HIV health promotion activity map for Greater London 1999–2000

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The LINK Evaluation

Evaluating the impact of London Health Authority commissioning on the incidence of HIV infection among gay men resident in Greater London

Preface

The LINK Evaluation is a collaborative planning and evaluation project concerning HIV health promotion and gay men across London. It is commissioned by a group of London Health Authorities.

This document has been written by The LINK Evaluation team. The team consists of researchers from Sigma Research (Faculty of Humanities & Social Sciences, University of Portsmouth) and The Thomas Coram Research Unit (Institute of Education, University of London). The intended audience for this document is people involved in the commissioning, planning, delivery and evaluation of HIV health promotion across Greater London.

Our thanks to all those agencies who provided the data represented in the following report, especially those who sat with us for hours describing their health promotion activity. Thanks also to those individuals who read earlier, wordier and more tortuous drafts of this report. Earlier drafts benefited from the attention of: Professor Peter Aggleton (Thomas Coram Research Unit); Will Huxter (Camden & Islington Health Authority) and Caron Bowen (Merton, Sutton & Wandsworth Health Authority).

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1 Introduction

At present, London Health Authorities spend substantial sums of money on activities which seek to contribute to fewer HIV infections during sex between men in London. In order to be confident that this expenditure is maximally contributing to a lower incidence of HIV infection among the resident population, Health Authorities need to know: (1) which needs of homosexually active men are related to the incidence of HIV infection and are the responsibility of the Health Authority to address; (2) how common are those needs in the resident population and how they are distributed; and (3) the (cost) effectiveness of interventions at meeting individual needs and of programmes of intervention at meeting population need.

1.1 PURPOSE AND SCOPE OF THE LINK EVALUATION

The LINK Evaluation is a multi-component programme evaluation which combines audit, needs assessment as well as intervention and programme evaluation. This process provides information to support an on-going strategic review of gay men's HIV health promotion provision and commissioning within London.

The LINK Evaluation is expressly linked to the collaborative planning framework *Making It Count* (CHAPS SDG, 1998). This planning framework has been adopted by four providers of HIV health promotion for gay men in London, [Terrence Higgins Trust (THT); Gay Men Fighting AIDS (GMFA); Big Up; and NAZ Project, London] and the HIV health promotion aims expressed therein have been endorsed by a further four [RS Health Ltd.; Project for Advice, Counselling and Education (PACE); Health First; and Camden & Islington Health Promotion Services]. One other agency [The Healthy Gay Living Centre (HGLC)] has adopted the framework with some modifications given the local context. We accept that the aims expressed in these strategies are related to the incidence of HIV infection. Also, that it is the responsibility of Health Authorities to strategically plan to address them (UK Health Departments, 1995; Department of Health, 1999a). Hence, by explicitly building on the existing consensus, this evaluation predominantly seeks to address questions (2) and (3) above, whilst also considering evidence as to the validity of these aims.

The LINK Evaluation seeks to generate evidence about the relationships between health authority commissioning and HIV health promotion needs among gay men, through:

- Mapping the activities made possible by Health Authority HIV prevention expenditure. This is being done by collecting information from a wide range of statutory and voluntary service providers, identifying what range of HIV health promotion services and interventions for gay men are being implemented in London.
- Mapping the needs of different groups of gay men. This is being done by collating information from other studies, as well as collecting information by repeated questionnaires and interviews from a consultative panel of 1,500 gay men.
- Studying gay men's experiences of interventions and their effectiveness at meeting need. This is being done in a number of focussed, individual studies of groups of HIV health promotion activities and groups of men.

Overlapping goals in HIV health promotion

There are two overall goals of HIV health promotion: to reduce the incidence of HIV infection; and to maintain or improve the health and well being of people with diagnosed HIV infection. Interventions may contribute to one, both or neither of these goals. Preventing primary infection is often unhelpfully conflated with care and support of people with diagnosed HIV infection. The overall goal of collaborative planning using *Making It Count* is to reduce HIV incidence by addressing the needs of both uninfected and infected men. Similarly, the LINK Evaluation is attempting to map need related to sexual HIV exposure and subsequent transmission. It is not the purpose of LINK to assess the impact of activity that does *not* aim to contribute to a reduction in HIV incidence.

Many of the HIV health promoters concerned with reducing incidence also carry out activities intended to address the *additional* health needs of men diagnosed with HIV infection. Currently, there exists no comparable consensus among providers of the aims of activities intended to address these needs. Such a consensus will be needed if the *additional* need related to the health of gay men with HIV infection is to be addressed by collaborative planning and evaluation.

1.2 PURPOSE AND SCOPE OF THIS DOCUMENT

After some preliminary work conducted in December 1998 and January 1999 The LINK Evaluation began on 1st February 1999. This document presents findings from the first phase of activity which aimed to produce an HIV Health Promotion Activity Map for Greater London. Consultation with agencies has been undertaken to produce a map of the provision of HIV health promotion across London in 1999–2000. This map provides an initial description of activities intended to contribute to a reduction in HIV incidence among gay men. In addition, we have sought to gather information on the human and financial resources invested in HIV health promotion for the purpose of examining the cost (effectiveness) of interventions. This map has been produced to inform the planning of interventions and their evaluation. It will be updated annually.

We do not comment here on either the efficacy of the planned interventions or the quality of their delivery. Nor do we comment on the ways in which the programme might be improved, although this forms a later part of LINK. This initial map is a descriptive exercise seeking to make transparent the activities of those engaged in service delivery. Later LINK documents will consider current unmet HIV health promotion need among gay men; what impact these interventions have on those needs; and what the collective impact of the 'programme' might be. Hence, we hope to provide some answers to the question of which combination of services might best meet these needs.

2 Collaborative planning for collective gain

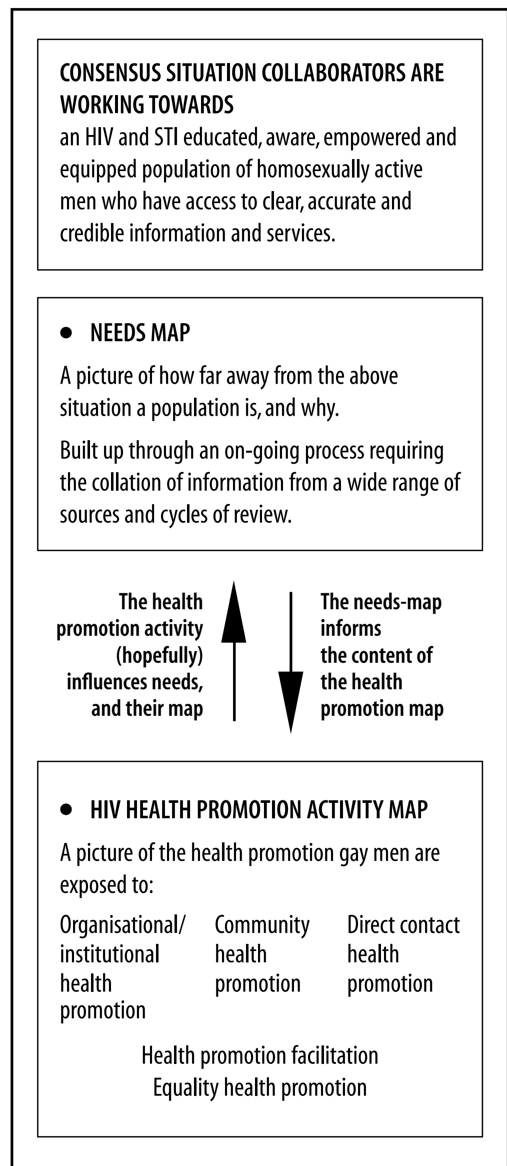
Saving Lives: Our Healthier Nation (Department of Health, 1999c) emphasised the importance of moving from competition to co-operation among those involved in service planning and delivery in the NHS. It is suggested that, given the complex influences on people's health, no single agency can hope to meet all the health-related needs of any population.

Making It Count is a framework for the collaborative planning of HIV health promotion. The general overview is shown opposite. The model recognises that men will encounter, and probably be influenced by, a number of different interventions, from a number of different agencies.

The collective task of those whose aim is to meet the needs of the population is to configure HIV health promotion activities so that they have the maximal impact on reducing need and hence HIV incidence. In other words, it is an attempt to identify the best combination of interventions to address needs.

Just as a service provider would vary the activity they undertook with a single man dependent on his unmet needs, so commissioners can make changes at the programmatic level to match changes in the unmet needs of the population.

An appropriate combination of services at one point in time, may not be appropriate at another. Changes in a programme may be required because of men's changing needs, but the needs of whole populations change far less quickly than individuals, and their HIV health promotion needs probably do not change radically from year to year.



The two 'maps' and their interaction

3 Health promotion activity mapping

A programme can be audited by examining the different activities which make it up. These activities might be such things as interventions, policies and procedures, as well as training and staff development (Simnet, 1995). 'Mapping' these activities is one feature of an audit.

HIV health promotion activity is on-going and has an impact, irrespective of whether we can describe this impact. An HIV Health Promotion Activity Map is a way of looking at the activity of organisations and groups of organisations. It is a tool for collaborative planning, that is, it can be used to facilitate the co-ordination of activity so it can have the maximum impact with the greatest degree of equity. Whilst Health Authorities have considerable influence over the content of maps (through financing), they usually only finance what providers are offering to do. Comprehensive HIV Health Promotion Activity Maps should include all interventions occurring in a geographic area, not only those financed by Health Authorities. However, as Health Authorities have a *statutory responsibility* (UK Health Departments, 1995; Department of Health, 1999a) to assess the HIV health promotion needs of their resident population and to use an allocated and finite amount of expenditure on commissioning services to meet as much need in the most equitable manner, it makes sense to start with Health Authority funded activity.

3.1 DESCRIBING INTERVENTIONS

A health promotion map, is simply a description of health promotion activity. For our description we take the basic unit of health promotion activity to be an intervention. Interventions are the units of activity which, together, make up a programme.

Intervention descriptions are tools, which can be used to facilitate both the replication and evaluation of interventions. The amount of information and detail included in an intervention description should be related to how much activity is being described and the reason for describing it. For example, the units will have to be relatively large, and the level of detail low in order to usefully describe a large amount of activity in a simple and clear way. On the other hand, an intervention description and evaluation report will need to contain far more detail. A large intervention will probably be able to be broken down into a number of constituent parts, each of which can be described separately.

3.2 TYPES OF INTERVENTION

Although HIV infection is viral and the virus infects individual men, not all health promotion activity is intended to directly influence individuals and the probability they are involved in HIV exposure. For example, some activities aim to enhance the social networks of gay men and the contributions they make to each others' needs being met.

For the purposes of this map, health promotion interventions are divided into six 'types' depending on how they relate to the overall health promotion aim. This can be thought of as the way *in which* the activity is intended to contribute to a reduction in incidence. It is possible for a single intervention to relate to the aim in a number of ways, and so the boundaries

between these types may not be sharp. The aims, targets, methods, settings and resources of different types of intervention vary but they should all be describable. The six 'types' are:

- **Direct contact health promotion**
  Activities which enable direct contact with men. Also known as a form of health education.
- **Community health promotion**
  Activities which engage with and develop community infrastructures.
  Also known as community based work.
- **Social diffusion**
  Activities which increase men's abilities to carry out health education with other men.
  One form of this is known as peer-led education.
- **Organisational/institutional health promotion**
  Activities which influence the policy and practice of organisations and institutions.
  Also known as organisational development.
- **Facilitation of health promotion**
  Activities which assist others plan and implement health promotion.
  Also known as developing health promotion competencies.
- **Equality work**
  Activities which reduce discrimination by influencing and using local and national policies.
  Also known as developing healthy public policy.

3.3 COMPONENTS OF INTERVENTIONS

Although there are numerous ways in which HIV health promotion interventions could be described, a single descriptive format termed ASTOR (Hickson, 1999) has been used in constructing this map. This method is already used by agencies (such as GMFA, THT, Big Up, The NAZ Project, London) whose activity is augmented by Community HIV and AIDS Prevention Strategy (CHAPS) funding and others who have subscribed to the *Making It Count* framework (such as HGLC). It allows interventions of all types to be conveniently described using the five headings in the panel over the page.

Providing information on each of these areas of an intervention is the basis of an intervention description.

	INTERVENTION DESCRIPTION
Aim and intended outcomes	What is intended to be changed? An aim provides general information about the purpose of the work (Applegarth, 1991). Comparing an intervention to a journey, it provides information about the general direction of travel. It may, for example, indicate a desire to increase something (such as awareness about testing options), a decrease in something (such as isolation), or a maintenance of something (such as access to condoms). Related to an aim can be a statement about intended outcomes. This provides a sense of how far the aim is to be achieved (for example, to what degree awareness is to be raised).
Setting (context)	Where does it take place? How do men come into contact with it? Information about a setting identifies how the target group will come into contact with the intervention, and if different, where the activity takes place.
Target group	Among whom is the proposed change intended to occur? Who is prioritised for the intervention? Who do you *not* want to encounter the intervention? This will usually be information about the people whom the intervention chiefly seeks to influence.
Objectives and methods	What does the intervention consists of? What do you actually do? Objectives provide information about specific events which take place during the life of an intervention (Applegarth, 1991). Using our comparison to a journey, objectives might include get a car, find a driver, drive, stop at services, drive again, etc. Implicit within objectives are the tools or method to be used.
Resources	What human and financial resources are needed? How much time is needed? Information about resources should identify what needs to be put into a project so that intended outcomes are achieved. This might, for example, cover such things as staff costs, volunteer time, numbers of resources needed, as well as travel and subsistence costs. The Department of Health in its recently published NHS Costing Manual, explains clearly that both a *comprehensive* and a *consistent approach* to costing services should be adopted. 'Costs', it is stated 'should be matched to the services that generate them and reflect the full and true cost of the service delivered' (Department of Health, 1999b).

3.4 EVALUATING INTERVENTIONS

Of course, we only want to replicate interventions which work (ie. the intervention does what you want it to, *and* you want what it does). Intervention evaluation questions are concerned with the 'performance' of an intervention. In order to examine the effectiveness of an intervention we first have to agree its parameters.

Describing interventions allows us to group those that share certain characteristics (eg. by aim, method, setting) and ask questions about them that it may be impossible to answer from a single instance of an intervention. These include questions of efficiency ('Which intervention will achieve this aim for the largest number of men with fewest resources?') and more detailed questions about performance (e.g. 'Is the setting of a face-to-face intervention important with respect to what it can achieve?').

	EXAMPLES OF EVALUATIVE QUESTIONS
Aim & intended outcomes	What changed? Who got what out of it? Was it effective (did it do what was intended)? Were there any other (unintended) outcomes?
Setting	How does the setting enhance or hamper its effectiveness? Was the intervention easy to execute in this setting? Is the location limiting access to the intervention?
Target group	Who actually encountered the intervention? What was its coverage of the target group? Was it encountered by those most in need of it?
Objectives and methods	How does it work? Who can do it? Which elements of the method are essential, and which are not? Could the successful elements be transferred to other methods?
Resources	How efficient is it (are there other interventions, which as effectively address the same need using fewer resources)?

Hence, there are at least two areas which need to be addressed when planning and developing HIV prevention services for gay men: programme management, largely the responsibility of commissioners; and project (or intervention) management, largely the responsibility of service providers (Simnet, 1995; Keogh *et al.*, 1997; Regional MSM Project (West Midlands),1998; Ewles and Simnet, 1999; Department of Health, 1999a).

4 Methods

4.1 THE PERIMETER OF THE MAP

This map seeks to include all London Health Authority funded activity intended to contribute to a reduction in the incidence of HIV infection among gay men resident in London. As with any map, the detail and contours will be built up over time. The map will be produced annually, as part of a two year cycle of mapping need and activity to explore impact.

Activity was judged to be relevant to the map if it met the following criteria:

- It was wholly or partly funded from London Health Authority HIV prevention budgets.
- It was planned to occur in London in the financial year 1999/2000.
- It focussed on HIV health promotion targeting any of the following: gay men; volunteers or professionals who work with gay men; or gay community infrastructures (such as community groups).

Figure 4.1: The Health Promotion Activity Map Perimeter

- **Activity funded by the following 16 Health Authorities, occurring in 1999/2000, and intended to contribute to a reduction in the incidence of HIV infection through sex between men resident in London**

Barking & Havering	Croydon	Ealing, Hammersmith & Hounslow
Barnet	Ealing, Hammersmith & Hounslow	Merton, Sutton & Wandsworth
Bexley & Greenwich	East London and The City	Kingston & Richmond
Brent & Harrow	Enfield & Haringey	Redbridge & Waltham Forest
Bromley	Hillingdon	
Camden & Islington	Kensington & Chelsea and Westminster	

4.2 SAMPLING FRAME

Initial reference to *Nambase®* yielded in excess of 100 organisations, agencies or departments in London that could be undertaking activity relevant to The LINK Evaluation. Organisations were perceived to fall into three major categories: agencies thought to have subscribed to *Making It Count* at the time of data collection; other HIV prevention providers (including Local Authorities and health promotion units); and GUM and other HIV testing services. Separate methods of data collection were developed for each group.

Agencies subscribing to the aims of Making It Count

These agencies were interviewed face-to-face by one or more members of The LINK Evaluation team. The agency activity as a whole and each intervention delivered by them were separately described using two questionnaires grounded in the framework informed by *Making It Count* and previously adopted by them to describe their interventions. A *Filemaker Pro* database was designed and built around the questionnaire to store the data collected. Where possible, existing intervention descriptions for these agencies were entered into the database and its output used to guide the interview. The questionnaire was used where no data already existed. Subsequent to the interview, and where time permitted, agencies were sent the database output with a view to making final amendments to it.

Other potential HIV prevention providers

These agencies were sent a self-complete questionnaire, non-response being followed by a further mailing and then telephone contact. This questionnaire closely resembled that drawn up for the agencies interviewed. Additional explanation was incorporated into the questionnaire as familiarity with the *Making It Count* framework could not be assumed. One single questionnaire was completed for all relevant activity delivered by the agency.

GUM and HIV testing services

These services were also sent a self-complete questionnaire informed by previous work that reviewed GUM services in London (Weatherburn *et al*., 1997). Initial postal contact was followed up with a second mailing to non-responders and a further telephone call. The data was stored as returned, on paper.

Response rate

In total,118 agencies were approached to participate in The LINK Evaluation. Subsequently we discovered four of these no longer existed. 100 responses were received, an overall response rate of 88%. Of those 100 responses, 61 were judged relevant against the criteria described at the start of this section. Responses were excluded from the analysis if: the agency did not consider the aim of its work to be reducing the incidence of HIV through sex between men; because the activity received no HA HIV prevention funding; or because the work of the agency was wholly national in remit.

Figure 4.2: Agencies reporting no relevant activity or not responding

Voluntary organisations

Response: no relevant activity
Gay and Lesbian Association of Doctors and Dentists (GLADD)
Gay and Lesbian Legal Advice (GLAD)
Irish Gay Helpline
Lesbian and Gay Bereavement Project
Lesbian and Gay Employment Rights (LAGER)
London Friend
Project LSD
Quest
Rank Outsiders
Regard
The Albert Kennedy Trust
The Lesbian and Gay Christian Movement

No response
Axiom Magazine
Bisexual Helpline
Black Lesbian and Gay Centre
City and Hackney Community Services NHS Trust
Cypriot HIV/AIDS Network for Turkish and Greek Speaking Communities (CHAN)
Jewish Lesbian and Gay Helpline
Middlesexy
Newham Independent Counselling Service
SM Gays

No longer in existence
HIV Response Projects
Rough Sex Safer Sex Seminars
South Asian Lesbian, Gay, Bisexual & Transexual Network

Health promotion departments of units

Response: no relevant activity
Bexley and Greenwich HA
Ealing Hammersmith and Hounslow HA
Kensington & Chelsea and Westminster HA
Redbridge and Waltham Forest HA
Health Education Authority
National HIV Prevention Information Service (NHPIS)

No response
Barnet AIDS Education Unit
Brent and Harrow HA

Clinical services

Response: no relevant activity
FACTS Centre
Healthy Options Team
Harrow and Hillingdon Psychological Service
St George's Hospital Paediatric Service

No response
Havering Hospital
Redbridge Hospital
Whipps Cross Hospital

No longer in existence
Barnet HIV Counsellors

Local Authorities

Response: no relevant activity
Bexley
Camden
City of London
Haringey (3)
Harrow
Islington
Kensington & Chelsea
Lambeth
Newham (2)
Southwark
Wandsworth
Westminster

No response
Bromley

4.3 THE PROCESS OF COLLECTING INTERVENTION DESCRIPTIONS

It was understood that the collection of intervention descriptions would not be simple because of the transparency it introduces in a competitive commissioning process and because nothing of this kind had been attempted before. A seminar held on 24th March 1999 aimed to engage the commissioners and providers of HIV health promotion in the LINK process. An overview of The LINK Evaluation, the specific activities within it and the use to which the findings of the evaluation could be put was presented. An hour of the two hour session was given over to questions from the floor.

The provider interviews all took in excess of two hours. The start of each interview was given over to further discussion of LINK and responding to the concerns of individual agencies. The remaining time was used to describe the agencies' interventions. Agencies were differently prepared: some had full intervention descriptions ready on paper and found the interview a little dry, but useful in ensuring that the descriptions were collected; others had little description on paper and staff members were guided through the descriptive process during the interview. Whilst the intentions of some agencies seemed clear, for some, there was a sense that a different day and staff member might result in different intervention descriptions.

Most providers who received a postal questionnaire had at least one additional copy of it posted to them, and many a further fax and one or two telephone calls. The deadline for receipt of information was extended twice during the collection process and completed questionnaires were still being received at the time of writing this report.

4.4 THE AGENCIES ACTIVITY OCCURS IN

Figure 4.3 shows in greater detail how the activity commissioned by 16 Health Authorities breaks down by the agency in which it occurs.

Figure 4.3: Agencies relevant activity is occurring in

■ Activity of 10 voluntary organisations

Big Up
GMFA
HGLC
Metro Centre
The NAZ Project, London
PACE
RS Health Ltd
THT
Streetwise Youth
London L&G Switchboard

■ Activity of 8 health promotion departments or units

Barking, Havering & Brentwood HP
Bromley HP Department
Camden & Islington HPS
Croydon HP Department
ELCHA Health Promotion Directorate
Enfield & Haringey HP
Health First
MSW HPS

■ Activity of 32 Clinical Services

Sexual Health Clinics
Archway Clinic
Beckenham Hospital
Central Middlesex
Charing Cross Hospital
Clare Simpson House
Ealing Hospital
Greenwich District Hospital
Guy's Hospital
Hillingdon Hospital
Homerton Hospital
John Hunter Clinic
King's College Hospital
Mayday University Hospital
Mortimer Market
Newham General Hospital
Northwick Park
Roehampton Clinic
Royal Free (2)
Royal London Hospital
St Ann's
St Bartholomew's Hospital (2)
St George's Hospital
St Helier's Hospital
St Mary's Hospital
St Thomas' Hospital
Town Clinic
Victoria Clinic
West Middlesex Hospital
Wolverton Centre

HIV Testing Services
Barts Same Day Testing
Broadgreen HIV Testing
Harrow HIV Counselling

■ Activity of 6 Local Authorities

Hackney
Hammersmith & Fulham
Hillingdon / The Hive
Hounslow (3)
Richmond-u-Thames
Waltham Forest

5 Findings

5.1 THE ACTIVITY OF 32 GUM AND HIV TESTING SERVICES

A clinic visit usually involves any or all of the following services: the diagnosis and treatment of presenting symptoms, STI screening, HIV testing, Hepatitis A and B vaccination, face-to-face health advice, and access to the gay and 'positive' press, extra strong condoms and lubricant and information leaflets and other small media. Most of these services are offered to *all* clients, in most clinics. Face-to-face health advice (11 clinics) then Hepatitis A and B vaccinations (5, 6) are those services most frequently offered *only* to some clients. Five clinics do not offer Hepatitis A vaccinations, one clinic does not provide lubricant but advised on its use.

A small number of clinics undertake direct contact interventions such as running groups for gay men or outreach to gay men or sex workers. In the main, those clinics describing facilitation, organisational or institutional and community health promotion (whose entries can seen in Figure 5.5) described structural roles such as working or liaising with local health promotion departments or (gay) voluntary agencies.

Five clinics reported services specifically targeting gay men. An additional 16 clinics reported actively promoting their service to gay men by advertising in the gay press (10), in other gay resources (6), in gay venues (4), by liaising with (gay) voluntary agencies (3) or at gay events (2).

5.2 THE ACTIVITY OF 24 AGENCIES

This section attempts to give a broad overview of the HIV health promotion activity of the 24 agencies, other than GUM and HIV testing services, whose activity was judged relevant to The LINK Evaluation. Care should be taken when interpreting this information since the investment in, or extent of activity of some agencies' work, might be less than a single intervention of another. The frequency counts that follow are therefore best considered as an indicator of the collective priorities attached to aims (and settings, methods or target groups) by the agencies participating.

5.2.1 Methods used

Figure 5.1 identifies how many agencies (n=24) use particular methods.

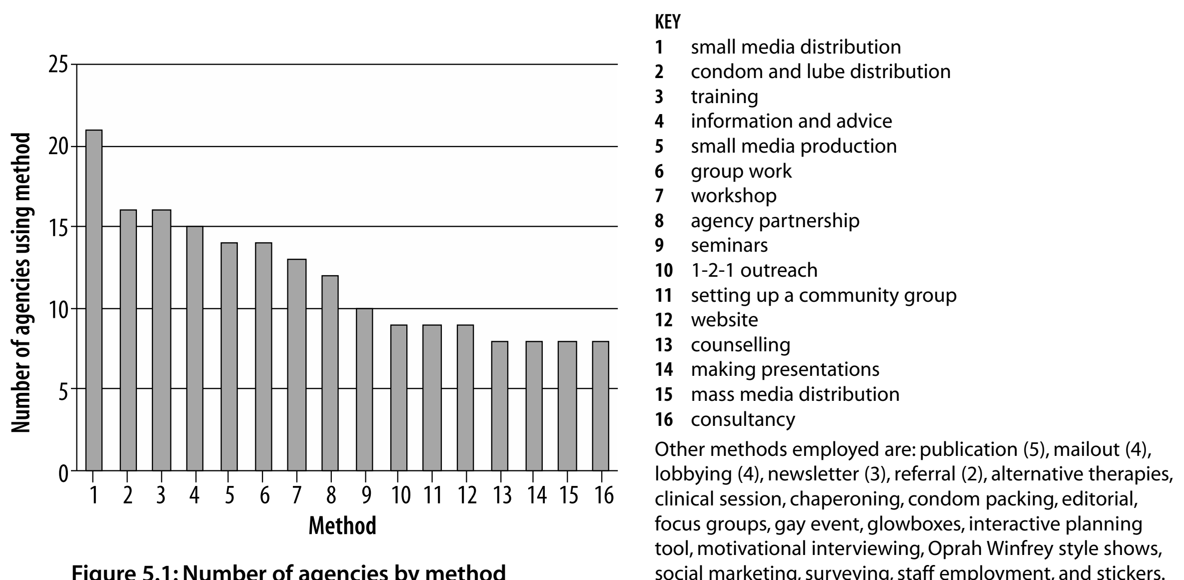


Figure 5.1: Number of agencies by method

The distribution of small media (post cards, informational leaflets etc.) is used by more agencies than any other method.

5.2.2 Settings used

Figure 5.2 identifies how many agencies (n=24) use particular settings.

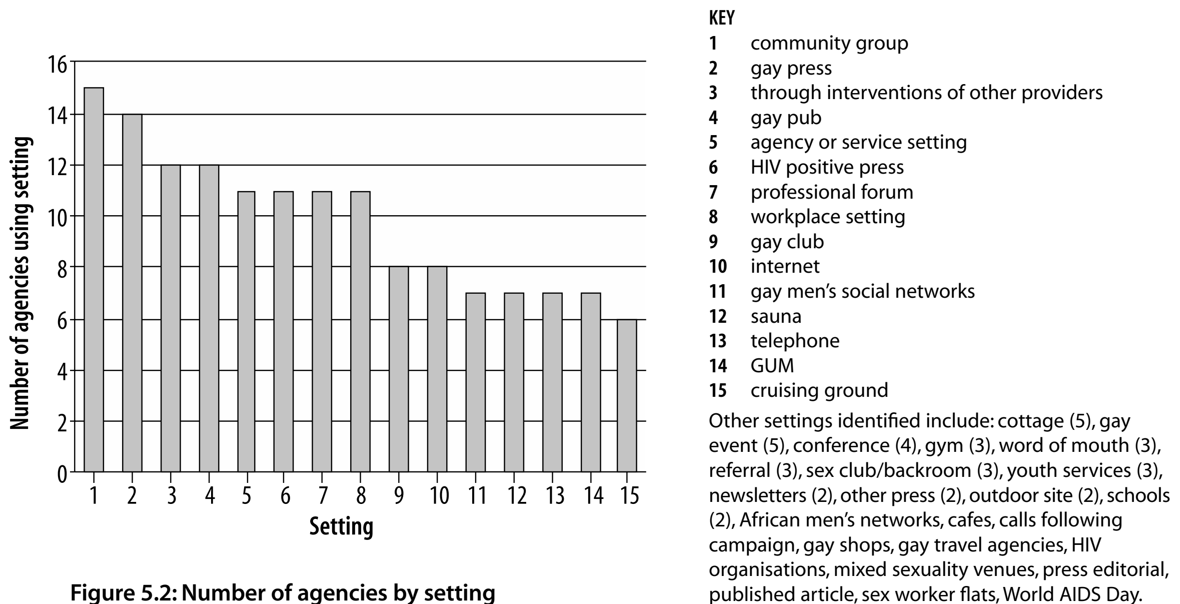


Figure 5.2: Number of agencies by setting

Community groups, the gay press and gay pubs are the most common settings for interventions. Two types of activity account for this priority. One is the use of the setting itself to do the work; taking the intervention to gay men, or what might be considered a 'push' intervention. The second is the use of the setting to recruit gay men to an intervention that may occur in the same setting or somewhere else, what might be considered a 'pull' intervention. The interventions of other providers are also prioritised, predominantly as a mechanism to disseminate resources to settings or areas not already targeted by an agency, or where the agency has little direct contact and substantial resource development activity.

Push and pull settings and interventions

It became clear during the mapping process that to be able to both replicate and evaluate an intervention, an understanding of the way in which its setting is used, and how gay men are intended to experience the intervention, is necessary. Take for example the use of the gay press, or outreach to a gay bar. In each of these settings it is possible to do work that contributes to reducing the need of the men who experience the work that occurs. An educational advertisement, aiming to increase men's knowledge about a particular aspect of HIV, might be placed in the gay press. An outreach session, aiming to make men aware of the implications of their behaviour, might resemble an informal counselling session. Alternatively, the intervention in each of these settings might be a pre-cursor to other planned work, the aim being to recruit gay men to another intervention. Whilst the setting remains the same the intention is wholly different, as would be the questions that need to be asked of an intervention for it to be replicated or evaluated. An intervention's effectiveness is dependent both upon access and its utility to gay men thereafter.

For this reason, a distinction has been made in the nature of both settings and interventions. Settings are push in nature if gay men can be directly contacted in them (a gay bar or sauna, or the gay press for example) and are pull in nature if they are one step removed and gay men

must take some form of action to be accessible via them (a service centre or GUM clinic, or mailing list for example). Interventions are push in nature if the aim of the intervention can be met during the initial contact (an educational advertisement in the gay press or an open access condom packing session in a gay bar) and pull in nature if subsequent contact must follow for the aim to be met (a service advertisement for a workshop to be held in an agency's building or outreach to recruit men to become volunteers). Push interventions occur in push settings. Pull interventions occur in both push and pull settings: contact being established in the push setting, the work taking place in the pull setting.

The element of a pull intervention that takes place in a push setting might equally be called service marketing or advertising, but in this document it has not been described as such.

5.2.3 Target groups

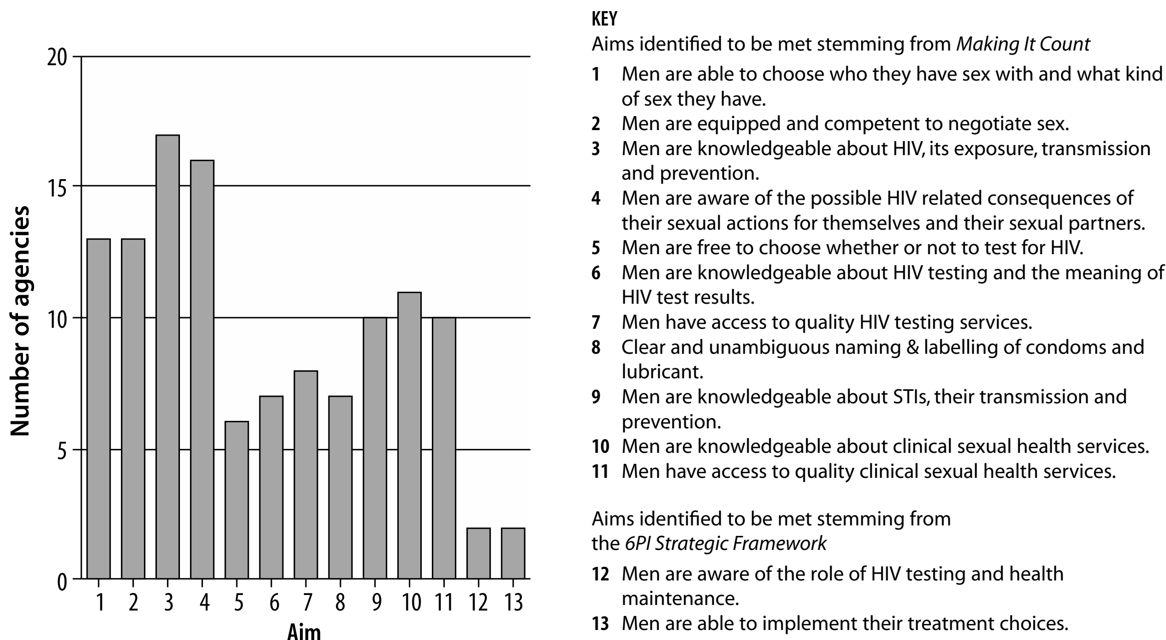
Figure 5.3 identifies how many of the agencies (n=24) target gay men, volunteers, professionals, the general population and sub-groups within these. All agencies identified more than one target group for their activities. For this reason, the following table has been organised by creating broad categories of target groups, divisions being made within these when they were described by agencies. The number of agencies targeting each group was then recorded. This description does not tell us which groups have the most activity targeted towards them, rather, it identifies the priority groups identified by agencies.

Figure 5.3: Target group by number of agencies

BROAD TARGET GROUP	BASIS ON WHICH TARGETED	NO. OF AGENCIES	SUB-CATEGORIES IDENTIFIED
gay men	sexuality	24	gay men
	by age	12	younger, older
	by HIV testing history	10	HIV positive men, untested men, HIV negative men
	by ethnicity	7	Black, S.Asian, M.Eastern, N.African, Latin American, S.E.Asian, Turkish, Arabic, Irish
	by setting use	5	PSE users, internet users, PSV users, gym users, GUM users, on holiday
	by relationship status	4	in relationships, in sero-discordant relationships, in relationship and giving up condoms, have been are or are seeking a relationship
	by recreational drug use	2	steroid users
	by education	1	GCSEs or less
	as sex workers	1	
	number of partners	1	men with 10 or more partners
	other	1 each of	married, coming out
volunteers	as service providers	4	
	as service users	3	
professionals	clinical staff (GUM, GP)	15	
	HIV prevention workers	14	
	who work with youth	11	
	service managers/funders	9	
	health advisors	4	
	HIV care workers	2	
	working on gay scene	1	
	other	1 each of	advice workers, counsellors, drugs workers, health promotion planners, nurses, voluntary organisations, professionals, social services.
general population	generic	4	

5.2.4 Aims of the agencies' activities

Figure 5.4 identifies how many agencies (n=24) intend to meet each of a range of aims. The figure does not reflect the investment in, nor the amount of activity undertaken, to achieve each of the aims. The lack of consistency in intervention description makes any direct comparison of this kind difficult. However, it does demonstrate a broad sense of the priority attached to achieving each of these aims within the sector and a broad acceptance of the common purpose *Making It Count* reflects.



A further 22 aims were identified. Each of these is described in the paragraph below. The number in brackets is the number of agencies describing that aim.

Figure 5.4: Number of agencies by intended aim

Other aims articulated by agencies include: schools and youth and other services are aware of lesbian, gay and bisexual needs (3 agencies), building community infrastructures (2), improving sexuality awareness (2), organisational PR (2), providing culturally appropriate social support and service access, maintaining a community safer sex culture, ensuring that other services have cultural awareness, providing coming out support, providing information and advice, providing individuals and couples with support, promoting a helpline, increasing local access to condoms and lube, co-ordinating local with Pan-London and national work, promoting service access, improving self-esteem, improving sexual health, providing role models for young gay men in the media, increasing men's awareness of support services, ensuring that men are knowledgeable about HIV treatments and their impact on HIV transmission, changing the way gay men think and feel about condoms, ensuring that gay bar staff are equipped to disseminate 6PI (the 6 Provider Initiative, a collective arrangement between Camden and Islington HPS, GMFA, Health First, PACE, RS Health Ltd. and THT to deliver an integrated programme of HIV prevention work) resources and make referrals and recruiting volunteers.

5.2.5 Resources used

All agencies (except GUM and HIV testing services) were asked to identify the overall income received to do HIV prevention with gay men. Those interviewed were also asked to identify the budget allocated to each intervention and the budget breakdown against staff costs, direct costs (e.g. printing, volunteer expenses etc.) and overheads (e.g. building maintenance etc.). This information is necessary to begin to explore cost effectiveness. When programme planning to meet a specific aim, it is both the potential of an intervention to impact on gay men and its cost relative to other interventions that can meet the same aim that will inform cost effectiveness.

The response to requests for budget information were limited. Some agencies withheld information and others were incapable of providing what was requested. Information was withheld for a variety of reasons, most agencies highlighting that they exist in a competitive market place in which they bid for contracts and a perceived fear that they would leave themselves vulnerable to being undercut by others. Some agencies were incapable of providing resource information either because their cost structures were incompatible with that used in the questionnaire, or because they did not know the resources necessary for the interventions they were planning.

Clearly, this is a major obstacle to The LINK Evaluation generating evidence about the efficiency of interventions. Providers are reluctant to make this information public, and where it is public, the data is not comparable. Whilst every effort is being made to facilitate the provision of this information in the future, no further description of resource division is possible here.

5.3 HOW THE ACTIVITY OF THE 56 AGENCIES CONTRIBUTES TO A REDUCTION IN INCIDENCE OF HIV

The activity of the 56 agencies (32 GUM and HIV testing services and 24 others) can be sub-divided according to how it is intended to contribute to a reduction in incidence of HIV. When an agency appears in a box in Figure 5.5, that agency indicated it carried out activity of that type. Note that the entries are not comparable with respect to the investment in them nor the quantity of activity undertaken, they simply indicate the number of agencies in each sector carrying out that type of health promotion.

5.4 THE ACTIVITY OF 9 AGENCIES WORKING TO *MAKING IT COUNT*

Ten agencies were thought to be working to the aims of *Making It Count* and were interviewed. Of those, 9 were doing so and are included in the following description. The agencies included are Big Up, Camden & Islington HPS, GMFA, Health First, HGLC, PACE, RS Health Ltd., THT and The Naz Project, London.

The agencies described 143 relevant interventions of which 49 draw on the services of volunteers. 25 are delivered once only, 33 for a specific time only and 85 are on-going throughout the year. 53 of the interventions have their access restricted to the target group only, the rest giving priority access to the target group (26 interventions) or being open access (64). Of the 143 interventions, 108 of them are solely health authority funded.

Figure 5.5: Agency activity categorised by how the activity contributes to a reduction in incidence (ie. target group and aim) n=56

	EQUALITY	FACILITATION AND ORGANISATIONAL/INSTITUTIONAL	SOCIAL DIFFUSION AND COMMUNITY INFRASTRUCTURE	DIRECT CONTACT
Activity of 10 voluntary organisations	■ Streetwise	■ Metro Centre ■ Switchboard ■ Streetwise	■ Metro Centre ■ Streetwise ■ Switchboard	■ Metro Centre ■ Streetwise ■ Switchboard
	■ GMFA	■ BIG UP ■ GMFA ■ HGLC ■ NAZ ■ PACE ■ RS Health ■ THT	■ BIG UP ■ GMFA ■ NAZ ■ RS Health	■ BIG UP ■ GMFA ■ HGLC ■ NAZ ■ PACE ■ RS Health ■ THT
Activity of 8 health promotion departments or units		■ Camden & Islington ■ Health First		■ Camden & Islington ■ Health First
	■ Bromley ■ ELCHA ■ Merton Sutton & Wandsworth	■ Barking, Havering & Brentwood ■ Bromley ■ Croydon ■ ELCHA ■ Merton Sutton & Wandsworth ■ Enfield & Haringey	■ Barking, Havering & Brentwood ■ Bromley ■ Croydon ■ ELCHA ■ Enfield & Haringey ■ Merton Sutton & Wandsworth	■ Barking, Havering & Brentwood ■ Bromley ■ ELCHA ■ Enfield & Haringey
Activity of 32 clinical services	■ Royal Free	■ Archway Clinic ■ Broadgreen HIV Testing ■ Clare Simpson House ■ Greenwich Dist. Hospital ■ Guy's Hospital ■ Homerton Hospital ■ King's College Hospital ■ Mortimer Market ■ Newham General Hospital ■ Roehampton Clinic ■ Royal Free ■ Royal London Hospital ■ St George's Hospital ■ St Thomas' Hospital ■ Town Clinic ■ West Middlesex Hospital ■ Wolverton Centre	■ Clare Simpson House ■ Greenwich Dist. Hospital ■ Hillingdon Hospital ■ Mortimer Market ■ Roehampton Clinic ■ St Mary's Hospital ■ Town Clinic ■ Wolverton Centre	■ Archway Clinic ■ Barts Same Day Testing ■ Beckenham Hospital ■ Broadgreen HIV Testing ■ Central Middlesex ■ Charing Cross Hospital ■ Clare Simpson House ■ Ealing Hospital ■ Greenwich Dist. Hospital ■ Guy's Hospital ■ Harrow HIV Counselling ■ Hillingdon Hospital ■ Homerton Hospital ■ John Hunter Clinic ■ King's College Hospital ■ Mayday Uni. Hospital ■ Mortimer Market ■ Newham General Hospital ■ Northwick Park ■ Roehampton Clinic ■ Royal Free ■ Royal London Hospital ■ St Ann's ■ St Bartholomew's Hospital ■ St George's Hospital ■ St Helier's Hospital ■ St Mary's Hospital ■ St Thomas' Hospital ■ Town Clinic ■ Victoria Clinic ■ West Middlesex Hospital ■ Wolverton Centre
Activity of 6 Local Authorities	■ Hammersmith & Fulham ■ Hillingdon ■ Hounslow ■ Waltham Forrest	■ Hackney ■ Hammersmith & Fulham ■ Hillingdon ■ Hounslow ■ Richmond-u-Thames ■ Waltham Forrest	■ Hackney ■ Hammersmith & Fulham ■ Hillingdon ■ Hounslow ■ Richmond-u-Thames ■ Waltham Forrest	■ Hackney ■ Hammersmith & Fulham ■ Hounslow ■ Richmond-u-Thames ■ Waltham Forrest
	n=10	n=41	n=27	n=53

Shaded area shows the 9 agencies working to *Making It Count*

5.4.1 Methods used

Figure 5.6 identifies how many interventions (n=143) use a particular method.

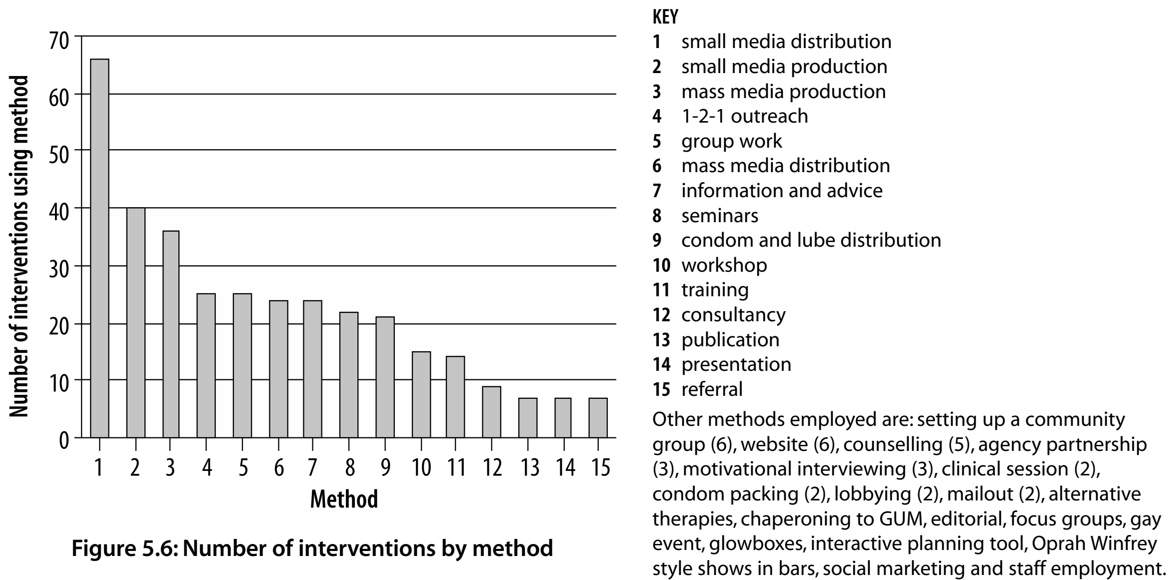


Figure 5.6: Number of interventions by method

Most interventions reported used more than one method. The production and dissemination of small media is the most common, with nearly half (46%) of all the interventions relying on this (and sometimes a combination of other methods) to bring about the intended aim. The production of mass media (posters) is more common than its distribution as some agencies produce materials intended to be distributed by other agencies.

5.4.2 Settings

Figure 5.7 identifies how many interventions (n=143) use a particular setting. The gay press is by far the most common setting to be used by these interventions, either to display educational advertisements as part of a push HIV health promotion intervention or to display service advertisements as part of a pull HIV health promotion intervention. Some interventions using the gay press do intend to facilitate an awareness amongst the press of the activities of the agency or the current thinking on HIV health promotion. Further to this, the interventions of other providers are used by many agencies to improve the access of men across London to an intervention they may otherwise not encounter.

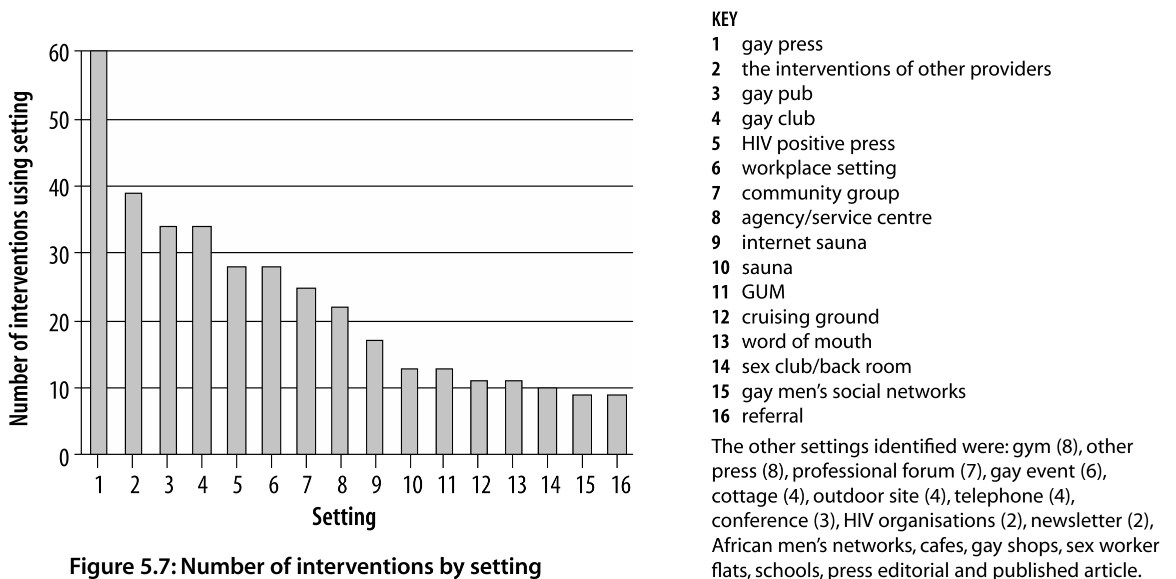


Figure 5.7: Number of interventions by setting

5.4.3 Target groups

Figure 5.8 identifies how many of the interventions (n=143) target gay men, volunteers, professionals, the general population and sub-groups within these.

Figure 5.8: Number of interventions by target group

BROAD TARGET GROUP	BASIS ON WHICH TARGETED	NO. OF INTERVENTIONS	SUB-CATEGORIES IDENTIFIED
gay men	sexuality	22	gay men
	by HIV testing history	51	HIV positive men, untested men, HIV negative men
	by ethnicity	21	Black, S.Asian, M.Eastern, N.African, Latin American, S.E.Asian, Turkish, Arabic, Irish
	by age	17	younger, older
	by setting use	16	PSE users, internet users, PSV users, gym users, GUM users, on holiday
	by relationship status	14	in relationships, in sero-discordant relationships, in relationship and giving up condoms, have been are or are seeking a relationship
	number of partners	8	men with 10 or more partners
	by education	7	men with GCSEs or less
	by recreational drug use	2	steroid users
	as sex workers	1	
	other	1	African MSM networks
volunteers	as service providers	1	
	as service users	8	
professionals	clinical staff (GUM, GP)	24	
	HIV prevention workers	20	
	service managers/funders	9	
	HIV positive care workers	9	
	who work with youth	5	
	health advisors	5	
	working on gay scene	1	
	other	1 each of	advice workers, churches, counsellors, drugs workers, health promotion planners, nurses, voluntary agencies, professionals, social services
general population	generic	8	

5.4.4 Aims

Figure 5.9 identifies how many interventions (n=143) are intended to meet each of a range of aims.

The majority of the interventions seek to bring about a situation where men have control over who and what kind of sex they have whilst being aware of the HIV related consequences of their actions (aims 1–4).

The next focus of activity is to ensure men have access to quality clinical services and is accounted for by consultancy or training interventions offered to clinical services with respect to gay men's issues. The other aims expressed by agencies for their interventions include: culturally appropriate social support and service access (7), organisation PR (4), other services having cultural awareness (2), bar staff are equipped to disseminate 6PI resources, building community infrastructure, to recruit volunteers and to change the way gay men think and feel about condoms. Three interventions had no aims described at the time of data collection.

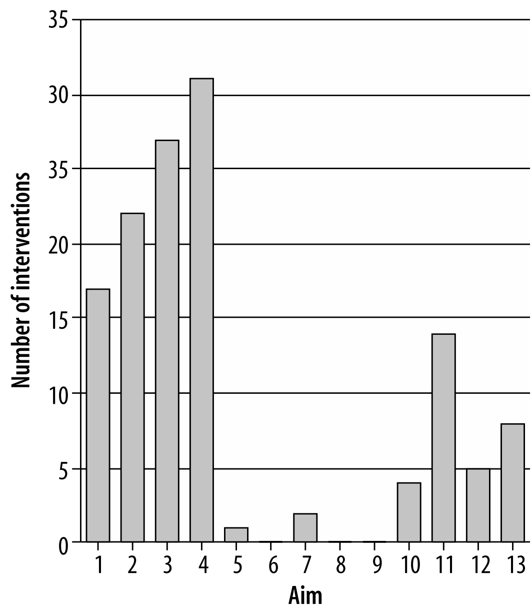


Figure 5.9: Number of agencies by intended aim

KEY

Aims identified to be met stemming from *Making It Count*

1. Men are able to choose who they have sex with and what kind of sex they have.
2. Men are equipped and competent to negotiate sex.
3. Men are knowledgeable about HIV, its exposure, transmission and prevention.
4. Men are aware of the possible HIV related consequences of their sexual actions for themselves and their sexual partners.
5. Men are free to choose whether or not to test for HIV.
6. Men are knowledgeable about HIV testing and the meaning of HIV test results.
7. Men have access to quality HIV testing services.
8. Clear and unambiguous naming & labelling of condoms and lubricant.
9. Men are knowledgeable about STIs, their transmission and prevention.
10. Men are knowledgeable about clinical sexual health services.
11. Men have access to quality clinical sexual health services.

Aims identified to be met stemming from the *6PI Strategic Framework*

12. Men are aware of the role of HIV testing and health maintenance.
13. Men are able to implement their treatment choices.

6 other aims were identified. Each of these is described in the paragraph above. The number in brackets represents the number of interventions seeking to achieve the aim described.

It was observed that the stated aim of some interventions were changed during the course of the interview. Interviewees were not asked why this was the case. The interviewers' sense was that the described aim of an intervention can serve as a marketing tool in the commissioning process. So, an intervention is planned and one of the *Making It Count* aims that has been prioritised by commissioning is chosen as its aim. It seemed that an aim of an intervention could be changed to one of greater commissioning priority without reference to the impact on the other dimensions of the intervention.

5.5 AN OVERVIEW OF THE 143 INTERVENTIONS BY HOW THEY ARE INTENDED TO CONTRIBUTE TO A REDUCTION IN INCIDENCE

The interventions were first allocated to one of the six types of HIV health promotion described earlier. Direct contact interventions were further sub-divided as either static or interactive and push or pull in nature. Static interventions seek to provide resources or tools to gay men without any additional contact or relationship. Interactive interventions seek to provide a personal relationship in context of which the activity takes place. Push interventions seek to take activity to gay men, pull interventions seeking to draw gay men to them.

The distinction between static and interactive intervention is useful as it represents a qualitatively different investment and possible return. Static interventions are best used when seeking a low impact on large numbers of men, interactive interventions best used when seeking a high impact on fewer men.

The distinction between push and pull intervention is important as it helps us describe the intervention setting. The setting of a push intervention is the place where the activity occurs. The setting of a pull intervention describes both where a gay man will come to know about an intervention (a service ad in the gay press for example) and where it occurs.

Figure 5.10: Overview of the 143 HA funded interventions of the 9 agencies

EQUALITY	FACILITATION & ORGANISATIONAL/INSTITUTIONAL	SOCIAL DIFFUSION & COMMUNITY INFRASTRUCTURE	DIRECT CONTACT
Lobbying ■ 1 intervention by 1 agency	**Research investigations** ■ 3 research investigations by 2 agencies **Resources for health promoters** ■ 2 resources by 2 agencies **Resource provision to other agencies** ■ 6 provisions by 4 agencies **Training** ■ 10 interventions by 4 agencies **Consultancy** ■ 7 interventions by 3 agencies **Seminar** ■ 13 interventions by 4 agencies **Press work** ■ 2 interventions by 1 agency	**Volunteer development** ■ 1 intervention by 1 agency **Venue training** ■ 1 intervention by 1 agency **Outreach** ■ 1 intervention by 1 agency **Group development** ■ 4 interventions by 2 agencies	RESOURCE DEVELOPMENT **To reproduce** ■ 1 audio-tape by 1 agency **To up-date & print/produce** ■ 7 leaflets by 1 agency ■ 1 workbook by 1 agency **To develop & print/produce** ■ 2 newsletters by 2 agencies ■ 17 mass media (posters) by 5 agencies ■ 19 post-cards by 5 agencies ■ 6 leaflets by 2 agencies ■ 38 service advertisements by 6 agencies ■ 6 developments of other resources by 4 agencies STATIC **Educational advertisements** ■ Display of 16 ads in the press by 6 agencies **Service advertisements** ■ Display of 39 service ads in the press by 6 agencies **Educational posters** ■ 3 poster displays in push settings by 2 agencies **Press articles** ■ Copy for press articles by 1 agency **Condom & lube distributor** ■ 3 free condom & lube pack distributions by 2 agencies **Web site postings** ■ Maintenance of 5 web sites by 5 agencies **Direct mailing** ■ Mailings to 5 lists by 4 agencies INTERACTIVE **Telephone** ■ 2 help-lines by 2 agencies **Face-to-face** ■ 22 'outreach' services by 5 agencies ■ 9 'centre' services by 5 agencies ■ 32 groups by 7 agencies **Mixed/clinic** ■ 3 events by 3 agencies ■ 3 clinics by 1 agency

5.5.1 Equality HIV health promotion

Equality interventions are those which seek to contribute to a reduction in HIV incidence by reducing discrimination which either makes health promotion activity more difficult (or impossible), or which makes the impact of discrimination on individuals or groups less common by making discrimination less common.

Only one intervention whose aim concerns social equality for gay men is funded by the HAs.

EQUALITY
Lobbying
■ Public relations (GMFA)

5.5.2 Facilitation and organisational/ institutional HIV health promotion

Both health promotion facilitation, and organisational (or institutional) health promotion seek to contribute to a reduction in HIV incidence by increasing the capacity or competencies of other health promoters or agencies to contribute to HIV health promotion. The distinction between facilitation and organisational/institutional is primarily drawn by examining the target group of the activity: facilitation of HIV health promotion targets HIV health promoters (HIV prevention workers, GUM health advisors), organisational or institutional HIV health promotion targets professionals or agencies that do not primarily intend to meet HIV health promotion aims but can do so (GPs, the gay press). A distinction between facilitation and organisational or institutional health promotion could not always be made in the interventions described, so these two categories have been collapsed.

It should be noted that neither the investment in, nor quantity of activity delivered during, each of the interventions in the table is comparable. That is, one of the seminar interventions represents a series of 15 seminars, whilst another is a single seminar. Equally, a resource production intervention may have between 1 to 15 resources as the output. Interventions are presented as they were described to the evaluation team.

These interventions are diverse in nature, many are broad based intending to increase generic competencies in working with gay men; others are intended to increase competencies with respect to certain methods of HIV health promotion; others seeking to ensure those disseminating resources are clear about the strengths and limitations of the resources they are distributing.

FACILITATION AND ORGANISATIONAL/INSTITUTIONAL
Research investigations
■ Peer support & adherence (HF)
■ Research project (Big Up)
■ Social networks: tools validation (HF)
Resources for health promoters
■ Resource catalogue (HF)
■ Newsletter (RS)
Resource provision to other agencies
■ Provider resource mailout (Naz)
■ Condom promotion: event condom supply (RS)
■ Condom promotion: event poster supply (RS)
■ Hard times to GUM (GMFA)
■ Resource provision to GUM (HF)
■ Condom stocking to providers (HF)
Training
■ Client centred sexual health strategies (C&I)
■ Miscellaneous training courses (C&I)
■ Gay men & drug use (C&I)
■ Adherence strategies (C&I)
■ Trainee posts: Black gay men (C&I)
■ Youth work training (HF)
■ An introduction to working with Gay & Bisexual men (HF)
■ Social networks: training course (HF)
■ Training (HGLC)
■ Training (Naz)
Consultancy
■ To Rainbow clinic (HF)
■ To GUM clinics (HF)
■ Voluntary sector programme (HF)
■ Local authority policy development (HF)
■ Professional advice & consultancy: general (HGLC)
■ Professional advice & consultancy: young gay men (HGLC)
■ Consultancy (Naz)
Seminar
■ HIV treatments, HIV and drug use (C&I)
■ Health promotion seminars (GMFA)
■ Sorted seminar (HF)
■ Protect seminar (HF)
■ Disclosure of status seminar (HF)
■ More 'In a positive light' seminar (HF)
■ Resource catalogue seminars (HF)
■ Resource promotion in primary care seminars (HF)
■ Professional development seminar programme (HF/C&I)
■ Clinical nurse specialist programme seminars (HF)
■ Knowing what's best for them seminar (THT)
■ Prioritising populations in need seminar(THT)
■ Assumptions about disclosure of status seminar (THT)
Press work
■ Gay press briefing (RS)
■ Gay press communications (RS)

5.5.3 Social diffusion and community HIV health promotion

Social diffusion intends to increase the competencies of members of a social network to contribute to achieving the aims of HIV health promotion (peer education for example). Community HIV health promotion seeks to support, or bring into existence, the social networks in which social diffusion may take place (setting up a youth group for example). No clear distinction could be made between social diffusion and community interventions in the interventions described to the evaluation team so these categories were collapsed.

SOCIAL DIFFUSION OR COMMUNITY
Volunteer development
■ Volunteer support (GMFA)
Venue training
■ Venue training (RS)
Outreach
■ Outreach (Big Up)
Group development
■ Gay youth group activity (NAZ)
■ Friday Group (Big Up)
■ Basement Sessions (Big Up)
■ Visions for Black Gay Men (Big Up)

Seven interventions whose aims concern social diffusion or community HIV health promotion for gay men are being funded by the H.A.s. The development of community groups is the most common method used for these types of HIV health promotion.

5.5.4 Direct contact health promotion: development and delivery

The majority of the activity of the nine agencies is direct contact health promotion or the production of resources to support direct contact health promotion. The distinction between these two is an important one when considering programme planning and evaluation. Some resources are produced and disseminated to gay men by the same agency, but others are produced for dissemination to gay men by other agencies. Differentiating between production and dissemination is important for two reasons:

- At the programme planning stage, all resources planned for development need to be identified separately from their delivery to avoid any possible duplication. An agency may not need to produce a resource if it is already in production or planned to be by another agency. Unless resource development is separately described from resource delivery, it is unclear what is actually in development.
- For evaluative purposes, it is important to know whether a resource is being produced to be disseminated directly to gay men or to agencies working with gay men. When considering impact, it may be either the utility of the resource to gay men, or gay men's access to the resource which yields the intended impact.

5.5.5 Direct contact health promotion: development

Figure 5.11 identifies the number of interventions which are solely, or have as a component, the production of materials to be used in direct contact health promotion. This activity predominantly concerns the development of new resources: the efficiency of this activity can only be judged when considering those resources that are already in existence and whether they are still fit for the purpose they were intended. The majority of this year's activity is devoted to producing new resources rather than re-printing or re-using previous materials.

Figure 5.11: Direct contact health promotion: development

	NEWSLETTER	SINGLE IMAGE/TEXT	POST-CARD	LEAFLET	SERVICE AD	OTHER
To reproduce						■ Fasten your seatbelts (GMFA)
To update & print/ produce				■ Positive about drugs (C&I) ■ In gear (C&I) ■ Fitness plus (C&I) ■ European language booklet (C&I) ■ Gay young London (C&I) ■ Sex life (C&I) ■ Getting it on (C&I)		■ Hard Times (GMFA)
To develop & print/ produce	■ Big Love (Big-Up) ■ F***Sheet (GMFA)	■ MM campaign (Big-Up) ■ Agreements in relationships (C&I) ■ Knowledge of status (C&I) ■ Realities of HIV (GMFA) ■ Clinic access: time to go (GMFA) ■ Affirmation (GMFA) ■ Treatment choices (GMFA) ■ Backrooms: take control (GMFA) ■ Bareback riders (GMFA) ■ Condom Promotion: posters (RS) ■ RSVP image (RS) ■ VIP image (RS) ■ Scene posters (RS) ■ Know the facts: sucking (THT) ■ Disclosure of status (THT) ■ Prevalence (THT) ■ Safer sex support (THT) ■ Treatment choices: starting out card (GMFA) ■ Backrooms: take control card (GMFA) ■ You won't get it from me card (GMFA) ■ Assertiveness training card (GMCA) ■ Service card (HGLC) ■ VIP image (RS) ■ Disclosure of status (THT) ■ Safer sex support (THT)	■ Agreements in relationships (C&I) ■ Knowledge of status (C&I) ■ Strategies for sex card: relationships (GMFA) ■ Strategies for sex card: bondage (GMFA) ■ Strategies for sex card: skills for gay life (GMFA) ■ Strategies for sex card: SM (GMFA) ■ Strategies for sex card: cruising skills (GMFA) ■ Strategies for sex card: sero-discordant relationships (GMFA) ■ Strategies for sex: Hard Times card (GMFA) ■ Dealing with +ve card: communication skills (GMCA) ■ Affirmation card (GMFA)	■ Survival guide (C&I) ■ Treatments adherence & drug use (C&I) ■ Sorted (HF) ■ Protect (HF) ■ Disclosure of status (HF) ■ More in a positive light (HF)	■ Negotiated safety w/s ad (C&I) ■ Clued-up at Axis ad (C&I) ■ Survival guide ad (C&I) ■ Adherence strategies seminar ad (C&I) ■ Meet the people ad (C&I) ■ Get the sex you want +ve ad (C&I) ■ Healthy life programme ad (C&I) ■ Health & fitness day ad (C&I) ■ Steroid clinic ad (C&I) ■ Getting the sex you want ad (C&I) ■ Men in relationships clinic ad (C&I) ■ Strategies for sex ad: relationships (GMFA) ■ Strategies for sex ad: bondage (GMFA) ■ Strategies for sex ad: skills for gay life (GMFA) ■ Strategies for sex ad: SM (GMFA) ■ Strategies for sex ad: cruising skills (GMFA) ■ Strategies for sex ad: sero-discordant rels (GMFA) ■ Dealing with +ve ad: communication skills (GMFA) ■ Treatment choices: planning tool ad (GMFA) ■ Treatment choices: starting out ad (GMFA) ■ Assertiveness training ad (GMFA) ■ Sorted ad (HF) ■ Protect ad (HF) ■ Disclosure of status ad (HF) ■ More in a positive light ad (HF) ■ Peer support & adherence recruitment ad (HF) ■ Service ad (HGLC) ■ Dost ad (Naz) ■ Dost youth ad (Naz) ■ Raat Ki Rani ad (Naz) ■ Naz Latina (Naz) ■ Naz Latina Amigos ad (Naz) ■ Naz Helpline ad (Naz) ■ Positive Groups ad (Naz) ■ Identity and Self-Esteem ■ Workshops ad (PACE) ■ Assertion, communication & relationships skills ad (PACE) ■ Communication about sex workshop ad (PACE) ■ HIV status specific workshops ad (PACE)	■ Treatment planning tool (GMFA) ■ Interactive cruising simulation (GMFA) ■ Sexual safety & on-line cruising (HF) ■ Maintenance for negative men cruise ads (GMFA) ■ Resource development (Naz) ■ Condom promotion: wraps (RS)

5.5.6 Direct contact health promotion: delivery

The following four figures (5.12 to 5.15) identify what direct contact interventions are planned to occur in the coming year by the nine agencies, and in what setting and by what method they will be operationalised. The interventions have been categorised as static or interactive and push or pull as described earlier. An intervention described by an agency may appear more than once, because it is undertaken in multiple settings or uses multiple methods.

Figure 5.12: Static direct contact push intervention

PUSH SETTINGS	static		
	single image display	leaflet distributor	condom & lube distributor
Press	**Educational advertisements** ■ Mass media adverts (Big-Up) ■ Mass media adverts (Naz) ■ Agreements in relationships (C&I) ■ Knowledge of status (C&I) ■ Realities of HIV (GMFA) ■ Clinic access: time to go (GMFA) ■ Affirmation (GMFA) ■ Treatment choices (GMFA) ■ Backrooms: take control (GMFA) ■ Bareback riders (GMFA) ■ RSVP (RS) ■ VIP image (RS) ■ Know the facts: sucking (THT) ■ Disclosure of status (THT) ■ Prevalence (THT) ■ Safer sex support (THT) **Service advertisements** ■ Negotiated safety w/s ad (C&I) ■ Clued-up at Axis ad (C&I) ■ Get the sex you want +ve ad (C&I) ■ Healthy life programme ad (C&I) ■ Survival guide ad (C&I) ■ Adherence strategies seminar ad (C&I) ■ Meet the people ad (C&I) ■ Health & fitness day ad (C&I) ■ Steroid clinic ad (C&I) ■ Getting the sex you want ad (C&I) ■ Men in relationships clinic ad (C&I) ■ Strategies for sex ad: relationships (GMFA) ■ Strategies for sex ad: bondage (GMFA) ■ Strategies for sex ad: skills for gay life (GMFA) ■ Strategies for sex ad: SM (GMFA) ■ Strategies for sex: cruising skills (GMFA) ■ Strategies for sex ad: sero-discordant relationships (GMFA) ■ Dealing with +ve card: communication skills (GMFA) ■ Fasten your seatbelts ad (GMFA) ■ Assertiveness training ad (GMFA) ■ Treatment planning tool ad (GMFA) ■ Treatment choices: starting out ad (GMFA) ■ Sorted ad (HF) ■ Protect ad (HF) ■ Disclosure of status ad (HF) ■ More in a positive light ad (HF) ■ Peer support & adherence recruitment ad (HF) ■ Service ad (HGLC) ■ Dost ad (Naz) ■ Dost Youth ad (Naz) ■ Raab Ki Rani ad (Naz) ■ Naz Latina ad (Naz) ■ Naz Latina Amigos ad (Naz) ■ Naz Helpline ad (Naz) ■ Positive Groups ad (Naz) ■ Identity and Self-Esteem Workshops ad (PACE) ■ Assertion, communication & relationships skills ad (PACE) ■ Communication about sex workshop ad (PACE) ■ HIV status specific workshops ad (PACE)	■ Healthy life features (C&I)	
Gay pub/ bar and non-sex club	■ Maintain posters (RS)		■ Condom Promotion: packs (RS)
Sex-on-premises venue			
Sauna			■ Condom Promotion: packs (RS)
PSE			■ Glowboxes (GMFA)
Gym	■ Maintain posters (RS)		■ Condom Promotion: packs (RS)
Other community setting	■ Maintain posters (RS)		■ Condom Promotion: packs (RS)
Outdoors public	■ Sexuality: homophobia (THT) ■ Talking about testing (THT)		

The majority of static direct contact interventions in a push setting are educational advertisements or service advertisements and are placed in the gay press. This category also includes other educational campaigns intended to be displayed on the gay scene or on outdoor sites such as in tube stations. Resources which gay men can take from an open access rack or display (such as leaflets) or condom and lubricant packs available to take from bars also fall within this category.

Figure 5.13: Static direct contact pull interventions

PULL SETTINGS	static		
	single image display	leaflet distributor	condom & lube distributor
Provider's centre	■ Condom Promotion: posters (RS)		■ Condom Promotion: packs (RS)
GUM clinic			
Community group meeting			
Mailing list	■ Peer support & adherence recruitment ad (HF) ■ VIP image (RS)	■ F***Sheet mailing (GMFA) ■ Service mailout (PACE) ■ Survey mailout (RS)	
Phone		■ Web site maintenance (Big-Up) ■ Web site maintenance (C&I) ■ Web site maintenance (GMFA) ■ Pleasure palace (HF) ■ Naz Latina web site maintenance (Naz)	

Static direct contact interventions in pull settings include a range of web sites which gay men might access after an internet search or having seen a web address advertised in a mass or small media resource. They also include adverts or resources men come into contact with in pull settings such as a mailing list they have subscribed to, or a service they access.

The majority of interactive direct contact push interventions are what is known as outreach by HIV health promoters. These interventions may be single in nature, in that a gay man is contacted once, or they may be recurrent or ongoing in that he is contacted several times at the same site or at different sites. Unlike pull interventions, whether the contact is single, recurrent or ongoing is not predetermined but unfolds over time (hence 'any to left' in figure 5.14). The group and mixed interventions are events organised by agencies in which men can participate, or shows and condom packing sessions which take place in a bar that men may engage with or not.

Figure 5.14: Interactive direct contact push interventions

PUSH SETTINGS	interactive						
	face-to-face						
	one-to-one meetings			group meetings			mixed/clinical
	single	recurrent	ongoing	single	recurrent	ongoing	
Gay pubs/bars and non-sex clubs	■ CLASH outreach (C&I) ■ Clinic access interviewing (GMFA) ■ Affirmation interviewing (GMFA) ■ You won't get it from me zaps (GMFA) ■ Motivational interviewing (GMFA) ■ Pub/club outreach (HGLC) ■ Pubs and Clubs Outreach (Naz) ■ Naz Latina Outreach (Naz) ■ Club Kali outreach (Naz)	any to left		■ RSVP (RS)			■ Events (GMFA) ■ Meet the people (C&I)
Sex-on-premises venue	■ PSV outreach (HGLC) ■ Naz Latina GUM Work (Naz)	any to left					
Sauna	■ PSV outreach (HGLC) ■ CLASH sauna outreach (C&I)	any to left					
PSE	■ CLASH outreach (C&I) ■ Clinic access interviewing (GMFA) ■ Affirmation interviewing (GMFA) ■ Motivational interviewing (GMFA) ■ Heath project (GMFA) ■ Finsbury Park project (GMFA/Big-Up) ■ PSE outreach (HGLC) ■ PSE outreach (Naz)	any to left					
Gym	■ CLASH outreach (C&I)	any to left		■ RSVP (RS)			■ Health & fitness day (C&I)
Other community setting	■ CLASH sex worker outreach (C&I) ■ African MSM outreach (C&I) ■ Café Outreach (Naz) ■ Sex Worker Outreach (Naz) ■ Naz Latina Outreach (Naz)	any to left		■ Schools Work (Naz) ■ RSVP (RS)			
Outdoor public							

Figure 5.15: Interactive direct contact pull interventions

PULL SETTINGS	interactive							
	telephone	face-to-face						
		one-to-one meetings			group meetings			mixed/ clinical
		single	recurrent	ongoing	single	recurrent	ongoing	
Provider's centre		■ Peer support & adherence interviews (HF) ■ Assessment (HGLC) ■ Advice and Support (Naz)	■ Counselling (HGLC) ■ Couple counselling (HGLC)		■ Negotiating safety work-shop (C&I) ■ Survival guide work-shop (C&I) ■ Adherence strategies seminar (C&I) ■ Treatment choices: starting out (GMFA) ■ Peer support & adherence focus groups (HF) ■ Workshops (HGLC)	■ Getting the sex you want (C&I) ■ Groups (HGLC) Identity and Self-Esteem Workshops (PACE) ■ Assertion, communication & relationships skills workshop (PACE) ■ Communication about sex workshop (PACE) ■ HIV status specific workshops (PACE)	■ VIP (RS)	■ Steroid users clinic (C&I) ■ Male sex worker clinic (C&I)
GUM clinic		■ Clued-up at Axis (C&I) ■ Naz Latina GUM Work (Naz)			■ Adherence strategies seminar (C&I) ■ Get the sex you want +ve (C&I)			■ Men in relationships clinic (C&I) ■ 28 GUM clinics
Scene					■ Strategies for sex: relationships (GMFA) ■ Strategies for sex: SM (GMFA) ■ Strategies for sex: cruising skills (GMFA) ■ Strategies for sex: sero-discordant relationships (GMFA)	■ Strategies for sex: bondage (GMFA) ■ Strategies for sex: skills for gay life (GMFA) ■ Strategies for sex: Hard Times (GMFA) ■ Dealing with +ve: communication skills (GMFA) ■ Assertiveness training (GMFA)		
Gym						■ Healthy life programme (C&I)		
Community group meeting		■ Outreach (C&I)	■ Talking shop (Big-up)		■ Adherence strategies seminar (C&I)		■ NRG (HF/HGLC) ■ Dost (Naz) ■ Dost Youth (Naz) ■ Raat Ki Rani (Naz) ■ Naz Latina Amigos (Naz) ■ Positive Groups (Naz)	
Their telephone	■ Helpline (Big-up) ■ Naz Helpline (Naz)							

Interactive direct contact pull interventions are structured in nature and are often topic based so as to appeal to gay men's lifestyle choices, targeted at particular population groups with known needs, or are designed to provide emotional support at key stages in a man's identity or sexual development. They predominantly involve men talking with one another about their life experiences.

6 Commentary: a way forward

The LINK Evaluation does not attempt to identify the 'best' agencies or even necessarily the 'best' interventions. It seeks to increase the efficiency and effectiveness of all HIV health promotion funded by Greater London Health Authorities and intended to contribute to a reduction in HIV incidence among gay and other homosexually active men. It strives to do this by focussing on sources of inefficiency in the delivery and configuration of an intervention programme.

Since a programme is a set of '...activities designed to fulfil particular strategic goals and targets related to a ...[particular] priority' (Simnet, 1995, p.101), any strategic combination of interventions may be thought of as a *programme* of work.

In any city with a number of interventions occurring, it is probable that men will encounter more than one. No agency has exclusive access to any one individual. The impact of a programme should be greater than the sum of the impact of its individual interventions. Describing interventions facilitates the construction and articulation of programmes. When the interventions under consideration are described in a comparable manner, they can be collected together to form a health promotion activity map. This allows us to avoid replication and maximise impact. It also allows us to increase the equity of a programme by covering as much of the population of concern as possible.

While some agencies describe programmes of work, these are insufficiently enmeshed with other work for us to claim that a strategic HIV health promotion programme is already in place across Greater London. While there certainly exists a 'portfolio' of HIV health promotion activities, this is not the same as a programme of interventions, collectively planned in the context of 'what works' and 'what is needed'. It is this sort of programme planning which findings from The LINK Evaluation seeks to inform.

In order to facilitate this, we propose to construct HIV Health Promotion Activity maps and Needs maps and maintain them. However, the overall task of achieving and maintaining an optimum health promotion map is shared by those who share the overall goal of the strategy (reducing HIV incidence) and the associated aims.

Currently, the detail of the two maps is variable and dispersed. No one has a comprehensive and detailed map of either needs or health promotion for the whole population. Large variation exists in maps for particular population groups and specific health promotion aims. However, health promoters and commissioners hold a lot of the information, especially for the health promotion activity map, and our task has been to collate and present this in as comprehensive a format as possible.

In any field, there are many and varied obstacles to the kinds of inter-agency (and intra-agency) collaboration that facilitate a strategic and programmatic approach to service delivery. Having noted that a strategic programme of HIV health promotion is not yet in place across Greater London, the remainder of this document highlights the structural and practical impediments to programme planning we have observed. We recommend that these obstacles are addressed to facilitate collective movement towards a coherent and strategic programme of interventions to meet the HIV health promotion needs of gay men and other homosexually active men in London.

6.1 OBSTACLES TO COLLABORATIVE PLANNING AND EVALUATION

The realisation of partnerships is impeded by a variety of factors such as task dependency, appreciating other agencies' cultures, goal consensus, exchange of resources, and geographical coherence (Douglas, 1998). While none of these obstacles are peculiar to London – or HIV health promotion – many are intensified by the size and mobility of the population of gay men in London, the number of authorities responsible for their needs and the number of agencies attempting to address them. From this survey we feel the obstacles can be categorised as follows.

6.1.1 Technical obstacles

Lack of systematic intervention descriptions
In order to plan, implement and evaluate, one needs to be able to describe. There is no uniform agreement about the precise meaning of many of the words used to describe health promotion interventions although there are general understandings of most of them (Simnet, 1995). It is important to recognise that the same activities may be described by different people using entirely different vocabularies.

In developing alliances and partnerships, a degree of standardisation with regard to how services are described is necessary to facilitate comparison (Douglas, 1998). Although there are numerous ways in which HIV health promotion interventions could be described we have adopted a single descriptive format we have termed ASTOR (Hickson, 1999). This method is already used by agencies (such as GMFA, THT, Big Up, The NAZ Project, London) whose activity is augmented by CHAPS funding and others who have subscribed to the *Making It Count* framework (HGLC).

Absence of documented planning and an overview of plans
In order to plan, implement and evaluate on a strategic or programmatic level it is essential to understand clearly the starting point. One way of doing this is to carry out an audit, which articulates what is being done, by whom, in what way. This document starts to provide such an overview. While its format and content have weaknesses, many of these occur because it is the first effort to undertake the task on this scale. In future years, the utility of this map will be extended as learning is carried forward.

Absence of a shared health promotion strategy
A health promotion strategy is an essential vehicle for ensuring movement towards shared aims, targets and goals. There now exists considerable evidence about what influences the probability men will be involved in sexual HIV exposure, and if they do so whether the negative partner will become infected (Aggleton, 1997). In this sense, a lot can be known about 'what works' in HIV prevention with gay men. What is needed to utilise this evidence are coherent strategies to match the extent and distribution of those needs with specific activities designed to meet them, among the variety of gay men living in London. *Making It Count* suggests a generic framework for doing this. Future activities of The LINK Evaluation will attempt to inform efforts to improve the match between need and activity across Greater London.

Absence of a coherent commissioning strategy
The responsibility for strategic commissioning lies with commissioners (in consultation with others) (Simnet, 1995; UK Health Departments 1995; Department of Health, 1999a). However, the commissioning and contracting activities of London Health Authorities are insufficiently collective or strategic to claim that any coherent, London-wide commissioning strategy exists.

The specific problems of commissioning HIV health promotion for gay and other homosexually active men that have been documented previously (Keogh *et al.*, 1996) are still common: commissioners 'purchase' what providers offer, and do relatively little to dictate the nature of these activities; and contracts and monies rarely arrive before work is planned to commence.

There continues to be considerable data generation which could inform strategic commissioning, both in terms of the needs of gay men and how best to respond to them. That this data is not utilised in any concerted or transparent way to facilitate strategic commissioning of a programme of health promotion is the consequence of an absence of processes and resources to do so. While this map will not overcome this problem, it collates some of the information necessary and provides some of the tools to do so.

6.1.2 Social & Political Obstacles

Mistrust
The provision of services in health promotion in general, and HIV prevention with gay men in particular, is influenced by the nature of relationships, alliances and partnerships among and between providers and commissioners (Scriven, 1998), and also with other parties such as the Department of Health and research agencies.

It is not easy for any agency to move towards effective partnerships. Agencies may be founded in express opposition to others and even articulate conflicting aims. The situations agencies are working towards may not necessarily be similar or compatible. This differences between the aims of those engaged in (and commissioning) HIV health promotion have often been obscured by agencies simply becoming associated with areas of expertise and 'market niches' rather than these differences being made transparent.

The 'market place' of providers
The historical and technical relationships between Health Authorities and the agencies they allocate resources to are varied, and these relationships shape resource allocation. Many health authorities have pre-existing, and unchanging resource arrangements or commitments with their 'in-house' or local NHS Trust health promotion service. These may include the core costs of the services. It is unrealistic to then treat these providers in 'market competition' for similar services with, for example, voluntary sector agencies. It is even less realistic (as we quickly realised when we attempted) to use providers costings of Health Authority expenditure as a marker for the resources needed to implement an intervention, and hence its efficiency (Keogh *et al*., 1996).

The rhetoric of the 'market place' has fostered intense competition between agencies, and focussed attention on selling 'products' to the Health Authorities. Secretiveness and obstruction are obvious responses to the need to compete for finite resources. This is now a considerable obstacle to programme planning and the evaluation of HIV health promotion.

No distinction between intervention and implementation
The rise of the HIV prevention 'market niche' in London has compounded the collapsing of interventions with their implementation. A useful analogy to understand this distinction is recipes for cakes and cooks. If we want to evaluate how good a cake recipe is, it would be better to have a number of cooks make the cake. If we have only one cook, and the cake is inedible, we are unable to tell whether the recipe is at fault, or the cook. Whereas, if 10 cooks make the cake and all but one cake tastes delicious, then we can conclude one of the cooks is at fault and the recipe is good.

In the case of HIV health promotion, intervention descriptions are the recipes which health promoters carry out specific implementations of. Two health promoters can implement the same intervention with varying degrees of success. Just as it is necessary for a successful restaurant to have both skilled cooks, and a collection of recipes that work, a successful collaborative HIV health promotion program must have a collection of interventions known 'to work' , as well as a skilled workforce of health promoters who can implement them.

For evaluation, the more times we can observe an implementation of an intervention, the better we will be able to make judgements its worth. Observing sufficient performances during a number of implementations, we would be able to comment on the ease of success (is it easy, or not?).

Resources

The attempt to describe the resource and cost aspects of the interventions described by those agencies working to the aims of *Making It Count* met with a limited response. The information requested of agencies on their overall income and then on the budgets allocated to individual interventions (and the associated breakdown of costs) was considered to be the minimum necessary for programme planning and evaluation purposes. Clearly, when even the minimum information is not available there is a problem to be addressed.

Some agencies were unable to identify their overall income due to delays in the contracting process. At the time of completing this data collection (24th May 1999), most agencies interviewed had still not had their contracts for the financial year 1999-2000 agreed. This must affect the budgets of single interventions and their associated cost breakdowns. When core costs are not separately identified and funded, it seems reasonable to assume they are allocated across all interventions purchased from an agency. When specific interventions within a portfolio an agency seeks to have purchased are not, then the core costs allocated to these must be reallocated against those that are purchased. The true cost of an intervention is therefore masked, and will remain so until at least the contract is signed off.

Also, there is no consensus about how interventions should be costed. As a consequence agencies calculate and represent costs in diverse ways, and any comparison is probably unsafe. Indeed some perceived costing their interventions to be such an arbitrary process that they were unsure whether to proceed with it at all.

Finally, some agencies chose to withhold information from the evaluation team and would presumably resist any moves towards the transparency necessary for programme planning. Reasons were given, but changed over time. The over-riding concern appears to be fear that public transparency in a competitive market would lead to rival bids and loss of contracts. This fear appears to be exacerbated by the lack of a consistent approach to costing, which makes some agencies seem more expensive than others when this might not be the case.

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