  - Which homosexually active men would benefit from increased assertiveness?
  - Which primary care teams would benefit from increased skill in sexual history taking?
  - Which MPs would benefit from knowing about homophobic hate crime?

- the extent to which all of the aims are met for a specific sub-population; for example,
  - What are the unmet HIV prevention needs of Black gay and bisexual men?
  - What do sauna owners need to reduce the HIV prevention needs of their customers?
What are the programme commissioning needs of PCT leads in the Northern NHS Directorate?

- the extent to which specific aims are met for a specific sub-population, for example, What don’t HIV positive gay men know about gonorrhoea?
- What are the community involvement needs of Asian homosexually active men?
- What do GPs need to manage a male patient who has been raped?

The health promotion needs of homosexually active men described in Chapter 3 are identical for all men but the extent to which they are met may vary between sub-populations and between individual men. A needs assessment for a population or sub-population should make an estimate of its size and relationship to other population groups.

A comprehensive needs assessment for an area should also estimate the size of all the stakeholder groups involved and make an assessment of how far away each is from the aims described in Chapter 5, 6 and 7.

Needs assessments are independent of the programme of activities intended to address them. Whether or not an aim is met for a target group is not dependent on the availability of a service to address that need. An assessment of need should not be guided by the range or configuration of existing services.

The NHS plan describes how PCTs should actively address the health needs of the local community, which includes local gay men. All PCTs have a statutory responsibility (Department of Health, 2001; 2003a) to assess the HIV health promotion needs of their resident population. They also have a responsibility to commission services to meet as much need as possible in the most equitable manner. However, the extent to which some health promotion aims are met, the obstacles to them being met and the health promotion initiatives that may best achieve them, can transcend PCT boundaries. Some needs therefore require assessments on geographical areas larger than single PCTs.

8.3 PRIORITISING NEEDS WITHIN HOMOSEXUALLY ACTIVE MEN

Prioritisation of activities to include in a health promotion programme must attend to the principle that all men are equally entitled to having all the health promotion aims met. However, HIV infection is not equally distributed among all homosexually active men (either geographically, demographically or by social networks). Prioritisation must therefore also be given to men who are most likely to be involved in HIV exposure during sex (Hickson et al., 1999; Weatherburn et al., 2000) to have maximum impact on HIV incidence.

We explicitly recognise that these two principles of prioritisation (equity and impact on incidence) may be in conflict. However, they are not alternative ways of prioritising. The following three principles should be considered together when making programming decisions:

**Impact on incidence**
Prioritise interventions encountered by population groups most likely to be involved in HIV exposure (such as men with diagnosed HIV infection, men in sero-discordant relationships, men with many sexual partners, men with lower educational qualifications).

**Impact on equity of need**
Prioritise interventions encountered by population groups for whom many needs (e.g., knowledge, choice, abilities, awareness) are poorly met compared with other population groups (such as men with lower educational achievement, men under 20 or over 50, behaviourally bisexual men, Asian men).

**Impact on both incidence & equity of health**
Prioritise interventions with aims that are poorly met for many of the population (such as expectation of disclosure of HIV status by sexual partners, ignorance of PEP, social justice).

Involvement in sexual HIV exposure and other behaviours that contribute to HIV incidence are not evenly distributed among all homosexually active men. The unmet needs associated with those behaviours are also unevenly distributed. However, some national priorities can be determined.
8.3.1 HIV infection

The first priority group identified are men with HIV infection (estimated at 3% of all homosexually active men). This group is present in every PCT in the country, although it will vary in size.

We distinguish between those with undiagnosed infection (estimated at 19% of those infected) and those with diagnosed infection (estimated as 81% of those infected). Because of the prevalence of HIV, both groups are more likely to be involved in exposure than uninfected men (estimated as 97% of homosexually active men). A man with HIV having UAI with a random partner will be 32 times more likely to have a HIV negative partner than a negative man engaged in exactly the same behaviour is to do so with a positive partner (since the ratio of positive men to negative men in the population is 1:32). On several indicators of HIV prevention need, particularly around negotiation and control, men with diagnosed infection also consistently show higher levels of unmet prevention needs.

Conversely, being more likely to be in contact with clinical HIV services, they are more knowledgeable about HIV and other STIs than men who have not tested positive. It is men who have never tested that are least knowledgeable about HIV and appear more naïve in their expectations that their health is primarily the responsibility of their sexual partners.

Men with undiagnosed HIV infection who have their HIV diagnosis needs unmet have the greatest amount of unmet HIV prevention need and should be the first priority for all programmes. However, because they are unidentifiable to themselves and others, they usually go unaddressed in prevention programmes.

The unmet HIV prevention needs that led a man to become infected with HIV are not resolved by his being diagnosed with HIV. Instead, they often continue to result in his involvement in sexual exposure, this time as the infected partner. Receiving a diagnosis may itself undermine men’s ability not to contribute to onward infection.

8.3.2 Age

The average age at which men are diagnosed with homosexually acquired HIV infection is 33 years. Among men not diagnosed with HIV, exposure to HIV appears to be fairly even throughout adulthood. As men grow into older age their sexual activity tends to drop off and anal intercourse becomes less likely when they do have sex. Subsequently involvement in sexual exposure is lower among senior citizens.

However, the context in which younger and middle-aged adult men are involved in exposure may vary. Men in their teens and twenties appear more likely to be involved in exposure without knowing it, while men in their thirties and forties are more likely to be in relationships with positive men and to know that exposure is occurring. Of course, both situations arise in all age groups, but these descriptions suggest a different weight of needs associated with exposure across the age range.

More important perhaps, is the observation that needs are more likely to be met with the interactions (with community, service, policy) that happen over time. On almost all measures of HIV prevention needs, younger men are more likely to be in need than older men. This suggests that the balance of prevention programmes should be weighted toward younger (teens and twenties) rather than older (thirties and forties) men.

8.3.3 Education / social class / wealth

Like almost all health morbidity, HIV is socially stratified among gay and bisexual men. Those men with least economic, social and political power are most likely to become infected and among those with infection are most likely to suffer poor health. When education is used as a marker of social stratification, we observe that men with lower levels of education take more sexual risks more often, are in greater need on almost all measures and are often least likely to benefit from service, community and policy interventions.

This inequality reflects the broader social stratification of health in the country and presents a substantial challenge to society, services, policy and gay communities. It is clear however, that the balance of activity to address HIV infection should be weighted toward men who have less.
8.3.4 Ethnicity / Black and ethnic minorities

There is sufficient evidence to prioritise the HIV prevention needs of Black men (men from or descended from Africa or the Caribbean) over those of other ethnic groups. We noted in Chapter 1 that African men are over-represented in diagnoses of homosexually acquired infection (Macdonald, personal communication) and sex with men is over-represented in samples of African men with HIV (Chinouya & Davidson, 2003). Black Caribbean men are also over-represented in HIV diagnoses and are more likely to acquire other STIs. In the National Gay Men’s Sex Surveys, compared to the White majority the Black men (African, Caribbean and other Black men) have been found to have:

- higher prevalence of diagnosed infection (Hickson et al., 1999; trend, Hickson et al., 2001; Reid et al., 2002)
- higher incidence of recent diagnosis of infection (trend, Hickson et al., 1999)
- higher incidence of HIV testing (Hickson et al., 1999; Weatherburn et al., 2000)
- higher incidence of other STIs (Hickson et al., 2001)
- higher incidence of casual unprotected anal intercourse (Hickson et al., 2001)
- higher incidence of multiple unprotected anal intercourse partners (Weatherburn et al., 2000)

In making the recommendation that Black men are over-served by HIV interventions and programmes we stress three points. First, the term ‘Black men’ covers a diverse population. The extent to which it is useful as a target group for interventions will depend on the specific population concerned. Distinguishing African men from Caribbean men may be a useful first step in refining interventions. While we prioritise the HIV prevention needs of ‘Black men’ we do not suggest that all Black men have the same unmet HIV prevention needs.

Secondly, migration features prominently in the histories of Black communities in Britain and continues to do so in the personal histories of many Black gay men, bisexual men and other homosexually active men. Migration has a major impact on health and well-being and is often the context in which men’s HIV prevention needs are elevated.

Thirdly, and more broadly, it is important to note that the inequalities in the entire population are also reproduced in each ethnic group. For example, it is widely acknowledged that Black and other minority ethnic groups in the UK are socially and economically disadvantaged relative to the ethnic majority. (Although this association has not been demonstrated amongst homosexually active men we so no reason to believe it is not the case here as well). We stress the need to ensure that it is the less well off strata of those groups which benefit. So for example, an intervention is not contributing to health inequalities if all of its recipients are Black men who are disproportionately well-educated, employed and relatively privileged members of that minority group.

Steps for health promotion agencies in moving towards over-serving Black men are outlined in Fenton, Cadette, Boayke et al., 2002.

With regard to men from other minority ethnic groups, even if equality of benefit from programmes is sought particular effort is needed with Black and ethnic minorities (BEM) due to the continuing culture of racism. Interventions which are tailored for and/or targeted at men from specific ethnic groups may be required in order to ensure they benefit equally from programmes. Including consideration of ethnicity is a pre-requisite of good HIV prevention planning and management.

8.3.5 Desirable biases

Extensive banks of data concerning indicators of HIV prevention needs exist from the annual National Gay Men’s Sex Survey between 1997 and 2002 (Hickson et al., 1998; Hickson et al., 1999; Weatherburn et al., 2000; Hickson et al., 2001; Reid et al., 2002). Overall, these data suggest that all programmes should over-serve:

- Men with HIV rather than men without HIV

Among men without HIV, Health promotion programmes should over-serve:

- Men in sexual relationships with men with HIV
- Men with larger numbers of sexual partners
- Younger rather than older men
- Men with lower rather than higher levels of education
- Black men (Caribbean and African) rather than other ethnic groups.
This does not mean that men without HIV, older men, single men, men who have little sex and non-Black men should be ignored. Nor even that there should not be interventions specifically targeting men from these groups. It does mean that if a programme over-serves these rather than the groups above, it would be reducing the needs of those in less need and with a lower probability of involvement in sexual exposure in the future.

Recognising priority groups in interventions means attending to the setting in which they are carried out and selecting settings on the basis of increased coverage of priority groups.

### 8.4 Prioritising between the needs of homosexually active men, community, services and policy

Few stakeholders in HIV incidence are able to equally impact on the prevention needs of homosexually active men, the needs of communities, the requirements and abilities of services and the needs of policy makers, resource allocators and researchers.

This means no one is in the position of having to prioritise between all these constituencies. Although all of these needs are sometimes placed on the shoulders of HIV designated health promotion officers, this is invariably a way of stakeholders eschewing their own responsibilities. Some ongoing action is required by each constituency (community, service, policy) both toward homosexually active men and toward the other two constituencies if HIV incidence is to be reduced. The precise areas of unmet need will vary greatly in different areas.

At a national level, policy needs are most wanting as evidenced in the absence of political leadership against the HIV epidemic, the downgrading of HIV as a public health imperative, the continuance of discriminatory legislation and the paucity of equality measures. While gay and bisexual men continue to need services and community support, they currently need social justice and equality even more.

### 8.5 Evaluating interventions & programmes of interventions

It is essential to distinguish between the effectiveness of individual interventions at influencing needs and the effectiveness of programmes of intervention in meeting strategic aims and therefore influencing the strategic goal.

#### 8.5.1 Evaluating interventions

It is against changes in needs (either those of homosexually active men, services, communities or policy makers and commissioners) that individual interventions should be judged. Evaluation of individual interventions should attend to what is done (objectives and methods), where (setting), with what (resources), to achieve what change (aims) for whom (target).

If these five dimensions of interventions are specified in advance and information on their actual performance is gathered we can ask about the quality of the interventions (see Figure 8.5.1).

Judgements of the worth of interventions are best made when they attend to as many dimensions of intervention performance as possible. Attending to one quality to the exclusion of others (for example, effectiveness) is likely to result in a partial assessment of an interventions worth. Also, changing any one dimension of the intervention (for example, the place it is done, or the men who are intended to benefit from it) will alter the qualities of the intervention.

Qualities of interventions should not be assumed unless they have been observed in practice. Learning from observation of interventions in practice can be shared among practitioners without recourse to formal evaluation. Discussion between those making interventions is central to judging intervention performance.

Formal evaluation and/or documentation of interventions will be most useful if they include data about all qualities of interventions. This is not an endorsement of one research design over another in evaluation. Data about the performance of interventions can be gathered through a number of mechanisms to suit a variety of questions. The most desirable design is that which generates the most information about the specific questions being
asked. Assessing whether interventions were needed, effective and efficient usually require substantial research designs to answer with confidence. When a range of interventions are both feasible and acceptable to achieve a particular aim with a particular population group, logic suggests programme planning should:

- **Impact on efficiency**
  Prioritise interventions that are the most efficient at reducing common needs.

### Figure 8.5.1: Qualities of an intervention

<table>
<thead>
<tr>
<th>Quality</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feasibility</strong></td>
<td>Is it possible? Can those objectives be done in that setting with those resources?</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>How many resources does it take (e.g., money, people, equipment)? How much is related to the setting (recruitment costs) and how much to the objectives (unit costs)?</td>
</tr>
<tr>
<td><strong>Acceptability</strong></td>
<td>What do the target think of the objectives, particularly in that setting?</td>
</tr>
<tr>
<td><strong>Coverage and access</strong></td>
<td>How many (or what proportion) of the target encounter the objectives in that setting and how do they differ from the people who do not encounter them?</td>
</tr>
<tr>
<td><strong>Needed</strong></td>
<td>Is the aim already true for the target before they encounter the objectives?</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td>Do the objectives bring about a change in the aim for the target? Who benefits most and who least?</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>Are all the resources necessary to bring about the change in the aim for this target? How does the intervention compare to others that bring about the same amount of change for the same people?</td>
</tr>
</tbody>
</table>

Even where there is evidence that an intervention is effective and/or efficient, if it does not address the priority needs of its target population it may make no substantial contribution to a reduction in incidence. Effective and efficient interventions are necessary but not sufficient to best direct resources: they also must be matched to common needs.

Comprehensive programmes of interventions (i.e., those which address the wide variety of stakeholders identified above) should be judged by change in the strategic aims specified in Chapters 3, 5, 6 and 7, namely:

**Homosexually active men:** gay men, bisexual men and other homosexually active men reduce the behaviours that contribute to HIV incidence (i.e., sexual exposure and HIV positive to HIV negative semen transfer) and increase those that detract from it (i.e., condom use, diagnosis and treatment of other infections, taking post-exposure prophylaxis if exposed).

**Community:** community members and businesses increase actions that contribute to a reduction in homosexually active men's HIV prevention needs and desist from those which exacerbate them, and increase those actions which address the needs of communities, policy makers and other services.

**Services:** education, health and social services increase their actions that reduce the homosexually active men's HIV prevention needs and desist from those which exacerbate them, and increase those actions which address the needs of communities, policy makers and other services.

**Policy:** policy makers, resource allocators and researchers increase actions which promote human rights and social equality, and which enable services and communities to reduce the HIV prevention needs of homosexually active men, and desist from those actions which exacerbate them.

It is unlikely that in any area a single agency can or should take responsibility for all men's HIV prevention needs. Hence, none of the above strategic aims can be expected to be achieved by any one agency. Rather, change in the strategic aims will be a consequence of all related activity of all agencies in a geographic area working collaboratively with each other and the community.
This framework is a means, not an end. It will only contribute to a reduction in the incidence of HIV through sex between men if it is used as a basis for collaborative planning of HIV prevention activity.

Like most population groups, gay men and other homosexually active men are a mobile population who do not recognise NHS boundaries. Regional level initiatives will be more effective and efficient to address some needs than multiple independent PCT-level initiatives. Adoption of this framework facilitates national, regional, district and agency-level planning groups that can include commissioners, providers, researchers and lay people.

A commitment to planning within this framework would mean an agency or authority:

- is commissioning or carrying out HIV health promotion (including HIV related education, treatment or care) with gay or other homosexually active men that contributes to the achievement of our shared aims and is not carrying out activities that make their achievement less likely; and

- recognises the need for a collaborative approach to reducing HIV incidence and is committed to working in partnership with other agencies to do so; and

- can describe its activity and is willing to share intervention performance information with other agencies.

This document represents the third version of our strategic response to the HIV epidemic among gay men and other homosexually active men. While the framework is not set in stone it is intended to provide a firm foundation on which to build.

This document provides the planning framework for all interventions carried out as part of the Community HIV and AIDS Prevention Strategy (CHAPS), for many of the other health promotion activities of the agencies participating in that collaboration, and for other agencies outside that partnership. It also provides the basis for the planning and purchasing of gay men’s HIV prevention services by PCTs.

It is intended that this framework be reviewed every two to three years. The Development Group at CHAPS welcomes comments and suggestions on this framework and its use in collaborative planning. These can be sent to MIC@sigmaresearch.org.uk
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