London counts

HIV prevention needs and interventions among gay and bisexual men in the sixteen London Health Authorities

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Original Research Report

Acknowledgments

This document reports on an collaborative research and evaluation project whose success so far has been due to the substantial support of a large number of organisations and individuals. Thanks, first to the 1649 gay men and bisexual men that contributed by taking the time to participate in the needs survey. They were able to participate thanks to the interest and support of the following agencies, who contributed to that survey by informing the content and/or distributing it to gay men and bisexual men:

- AIDS Education Unit (Barnet Healthcare NHS Trust)
- Big-Up
- Health Promotion (Barking, Havering & Brentwood Community Healthcare NHS Trust)
- Community Involvement and Health Promotion (Brent and Harrow Health Authority)
- Health Promotion Service (Camden & Islington Community Health Services NHS Trust)
- West London Centre for Sexual Health (Chelsea and Westminster Healthcare NHS Trust)
- CLASH (Camden & Islington Community Health Services NHS Trust)
- Croydon HIV Counselling and Testing Service (Croydon Community Health NHS Trust)
- Health Promotion Department (Croydon Community Health NHS Trust)
- Ealing, Hammersmith and Hounslow Gay Men's Project
- Ealing Hospital GUM Department (Ealing Hospital NHS Trust)
- Sexual Health Promotion Team (Enfield & Haringey Health Authority)
- Gay Men Fighting AIDS
- Gay Men's Project, HIV & Drugs Team, Hounslow Council
- The Healthy Gay Living Centre (HGLC)
- Homerton Hospital Department of Sexual Health (Homerton Hospital NHS Trust)
- John Hunter Clinic (Chelsea and Westminster Healthcare NHS Trust)
- Caldecot Centre, Department of Sexual Health (King's Healthcare NHS Trust)
- Directorate of Health Policy & Public Health (Lambeth, Southwark and Lewisham Health Authority)
- LEAN (London East AIDS Network)
- The Metro Centre
- The Mortimer Market Centre (Camden & Islington Community Health Services NHS Trust)
- The Naz Project, London
- PACE (Project for Advice, Counselling & Education)
- QUEST
- REGARD
- RS Health Ltd. (Rubberstuffers)
- St. Mary's Hospital Jefferiss Wing Centre for Sexual Health (St. Mary's NHS Trust)
- Stonewall
- Streetwise Youth
- Terrence Higgins Trust London
- Thomas Coram Research Unit
- Hillingdon Hospital Tudor Wing Sexual Health Centre (Hillingdon Hospital NHS Trust)

David Reid and Michael Stephens at Sigma Research co-ordinated the distribution and return of questionnaires.

We also need to thank all those agencies that invested so much time in the description of their health promotion activity – their names appear repeatedly in Part 2 of this document, and do not need to be duplicated here.

The work was funded by the Specialist Commissioning Advisory Group (HIV/ AIDS and GUM) a consortium of London Health Authorities. Thanks especially to Will Huxter (Camden & Islington Health Authority), David Jobbins (Lambeth, Southwark & Lewisham Health Authority) and Caron Bowen (Merton, Sutton & Wandsworth Health Authority) for their support throughout.

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A partnership project between
Sigma Research and the
Thomas Coram Research Unit
(Institute of Education)

ISBN: 0 872956 51 3

February 2001

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ABBREVIATIONS AND JARGON

Letters	What they stand for	Further explanation of their use in this report
AI	anal intercourse	fucking between men
IAI	insertive anal intercourse	active or insertive AI; doing the fucking
RAI	receptive anal intercourse	passive or receptive AI; getting fucked
PAI	protected anal intercourse	AI always with a condom
UAI	unprotected anal intercourse	AI without a condom
sdUAI	sero-discordant unprotected anal intercourse	UAI between HIV infected and uninfected men
HA	Health Authority	
HAM	homosexually active men	men who have sex with other men (in this instance, in the last year)
ExHAM	Exclusively homosexually active men	men who have sex ONLY with other men and not with women (in this instance, in the last year)
BB	behaviourally bisexual	men who have sex with men and women (in this instance, in the last year)
HIV	human immune deficiency virus	an infectious agent most commonly acquired in England during sex between men
HEQ	highest education qualification	
STI	sexually transmitted infection	infectious agents acquired during sex (including HIV)
<	less than	
>	more than	
NS	non significant	if we had done the survey multiple times, this difference would probably be observed in *more than one in a hundred* of the surveys, purely by chance
p<.01	probability less than 1%	if we had done the survey multiple times, this difference would probably be observed in *fewer than one in a hundred* of the surveys, purely by chance

BHB HP	Barking, Havering and Brentwood Health Promotion
Barnet AEU	Barnet AIDS Education Unit
BH CIHP	Brent and Harrow Community Involvement and Health Promotion
C and I HPS	Camden and Islington Health Promotion Service
Croydon CH	Croydon Community Health
ELCHA PH	East London and City Health Authority Public Health Department
EH HIV/AIDS SCHP	Enfield and Haringey HIV/AIDS Service Co-ordination and Health Promotion
GMFA	Gay Men Fighting AIDS
HF	Health First
HGLC	Healthy Gay Living Centre
Hounslow CSCPU	Hounslow Corporate Strategy and Community Partnership Unit
LEAN	London East AIDS Network
LLGS	London Lesbian and Gay Switchboard
PACE	Project for Advice Counselling and Education
SHOC	Sexual Health On Call, Brent and Harrow HA
THT	Terrence Higgins Trust

1 Overview and methods

This document attempts to describe both the HIV prevention needs of gay and bisexual men resident in London, and the HIV prevention activities intended to address those needs. The target audience for the document is agencies and individuals concerned with the incidence of HIV infection among gay and bisexual men in London, particularly commissioners and providers of HIV prevention services. The report is one part of the LINK Evaluation.

The LINK Evaluation is a collaborative planning and evaluation project concerning HIV health promotion and gay men across London. It is designed within the collaborative planning framework *Making It Count* (Hickson et al, 2000). The current report builds on the work reported in the first health promotion map (Hartley *et al.,* 1999) and the collective coverage evaluation *Scene It? Done It?* (Hartley *et al.,* 2000). Each of these three documents are essential background reading to the current report.

The information presented here is intended to facilitate needs-led planning and collaboration for HIV health promotion within the framework of *Making It Count*.

1.1 OVERVIEW

The general overview of the *Making It Count* model and this document is shown opposite. The model recognises that gay and bisexual men encounter (and may 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 maximum 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 it undertook with a single man dependent on his unmet needs, so collaborating agencies make changes at the programmatic level, to match 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 those of individuals, and their HIV health promotion needs probably do not change radically from year to year.

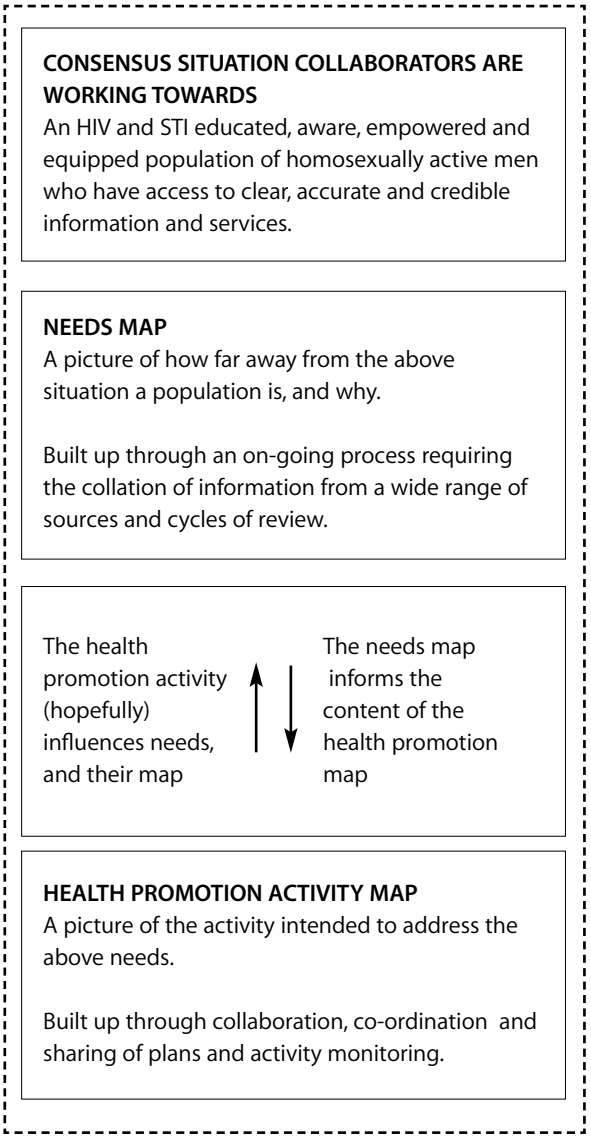

Figure 1.1: The interaction between collective HIV health promotion and need in the population

Part One of this document presents the needs map. It outlines the size of the population of concern, and presents evidence of the scale and patterning of HIV prevention need among a sample drawn from them. Part Two describes the HIV health promotion activity map which describes the activity occurring to address the needs described in Part One. This includes the activity of more than 35 London-based agencies.

Although the document can be read from front to back, it is intended as a reference and foundation for future mapping. After reading and referring to this document, the reader should have a clearer and more detailed overview of the magnitude and diversity of HIV prevention need in the area, and a similar appreciation of the activities occurring to meet those needs. Agencies featured in the activity map should be able to identify others delivering similar work to themselves, and those outside the area should be able to identify agencies implementing interventions they may wish to replicate.

It is not the aim of this document to make a judgement about the goodness of fit between the needs identified and the activities intended to address them, nor to make judgements about the performance of any of those interventions. This is not an evaluation but an attempt to sketch the quantity of need that preventing HIV generates, and to set a frame of reference for expectations of the impact of interventions.

1.2 NEEDS MAP: RATIONALE AND METHODS

Health Authorities are responsible for the assessment of HIV health promotion need for their resident population. A needs map is a picture of how well met the HIV health promotion aims are for a population. Area needs maps concern all men resident in a precisely defined geographic area, in this case a region (London). However, the extent to which some of the health promotion aims are met or not, the obstacles to them being met and the health promotion initiatives that may best achieve them, usually transcend Health Authority boundaries. Hence, it is usually desirable that area needs maps cover geographical areas larger than single Health Authorities.

Collaborators building a needs map need to agree the population they are concerned with, since they are taking joint responsibility for the exploration and articulation of the needs of that population. As this is an articulation of need, it does not include the endorsement of particular interventions to meet those needs. As HIV health promoters are often in close contact with their population of concern, they are often collecting evidence of need in the course of their work and thus have an important contribution to a needs map. The building of a needs map involves the generation and collation of data, and will need research expertise.

All populations are diverse and it will be possible to divide any population into a number of sub-groups. Needs may differ by identifiable population groups and this is important information to extract from a needs map. When sub-populations are constructed, the categorisation system must be able to account for the entire population of concern in order for groups to be compared.

In order to be coherent and containable needs mapping should occur within a transparent strategic framework which articulates the broad situation the collaborators are working towards.
The overall HIV health promotion aims should be contained within this strategic framework.

This map uses *Making It Count* (Hickson *et al.,* 2000) as its framework for the reduction of HIV incidence among gay men and bisexual men resident in Greater London. The aims of *Making It Count* can be summed up as a situation in which people have control over HIV in their everyday lives. The general overview is shown overleaf. Needs assessment is making a judgement about how true this situation is for the population of concern. There are many reasons why this situation may

not be true for men, and these are articulated (in some detail) in the health promotion aims of *Making It Count*. These are summarised as:

In order for men to...	**They need...**
Have control over sero-discordant unprotected anal intercourse (sdUAI)	• to have control over the sex they have; • to be equipped and competent to negotiate sex; • to be knowledgeable about HIV, its exposure, transmission and prevention; • to be aware of the possible HIV related consequences of their sexual actions for themselves and their sexual partners, for which they may need to be able to find out their HIV status.
Be able to find out their HIV status	• to be free to choose whether and when to test for HIV; • to be knowledgeable about HIV testing and the meaning of HIV test results; • to have access to quality HIV testing services.
Reduce condom failure	• to have maximum control over condom failure in UAI.
Control over diagnosis and treatment of gonorrhoea and NSU	• to be knowledgeable about gonorrhoea and NSU, and how to prevent them, including their transmission, detection and treatment; • to have access to quality sexual health clinical services.

Evidence of the absence in the population of the qualities on the right is indication of need; that is, of times when people do not have control over HIV. As both the population and the possible range of needs are very diverse, building needs maps involves increasing their detail and coverage over time, introducing new information as it becomes available. Indicators of need can be both quantitative and qualitative.

1.2.1 Design

All agencies engaged in HIV health promotion with gay men in London were invited to participate in the design of the survey, as were all HIV commissioners and GUM clinics. In total 114 agencies were sent a form asking about their prevention planning information needs. Ten agencies responded with suggestions for the survey, including commissioners, voluntary and statutory providers, clinical and non-clinical services.

The final questionnaire included all items used in *The National Gay Men's Sex Survey 1999* (see Weatherburn *et al.,* 2000) plus additional items from previous surveys and a number of new items to cover requests from providers and commissioners. The items on this survey included descriptive variables, measures of HIV prevention targets, indicators of HIV prevention need, use of potential health promotion settings and experience of interventions (see Figure 1.2.1).

The questionnaire was designed as a small (A5) leaflet with a fold-over back page, which was gummed so that it self-sealed and had a Freepost address. After completion men were asked to seal and post the leaflet direct to Sigma Research.

Demographics and lifestyle description
Age
Ethnicity
Country of birth
Education
Employment
Household
Partnership status
Length of residence in London
London borough of residence
Gender of sexual partners
Sexuality
Numbers of sexual partners
  males partners
    regular male partners
  female partners
    regular female partners
Whether sold sex
Whether bought sex
History of having been sexually assaulted
Which recreational drugs used
Whether injected drugs

HIV testing
Ever tested
Most recent result
Recency of negative result
Date of positive diagnosis
Current status belief

Target 1: Involvement in HIV sdUAI
Self-rating of likelihood of sdUAI
Any anal intercourse (AI)
Any unprotected anal intercourse (UAI)
Number of UAI partners
Any UAI with known negative partner
Any UAI with known positive partner
Any UAI with partner of unknown HIV status

Indicators of sdUAI related need
Whether sexually assaulted in last year
Whether raped in last year
Agreement or disagreement with:
  "I'd expect a man with HIV to tell me he was positive before we had sex."
  "I'd expect a man with HIV to tell me he was positive before we fuck (either way)."
  "If my sexual partners don't mention HIV, I usually assume they are positive."
  "The sex I have is always as safe as I want it to be."
  "I find it hard to say 'NO' to sex I don't want."
  "I find it difficult to talk about my HIV status with new sexual partners."
  "I sometimes have a problem getting hold of extra strong condoms."
  "I'm happy with what I know about HIV."
Knowing or not knowing the following facts:
  Men can have HIV without knowing it.
  There is no vaccine against HIV.
  There is no test to tell whether or not someone is immune to HIV.
  An HIV negative man can pick up HIV by fucking an HIV positive man without a condom.
  An HIV negative man is more likely to pick up HIV by getting fucked by an HIV positive man than by fucking him.
  Even if he does not ejaculate (cum), an HIV positive man can pass on HIV infection through fucking an HIV negative man.
  When fucking an HIV negative man without a condom, an HIV positive man is more likely to pass on HIV infection if he does ejaculate (cum) in his partner.

Target 2: Experience of condom failure
Any protected insertive anal intercourse
Any condom torn
  number of times torn
Any condom slipped
  number of times slipped

Indicators of condom failure related need
Agreement or disagreement with:
  "Water-based lubricant is sometimes hard to get hold of."
  Knowing or not knowing the following facts:
  Condoms are less likely to break if you use a water based lubricant.
  Wearing two condoms for fucking (one on top of the other) increases the likelihood of them breaking.
  Using oil based lubricants with condoms increases the likelihood of condoms breaking.

Target 3: Duration of gonorrhoea and NSU infections
Recency of STI check-up
Whether diagnosed with STI in last year

Indicators of STI diagnosis & treatment related need
Knowing or not knowing the following facts:
  You can go to any sexual health / GUM clinic, it doesn't have to be your local one.
  Gonorrhoea is caused by a bacteria.
  Men can have gonorrhoea without knowing it.
  Gonorrhoea is easily treated with antibiotics.
  No one is immune to Gonorrhoea.

Indicators of anti-gay discrimination
Whether verbally abused in last year
Whether physically assaulted in last year

Indicators of social need
Agreement or disagreement with:
  "I sometimes feel lonely."
  "I sometimes worry about how much I drink."
  "I would like more control over my recreational drug use."

Use of settings in which health promotion may occur
Recency of use of nineteen settings
Most frequently visited pubs/clubs
Frequency of West End use

Collective intervention performance
Where condoms came from in the last year
Location of most recent STI check-up

Survey administration & monitoring
Type of setting the leaflet was acquired in
Name of location leaflet was acquired in
Whether already completed survey this year
Mother's first name
Primary school attended

Figure 1.2.1: Items in the survey

As we wanted men to complete the survey again at yearly intervals, they were asked (but not required) to provide a contact name and address. As a general incentive to participate, and a specific incentive to provide their names and addresses a Prize Draw was offered. All men providing their name and address were entered into a draw with two prizes of holiday vouchers for £1000 and £500 respectively. The prize draw was subsequently made at the offices of the Pink Paper and prizes were awarded.

In addition, men were asked for two pieces of information that would allow us to link any subsequent questionnaires received, in the absence of a name and address. These were their mothers first name and the name of their primary (first) school. We hope to use this information to link surveys for men who move home or with whom we lose contact for some other reason.

1.2.2 Distribution, returns and exclusions

One hundred and fourteen agencies engaged in HIV health promotion with gay men in London were identified through the *Nambase* (NAM, 1999) and were invited to participate in the distribution of the survey. They were sent a letter explaining the aims and objectives of the survey and a sample leaflet. Of these, 26 agreed to take part (see Acknowledgements for list).

In total, 11,552 leaflets were requested by and sent out to agencies. They were asked to distribute the leaflet to men they came into contact with in the course of their work. This included handing the leaflet out face-to-face and also placing them in information racks in community settings. In similar surveys (Weatherburn *et al.,* 2000) when we have contacted distributing agencies to request they discontinue distribution we have asked how many leaflets they had left. The average (mean) proportion of leaflets distributed is usually about 70%. Hence, we estimate about 8,000 leaflets were distributed by 26 agencies across London in this 3 month period.

The remainder of our 20,000 print run for the leaflet (approximately 8,000 leaflets) were inserted into *Boyz,* a free gay weekly newspaper. There were insufficient leaflets remaining to insert one in every paper in the print run and insertion took place only three weeks prior to the closing date.

Overall 1,738 leaflets were returned via Freepost to the Sigma office, giving a return rate of about 10% of those leaflets in circulation. Of the returns, 95% qualified for inclusion in the sample by being from men resident in London who had sex with another man in the last year. The final sample size was 1,649. After exclusion of men resident outside London or who had not had sex with a man in the last year, the average (mean) number of leaflets returned per agency was 55 (range 1 to 215). Overall, 84% of returned leaflets contained a name and address which will be used to send men a second wave questionnaire in 2000.

Returned leaflets	1738
Live outside London	51
Residence missing	6
No sex with men in last year	26
Spoiled/incomplete	6
Qualifiers	1649

Figure 1.2.2: Exclusions

The nine agencies who recruited twenty or more men received a data report on the men they had recruited. This included demographic and needs data and was mailed directly to those agencies. Two health authorities also requested specific data on the men resident in their area, and a similar data report was prepared for these authorities.

1.3 HEALTH PROMOTION MAP: RATIONALE AND METHODS

This is the second health promotion map generated as part of the LINK Evaluation. The first, of gay and bisexual men's HIV prevention work occurring in the financial year 1999/2000, is reported in Hartley *et al*. (1999). This report contains a full account of the methods and rationale of health promotion mapping which are outlined here.

1.3.1 The map perimeter, sampling and exclusions

The 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. Activity was judged to be relevant to the map if it:

- was wholly or partly funded from London Health Authority HIV prevention budgets.
- was planned to occur in London in the financial year 2000/ 2001.
- 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).

■ Activity funded by the following sixteen Health Authorities, occurring in 2000/ 2001, and intended to contribute to a reduction in the incidence of HIV infection through sex between men resident in London.

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

Figure 1.3.1a: The perimeter of the health promotion activity map

The sampling frame for this map was established through reference to the previous year's (Hartley *et al.,* 1999) and to Nambase® for any agencies that had come into being in the interim. Agencies were put into one of four groups as follows:

- no relevant activity reported in 1999;
- relevant activity in GUM and HIV testing site in 1999;
- relevant non-clinical services in 1999; and
- no response in 1999 or new in 2000.

Agencies describing no relevant activity in 1999 were written to and asked to reply only if they had relevant activity planned for the coming year. A total of 33 agencies were contacted and no replies were received.

Kobler Clinic	Newham Social Services
FACTS Centre	Southwark Social Services
Ian Charleson Day Centre	Shades
HOT	Wandsworth Social Services
HIV Counselling, Hillingdon	Westminster Social Services
Bexley and Greenwich HPU	Gay and Lesbian Association of Doctors and Dentists
West London Health Promotion Agency	
KCW Department of Health Promotion	Gay and Lesbian Legal Advice
Redbridge and Waltham Forest Health Promotion Service	Irish Gay Helpline
	LAGER
Bexley Social Services	Lesbian and Gay Bereavement Project
Camden Social Services	Lesbian and Gay Christian Movement
City of London Social Services	London Friend
Haringey HIV Services	QUEST
Harrow Social Services	Rank Outsiders
iCARE	REGARD
Kensington & Chelsea Social Services	The Albert Kennedy Trust
Lambeth Social Services	

Figure 1.3.1b: Agencies that reported no relevant activity in 1999 and made no response in 2000

All of London's GUM and HIV testing sites were contacted and requested to report both any changes to the services they had previously described and whether they had any additional relevant activity planned for the coming year. A total of 34 GUM and HIV testing services were contacted: 8 responded and were interviewed either face-to-face or over the phone. All are listed in Figure 7.1.

Agencies describing relevant non-clinical activity in 1999 were contacted to arrange a telephone or face-to-face interview. An initial telephone conversation was used to determine the volume of planned activity for the coming year, and where possible, interviews were conducted on the phone. A total of 20 agencies were contacted and 19 described their interventions in full: a response rate of 95%. All are listed in Figure 7.1. In addition, 9 of the agencies in this group were described at the level of the intervention in last year's map and a review of the delivery of these interventions was undertaken.

Any agency that had not responded in 1999, or that appeared in *Nambase*® for the first time in the interim, or whose name arose in interviews with other agencies, were contacted and asked to respond if relevant activity was planned for the coming year. In total 20 agencies were contacted and 10 responded. Those that responded are listed in Figure 1.3.1c.

Bromley Social Services	CHAN (Cypriot HIV/AIDS Network for Turkish and Greek Speaking Community)
Bisexual Helpline	
Black Lesbian and Gay Centre	Middlesexy
City and Hackney Young People's Services	Newham Independent Counselling Service
Jewish Lesbian and Gay Helpline	SM Gays
	Boy Blue

Figure 1.3.1c: Agencies that did not respond in 1999 or were new in 2000 but made no response

1.3.2 Data Collection

In interviews agencies were asked to describe all the interventions to be delivered in 2000-2001 that fit the criteria described above. Although there are numerous ways in which HIV health promotion interventions can be described, we have adopted a single descriptive format termed ASTOR. This format was used in the last years activity map and is described in detail, both in that report (Hartley *et al.,* 1999) and in *Making It Count* (Hickson *et al.,* 2000).

A closed-ended questionnaire was used to record information about the various dimensions of each intervention. Determining the cost of interventions proved to be a significant problem during last year's mapping exercise (Hartley *et al.,* 1999). Some providers had not calculated the cost of interventions, others would not disclose their costs. When costs were available, they were rarely comparable. In this year's mapping exercise we decided to simplify the cost information requested in an attempt to get sufficient information to begin the most basic comparison.

We asked each agency its overall HIV prevention income and the breakdown of their funding sources. In addition, we asked the budget allocated to each intervention described. We asked whether this budget covered all the costs of the intervention or whether it was a partial costing. Hence, the financial information given for each intervention described is the budget an agency has allocated to it, that is the amount they will spend on delivering it rather than the amount the HAs are spending on it. This figure is perhaps the closest we have to the cost of the intervention – although given the lack of consistency in costing, it should be read with some caution.

The responses were entered into a *Filemaker Pro®* database for storage and analysis. Providers were sent a copy of the database output for each intervention they described, both for their own records and so that their entry could be confirmed before our analysis began.

Part I

HIV prevention needs among gay men resident in London

2 The population of concern and sample description

This chapter is concerned with describing the sample, both demographically and in terms of sexual and drug behaviours. None of the variables described are targets for intervention. That is, change in these behaviours at the population level is not part of the meaning of success of HIV prevention activity (although some of the behaviours may change as an consequence of those activities).

All the men in the sample live in London and had sex with another man in the last year; these were the inclusion criteria for the sample. The chapter describes the sample using the following variables:

Borough of residence
Age
Education & employment
Sexuality and gender of sexual partners
Buying and selling sex
Use of recreational drugs (including injecting)
Length of residence in London
Ethnicity & country of birth
Partnership status & household
Numbers of male sexual partners
History of sexual assault

These characteristics were asked as they are the ways in which health promoters in London group men when targeting HIV prevention activity. Obviously, not all health promotion agencies use all groupings. Together, they provide a description of the sample that allows us to compare these men with other groups of men recruited to studies of gay and bisexual men in London.

The most important other HIV related survey among gay men in London is *The Gay Men's Sexual Health Survey* conducted by Julie Dodds and colleges at University College Medical School (Dodds and Mercey, 2000). This behavioural survey started in 1996, building on the Pride surveys carried out by Sigma Research between 1993 and 1995 (Hickson *et al*., 1996). It is a yearly cross-sectional survey using a short self-completion questionnaire. Dodds *et al*. recruit to their survey by distribution of questionnaires by health promoters working in a variety of bars and clubs and via GUM clinics. Where possible in the following, we have made comparisons with the samples recruited to these surveys. However, it is worth noting that men do not need to live in London to be part of Dodds *et al*.'s sample, nor to be homosexually active.

2.1 BOROUGH OF RESIDENCE

It is widely recognised that the proportion of men resident in London who have sex with other men is higher than the rest of the UK. In 1990 the *National Survey of Sexual Attitudes and Lifestyles* (NSSAL, Johnson *et al*. 1994) interviewed 1121 randomly selected men resident in London. Overall, 4.6% said they had a male sexual partner in the last five years and this was higher than any other area of the country (p.463). This is probably because of disproportionate migration of gay men to London from the rest of the UK and also from overseas.

If migration accounts for the difference between London and the rest of the country, is seems reasonable to assume that compared to the adult male population of London, gay men disproportionately live in Inner rather than Outer London. Hickman *et al*. (1997) re-analysed this data in greater detail and found that 1.9% of men living in Outer London (13 out of 670) had sex with men, while 8.6% of men living in Inner London (38 out of 450) had.

Figure 2.1 shows the number of adult men (16 years and older) living in each of the London boroughs at the 1991 Census (OPCS, 1998). We have used 1.9% and 8.6% to estimate the number of homosexually active men in each borough, depending on whether they are Inner or Outer London (Inner London Boroughs are underlined in Figure 2.1). These numbers are then summed for health authorities and the overall proportion of homosexually active men each HA accounts for is given. These proportions are then compared with our sample.

The geographic distribution of the sample is very similar to our calculation of the distribution of homosexually active men in London. Overall, our calculation suggests that 69.5% of men who have sex with men in London live in Inner rather than Outer London. In our sample the proportion is 73.0%. If our calculations are correct, we have slightly over-sampled men living in Camden & Islington, Lambeth Southwalk & Lewisham and Enfield & Haringey Health Authorities, and we have under-sampled men living in Bexley & Greenwich Health Authority.

2.2 LENGTH OF RESIDENCE IN LONDON

The proposition that when gay men move to London they are more likely to move to Inner rather than Outer London is given further support when we consider the length of time men had been resident in the capital (Figure 2.2). Overall, 17.7% indicated they had always lived in London (cf. 22.9% in Kelley *et al.,* 1996). However, this proportion is smaller among men resident in Inner London (14.7%) compared to outer London (26.0%). Conversely, while 60.5% of those men who had always lived in the capital lived in Inner London, 75.7% of those who had moved to the city lived in Inner London (χ^2=28.23, df=1, p<.001).

	total	Inner	Outer
< 1 year	6.8	7.0	6.1
1 to 5 years	23.9	25.1	20.8
5 to 10 years	16.9	18.7	12.0
over 10 years	34.7	34.5	35.2
always	17.7	14.7	26.0

Figure 2.2: Length of residence in London (total N=1642, Inner n=1199, Outer n=443)

If we exclude those men who had always lived in the city, men's length of residence was not related to whether they live in Inner or Outer London, suggesting no overall migration to the suburbs with increasing age.

The relationship between age and length of residence in London is described in the next section.

Local Authorities *(those in italics are Inner London Boroughs)*	Total Adult Males (1991 Census)	# homosexually active men (1.9% of Outer London boroughs & 8.6% of Inner London boroughs)		% of all H.A.M. in London	Frequency in sample		% of sample	% difference from all H.A.M. in London	Health Authorities
Hillingdon	90941	1728	1728	1.5	16	16	1	–0.5	Hillingdon
Brent	94156	1789	3251	2.7	21	23	1.4	–1.3	Brent & Harrow
Harrow	76971	1462			2				
Barnet	111862	2125	2125	1.8	40	40	2.4	0.6	Barnet
Enfield	99190	1885	3376	2.8	24	97	5.9	3.1	Enfield & Haringey
Haringey	78450	1491			73				
Redbridge	87511	1663	3200	2.7	15	56	3.4	0.7	Redbridge & Waltham Forest
Waltham Forrest	80877	1537			41				
Barking & Dagenham	54119	1028	2729	2.3	11	16	1	–1.3	Barking & Havering
Havering	89525	1701			5				
Ealing	106643	2026	8552	7.2	44	139	8.4	1.2	Ealing, Hammersmith & Hounslow
Hounslow	79604	1512			35				
Hamm. & Fulham	58297	5014			60				
Kensing. & Chelsea	55585	4780	10934	9.2	63	145	8.8	–0.4	Kensington, Chelsea & Westminster
Westminster	71561	6154			82				
Camden	66937	5757	11168	9.4	124	249	15.1	5.7	Camden & Islington
Islington	62920	5411			125				
City of London	2037	175	17746	14.9	8	237	4.1	–0.5	East London & the City
Hackney	66604	5728			85				
Tower Hamlets	59231	5094			106				
Newham	78479	6749			38				
Lambeth	93561	8046	22610	19	167	383	23.2	4.2	Lambeth, Southwark & Lewisham
Southwark	82261	7074			131				
Lewisham	87100	7490			85				
Greenwich	76801	6605	13797	11.6	37	50	3	–8.6	Bexley & Greenwich
Bexley	83623	7192			13				
Croydon	120544	2290	2290	1.9	33	33	2	0.1	Croydon
Bromley	113460	2156	2156	1.8	17	17	1	–0.8	Bromley
Merton	65650	1247	11053	9.3	26	120	7.3	–2.0	Merton, Sutton & Wandsworth
Sutton	64917	1233			1				
Wandsworth	99684	8573			93				
Kingston-u-Thames	52522	998	2197	1.8	2	28	1.7	–0.1	Kingston & Richmond
Richmond-u-Tames	63119	1199			26				
TOTALS	2574742	118912	118912	—	1649	1649	—	—	TOTALS

Figure 2.1: Residence of male population, estimated homosexually active population and current sample

2.3 AGE

Figure 2.3.1 shows the age profile of the sample. The average (mean) age of the entire sample was 35.3 years (standard deviation = 10.1, median 34, range 14 to 79). This sample is older than Dodds *et al*.'s 1999 sample but with a wider range and a similar distribution (mean 33.2, median 32, range 15 to 76).

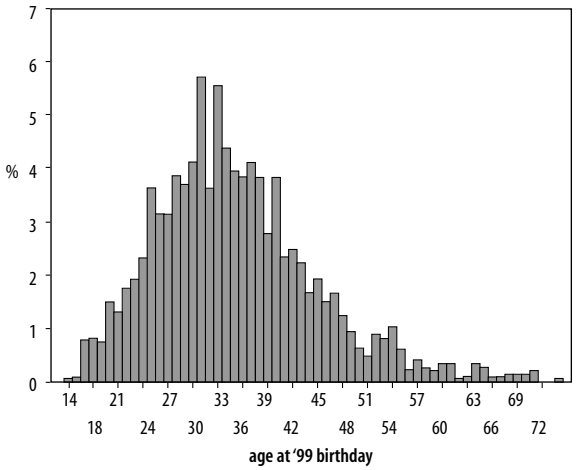

Figure 2.3.1: Age profile of sample (N=1642)

NSSAL suggests sex with men becomes less common with increasing age, so we should expect the homosexually active men in London to be considerably younger than the general male population. Figure 2.3.2 shows how the resident adult male population compares with the current sample for both Outer and Inner London. In both cases there are far fewer older men in the sample than in the population and also fewer men under 20.

In the resident adult male population, men living in Outer London are, as a group, older than those living in Inner London and this was also the case with the current sample (F=7.66, p.<.01).

The age profile of men who had always lived in London was not significantly different from those who had moved to the city.

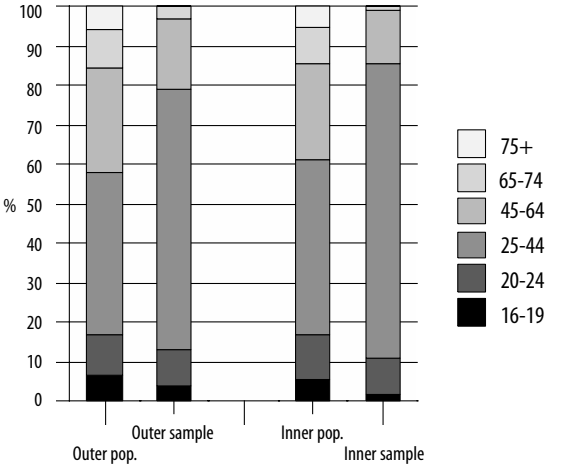

Figure 2.3.2: Age profile of resident population and sample split by Outer and inner London (source for population, OPCS 1991 Census: Outer London sample N=444, Inner London sample N=1197)

Clearly, among those who moved into the city, older men have had a longer time in which to be resident here. The mean age of men who had lived in the city over ten years was 41, of those who have lived here between five and ten years was 33, of those who lived here between one and five years was 31 and of those who lived here under one year was 29. However, recent arrivals to the city cannot be equated with 'young men', although obviously they are younger than men who have lived here some time. Among the 111 men in sample who had moved to London within the last year, 40% were aged thirty years or older.

2.4 ETHNICITY & COUNTRY OF BIRTH

Overall, 90.8% of the sample indicated one of three White ethnicities: White British (69.7%, n=1142), White Irish (5.1%, n=84) or other White (16.0%, n=262). Of the 9.7% of the sample from non-White ethnicities, 1.8% (n=30) were members of Asian ethnicities (cf. 1.7% in Dodds), 2.7% (n=45) were from Black ethnic groups (cf. 3.3% in Dodds) and the remaining 4.6% (n=76) indicated a wide range of other ethnicities.

Men were asked which country they were born in. This is obviously not co-terminus with ethnicity (or Nationality, which was not asked about). Overall, 23.5% specified a country of birth outside the UK, who between them named 71 different countries of birth across all continents.

Kelly *et al.* (1996) asked a community recruited sample of 847 gay and bisexual men resident in London, where they had grown up. They found that 76.7% had grown up in the UK, 11.4% in other European countries and 11.9% in the rest of the world. These proportions are extremely close to the current sample's country of birth. Clearly, London is a 'magnet' for gay men from around the UK, and from around the world.

	%
United Kingdom	76.5
Other European country	11.7
African country	2.7
Asian country	2.0
Oceanic country	2.7
North American country	3.0
South American country	1.5

Figure 2.4: Country of birth (N=1631)

2.5 EDUCATION & EMPLOYMENT

Sex between men is more common among men with higher education than among men with lower education (Johnson *et al.,* 1994, p.464). Or put another way, gay men are better educated than their heterosexual counterparts. There may be several reasons for this including educational aspirations on the part of young men who know they are gay (education as a 'way out'), and less bigotry and prejudice among the middle classes than the working classes 'allow' more of the former to be gay. It is also possible that homosexual desire is accompanied by social advancement among the middle classes, but increasing disadvantage among the working classes (Weatherburn *et al.,* 1999). This would mean we should expect to find a sample of gay and bisexual men to be better educated than a comparable sample of straight men. In addition, gay men in London are better educated than gay men living elsewhere in the country so a representative sample of gay Londoners should be fairly well educated.

Of the current sample, 17.3% had left education with O-levels or no qualifications (cf. 16.5% of Dodds' sample who had no education after the age of 16). In the rest of the report this group is referred to as the 'low' education group. The 'high' education group are those 57.5% who had a degree (cf. 57.0% of Dodds' sample who had three or more years full time education since the age of sixteen). The remaining 25.2% are referred to as the 'medium' education group.

Men were asked whether they were currently in education, employed, unemployed or retired. Overall, 60.9% indicated they were employed full-time. Of those who were not in full-time employment: 10.7% were in full-time education; 13.0% were retired (over three quarters of these indicated 'medically retired, on long-term sick benefits'); 8.4% were employed part time only; and the remaining 7.1% were unemployed. Overall, 27.9% were not employed, either full or part time (cf. 15.8% of Dodds' sample who said 'no' to "Are you employed at present?").

Among those men who were neither retired or students, education level was associated with employment. While 6.4% of those with high education were unemployed, this rose to 10.3% of those with medium education and 17.6% of those with low education.

2.6 PARTNERSHIP STATUS & HOUSEHOLD

Men were asked whether they had a regular male sexual partner at the moment and if so, how many. Overall, 47.5% said they did. Of the men with a regular partner, the majority (84.4%) said they had only one, while fewer had two (8.5%) or three (3.9%) partners. A very small number of men (1.4% of the sample) had more than three regular sexual partners at the time of interview.

Those men with a regular partner were asked how long they and their (main) partner had been together. The mean length men had been with their partner was 52 months (a little over four years). A quarter (24.6%) were under eight months, half (49.7%) were over two years and a quarter (25.3%) were over five and a half years. Ten per cent of men in relationships had been with their partner over eleven years.

Men were asked who they live with and given a list of options to tick. Over a third (39.2%) indicated that they lived alone, although several of these men added that they shared their home with pets. A quarter (26.3%) lived with a male partner, or just over half of those who said they had a regular male sexual partner. One respondent, who had indicated he did not have a regular male sexual partner at the moment specified that he and his partner had been together almost 20 years. He annotated his questionnaire with "My partner and I are no longer sexual partners". This illustrates that 'partner' and 'sexual partner' are not necessarily the same thing. In fact, 2.8% of the men who had said they did not have a regular sexual partner also indicated they lived with a male partner.

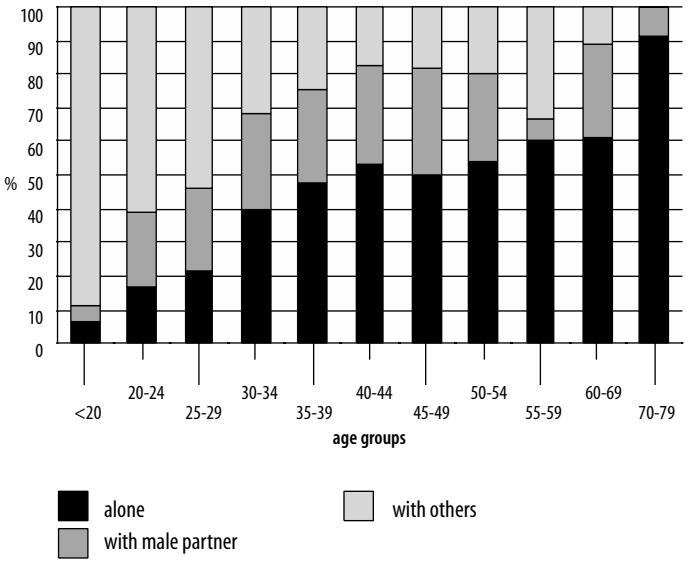

Figure 2.6: Household across the age range (N=1640)

One in five (20.8%) lived with friends. Very few men lived with a female partner (0.8%, n=13) or children (0.5%, n=9). More (5.3%) lived with other family members including grandparents, parents, siblings and other relatives. The remainder lived with a wide variety of other people (including ex-partner, flat mate, lodger, landlady/lord, employer and work colleagues) and in a variety of living situations (including religious community, co-op house, halls of residence, homeless, hostel, hospital staff accommodation and live-in job).

2.7 SEXUALITY AND GENDER OF SEXUAL PARTNERS

Respondents were asked what term they usually used to describe themselves sexually. The vast majority (89.5%) indicated 'gay', with 3.8% indicating 'bisexual'. A larger proportion (4.3%) indicated 'I don't usually use a term'. The remaining 2.4% indicated 'Any other term' and between them specified a variety of words and phrases (see Figure 2.7).

a mess • ambiguous • bisexual personality • cocksucker • fag • floating voter • gay but a bit bi • gay identified bisexual • happy • homosexual • horny • I like sex with men • man who has sex with men • me • mostly gay but fancy women • ordinary male • pansexual • pedé • pervert • poof • post-gay • prefer men • queen • queer • s/m gay • sexual • straight

Figure 2.7: Other terms used for sexuality (N=39)

Overall, 4.9% of the sample had sex with a woman (or women) in the last year as well as a man (or men). While only 1.8% of the gay men had sex with a woman, 53.2% of the bisexual men had, 15.5% of those who used no term and 21.4% of those who used any other term.

Among behaviourally bisexual men, the median number of female partners was one (maximum 20, mean 2.8, standard deviation 3.5). Half of the men who had a female partner (2.4% of the sample) had a regular female sexual partner in the last year (0.8% of the gay men, 29.1% of the bisexual men, 11.3% of those who did not use a term and 9.8% of those who used any other term).

2.8 NUMBER OF MALE SEXUAL PARTNERS

Gay men who live in London average a higher number of male sexual partners than men living elsewhere in England (Weatherburn *et al.,* 2000, p.13). In this sample, the median number of male sexual partners in the last year was 10 (range 1 to 1000, mean 29.9, standard deviation 65.6). The majority of men (82.3%) had a regular male partner in the last year while slightly more (88.7%) had a casual partner.

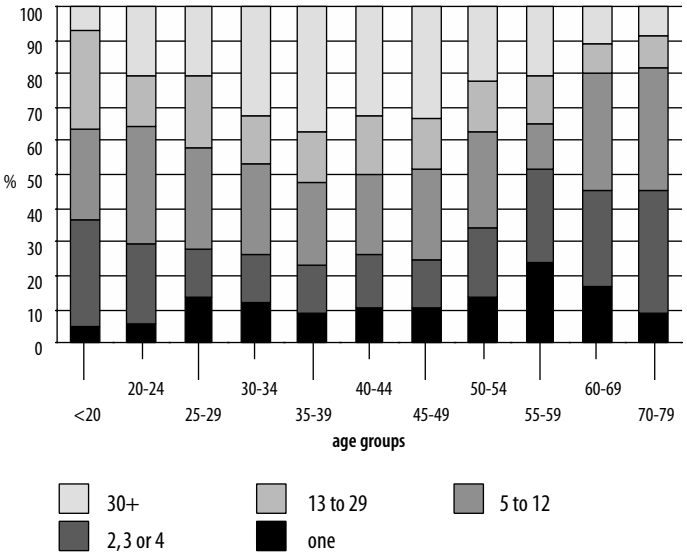

Figure 2.8: Number of male sexual partners in the last year across the age range (N=1607)

The number of male partners of behaviourally bisexual men was similar to that of exclusively homosexually active men. Numbers of sexual partners did significantly vary across the age range however. Very large numbers of sexual partners (30 or more in a year) is uncommon among the under 20 year olds (7.3% had this many partners) and increases with increasing age up to a maximum of 37.2% having 30 or more partners among the 35 to 39 year olds. It then becomes less common with increasing age.

2.9 BUYING & SELLING SEX

Overall, 7.6% of the sample had bought sex in the last year while 6.4% had sold it. The buyers and sellers were mainly different men although 0.7% indicated they had done both.

Buying and selling were not associated with living in Inner or Outer London, having sex with women, or having a regular male partner. Both were closely associated with age (see Figure 2.9). While we found no evidence that buying sex was associated with education levels, selling sex became significantly less common with increasing education: 11.3% of men with low education had sold sex in the last year, 7.5% of men with medium education and 4.3% of those with high education.

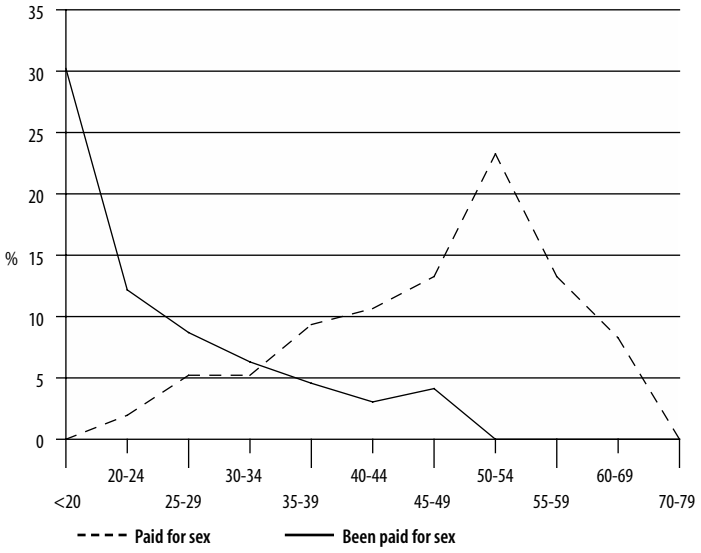

Figure 2.9: Proportion buying and selling sex in the last year across the age range (age group n=43, 147, 289, 385, 306, 208, 122, 65, 30, 36, 11)

2.10 HISTORY OF SEXUAL ASSAULT

Men were asked whether they had ever been sexually assaulted or forced to have any kind of sex against their will, and whether this had happened before or since the age of 16 years. Overall, 24.1% indicated they had been sexually assaulted: 9.5% indicated this had happened to them as a child and 17.2% had it happen to them as adults. A minority (2.6%) indicated this had happened to them as both a child and an adult, suggesting that assault is not exclusively tied to individual victims who are victimised throughout their lives.

Men who indicated they had been sexually assaulted as children were no more or less likely to have bought sex in the last year than men who had not been assaulted. They were, however, much more likely to have sold sex in the last year (14.3% compared with 5.5%).

2.11 USE OF RECREATIONAL DRUGS AND INJECTING

Men were asked which of thirteen drugs they had used 'recreationally' in the last year, including alcohol. The proportion using each drug is shown in Figure 2.11. Overall, 6.5% indicated they had used no drugs. As might be expected, alcohol is the most widely used drug followed by poppers and cannabis.

Men were also asked whether they had injected any drugs. Injecting was uncommon among this sample, with 1.6% (n=26) having done so in the last year.

There was a positive and significant association between injecting drugs and selling sex in the last year (χ^2=7.43, df=1, p<.01). However, the majority (95.1%) of men who sold sex did not inject drugs and the majority (80.8%) of men who injected drugs had not sold sex.

	% used
alcohol	86.3
poppers	55.8
cannabis	45.1
ecstasy	29.0
cocaine	28.6
speed	21.4
ketamine	11.8
acid	10.4
Viagra®	7.4
GHB / GBH	4.6
crack cocaine	1.8
steroids	1.6
heroin	0.8

Figure 2.11: Proportion using each of 13 drugs in the last year

2.12 SUMMARY

The sample consists of 1649 men. All live in a London Borough and all had sex with another man in the last year. The proportion living in each borough is what we might expect from a geographically representative sample. The majority are gay identified and have sex with men only (87.7%). Half the sample is aged between 28 and 40, they are very sexually active and a large proportion use recreational drugs. A quarter were born outside the UK and over half have university education. Almost half had a regular partner and over half of those cohabited with them.

As a group they are very similar to other community recruited samples such as Dodds *et al*.'s and Kelly *et al*.'s. They also frequent the venues in which these other studies recruit. This suggests that all these studies are drawing men from the same population.

3 HIV testing and current status belief

Respondents were asked a series of question about HIV testing. Firstly whether they had ever received an HIV test result. If so they were asked what their most recent test result was. Men who had tested positive were asked the year and month they were first diagnosed with HIV. Those whose most recent test was negative were asked when their most recent test was. Men who had never tested for HIV were asked to say briefly why they had chosen not to test for HIV. Finally, all men were asked what they believed their HIV status to be currently.

3.1 HIV TESTING HISTORY AND RECENCY

Eight men declined to indicate whether they had ever tested but no respondent declined to tell us his test result. Overall, 27.1% (n=444) had never tested, 57.7% (n=947) had last tested negative and 15.2% (n=250) had tested positive. (This compares with 35% of Dodds *et al.*'s 1999 sample who had never tested, 58% whose last test was negative and 7% who had tested positive.)

	%	%
Tested negative		**57.7**
in last 6 months	17.5	
6 months to 1 year	14.3	
1 to 5 years	19.7	
5 to 10 years	4.4	
Over 10 years ago	1.7	
Tested positive		**15.2**
'95 to '99	6.6	
'90 to '94	4.0	
before 1990	4.6	
Never tested		**27.1**

Figure 3.1a: HIV testing history (N=1630)

Figure 3.1a shows the proportions who had tested negative within various time periods. Of those who had tested negative, 55.1% had done so in the last year and 10.6% had not done so for over five years.

The number of men diagnosed with HIV in each year is shown in Figure 3.1b.

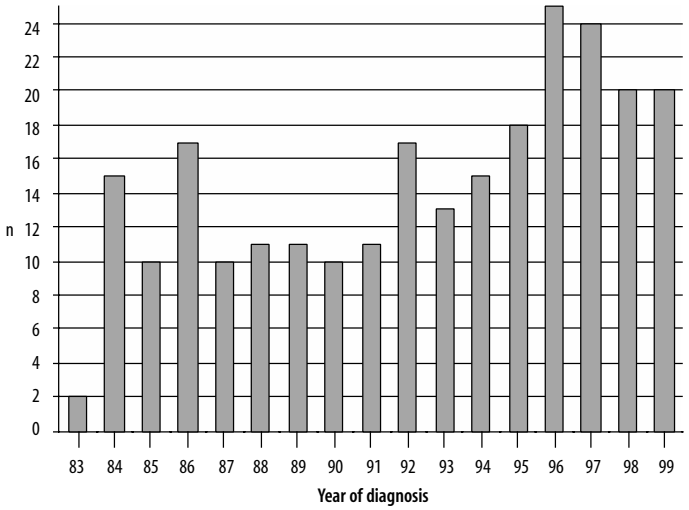

Figure 3.1b: Year of diagnosis among HIV positive respondents (n=249)

The Survey of Prevalent Diagnosed HIV Infection (known as SOPHID) recorded 6417 gay and bisexual men living in London with HIV infection who were in touch with services in 1999. If there are 119,000 gay and bisexual men in London (see section 2.1), this would mean the proportion with diagnosed infection would be 5.4%.

Our figure for HIV prevalence is obviously far higher than SOPHID. While this may be because our there are fewer gay and bisexual men in the city than we have estimated, we think it is more likely that SOPHID is an under-estimate AND men with HIV are more likely to take part in the survey than men without HIV, both because they are more likely to encounter the survey and they are more likely to participate when they do.

3.2 CURRENT STATUS BELIEF

All men were asked *"What do you believe your HIV status is currently?"* and were asked to indicate one of: definitely negative; probably negative; couldn't say / don't know; probably positive; definitely positive; or other. If they indicated 'other' they were asked to specify an answer. Twenty men declined to answer this question and eight indicated 'other'. These 28 men are excluded from the following. For the rest of the men, the figure below shows the proportion indicating each answer overall, and the proportion within each testing history.

		% of all respondents (N=1621)	% by HIV testing history			
			Last tested negative within year (n=511)	Last tested negative over a year ago (n=412)	Never tested (n=439)	Tested positive (n=244)
Current status belief	Definitely negative	28.5	51.9	28.4	16.6	0.4
	Probably negative	43.7	40.5	58.3	57.6	0.0
	Couldn't say / don't know	11.5	6.7	11.9	23.5	0.4
	Probably positive	1.2	0.6	1.0	2.1	1.2
	Definitely positive	15.1	0.4	0.5	0.2	98.0

Figure 3.2: Current HIV status belief and HIV testing history

Almost all the men who had tested positive thought they were currently positive, the vast majority thinking this was definitely the case. Men who had never tested were much more likely to indicate they did not know what their HIV status was (23.5%) compared with men whose last test was negative (8.9% of all those whose last test was negative). Among men whose last test was negative, being unsure of their current status became more common the longer the period since the last negative test. Dodds *et al*. (2000) equate men whose last HIV test was negative with men "who perceive themselves to be negative" (p.17). This is clearly not the case. HIV testing history and perception of current HIV status was not the same for over 20% of these men.

Of the men who had never tested, 2.3% thought they were positive, 23.5% were not sure of their status and 74.2% thought they were negative. Men who had never tested for HIV were asked *"Could you briefly say why you have chosen not to test for HIV?"* followed by a blank space. Answers to this question were associated with what men thought their current HIV status was.

As we can see above, 16.6% (n=73) of the men who had never tested currently thought they were definitely HIV negative. Generally, these men had not tested as they did not think there was any need to test, because they thought they were HIV negative. Those men who had not tested although they thought they were or might be positive had not done so because they were fearful of the result and/or they were unaware of the benefits of having their infection diagnosed. Those who were unsure of their status gave a combination of these reasons.

3.3 VARIATION IN HIV TESTING HISTORY ACROSS THE DEMOGRAPHIC GROUPS

Testing for HIV, and testing positive, are not equally common among all groups of men. There may be a wide variety of reasons for differences in testing and in test results across groups. One key factor is probably differences in HIV incidence. However, we cannot simply assume that incidence is highest in those groups with the highest prevalence of diagnosed infection. The data collected in this first survey in the LINK Evaluation is cross-sectional. It can only tell us about the associations between variables and not any causal relationships. However, logic suggests that for the majority of men some events (eg. educational attainment) precede testing histories, while others (eg. numbers of sexual partners in the last year) follow them. We point out the possible directions of any causal relationships in the associations found between variables.

3.3.1 Borough of residence & HIV testing history

Men who lived in Inner London were more likely to have tested for HIV (74.6%) than were men who lived in outer London (68.5%: χ^2=6.17, df=1, p<.01). However, among those who had tested, men in Inner and Outer London were equally likely to have tested positive. Hence, we found no evidence to support the hypothesis that the prevalence of diagnosed infection is higher in Inner London than Outer London. Although the absolute number of men living with diagnosed HIV infection is much larger in the Inner London HAs, because these HAs contain a much larger number of gay men (see section 2.1), the prevalence of infection is similar.

3.3.2 Length of residence in London & HIV testing history

Among those who had moved to the city, length of residence was not associated with having tested for HIV but it was associated with having tested positive. The longer a man had lived in London, the more likely he was to have tested positive. Obviously, older men have had both more time in which to be exposed to HIV and have had longer to live in London.

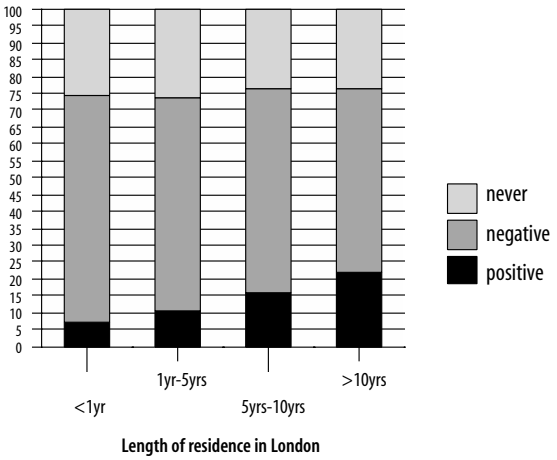

Figure 3.3.2a: Length of residence in London and HIV testing history among men aged 20 to 49 years who were not born in London (n=102, 379, 261, 641)

Are men who have lived in London longer more likely to have tested positive simply because they are older? Figure 3.3.2b shows the proportion of men who had tested positive in each ten year age band, separated by their length of residence in London. This figure suggests that both age and length of residence predict having tested positive.

For example, among all men in their thirties, 19% had tested positive. This figure was 10% of those who had lived in London a year but 24% for those who had lived here over ten years.

Conversely, among those who had moved to London within the last year, 6% had tested positive. This was 2% of those in their twenties, 10% of those in their thirties and 27% of those in their forties.

This last observation strongly suggests that the prevalence of HIV infection among gay men in

% with diagnosed HIV infection

		length of residence in London			
	all	<1yr	1-5yrs	5-10yrs	>10yrs
age group					
all	15	6	11	16	21
20s	7	2	7	9	14
30s	19	10	13	18	24
40s	21	27	18	27	20

Figure 3.3.2b: Proportion of men with diagnosed HIV in each age and length of residence group (n=60, 192, 79, 22; 31, 143, 167, 257; 11, 44, 15, 182)

London is increased by men diagnosed with HIV elsewhere moving to the capital *after* their diagnosis. Although we asked men the month and year of their positive diagnosis, because we asked when they moved to London in bands, we are unable to determine whether diagnosis preceded or followed moving to London for many men. However, it is worth noting that 23 of the 249 men who had tested positive had definitely done so before moving to London. This suggests an minimum of 9% of positive men in London received their diagnosis elsewhere, before moving to the city.

3.3.3 Age & HIV testing history

Figure 3.3.3 shows how HIV testing history varied across the age range. As we might expect HIV prevalence increases with increasing age as older men have had a longer period of time in which to be exposed to HIV.

Of the 42 men under 20 years of age, a third had tested for HIV but none had tested HIV positive. However, 4% (6/147) of those aged 20 to 24 had tested positive and this proportion rose, stepwise to a peak of 22% among the men between 35 to 45 after which prevalence declined.

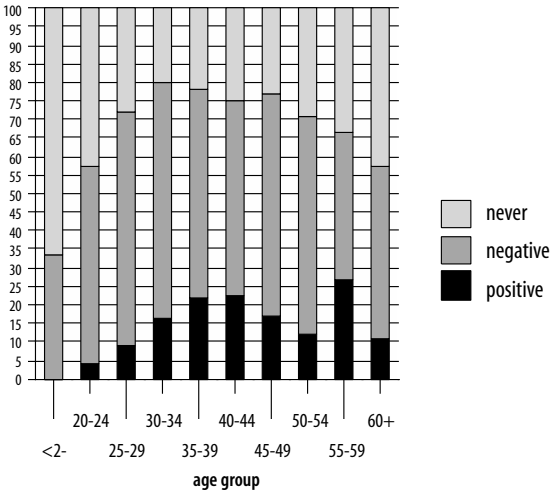

Figure 3.3.3: Age groups and HIV testing history (n=42, 147, 283, 385, 306, 207, 122, 65, 30, 47)

3.3.4 Ethnicity, country of birth & HIV testing history

Considering all minority ethnic groups together (30.6% of the sample) and comparing them to the White British men, members of the minority ethnic groups were significantly more likely to have ever tested for HIV (77.1% compared to 71.1%: χ^2=6.30, df=1, p<.02). Among those who had tested, members of minority ethnic groups were not significantly more likely to have tested positive (23.8%) than White British men (19.5%). These data do not support hypotheses that members of any minority ethnic group are more likely to have tested HIV positive than the ethnic majority.

Ethnic group	n	% tested	% +ve (of tested)
White British	1139	71.1	19.5
All other groups	502	77.1	23.8
Asian/Asian British	30	60.0	5.6
Black/Black British	42	69.0	17.2
Irish	84	77.4	12.3
other White	260	83.8	28.4
other not-White	76	68.4	26.9

Figure 3.3.4a: Ever having tested for HIV and HIV test result by ethnic group

A recent paper (McGarrigle & Nicoll, 1998) has suggested that gay and bisexual men living in the UK who born outside the UK are more likely to have HIV infection than those born in this country. In this sample, men who were born outside the UK (23.5% of the sample) were more likely to have ever tested for HIV than men born in the UK (Figure 3.3.4b, χ^2=14.46, df=1, p<.001). This was true for men born in all continents except Asia.

Place of birth	n	% tested	% +ve (of tested)
UK	1243	70.4	20.1
Outside UK	381	80.3	21.9
Europe	189	79.9	25.2
Africa	44	79.5	22.9
Asia	32	56.3	11.1
Oceania	44	86.4	18.4
North America	49	87.8	16.3
South America	23	91.3	23.8

Figure 3.3.4b: Ever having tested for HIV and HIV test results by continent of birth

However, among those who had tested, similar proportions had tested positive (21.9% of those born outside the UK and 20.1% of those born in it). Overall then, 14.2% of those men born in the UK had tested positive compared with 17.6% of those born outside the country. This difference is not statistically significant. This data does not support the hypothesis that gay men born outside the UK are more likely to have HIV infection than those born in the UK.

3.3.5 Education & HIV testing history

Previous research (eg. Hickson *et al.,* 1998) has suggested HIV incidence is higher among men with lower education compared to men with higher education. In this sample ever having tested for HIV became significantly less common with increasing education (77.9%, 74.3%, 70.7%: χ^2=6.32, df=2, p<.05). Among those who had tested, testing positive also became less common with increasing education (28.3%, 23.4%, 17.2%: χ^2=13.73, df=2, p<.001).

Together, these differences meant that while 12.2% of men with a degree had tested positive (Figure 3.3.5a), 22.1% of those who left school at or before 16 years old had done so.

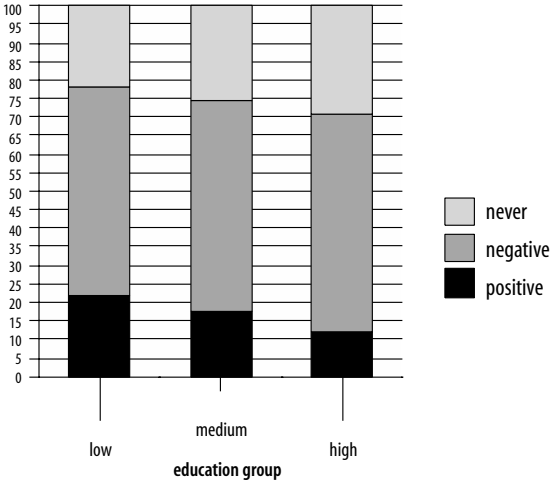

Figure 3.3.5a: Educational level and HIV testing history (n=281, 409, 935)

This educational stratification of HIV infection was apparent in all age groups (Figure 3.3.5b) and was statistically significant among men in their 20s, 30s and 40s. It was also apparent among most ethnic groups and was statistically significant among Black/Black British men as well as White British men.

	education group		
	low	medium	high
age group			
20s	15.9	7.8	4.8
30s	27.2	22.8	14.7
40s	24.5	30.8	16.0
50s	27.3	11.5	11.0

Figure 3.3.5b: Proportion of men in each age and education group who had tested HIV positive (n=69, 128, 229; 103, 167, 415; 53, 65, 206; 33, 26, 82)

• Men with higher education are less likely to become infected with HIV than men with lower levels of education.

3.3.6 Partnership status, household & HIV testing history

Men who were currently in a relationship with another man were more likely to have tested for HIV (76.6% had) than men who were not currently in a relationship (69.5%: χ^2=10.34, df=1, p<.001). This association may be because men use HIV testing when entering relationships as part of a 'risk reduction' strategy. Among men who had tested, their test result was not associated with whether they were currently in a relationship. This meant men with diagnosed HIV were as likely as men who had tested negative to be currently partnered, and both were more likely to be so than men who had

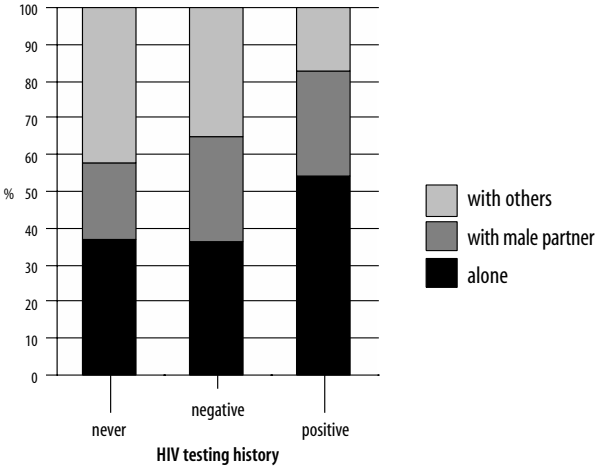

Figure 3.3.6a: Household and HIV testing history (n=444, 945, 250)

never tested. We found no evidence for an association between HIV testing history and the length of current relationships.

Figure 3.3.6a shows how household differed in the three testing history groups. Overall, men who had tested positive were more likely to live alone and less likely to live with people other than a male partner compared with men who had not tested positive.

As men who had tested positive were, as a group, older than those who had not tested positive, and living alone became more common with increasing age, testing positive and living alone may simply both be a function of age.

Figure 3.3.6b shows this is not the case but that the association between testing history and household varies across the age groups. Among men in their 40s (the three columns on the right) and their 30s (the central three columns), positive men were more likely to live alone than men who had not tested positive. However, among men in their twenties (the three columns on the left), men who had tested positive were more likely to live with a male partner than men who had not tested positive.

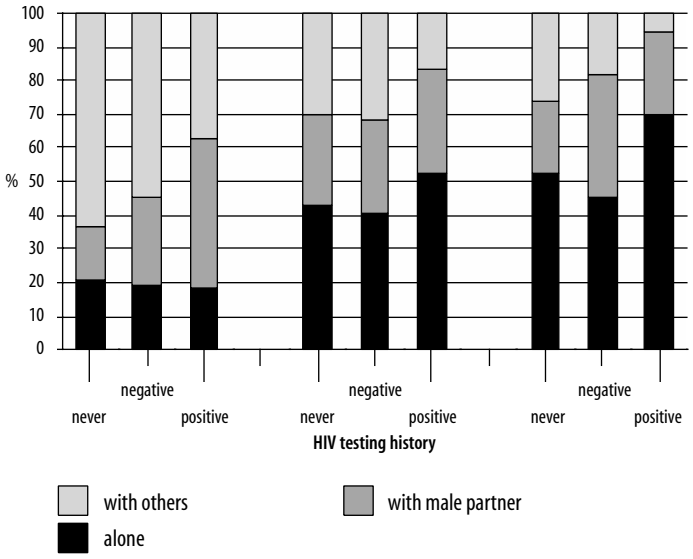

Figure 3.3.6b: Household and HIV testing history among men in their 20s, 30s and 40s (N=430, 689, 329)

3.3.7 Sexuality, gender of sexual partners & HIV testing history

We saw in the previous chapter that sexual identity and having sex with women as well as men were closely associated. Very few gay men (<2%) had sex with women in the last year whereas about half the bisexual men had. Consequently, the association between HIV testing and sexuality are similar to those between testing and gender of sexual partners. While all groups were equally likely to have tested for HIV, gay men (16.3%) and those who had sex with men only (15.9%), were much more likely to have tested positive than were bisexual men (1.6%, 1 out of 62) and those who had sex with both men and women (2.5%, 2 out of 79).

The bisexual identified man who had tested positive had sex with men only in the last year; of the two behaviourally bisexual men who had tested positive, one identified as gay and the other indicated he used some other term to describe his sexuality but did not specify what it was. None of the behaviourally bisexual bisexual-identified men (n=62) had tested HIV positive.

3.3.8 Number of male sexual partners & HIV testing history

Previous surveys have suggested men who have tested for HIV have, on average, more sexual partners than men who have not tested, and that among those who have tested, men who have tested positive have more sexual partners than men who have tested negative (Hickson *et al.,* 1999; Weatherburn *et al.,* 2000). This survey reinforced these findings. While the median number of partners for the whole sample was ten, men who had never tested averaged seven, those whose last test was negative averaged 10 and men who tested positive averaged fourteen.

Figure 3.3.8a shows that of the positive men, 39.4% had 30 or more partners in the last year, compared with 28.6% of the negative men and 21.8% of the never tested men. Conversely, while 9.7% of the negative men and 10.0% of the positive men had one partner only, 15.1% of the never tested men did.

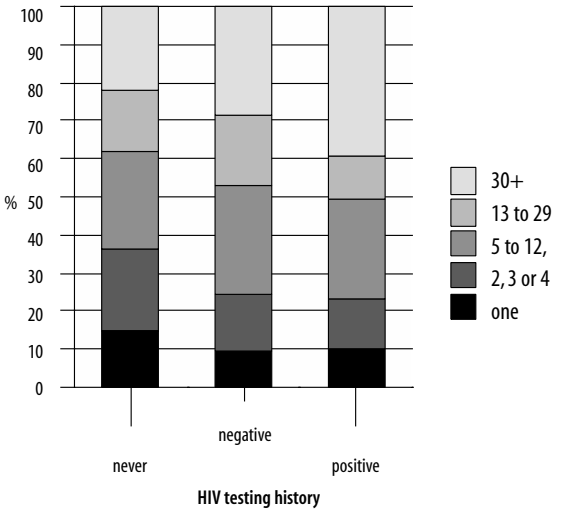

Figure 3.3.8a: Number of male sexual partners last year by HIV testing history (n=436, 930, 241)

The vast majority of the positive men in this sample received their diagnosis more than a year ago. Therefore having more sexual partners may be a response to diagnosis (for evidence of this hypothesis, see Keogh *et al.,* 1999). However, it is also reasonable to hypothesise that men who have large numbers of partners are more likely to become infected with HIV, and that this preference does not change upon diagnosis (ie. they continue to have higher than average numbers of partners). It is also possible that both of these hypotheses are true.

Men who had tested positive were also more likely to have sold sex in the last year (see below). However, the higher prevalence of selling sex among positive men was not the explanation for positive men having higher numbers of partners, as the pattern observed was separately the case among men who sold sex and those who did not.

Overall, 55.5% of men who had tested negative received their most recent result within the last year. This proportion dropped to 42.0% of negative men who had only one sexual partner in the last year, and rose to 63.9% of those who had 30 or more partners. Figure 3.3.8b shows that recent testing, and hence presumably more frequent testing, is more common among men with larger numbers of sexual partners.

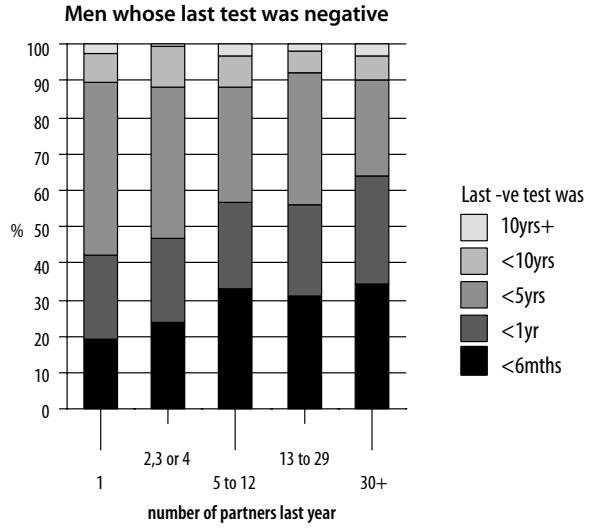

Figure 3.3.8b: Recency of negative test by number of male sexual partners last year (n=88, 138, 264, 168, 263)

3.3.9 Buying, selling sex & HIV testing history

Having paid for sex in the last year was more common among men who had ever tested for HIV (8.5%) than men who had never tested (5.2%: χ^2=5.14, df=1, p<.03). This association was observed across the age range and may be a result of men thinking of purchasing sex as an HIV-related risk behaviour and subsequently testing. We found no association between buying sex and test results.

Men who had sold sex in the last year were no more or less likely to have tested for HIV than men who had not sold sex. However, among men in their twenties or thirties, those who had tested positive were twice as likely to have sold sex in the last year (13.7% had) than those who had not tested positive (6.1%: χ^2=11.62, df=1, p<.001).

3.3.10 History of sexual assault & HIV testing

The National Gay Men's Sex Survey (Hickson *et al.,* 1999; Weatherburn *et al.,* 2000) has suggested that men who have experienced sexual abuse as a child or assault as an adult are more likely to have tested HIV positive than those who have not experienced these, and that this is due to increased testing in these groups.

In the current survey, men who indicated they had been forced to have sex against their will before the age of 16 were more likely to have ever tested for HIV (81.6%) compared to those who had not (72.2%: χ^2=6.18, df=1, p<.02) but among those who had tested those who had experienced assault in childhood were not more likely to have tested positive.

Similarly, those men who indicated they had been forced to have sex as adults (since the age of 16) were more likely to have tested (78.5% compared with 71.9%: χ^2=5.05, df=1, p<.03) but were no more likely to have tested positive.

3.3.11 Use of recreational drugs, injecting & HIV testing history

Comparing the three HIV testing histories, men who had tested positive were most likely to take just about every drug and men who had never tested were least likely to take almost all drugs. The only drugs for which this was not the case were the most popular (alcohol) and the least popular (heroin). The following figure shows the proportion of each testing history who used each drug in the preceding year.

drug	% using that drug in the last year			
	all respondents	never tested (n=443)	last test negative (n=947)	tested positive (n=250)
alcohol	86.3	86.5	87.6	81.6
poppers	55.8	44.9	57.1	70.8
cannabis	45.1	38.4	45.1	57.6
ecstasy	29.0	19.9	31.1	36.8
cocaine	28.6	19.0	30.3	39.6
speed	21.4	16.0	23.2	24.8
ketamine	11.8	5.2	13.5	17.2
acid	10.4	5.0	11.2	16.8
Viagra ®	7.4	3.6	7.6	13.6
GHB / GBH	4.6	2.3	5.2	6.0
crack cocaine	1.8	1.4	1.5	4.0
steroids	1.6	0.5	1.3	5.2
heroin	0.8	1.1	0.4	2.0

Figure 3.3.11: Proportion using each of thirteen drugs in the last year by testing history

3.4 CONCLUSIONS

Clearly, some of the above characteristics are historical and preceded men's HIV testing history. Associations between having tested HIV positive and age and education suggest these factors have a bearing on whether men become infected or not or whether they have their infection diagnosed or not. If this is the case, men who become positive are more likely to:

- be under rather than over 40 years old;
- have left school at 16 rather than be university educated.

These associations are likely to be true for all ethnic groups. Consequently, agencies and interventions whose target groups are men from ethnic minority groups should prioritise members of those groups who are younger and less well educated.

It seems unlikely that men who become positive then stop having sex with women and that having sex with men only precedes rather than follows infection. If this is the case, men who become positive are more likely to:

- have sex with men only rather than have sex with both men and women.

However, associations with current characteristics such as where men live, their partnership status and household, drug use, numbers of sexual partners, and involvement in commercial sex could be a consequence of having tested positive rather than a precedent of it. However, we feel it generally likely that men who will become positive are similar to men who are positive. That is, multi-drug using gay men with large numbers of partners, particularly those selling sex, are more likely to become infected with HIV than men who have fewer partners and who use fewer drugs.

4 Programme targets: population parameters influencing HIV incidence

In this chapter, we consider HIV incidence and the behaviours associated with it. We use the overall goal and three targets of *Making It Count* (Hickson *et al.,* 2000) to describe this data. That is: HIV sero-discordant unprotected anal intercourse (sdUAI), condom failure and diagnosis and treatment of gonorrhoea/ NSU.

4.1 OVERALL GOAL: A REDUCTION IN HIV INCIDENCE

The overall goal of *Making It Count* is a reduction in the incidence of HIV infection during sex between men. HIV incidence is the proportion of uninfected men who will become infected with HIV in the next twelve months. In London, this figure is in the region of 1,000 new infections in the next twelve months, in a population of 100,000 men who today live in London, do not have HIV and will have sex with another man in the next twelve months. This would be an incidence of 1% (or one in a hundred uninfected men becoming infected each year).

What we are collectively trying to do is "push" incidence down. Although we can approximate it, no one knows the precise incidence of HIV infection among homosexually active men in London. We can only estimate the number of new infections occurring from the numbers of men being diagnosed with HIV, and we can only estimate the number of homosexually active men in the city who do not have HIV infection.

This section looks at HIV testing and HIV diagnosis in the last year among those men who had not already tested positive twelve months ago. It is important to recognise that the events in this section are diagnoses and not infections. The infections will, obviously, have preceded these diagnoses, so will, for example have occurred at a younger age.

There were 1409 respondents who did not have diagnosed HIV twelve months prior to filling in the survey. Of these, 38.9% tested for HIV during the year, and 2.0% (n=28) tested positive. This is an incidence of HIV diagnoses of 2.0%. We therefore conclude that:

- The incidence of HIV infection among gay and bisexual men living in London is probably between 1% and 2%.

We found no evidence that testing positive was more or less common among different ethnic groups. Where men currently live may have followed rather than preceded a new diagnosis, but we found no evidence that men living in Inner London were more likely to have recently tested positive than men living in Outer London. Having recently tested positive did however clearly vary by age and education.

HIV testing in last year (men not previously tested positive)	age group				
	<20 (n=42)	20s (n=403)	30s (n=577)	40s (n=261)	50+ (n=120)
not tested	71.4	57.1	57.4	67.0	76.7
tested negative	28.6	40.9	39.7	32.2	22.5
tested positive	0.0	2.0	2.9	0.8	0.8

Figure 4.1a: Yearly incidence of HIV testing by age group

Recent testing was most common among men in their 20s and 30s (43% in each group had tested for HIV within the last year). Testing positive was most common among men in their 30s where incidence was 2.9%.

- The majority of men who will become infected with HIV in the next twelve months are under 40 years old.

The implication of this finding is that the limited resources in London's gay men's HIV prevention programme should be used to disproportionately benefit younger men.

Previous survey work has demonstrated that the prevalence of diagnosed HIV infection is higher among men with lower education than among men with higher education (Hickson *et al.,* 1998; Hickson *et al.,* 1999; Weatherburn *et al.,* 2000). It is likely that this is due to a higher incidence of infection among these men (Weatherburn *et al.,* 1999). In the current survey, having recently tested HIV positive varied by education level.

HIV testing in last year (men not previously tested positive)	education group		
	low (n=225)	medium (n=341)	high (n=829)
not tested	54.2	58.7	64.2
tested negative	42.2	39.9	34.1
tested positive	3.6	1.5	1.7

Figure 4.1b: Yearly incidence of HIV testing by education group

The incidence of positive tests was twice as high among men in the lower education group compared with the other two groups.

- Men who left school at or before 16 years of age are twice as likely to become infected with HIV in the next twelve months as men who went to university.

The implication of this finding is that the limited resources in London's gay men's HIV prevention programme should be used to disproportionately benefit men with lower levels of education.

4.2 TARGET ONE: OCCASIONS OF SERO-DISCORDANT UNPROTECTED ANAL INTERCOURSE

The first behavioural target of *Making It Count* is the number of occasions of unprotected anal intercourse occurring between HIV infected and uninfected men (sero-discordant UAI, or sdUAI). Every occurrence of sdUAI must feature both an HIV positive and an HIV negative man. Therefore the number of sdUAI occurrences negative men are involved in must be the same as the number of occurrences positive men are involved in. Within any given time period (say a year):

number of sdUAI occurrences = (number of -ve men) x (% who had sdUAI) x (mean number of sdUAI had)
= (number of +ve men) x (% who had sdUAI) x (mean number of sdUAI had)

As the number of uninfected men is much larger than the number of infected men, either the proportion of infected men who engaged in sdUAI, or the average number of times they did so, or both, must be higher than for uninfected men.

The current survey asked a number of questions regarding engagement in sdUAI in the preceding year. We asked a series of sexual behaviour questions and what men knew about the HIV status of the partners they had UAI with. Along with their own HIV testing history, this information was used to allocate them to a 'likelihood of involvement in sdUAI' category. The sexual behaviour questions, and the proportions responding positively, are outlined below.

Anal intercourse and unprotected anal intercourse (N=1649)		% yes of total sample	% yes of those who had AI/UAI
In the last year, have you fucked a man (been the active partner in anal intercourse) OR been fucked by a man (been passive)? (missing 2)		85.6	
In the last year, have you fucked or been fucked by a man WITHOUT a condom (with a man)? (missing 1)		46.4	54.2
In the last year, how many different men have you fucked or been fucked by WITHOUT a condom? (missing 12)	none	53.6	
	one	22.8	49.3
	two	9.0	19.4
	three+	14.5	31.3

Figure 4.2a: Parameters influencing sdUAI

From these figures, we can observe that anal intercourse (AI) in a year period is the norm among this sample with 85.6% having done so at least once. Over half of the men who had AI had done so without a condom at least once, that is 46.4% of the entire sample had UAI in the last year.

Half (49.3%) of the men who had UAI had done so with one partner only, while almost a third (31.3%) of those who had UAI had done it with three or more partners. For the entire sample then, 14.4% had no anal intercourse, 39.2% had protected anal intercourse only, 22.8% had UAI with one partner, 9.0% had it with two and 14.5% had UAI with three or more partners.

Since having UAI is a prerequisite to having sdUAI, 53.6% had not had UAI because they either had no AI or they always used a condom when they had it. Therefore, a maximum of 46.4% of this sample could have had sdUAI in the preceding year. However, clearly not all UAI is sero-discordant and some men have UAI only with partners they know have the same HIV status to themselves (sero-concordant UAI).

Those men who indicated they had UAI in the last year were asked three additional questions:

In the last year, have you fucked without a condom (either way) with a man...

...who you knew at the time was HIV negative?

...who you knew at the time was HIV positive?

...whose HIV status you did not know at the time?

The aim of this series of questions is to attempt to determine whether or not respondents have been involved in sdUAI in the preceding year. As each of the above three questions could be answered yes or no, there are a number of combinations in which men could answer. The following figure gives the proportion of each testing history who gave each combination of answers. The proportion of each testing history that declined to answer at least one of the three questions was identical (2.8%).

[Men who had UAI in the last year] In the last year, had UAI with...	**HIV testing history**		
	% never tested (n=138, missing 4)	**% last test negative (n=459, missing 13)**	**% tested positive (n=143, missing 4)**
none of negative, positive or unknown	5.8	2.8	1.4
negative only	22.5	36.6	**7.0**
positive only	1.4	**0.9**	31.0
unknown status only	54.3	31.4	22.4
negative and positive	0.0	**0.7**	**2.8**
negative and unknown	13.0	21.8	**3.5**
positive and unknown	2.2	**1.1**	25.9
all three of negative, positive and unknown	0.7	**4.8**	**7.0**

Figure 4.2b: Knowledge of UAI partners' HIV status by HIV testing history

It seems likely that men whose last test was negative who had UAI with a man they knew was positive, and men who had tested positive who had UAI with a man they knew was negative, had sdUAI in the last year. In the figure, these men are highlighted with bold print.

It also seems likely that men who had tested negative who had UAI only with men they thought at the time to be negative as well (36.6% of negative men who had UAI), and men who had tested positive who had UAI only with men they thought at the time to be HIV positive (31.0% of positive men who had UAI), had not been engaging in sdUAI, but sero-concordant UAI. These men are underlined in the figure. It seems more likely these men were not engaging in sdUAI than the preceding group.

All the rest of the men in the figure who had UAI constitute a third group, those who may or may not have had sdUAI in the last year. This includes all men who had UAI but who had never tested and all men who had status unknown UAI but not known discordant UAI. This group also includes men who indicated they had UAI but declined to answer all three questions and those who said 'no' to all three questions. Although all of these men had indicated they had UAI in the preceding year, a total of 3.1% ticked 'no' to all three. This proportion was greatest for men who had never tested (5.8%) and smallest for men who had tested positive (1.4%). This suggests a greater lack of awareness about the potential for exposure among men who have never tested.

The following figure summarises the above figure using whole sample percentages.

Likelihood of sdUAI based on HIV testing history, sexual behaviour and knowledge of UAI partners' HIV status	% of all sample (n=1648, missing 1)	HIV testing history		
		never tested (n=444)	last test negative (n=946)	tested positive (n=250)
definitely not: no AI, PAI only	53.6	68.0	50.0	41.2
probably not: thought concordant UAI only	12.8	—	17.8	17.2
maybe, maybe not: some unknown UAI	29.7	32.0	28.5	30.0
probably have: thought discordant UAI	3.9	—	3.7	11.6

Figure 4.2c: Proportions probably (and probably not) engaging in sdUAI by testing history

Overall, these figures suggest that 3.9% of the sample were definitely involved in HIV exposure, and another 29.7% may have been. Over half (53.6%) almost certainly were not and the remaining 12.8% probably were not. On these measures, men who had tested positive were far more likely to have been involved in sdUAI than men who had not tested positive. This leads to the following implication for planning London's HIV prevention programme:

- Prioritise the unmet sdUAI related needs of men who have tested HIV positive before those of men who have not tested positive.

4.3 TARGET TWO: CONDOM FAILURE

Even if all anal intercourse between HIV infected and uninfected men featured condoms, exposure would still occur due to condom failure. Although the majority of HIV exposure probably occurs through non-condom use rather than condom failure, the latter may still contribute to incidence.

More importantly perhaps is the discouraging effect of condom failure on future use. *Making It Count* adopts the rate of condom failure among all men (failures per 100 uses) as a second behavioural target for the population. The target is the rate of failure, rather than the absolute number of failures, as the latter is a function of the absolute number of condom uses, which we are attempting to increase. The failure rate can be expressed as:

$$\text{failure rate} = \frac{\text{all failures}}{\text{all uses}} = \frac{(N \times \%\ \text{exp.failure}) \times \text{mean number of failures}}{(N \times \%\ \text{used}) \times \text{mean number of uses}}$$

The current survey generated data about the proportion of respondents who used condoms, the proportion of users who experienced failure and the number of failures they experienced but not about their total number of uses. We asked men separately about condoms tearing and condoms slipping. The following figure gives the condom failure measures for the entire sample.

Condom failure (N=1649)			% of entire sample	% of users / of those experiencing failure
Have you fucked a man (been the active partner) WITH a condom in the last year? (% yes, N=1633, missing 16)			69.7	
Have any of the condoms YOU have worn in the last year TORN OR SPLIT while you were fucking? (% yes, N=1125, missing14)			6.8	9.9
	How many times has this happened? (N=105, missing 6)	1	3.4	49.5
		2	1.9	28.6
		3+	1.5	21.9
Have any of the condoms YOU have worn in the last year SLIPPED OFF while you were fucking? (% yes, N=1129, missing10)			12.5	18.1
	How many times has this happened? (N=188, missing 16)	1	6.8	54.3
		2	3.1	24.5
		3+	2.6	21.2
Composite measure	No condom use for insertive AI		30.3	
	Condom use, no failure		53.2	
	Experienced any failure		16.5	

Figure 4.3a: Parameters influencing the number of condom failures

Over two thirds of the sample had worn a condom for i*nsertive anal intercourse* in the last year (men who have used one when they were receptive in anal intercourse but not insertive are not in this figure). It is worth remembering that protected anal intercourse (PAI) and unprotected anal intercourse (UAI) are independent events; an increase in one does not necessarily mean a decrease in the other.

That is, condom use was more common among men who had UAI in the last year (76.3% had used one) compared with men who did not have UAI (63.9% had used one: χ^2=29.45, df=1, p<.001). Hence, PAI and UAI are both associated with AI. As a consequence, the finding that UAI is more common in one group than another cannot be interpreted as the former group 'not getting the safer sex message', as they may also be more likely to have PAI.

Of the men who had worn a condom, 23.7% (or 16.5% of the entire sample) had experienced some failure in the last year, either breakage, slippage or both. Tearing and splitting was experienced by 9.9% of users (or 6.8% of the entire sample). Among those experiencing this, the mean number of breakages was 2.2 (standard deviation 2.35, median 2, range 1 to 20). Slippage was almost twice as common as breakage with 18.1% of users experiencing it (or 12.5% of the entire sample). The mean number of slippages among men experiencing slippage was 1.8 (standard deviation 1.15, median 1, range 1 to 6) .

Experience of breakage and slippage were associated. Overall, 9.9% of users had a breakage: 7.2% of those who had not experienced slippage had a breakage, compared with 22.5% of those who did have a slippage (χ^2=43.48, df=1, p<.001). The distribution of breakage and slippage among users suggest that condom failure is a function of the user and is concentrated in particular users (ie. it is not necessarily just due to faults in the condoms).

4.4 TARGET THREE: DURATION OF GONORRHOEA AND NSU INFECTIONS

The third population target in *Making It Count* is the average length of time men who acquire gonorrhoea or NSU have their infection. The duration of these infections (along with the frequency with which the infection is exposed to others and the probability of transmission when they are exposed) is a key determinant of their prevalence in the population. It is not possible to measure the average duration of gonorrhoea and NSU infections with a self-completion questionnaire. However, two questions on the survey pertained to this target: recency of STI check-ups and self-identified STIs.

When was the last time you had a check-up for sexually transmitted infections (STIs)? (N=1633, missing16)	%
I've never had a check-up	15.3
More than 5 years ago	10.7
More than a year ago but less than 5 years	24.9
Within the last year but not in the last month	37.5
Within the last month	11.7

Figure 4.4a: Recency of STI check-ups

Half of this sample had been for an STI check-up within the last year. Men were asked *"In the last year, have you been diagnosed with a sexually transmitted infection?".* Overall, 23.8% (n=392) indicated yes. They were then presented with a list of infections and asked which.

[Which infections have you been diagnosed with in the last year?]	**n**	**% of entire sample (N=1649 missing none)**	**% of those diagnosed with an infection (N=392)**
Don't know / not sure	10	0.6	2.6
NSU	149	9.0	38.0
crabs	98	5.9	25.0
gonorrhoea	96	5.8	24.5
genital warts	71	4.3	18.1
scabies	34	2.1	8.7
herpes	32	1.9	8.2
chlamydia	27	1.6	6.9
molluscum	11	0.6	2.8
hepatitis A	11	0.7	2.8
hepatitis B	7	0.4	1.8
syphilis	3	0.2	0.8
hepatitis C	2	0.1	0.5

Figure 4.4b: Whether diagnosed with STI in last year

Only a small proportion of men were unable to indicate what their infection was (although it should be born in mind that this list was offered). Other than crabs (which have no impact on HIV transmission), gonorrhoea and NSU were the most commonly diagnosed infections in the last year. Overall, 12.7% of the sample were diagnosed with one or both of these infections.

As with HIV infections and their diagnoses, it is essential that we do not confuse acquisition of gonorrhoea and NSU with their diagnoses. Diagnosis of infections is a good thing and aim to diagnose infections in as short a time as possible from their acquisition. However, as with HIV, it is likely that, after time, all gonorrhoea and NSU infections will become apparent and be diagnosed.

5 Aims for interventions: Unmet HIV prevention need

The survey was concerned with gay men's HIV prevention needs, not all their health and social needs. We are concerned with how far from our HIV prevention aims we are, and where the greatest shortfalls are apparent. The aims of interventions against which need is being measured are those of *Making It Count*. Therefore the meaning of HIV prevention need is that outlined in *Making It Count*, the collaborative planning framework within which the survey has been designed. While these aims are open to change, this document is not the place to consider what we are trying to achieve. Disagreement about the nature or substance of HIV prevention needs takes place in the development of *Making It Count*, not in its application. The following is an assessment of the extent of unmet HIV prevention need, not a description of what those needs are.

We take it that HIV prevention needs are instrumental; they are what gay men need in order to have control over HIV in their everyday lives. Specifically, they are what men need in order to have control over their involvement in HIV sero-discordant unprotected anal intercourse, what they need to reduce condom failure, what they need to get other STIs diagnosed and treated. The needs about which we are making an assessment are therefore grouped according to the health promotion aims they are thought to contribute toward.

Programme planning (and HIV prevention activity) does not stop while we decide what to do. This chapter considers HIV prevention need, not HIV prevention services. No one needs a leaflet. They may need the information contained in it, but that information may be better acquired by, for example, talking with a friend. The second part of this report (the activity mapping) considers the services that are intended to meet the needs described in this part.

5.1 NEEDS FOR CONTROL OVER SERO-DISCORDANT UNPROTECTED ANAL INTERCOURSE

5.1.1 Need for physical autonomy

Aim One of *Making It Count* includes the aim that 'No man is raped or otherwise sexually assaulted'. This survey asked two questions about recent sexual assault.

N=1649	% Yes
Have you been sexually assaulted or forced to have any kind of sex against your will in the last year? (missing 16)	3.1
Have you been fucked by a man against your will in the last year? (missing 17)	2.2

The majority (71%) of men who had been sexually assaulted had been raped rather than having some other sexual act forced on them. The proportion of men who indicated having been raped in the last year (ie. anally penetrated against their will) was very similar to that in the *National Gay Men's Sex Survey* 1998 (Hickson *et al.,* 1999). If our sample is representative, with an estimated 119,000 gay men in London these figures suggest approximately 3,700 gay victims of sexual assault every year, of whom 2,600 had been raped. These men would benefit from an intervention which reduces trauma associated with sexual assault. Gay men in London would also benefit from interventions which reduce the factors contributing to sexual assault.

Men who had been sexually assaulted in the last year were more likely to also indicate they had been involved in sdUAI than men who had not been assaulted (Figure 5.1.1). Although this data is cross sectional (and therefore we cannot determine which came first), it supports the hypothesis that men who have been sexually assaulted are more likely to be involved in sdUAI and that reducing sexual assault is a valid aim for HIV prevention interventions.

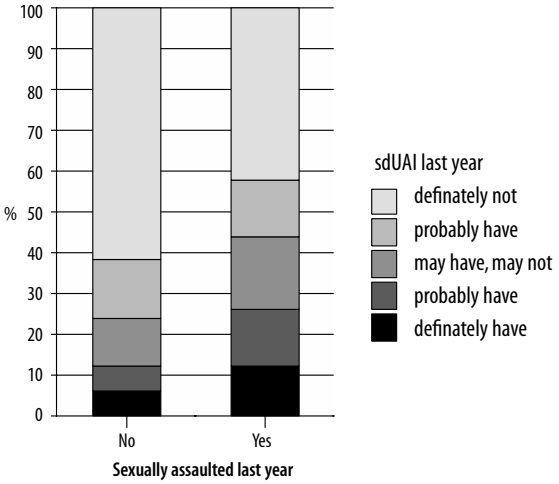

Figure 5.1.1: Self-rating of likelihood of sdUAI in last year by whether sexually assaulted last year (n=1576, 50)

5.1.2 Need for self-efficacy over safety of sexual behaviour

Aim One of *Making It Count* includes the aim that 'No man's sexual behaviour is a problem to him if his sexual behaviour is not a problem to his sexual partners'. This survey asked respondents to agree or disagree with a statement reflecting satisfaction with sexual safety.

N=1649	%				
	strongly agree	agree	not sure	disagree	strongly disagree
"The sex I have is always as safe as I want it to be." (missing 8)	46.0	37.0	6.2	9.8	1.0

One in ten men (10.8%) indicated unmet need about satisfaction with sexual safety, the majority of these indicating weakly rather than strongly. The majority of men suggested they were happy and in control of how safe the sex they had was. If this is a representative sample, there are approximately 12,800 gay men who want to be safer sexually and who might benefit from an intervention which can help them achieve this.

Whether men felt the sex they had was as safe as they want it to be was strongly associated with whether they judged themselves to have been involved in sdUAI in the last year (Figure 5.1.2). While 9.0% of men who agreed they were are safe as they want to be also said they probably or definitely had sdUAI, 35.6% of those who disagreed judged themselves to have had sdUAI. This clearly shows that men who are concerned about their sexual safety are much more likely to have been involved in HIV exposure than men who hare not concerned.

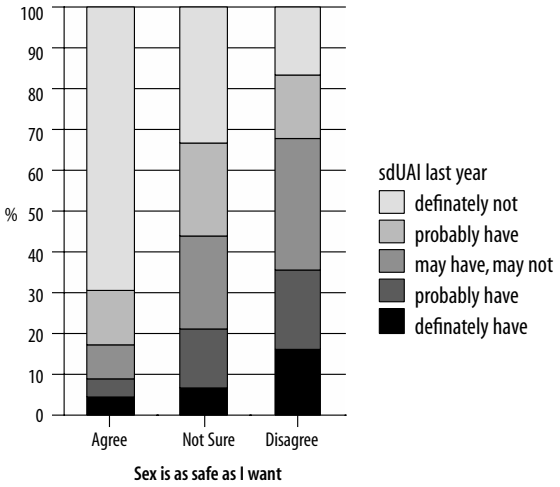

Figure 5.1.2: Self-rating of likelihood of sdUAI in last year by whether sex is as safe as I want it to be (n=1357, 100, 177)

However, it is also worth noting that 64% of men who said they had definitely been involved in sdUAI, also said the sex they had was as safe as they want it to be. This was 68% of 47 men who had tested positive and 60% of 52 men who not tested positive.

5.1.3 Need not to be intoxicated (all the time)

One reason men may not have control over the sex they have is incapacitation due to alcohol or drug use. Men were asked two questions regarding their concerns about intoxicating substances.

The first was whether they agreed or disagreed with *"I sometimes worry about how much I drink."* Overall, 35.7% agreed with this statement, with 9.9% agreeing strongly. If this sample is representative, this suggests there are 42,500 gay men in London who are concerned about their drinking and who might benefit from an intervention which increases their control over alcohol.

The second statement was "I would like more control over my recreational drug use." Overall, 15.5% agreed, including 4.5% who agreed strongly. This would suggest about half as many men as are concerned about alcohol are concerned about other drug use: approximately 18,500 men who might benefit from an intervention which increases their control over drug use.

5.1.4 Need for assertion and communication

Aim Two of *Making It Count* includes the aims that 'men have the self confidence to negotiate sex' and that 'men have the interpersonal skills to negotiate sex'. This survey asked men to agree or disagree with two statements reflecting this aim.

N=1649	%				
	strongly agree	agree	not sure	disagree	strongly disagree
"I find it hard to say 'NO' to sex I don't want." (missing 7)	35.5	41.6	8.5	11.4	2.9
"I find it difficult to talk about my HIV status with new sexual partners." (missing 60)	23.9	35.0	15.5	19.7	5.9

Overall, 14.3% indicated they find it hard to say 'no' to unwanted sex. Although agreeing with this statement was more common among men who said they were not as safe as they wanted to be, only 3.7% indicated need on both indicators. Overall, 21.6% indicated either the sex they had was not as safe as they wanted it to be or that they find it hard to say 'no' to sex they do not want. Agreement with this statement was associated with judging oneself to have been involved in sdUAI in the last year (Figure 5.1.4a).

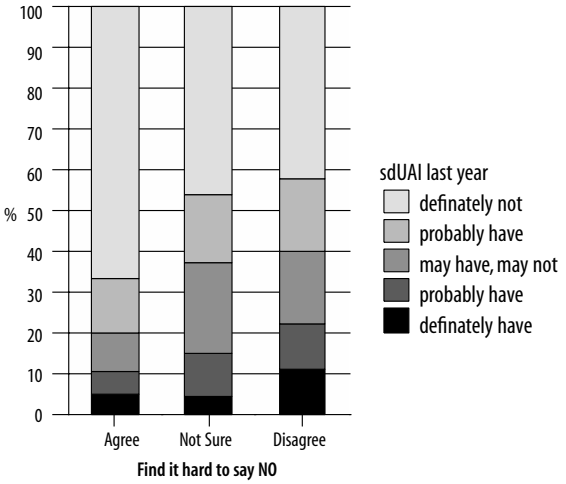

Figure 5.1.4a: Self rating of likelihood of sdUAI in last year by whether I find it hard to say NO to unwanted sex or not (n=1261, 139, 236)

More men, 25.6%, found it difficult to talk about their HIV status with sexual partners. Agreement with this statement was also associated with judging oneself to have been involved in sdUAI in the last year (Figure 5.1.4b).

Overall, 35% of men said they had trouble talking to their sexual partners about their HIV status and/ or they found it hard to say 'no' to sex they did not want. If this is a representative sample, this would suggest approximately 41,500 gay men in London who might benefit from an intervention which increases assertiveness and communication skills.

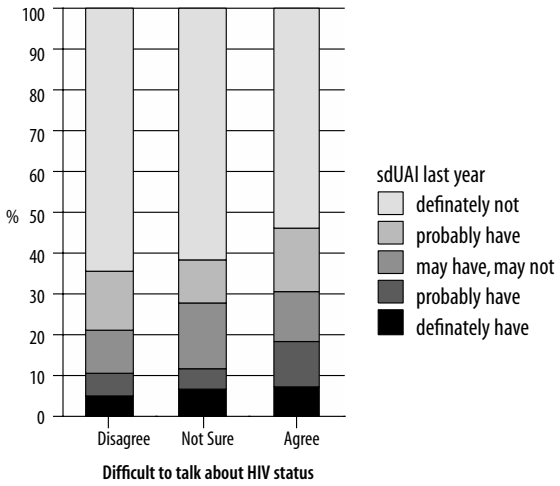

Figure 5.1.4b: Self rating of likelihood of sdUAI in last year by whether I find it difficult to talk about my HIV status with new sexual partners (n=597, 152, 220)

5.1.5 Need for knowledge about HIV and its transmission

It is widely recognised that knowledge alone is insufficient for men to have control over their involvement in sdUAI. Statements such as 'You know the risks, the choice is yours' (an early government campaign message) have been criticised for ignoring the structural and interpersonal factors which determine the way in which what we know can be used. Conversely, knowledge and understanding has sometimes been reduced to knowing a set of behavioural 'safer sex rules'. When men know these rules and do not follow them, lack of knowledge is often disregarded as the reason for men choosing not to take preventative action. Both extremes do an injustice to the role of education in health promotion.

Aim Three of *Making It Count* is that 'men are knowledgeable about HIV, its exposure, transmission and prevention'. Respondents were asked to agree or disagree with a general statement concerning their satisfaction with their current knowledge, before being asked a series of factual statements.

N=1649	%				
	strongly agree	agree	not sure	disagree	strongly disagree
"I'm happy with what I know about HIV." (missing 6)	32.5	51.7	10.3	4.9	0.6

Although the majority appear to be satisfied with their current knowledge, 5.5% indicated not being happy with what they knew, and twice as many were unsure about whether what they knew was satisfactory. If this is a representative sample, there are approximately 6,500 gay men in London who would like to know more about HIV and another 12,300 who might like to know more if given the opportunity.

Men were then given a series of statements about HIV. They were told the statements are true, and were asked to indicate whether they knew this fact already, whether they were not sure, or whether they did not know this fact. While a question form of this kind undoubtedly underestimates need for knowledge, we feel it is unethical in a self-completion questionnaire to mix true and false statements and ask men whether they are true or false, as this could be misleading. Our preferred question form also increases the educative function of the survey. Men were asked to respond to the first general statement of satisfaction (above) before being asked the specific information below. It is possible that more may have indicated dissatisfaction with what they knew if we had asked them after these factual questions.

N=1649	%		
	Knew that	Not sure	Didn't know
Men can have HIV without knowing it. (missing 5)	98.0	1.3	0.7
There is no vaccine against HIV. (missing 4)	97.7	1.8	0.5
There is no test to tell whether or not someone is immune to HIV. (missing 12)	75.2	17.4	7.4
An HIV negative man can pick up HIV by fucking an HIV positive man without a condom. (missing 6)	96.3	3.0	0.7
An HIV negative man is more likely to pick up HIV by getting fucked by an HIV positive man than by fucking him. (missing 12)	85.4	10.0	4.6
Even if he does not ejaculate (cum), an HIV positive man can pass on HIV infection through fucking an HIV negative man. (missing 7)	86.8	10.0	3.2
When fucking an HIV negative man without a condom, an HIV positive man is more likely to pass on HIV infection if he does ejaculate (cum) in his partner. (missing 10)	92.3	6.2	1.5

Very few men did not know or were not sure that HIV infection is not necessarily apparent (2.0%) or that there is currently no vaccine against HIV (2.3%). A much larger proportion did not know or were not sure that no test for HIV immunity exists (24.8%).

5.1.6 Need to assume nothing about the HIV status of sexual partners

Aim Four of *Making it Count* includes the aims that 'men are aware that some men who do not know they have HIV', and 'some men who know they are (not) infected with HIV, will engage in UAI without revealing what they know of their HIV status'. This survey asked men to agree or disagree with following three statements regarding expectations of disclosure of a HIV status.

N=1649	%				
	strongly disagree	disagree	not sure	agree	strongly agree
"I'd expect a man with HIV to tell me he was positive before we had sex." (missing 19)	12.5	29.1	13.3	19.4	25.7
"I'd expect a man with HIV to tell me he was positive before we fucked (either way)." (missing 26)	9.7	25.1	12.9	20.0	32.3
"If my sexual partners don't mention HIV, I usually assume they are positive." (missing 17)	18.6	43.0	17.8	14.0	6.6

Overall, 58.3% of men either expected men with HIV to reveal their status before sex or were unsure as to whether they would. Even more (65.2%) expected disclosure before anal intercourse or were unsure. Fewer (20.6%) made assumptions about partners being HIV positive is such information was not offered. This is one of the most widespread unmet HIV prevention needs found in this survey. It suggests that over half the gay men in London, approximately 70,000 men, would benefit from an intervention which can raise their awareness of when their sexual partners have or do not have HIV.

5.2 NEEDS TO REDUCE CONDOM FAILURE

5.2.1 Need for access to extra strong condoms

Aim Eight of *Making It Count* includes the aim that 'men have easy access to appropriate condoms and water-based lubricant'. What constitutes appropriate condoms for anal sex remains contentious in London and the rest of the UK. It has long been common practice to advise gay men to use 'extra strong' condoms if they are going to use condoms for anal intercourse. This is despite a lack of evidence that extra-strong condoms are less likely to fail than regular condoms. This survey asked men about access to extra strong condoms in particular.

N=1649	%				
	strongly disagree	disagree	not sure	agree	strongly agree
"I sometimes have a problem getting hold of extra strong condoms." (missing 25)	32.1	39.1	11.5	13.2	4.1

Overall, 17.3% indicated they sometimes had problems getting hold of extra strong condoms. This is far more than the 5.6% of Londoners who agreed with the statement "I sometimes have a problem getting hold of condoms" (ie. omitted the term 'extra-strong) in the *National Gay Men's Sex Survey* 1998 (Hickson *et al.,* 1999). If this is a representative sample, this suggests approximately 20,500 gay men in London who would benefit from greater access to extra-strong condoms.

We found no evidence of an association between agreement with this statement and involvement in sdUAI. However, there was a positive association between agreement and experience of condom failure (Figure 5.2.1). Among men who had worn a condom in the past year, the proportion who had experienced failure increased from 7.4% of those who strongly disagreed with the statement, through 9.0%, 12.0%, 11.9% to 24.0% of those who strongly agreed (χ^2=15.54, df=4, p<.01). Among those who experienced breakage, those who agreed with the statement had more breakages than those who disagreed.

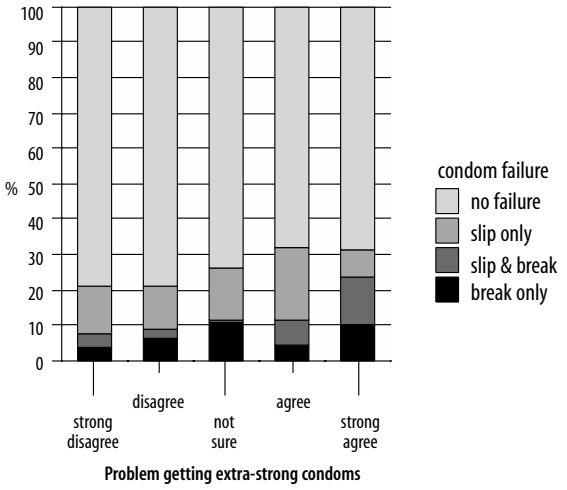

Figure 5.2.1: Experience of condom failure by problems getting extra-strong condoms (those who had worn a condom for insertive AI in last year (n=515, 631, 186, 211, 66))

5.2.2 Need for access to water-based lubricant

Aim Eight of *Making It Count* also includes the aim that "men have easy access to water-based lubricant". While the need for condoms to be extra-strong is currently being questioned, the need to use water-based lubricant when having anal intercourse with condoms is widely recognised.

N=1649	%				
	strongly disagree	disagree	not sure	agree	strongly agree
"Water-based lubricant is sometimes hard to get hold of." (missing 20)	38.2	41.3	8.1	9.3	3.1

Getting hold of water-based lubricant was a problem for 12.4% of men, fewer than had a problem getting extra-strong condoms. If this is a representative sample, this would suggest approximately 14,700 men who would benefit from greater access to water-based lubricant. In contrast to the statement about extra-strong condoms, we found no evidence that agreement with this statement is associated with condom failure.

5.2.3 Need for knowledge about condom failure

Aim Eight of Making it Count includes that "men know and understand the differences between condoms and between lubricants and their relationship to condom failure". To generate needs data in relation to this aim respondents were given three statements about condom failure, they were told they were true and were asked if they already knew this.

N=1649	%		
	Knew that	Not sure	Didn't know
Condoms are less likely to break if you use a water based lubricant. (missing 11)	95.8	2.8	1.4
Using oil based lubricants with condoms increases the likelihood of condoms breaking. (missing 15)	92.8	4.2	3.1
Wearing two condoms for fucking (one on top of the other) increases the likelihood of them breaking. (missing 15)	33.6	13.8	52.6

A relatively small proportion (4.2%) did not know that water-based lubricant reduces the likelihood of condom failure. Among condom wearers, experience of breakage was much more common among those who did not know or were not sure of this (25.6%) than those who did know (9.3%: χ^2=11.21, df=1, p<.001).

Slightly more men (7.3%) did not know that oil-based lubricant increases the likelihood of condom failure. Again, among condom wearers, experience of breakage was much more common among those who did not know or were not sure of this (17.4%) than those who did know (9.3%: χ^2=4.72, df=1, p<.03).

The majority of men (56.4%) did not know that wear one condom on top of another increases the likelihood of them breaking. We found no evidence for an association between knowing this and experience of breakage.

5.3 NEEDS TO HAVE GONORRHOEA AND NSU DIAGNOSED & TREATED

5.3.1 Need to know GUM is open access

Clinical sexual health services in the UK are relatively unique, in that they are free and open access. The rationale for this is that open access services encourage attendance, thus diagnosing and treating STIs more quickly. Men were asked whether they knew about this.

N=1649	%		
	Knew that	Not sure	Didn't know
You can go to any sexual health / GUM clinic, it doesn't have to be your local one. (missing 11)	82.8	11.8	5.4

Overall, 17.2% did not know or were not sure that GUM services in the UK are open access. Among men who had ever had an STI check-up, those who knew they could go to any GUM clinic had a check-up more recently than those who did not know this.

5.3.2 Need for knowledge about gonorrhoea

Respondents were given four statements about gonorrhoea, were told they were true and were asked if they already knew this.

N=1649	%		
	Knew that	Not sure	Didn't know
Gonorrhoea is caused by a bacteria. (missing 12)	58.0	25.0	16.9
Men can have gonorrhoea without knowing it. (missing 12)	64.3	19.6	16.1
Gonorrhoea is easily treated with antibiotics. (missing 13)	80.9	11.6	7.5
No one is immune to gonorrhoea. (missing 12)	70.6	17.4	12.0

Knowledge about gonorrhoea was generally much lower than knowledge about HIV: 19.1% did not know that gonorrhoea is easily treated, 29.4% were unaware that no one is immune and 35.7% did not know they could have gonorrhoea without knowing it (compared with 2.0% who did not know this about HIV). Least known of these four facts (with 42.0%) was that gonorrhoea is caused by a bacteria.

Overall, 41.6% of men already knew all four facts and 3.3% indicated they knew none of them. If we score knowing a fact as 3, not being sure as 2 and not knowing as 1, responses to the four facts together give men a score between 4 (did not know any) and 12 (already knew all four facts).

	n	mean score
Last STI check-up was...		
never	250	9.27
over 5yrs ago	171	10.07
between 1yr and 5yrs	405	10.15
between 1mth and 1yr	610	10.55
within 1 month	189	10.61

Figure 5.3.2: Mean score on gonorrhoea knowledge by recency of STI check-up

Figure 5.3.2 shows that there is a step-wise increase in the mean score among men attending for a check-up with increasing recency. That is, the more knowledgeable men were about gonorrhoea the more recently they had been for an STI check-up ($F=18.18$, $df=4$, $p<.001$).

5.4 SOCIAL NEED

Making It Count recognises the social networks between gay men are important in whether or not men's HIV prevention needs are met. It considers the absence of community infrastructures as evidence of HIV prevention need. *The National Gay Men's Sex Survey* 1999 (Weatherburn *et al*., 2000) has shown loneliness to be associated with a higher likelihood of involvement in sdUAI. The current survey attempted to make an assessment of social isolation and hence the strength of gay men's social networks in London.

N=1649	%				
	strongly disagree	disagree	not sure	agree	strongly agree
"I sometimes feel lonely." (missing 9)	7.1	17.4	5.6	43.8	26.0

Over two thirds of respondents (69.9%) agreed that they sometimes felt lonely. Despite London having a very developed gay scene in terms of commercial venues such as pubs and clubs, these figures suggest a paucity of places where men can meet socially and develop friendships. The presence of a commercial gay scene does not obviate the need for community development and the above can be taken as evidence of need for the interventions which build community infrastructures.

5.5 EQUALITY RELATED NEED

Making It Count (Hickson *et al.,* 2000) states "Social justice and equity are fundamental prerequisites for health and social exclusion has been identified as a key cause of ill health" (p.29). The current survey asked two questions about the most basic form of discrimination against gay men, verbal and physical homophobic abuse.

N=1649	% yes
In the last year, have you been verbally abused because of your sexuality? (missing 15)	29.8
In the last year, have you been physically attacked or assaulted because of your sexuality? (missing 17)	5.0

The *National Gay Men's Sex Survey* in 1997 found that over a third of gay men in Leeds and Bristol had experienced homophobic hate crime in the last five years (Hickson *et al*, 1998) and that this was substantially higher among younger men. The above figures imply that harassment and abuse are a very common experience for gay men in London also, supposedly the 'easiest' place to be gay in the country. This is evidence of need for interventions which reduce the discrimination which approximately 36,000 gay men in London experience every year.

5.6 VARIATION IN NEED ACROSS GROUPS

We now consider how the indicators of need described in the previous sections varied across the population groups described in Chapter 2. The data is presented as whole tables where the columns are the population groups and each row represents an indicator of need. For each row, if the indicator varies significantly across the population groups, the group with the highest value (ie. largest amount of unmet need) is shaded. Alternatively, if one group appears to be lower than the other groups, that value is underlined. Looking at the entire table, if a group often shows higher levels of need than other groups, this will appear as a column of shading and indicate a population group for whom many of the HIV prevention needs are poorly met.

5.6.0 HIV testing history and variations in needs

Many indicators varied by testing history, but it is not the case that the same group always shows the greatest amount of need. Almost all the knowledge indicators showed men who had never tested to be in greatest need of more information. This included the self-rating of how happy men were with what they know. Men who had never tested also appear most naive about when their sexual partners may have HIV infection and whether they will be told that before sex. Perhaps not surprisingly, men who had tested positive were least likely to expect men who have HIV to tell them before sex (and anal intercourse).

However, men who had tested positive did show the greatest amount of need with regard to the converse assumption that partners are positive (when they could not know this). This is compounded and perhaps reinforced by the more common problems they have with bringing up their own HIV status with sexual partners. They are significantly more likely to identify they sex they have as not being as safe as they would like and also appear to have more problems accessing condoms than men who have not tested positive.

Overall, these data suggest that men with all testing histories show evidence of need on all indicators, but that generally men who have never tested are more often in need of knowledge and awareness while men who have tested positive would benefit from greater communication skills and access to resources.

Knowledge items show proportion who did not know or were unsure.	HIV testing history		
	never tested	last test negative	tested positive
Sexually assaulted in last year	3.2	3.2	2.4
Raped in last year	2.5	2.1	2.0
"I'd expect a man with HIV to tell me before sex."	54.3	45.9	25.0
"I'd expect a man with HIV to tell me before fucking."	61.9	54.1	27.8
"If partners don't mention HIV I assume they are positive."	17.2	20.4	27.7
"[Not] always as safe as I want to be."	8.2	10.8	15.6
"I find it hard to say 'NO' to sex I don't want."	13.3	14.4	15.6
"Find it difficult to talk about my HIV status."	22.6	19.5	53.7
"Have problem getting extra strong condoms."	16.2	16.2	23.1
"I'm [not] happy with what I know about HIV."	8.1	4.6	4.8
• Men can have HIV without knowing it.	3.8	1.5	0.0
• There is no vaccine against HIV.	5.2	1.4	0.4
• There is no test to tell whether someone is immune.	31.6	23.1	18.5
• Can pick up HIV by fucking.	5.0	3.3	3.2
• More likely to pick up HIV getting fucked.	20.5	12.8	10.6
• Can pass on HIV without ejaculating.	17.2	12.1	10.8
• More likely to pass on HIV infection if ejaculate.	10.8	7.5	2.8
"Water-based lubricant is hard to get hold of."	12.6	11.5	14.6
• Condoms less likely to break with water based lubricant.	7.9	3.2	1.6
• Two condoms increase breaking.	69.4	66.1	63.2
• Oil lubricants increase breaking.	10.5	5.9	6.0
• Can go to any sexual health / GUM clinic.	24.5	15.2	11.6
• Gonorrhoea is caused by a bacteria.	48.3	43.1	26.4
• Men can have gonorrhoea without knowing it.	45.0	34.4	23.6
• Gonorrhoea is easily treated with antibiotics.	25.2	18.9	8.8
• No one is immune to gonorrhoea.	36.1	29.7	16.4
Verbally abused in last year	25.8	32.3	27.8
Physically assaulted in last year	5.0	4.9	5.6
"I sometimes feel lonely."	67.3	69.9	73.5
"I sometimes worry about how much I drink."	36.1	37.1	29.3
"I'd like more control over my recreational drug use."	15.0	15.8	15.5

5.6.1 Area of residence and variations in needs

Unlike all other ways of grouping men, the indicators of need did not significantly vary by where men lived. This was the case however the sample was grouped by residence. That is, men living in Inner London showed no more or less need as a group than men in Outer London on any of the measures, nor did men in North London compared to South, or in any health authority.

5.6.2 Length of residence in London and variations in needs

Several indicators varied by length of residence in the capital. These include a number of the knowledge indicators suggesting many gay men arrive in London from other parts of the country (and outside the country) ill equipped and poorly informed about HIV. Most striking is the reduction in expectations of HIV disclosure with length of residence. This occurs, perhaps, as men get to know other men in the city and become more familiar with social practices. Loneliness also appears to reduce with length of residence in the city, perhaps as men's social networks expand.

Knowledge items show proportion who did not know or were unsure	Length of residence in London			
	less than 1 year	1 to 5 years	5 to 10 years	over 10 years
Sexually assaulted in last year	3.7	4.3	3.3	1.8
Raped in last year	2.8	3.6	2.9	0.7
"I'd expect a man with HIV to tell me before sex."	53.6	50.5	40.4	38.8
"I'd expect a man with HIV to tell me before fucking."	65.1	56.2	47.8	44.9
"If partners don't mention HIV I assume they are positive."	23.9	15.6	19.9	26.1
"[Not] always as safe as I want to be."	8.1	13.3	12.0	10.0
"I find it hard to say 'NO' to sex I don't want."	13.5	16.5	14.9	11.2
"Find it difficult to talk about my HIV status."	24.8	26.0	25.4	28.0
"Have problem getting extra strong condoms."	22.0	18.3	12.4	18.3
"I'm [not] happy with what I know about HIV."	7.2	7.9	4.3	2.8
• Men can have HIV without knowing it.	1.8	1.5	1.1	1.4
• There is no vaccine against HIV.	0.0	1.5	1.8	2.1
• There is no test to tell whether someone is immune.	22.9	25.7	24.1	22.8
• Can pick up HIV by fucking.	3.6	5.4	3.6	3.0
• More likely to pick up HIV getting fucked.	16.4	17.4	13.1	11.1
• Can pass on HIV without ejaculating.	9.0	14.1	13.1	12.9
• More likely to pass on HIV infection if ejaculate.	9.9	9.2	5.1	6.2
"Water-based lubricant hard to get hold of."	18.2	11.6	10.6	12.9
• Condoms less likely to break with water based lubricant.	10.9	4.4	1.8	3.0
• Two condoms increase breaking.	62.7	65.4	68.2	67.7
• Oil lubricants increase breaking.	13.8	9.8	5.8	5.6
• Can go to any sexual health / GUM clinic.	32.1	23.0	13.8	12.5
• Gonorrhoea is caused by a bacteria.	49.5	50.3	44.0	34.3
• Men can have gonorrhoea without knowing it.	37.6	39.8	36.0	32.3
• Gonorrhoea is easily treated with antibiotics.	31.2	28.8	20.7	9.4
• No one is immune to gonorrhoea.	33.0	36.5	29.8	23.7
Verbally abused in last year	28.4	34.3	29.1	26.2
Physically assaulted in last year	0.9	5.6	4.7	3.7
"I sometimes feel lonely."	75.2	72.4	66.9	65.5
"I sometimes worry about how much I drink."	30.3	37.1	35.5	35.8
"I'd like more control over my recreational drug use."	7.6	16.8	15.0	16.3

5.6.3 Age and variations in needs

Almost all the indicators showed variation across the age range, many showing a U-shaped curve of need with need decreasing with increasing age but then turning up again among the oldest age group. Expectations of HIV positive disclosure show this pattern, as do several of the knowledge indicators. The removal of sexual autonomy through sexual assault and rape are particularly experienced by younger men. A staggering 17% of gay men under 20 have experienced sexual assault in last year and over one in ten have been raped. Concern about drug use (other than alcohol) was also much more common among younger men, with over a quarter wanting more control in this area. The majority of knowledge items were least known by younger men, who were also most likely to be dissatisfied with what they knew. Problems with access to condoms and lubricant, lack of assertiveness, not being as safe as they want to be, loneliness and concern about alcohol were all equally common unmet needs across the age range.

Knowledge items show proportion who did not know or were unsure.	**Age**				
	<20	**20s**	**30s**	**40s**	**50+**
Sexually assaulted in last year	16.7	3.7	2.6	2.1	0.7
Raped in last year	11.9	3.3	1.6	1.5	0.7
"I'd expect a man with HIV to tell me before sex."	66.7	53.1	36.8	40.7	64.1
"I'd expect a man with HIV to tell me before fucking."	80.5	57.7	45.8	48.2	68.1
"If partners don't mention HIV I assume they are positive."	7.1	13.7	22.4	27.7	22.5
"[Not] always as safe as I want to be."	9.3	11.6	12.8	7.9	6.4
"I find it hard to say 'NO' to sex I don't want."	16.3	17.5	13.1	13.0	13.4
"Find it difficult to talk about my HIV status."	26.8	20.9	25.9	31.9	24.3
"Have problem getting extra strong condoms."	9.5	18.3	16.4	19.0	18.1
"I'm [not] happy with what I know about HIV."	9.3	8.1	5.1	3.0	3.5
• Men can have HIV without knowing it.	7.0	3.5	1.2	0.6	2.8
• There is no vaccine against HIV.	9.3	2.8	1.6	2.7	1.4
• There is no test to tell whether someone is immune.	44.2	26.9	24.0	22.3	21.1
• Can pick up HIV by fucking.	2.3	4.4	3.3	3.4	4.9
• More likely to pick up HIV getting fucked.	30.2	20.0	10.6	13.7	14.8
• Can pass on HIV without ejaculating.	16.3	12.3	11.0	14.9	21.8
• More likely to pass on HIV infection if ejaculate.	20.9	10.2	6.0	7.3	5.0
"Water-based lubricant hard to get hold of."	14.0	11.7	12.6	13.2	11.5
• Condoms less likely to break with water based lubricant.	16.3	4.9	3.3	3.0	5.6
• Two condoms increase breaking.	62.8	59.7	67.5	71.0	72.5
• Oil lubricants increase breaking.	18.6	8.4	6.3	5.8	8.5
• Can go to any sexual health / GUM clinic.	33.3	23.4	15.8	13.1	10.0
• Gonorrhoea is caused by a bacteria.	64.3	48.0	43.4	33.1	30.7
• Men can have gonorrhoea without knowing it.	59.5	40.1	35.7	28.7	32.9
• Gonorrhoea is easily treated with antibiotics.	54.8	32.6	16.0	9.7	3.6
• No one is immune to gonorrhoea.	47.6	38.1	28.6	23.7	14.3
Verbally abused in last year	54.8	33.6	30.6	24.5	17.7
Physically assaulted in last year	16.7	6.5	5.1	2.4	2.2
"I sometimes feel lonely."	83.3	70.5	67.9	73.3	65.2
"I sometimes worry about how much I drink."	31.7	34.4	37.3	38.1	28.6
"I'd like more control over my recreational drug use."	26.3	13.2	17.7	15.1	10.1

5.6.4 Ethnicity and variations in needs

Unlike age and education, few of the indicators of need showed variation across ethnic groups. Those that did were mainly knowledge items. Black men appear to least likely to know that men can have HIV without knowing it, which may suggest need for a specific intervention to meet this need among this group. Asian men appear least knowledgeable on a few other knowledge items and also to be most likely to be concerned about alcohol use.

Knowledge items show proportion who did not know or were unsure.	Ethnicity					
	Asian/Asian British	Black/Black British	Irish	White British	Other White	All others
Sexually assaulted in last year	6.7	2.4	4.9	2.7	4.6	1.3
Raped in last year	0.0	2.4	3.7	1.9	3.8	1.3
"I'd expect a man with HIV to tell me before sex."	53.3	44.4	42.2	45.6	43.5	44.0
"I'd expect a man with HIV to tell me before fucking."	63.3	45.5	48.8	43.3	48.5	54.1
"If partners don't mention HIV I assume they are positive."	20.0	20.0	18.1	20.6	24.8	12.3
"[Not] always as safe as I want to be."	13.3	13.3	7.2	11.3	9.5	10.5
"I find it hard to say 'NO' to sex I don't want."	23.3	20.0	8.3	14.8	13.0	13.3
"Find it difficult to talk about my HIV status."	30.0	32.5	24.4	24.0	28.8	32.5
"Have problem getting extra strong condoms."	13.3	24.4	18.3 1	5.8	20.5	27.6
"I'm [not] happy with what I know about HIV."	0.0	11.1	7.1	4.7	6.1	9.3
• Men can have HIV without knowing it.	3.3	11.1	2.4	1.7	0.4	6.6
• There is no vaccine against HIV.	0.0	6.7	3.6	2.2	1.2	5.3
• There is no test to tell whether someone is immune.	23.3	37.8	24.1	24.8	20.9	28.0
• Can pick up HIV by fucking.	13.3	4.4	1.2	3.6	4.6	1.3
• More likely to pick up HIV getting fucked.	16.7	20.5	12.0	13.8	17.8	13.5
• Can pass on HIV without ejaculating.	10.0	27.3	11.9	12.9	14.7	9.2
• More likely to pass on HIV infection if ejaculate.	16.7	14.0	7.1	7.1	8.1	9.2
"Water-based lubricant hard to get hold of."	13.3	17.1	15.7	11.5	13.5	14.5
• Condoms less likely to break with water based lubricant.	13.3	4.8	6.0	3.3	6.5	5.3
• Two condoms increase breaking.	70.0	57.1	72.3	67.5	63.5	56.6
• Oil lubricants increase breaking.	20.0	4.8	10.8	5.7	9.6	13.2
• Can go to any sexual health / GUM clinic.	16.7	12.2	19.3	15.2	24.4	24.0
• Gonorrhoea is caused by a bacteria.	40.0	46.3	47.0	41.4	40.8	48.0
• Men can have gonorrhoea without knowing it.	53.3	36.6	38.6	34.9	34.7	41.3
• Gonorrhoea is easily treated with antibiotics.	30.0	24.4	19.3	17.4	22.1	25.3
• No one is immune to gonorrhoea.	36.7	31.7	34.9	28.8	26.7	37.3
Verbally abused in last year	33.3	24.4	44.6	28.4	31.9	27.6
Physically assaulted in last year	6.7	0.0	7.3	4.4	6.1	7.9
"I sometimes feel lonely."	63.3	71.8	75.0	68.4	26.7	22.4
"I sometimes worry about how much I drink."	41.4	35.9	33.3	38.4	28.0	25.0"
I'd like more control over my recreational drug use."	17.2	8.3	24.4	13.9	17.6	27.8

5.6.5 Education level and variations in needs

Half the indicators of need showed significant variation across education groups and all varied in the same direction: men with lower levels of education have more unmet need than men with higher levels of education. Ten of the fifteen knowledge items indicate greater need among men with lower education as did five of the sixteen other indicators. Many of the other indicators showed a trend in the same direction. Section 3.3.5 showed that having HIV is more common among men with lower education than among men with a university degree (as have previous surveys). The data in this section provide compelling reasons why this is the case: fewer men with lower education have their HIV prevention needs met.

Knowledge items show proportion who did not know or were unsure.	Education level		
	low	medium	high
Sexually assaulted in last year	4.3	3.2	2.5
Raped in last year	2.9	2.7	1.6
"I'd expect a man with HIV to tell me before sex."	56.8	49.4	39.4
"I'd expect a man with HIV to tell me before fucking."	62.7	56.7	47.0
"If partners don't mention HIV I assume they are positive."	21.4	19.0	21.2
"[Not] always as safe as I want to be."	11.5	11.3	10.5
"I find it hard to say 'NO' to sex I don't want."	19.7	14.6	12.4
"Find it difficult to talk about my HIV status."	26.1	22.9	26.5
"Have problem getting extra strong condoms."	22.7	16.3	16.1
"I'm [not] happy with what I know about HIV."	7.2	7.1	4.4
• Men can have HIV without knowing it.	5.3	2.5	0.6
• There is no vaccine against HIV.	5.0	2.2	1.2
• There is no test to tell whether someone is immune.	34.8	26.7	20.9
• Can pick up HIV by fucking.	4.3	3.4	3.6
• More likely to pick up HIV getting fucked.	20.4	17.2	11.7
• Can pass on HIV without ejaculating.	17.1	15.4	11.2
• More likely to pass on HIV infection if ejaculate.	14.6	6.9	5.9
"Water-based lubricant hard to get hold of."	13.6	12.6	11.9
• Condoms less likely to break with water based lubricant.	6.4	4.4	3.5
• Two condoms increase breaking.	67.6	70.0	64.3
• Oil lubricants increase breaking.	14.0	6.9	5.1
• Can go to any sexual health / GUM clinic.	18.2	19.3	16.1
• Gonorrhoea is caused by a bacteria.	47.5	44.7	39.1
• Men can have gonorrhoea without knowing it.	44.6	36.8	32.8
• Gonorrhoea is easily treated with antibiotics.	21.4	22.7	16.8
• No one is immune to gonorrhoea.	32.5	32.0	27.2
Verbally abused in last year	30.3	33.4	28.4
Physically assaulted in last year	7.2	7.1	3.6
"I sometimes feel lonely."	77.6	73.8	65.7
"I sometimes worry about how much I drink."	36.9	32.2	36.8
"I'd like more control over my recreational drug use."	18.5	16.3	14.3

5.6.6 Partnership status and variations in needs

Single men showed greater levels of need than men in relationships on a number of indicators, particularly sexual assault, loneliness and concern about drug use other than alcohol. There was far less variation on the knowledge indicators and none on those concerning access to resources. It is interesting to note that the proportion of men who are not always as safe as they want to be *did not* significantly vary by partnership status. This would suggest that interventions are needed for both men in and out of relationships. We might expect single men to disproportionately benefit from interventions which build community infrastructures. Since the majority of gay men will be single at some point in the future, this would mean the majority of men.

Knowledge items show proportion who did not know or were unsure.	Current partnership status		
	single	partnered less than 1 year	partnered over 1 year
Sexually assaulted in last year	4.3	1.3	1.5
Raped in last year	2.9	0.9	1.3
"I'd expect a man with HIV to tell me before sex."	45.5	49.4	41.9
"I'd expect a man with HIV to tell me before fucking."	52.1	58.1	49.7
"If partners don't mention HIV I assume they are positive."	21.9	14.8	21.4
"[Not] always as safe as I want to be."	11.9	13.0	8.4
"I find it hard to say 'NO' to sex I don't want."	15.1	14.5	12.9
"Find it difficult to talk about my HIV status."	27.7	22.2	23.4
"Have problem getting extra strong condoms."	16.9	19.7	16.8
"I'm [not] happy with what I know about HIV."	7.3	6.4	2.1
• Men can have HIV without knowing it.	2.7	1.3	1.3
• There is no vaccine against HIV.	2.2	3.0	1.9
• There is no test to tell whether someone is immune.	25.0	33.8	21.1
• Can pick up HIV by fucking.	3.6	5.1	3.4
• More likely to pick up HIV getting fucked.	16.4	15.0	11.2
• Can pass on HIV without ejaculating.	14.5	13.6	10.8
• More likely to pass on HIV infection if ejaculate.	8.3	7.3	7.0
"Water-based lubricant hard to get hold of."	12.4	14.1	11.9
• Condoms less likely to break with water based lubricant.	5.8	3.4	2.1
• Two condoms increase breaking.	67.2	63.5	66.5
• Oil lubricants increase breaking.	8.8	5.6	5.5
• Can go to any sexual health / GUM clinic.	19.1	19.1	13.9
• Gonorrhoea is caused by a bacteria.	43.4	46.0	38.0
• Men can have gonorrhoea without knowing it.	37.5	38.3	31.5
• Gonorrhoea is easily treated with antibiotics.	19.9	21.7	16.6
• No one is immune to gonorrhoea.	30.0	34.9	26.0
Verbally abused in last year	28.3	32.2	31.4
Physically assaulted in last year	5.0	7.3	4.0
"I sometimes feel lonely."	83.7	64.8	48.6
"I sometimes worry about how much I drink."	36.5	32.3	36.0
"I'd like more control over my recreational drug use."	17.9	13.4	12.9

5.6.7 Gender of sexual partners and variations in needs

No indicator of need was significantly higher among men who had sex with men only than among men who had sex with both men and women. However, several indicators showed difference in the other direction. Almost all of the indicators of need for knowledge showed more need among behaviourally bisexual men than among exclusively homosexually active men. In some cases the differences were very large. For example, ten per cent of behaviourally bisexual men did not know that men can have HIV without knowing it compared with less than two per cent of other men. Bisexual men were also far more likely to be naive about HIV disclosure than were men who had sex with men only. Although similar proportions of both groups had problems accessing condoms, more bisexual men had problems getting hold of water-based lubricant. Finally, sexual assault appears more common an experience for bisexual men than for exclusively homosexually active men.

Taking account of these findings in planning the HIV prevention programme for London's male homosexually active population poses challenges. While data about HIV infection all suggest it is gay men (those who have sex with men only) and not bisexual men (those who have sex with both men and women) who are most likely to become infected with HIV, it is the latter group who display the greater amount of unmet need. How this influences the programme, and whether the unmet needs of gay men or bisexual men are prioritised, will depend on the relative weight given to ensuring the programme has the largest possible epidemiological impact (prioritise gay men) and the weight given to ensuring all men have an equal opportunity to have their HIV prevention needs met (prioritise bisexual men). In practice, we feel both these principles (impact and equity) must be attended to and *Making It Count* suggests programmes attend to both.

Knowledge items show proportion who did not know or were unsure.	Gender of sexual partners in last year	
	men & women	men only
Sexually assaulted in last year	7.8	2.8
Raped in last year	3.9	2.1
"I'd expect a man with HIV to tell me before sex."	60.8	44.3
"I'd expect a man with HIV to tell me before fucking."	68.8	51.5
"If partners don't mention HIV I assume they are positive."	15.6	21.0
"[Not] always as safe as I want to be."	12.5	10.7
"I find it hard to say 'NO' to sex I don't want."	16.5	14.3
"Find it difficult to talk about my HIV status."	23.7	25.7
"Have problem getting extra strong condoms."	17.1	17.3
"I'm [not] happy with what I know about HIV."	8.8	5.4
• Men can have HIV without knowing it.	10.0	1.6
• There is no vaccine against HIV.	6.3	2.1
• There is no test to tell whether someone is immune. 3	5.0	24.3
• Can pick up HIV by fucking.	13.8	3.2
• More likely to pick up HIV getting fucked.	23.8	14.1
• Can pass on HIV without ejaculating.	21.5	12.8
• More likely to pass on HIV infection if ejaculate.	15.4	7.3
"Water-based lubricant hard to get hold of."	19.7	12.0
• Condoms less likely to break with water based lubricant.	15.8	3.6
• Two condoms increase breaking.	67.5	66.3
• Oil lubricants increase breaking.	17.3	6.7
• Can go to any sexual health / GUM clinic.	26.3	16.8
• Gonorrhoea is caused by a bacteria.	40.8	42.0
• Men can have gonorrhoea without knowing it.	40.0	35.5
• Gonorrhoea is easily treated with antibiotics.	31.6	18.5
• No one is immune to gonorrhoea.	42.1	28.8
Verbally abused in last year	24.7	30.1
Physically assaulted in last year	7.8	4.9
"I sometimes feel lonely."	71.4	69.8
"I sometimes worry about how much I drink."	36.4	35.7
"I'd like more control over my recreational drug use."	20.6	15.3

5.6.8 Number of male sexual partners and variations in needs

Several indicators of need varied by men's numbers of sexual partners. Men with fewer sexual partners tended to be more naive about HIV disclosure and to show greater need on a number of the knowledge items. Conversely, they were least likely to express sometimes being lonely. Men with large numbers of partners appear more knowledgeable about HIV but did show greater levels of need around an ability to say no to sex they did not want. This suggests that at least some of their larger number of sexual partners are unwanted, and is reflected in a greater degree of concern about sexual safety.

Knowledge items show proportion who did not know or were unsure.	Number of male sexual partners in last year				
	1	2, 3 or 4	5 to 12	13 to 29	30+
Sexually assaulted in last year	1.1	1.9	2.9	4.2	3.8
Raped in last year	1.1	1.5	2.0	3.4	2.4
"I'd expect a man with HIV to tell me before sex."	59.4	61.4	46.7	37.5	32.2
"I'd expect a man with HIV to tell me before fucking."	69.5	65.6	55.8	48.9	35.9
"If partners don't mention HIV I assume they are positive."	14.9	21.0	20.4	23.4	21.3
"Sex I have is [not] always as safe as I want to be."	3.9	4.2	10.2	15.1	16.0
"I find it hard to say 'NO' to sex I don't want."	7.8	12.5	15.1	14.0	17.3
"Find it difficult to talk about my HIV status."	16.6	26.0	27.6	25.8	26.9
"Have problem getting extra strong condoms."	15.8	18.8	17.2	13.4	19.3
"I'm [not] happy with what I know about HIV."	4.4	5.7	6.5	3.8	5.9
• Men can have HIV without knowing it.	2.2	2.6	2.3	1.1	1.5
• There is no vaccine against HIV.	3.9	3.8	1.8	1.5	1.3
• There is no test to tell whether someone is immune.	30.4	30.6	23.0	27.2	19.9
• Can pick up HIV by fucking.	4.4	3.8	4.5	3.0	2.9
• More likely to pick up HIV getting fucked.	14.4	18.6	14.8	13.5	12.6
• Can pass on HIV without ejaculating.	15.5	14.4	14.5	13.5	9.5
• More likely to pass on HIV infection if ejaculate.	5.5	9.8	7.7	9.1	6.4
"Water-based lubricant hard to get hold of."	10.0	10.8	14.4	10.3	13.4
• Condoms less likely to break with water based lubricant.	4.4	5.0	4.3	5.3	2.9
• Two condoms increase breaking.	70.2	66.0	67.8	63.8	66.2
• Oil lubricants increase breaking.	6.1	8.4	7.0	8.3	6.1
• Can go to any sexual health / GUM clinic.	22.8	18.9	18.1	14.7	13.8
• Gonorrhoea is caused by a bacteria.	43.3	49.2	44.9	41.9	33.6
• Men can have gonorrhoea without knowing it.	41.9	40.2	37.4	32.1	30.9
• Gonorrhoea is easily treated with antibiotics.	26.1	22.7	20.2	20.5	11.8
• No one is immune to gonorrhoea.	30.6	29.9	29.9	31.4	27.2
Verbally abused in last year	23.5	27.8	29.9	29.4	33.3
Physically assaulted in last year	5.0	4.2	3.7	7.6	5.3
"I sometimes feel lonely."	54.4	68.2	73.3	72.5	72.1
"I sometimes worry about how much I drink."	35.4	35.9	36.7	33.8	36.5
"I'd like more control over my recreational drug use."	12.7	12.7	16.1	17.2	16.9

5.6.9 Selling sex and variations in needs

There are numerous sexual health hazards associated with selling sex and these vary depending on the circumstances in which sex is sold. Anticipating age to be important in the resources men have to manage selling sex safely, the following table separates men under and over 30 years of age, before comparing those men who sold sex with those who did not. Selling sex, irrespective of age, was associated with greater likelihood of sexual assault and rape, and concern about drug use.

The two columns on the left show the indicators of need for men under 30 years of age, those who had not sold sex (on the left) and those who had (on the right). Many indicators show substantially greater HIV prevention need among younger men selling sex than among younger men not selling sex. These include many of the knowledge items as well as verbal and physical anti-gay abuse. Selling sex was also associated with higher levels of loneliness among younger (but not older) men. Among the men over 30 (the two columns on the right), selling sex was far less often associated with greater levels of HIV prevention need that among younger men, although older sex workers did express greater dissatisfaction about their HIV knowledge than older men who did not sell sex. In regard to naivete about HIV disclosure, selling sex was associated with less need.

Clearly many sex workers across the age range would benefit from interventions that enable them to work more safely and increase their control over the drugs they take. Sexual assault should not be regarded simply as an occupational hazard of sex work or something which men selling sex should expect and put up with. The more widespread need shown among younger men selling sex suggests this is a group for whom many HIV prevention needs are poorly met, and that this group should be prioritised for intervention.

Knowledge items show proportion who did not know or were unsure.	under 30 years old		30 years or older	
	not sold sex	sold sex	not sold sex	sold sex
Sexually assaulted in last year	3.8	12.5	1.9	10.4
Raped in last year	3.1	10.7	1.2	8.3
"I'd expect a man with HIV to tell me before sex."	53.7	58.9	42.1	22.4
"I'd expect a man with HIV to tell me before fucking."	59.7	60.0	50.3	23.4
"If partners don't mention HIV I assume they are positive."	12.3	19.6	23.8	26.5
"[Not] always as safe as I want to be."	10.9	15.1	10.5	14.3
"I find it hard to say 'NO' to sex I don't want."	17.1	20.0	13.3	10.2
"Find it difficult to talk about my HIV status."	19.4	36.4	27.2	31.9
"Have problem getting extra strong condoms."	16.7	23.2	17.3	18.4
"I'm [not] happy with what I know about HIV."	7.3	14.5	4.1	10.2
• Men can have HIV without knowing it.	2.6	12.5	1.3	0.0
• There is no vaccine against HIV.	2.6	8.9	1.9	2.0
• There is no test to tell whether someone is immune.	27.5	35.7	22.9	28.6
• Can pick up HIV by fucking.	3.1	12.5	3.7	0.0
• More likely to pick up HIV getting fucked.	19.2	33.9	12.0	10.9
• Can pass on HIV without ejaculating.	11.0	25.0	13.7	8.2
• More likely to pass on HIV infection if ejaculate.	10.1	19.6	6.2	6.1
"Water-based lubricant hard to get hold of."	11.1	17.9	12.5	16.3
• Condoms less likely to break with water based lubricant.	5.5	8.9	3.7	0.0
• Two condoms increase breaking.	59.0	67.3	69.3	65.3
• Oil lubricants increase breaking.	8.0	19.6	6.5	4.1
• Can go to any sexual health / GUM clinic.	24.5	23.2	14.7	6.1
• Gonorrhoea is caused by a bacteria.	49.6	48.2	39.4	28.6
• Men can have gonorrhoea without knowing it.	40.3	53.6	33.6	26.5
• Gonorrhoea is easily treated with antibiotics.	33.7	41.1	13.1	4.1
• No one is immune to gonorrhoea.	37.2	51.8	25.5	24.5
Verbally abused in last year	33.8	48.2	27.0	33.3
Physically assaulted in last year	6.3	16.4	3.8	8.3
"I sometimes feel lonely."	70.0	83.9	69.4	63.3
"I sometimes worry about how much I drink."	33.3	41.1	36.8	28.6
"I'd like more control over my recreational drug use."	11.5	35.2	15.4	31.3

5.6.10 Sexual assault history and variations in needs

Since all men who had experienced sexual assault in the last year (including rape) had a history of sexual assault, these two indicators of need do not appear in this table. Men who had experienced sexual abuse or assault showed higher levels of homophobic victimisation also. Both verbal and physical assault were more common among men who had experienced any previous sexual assault, but particularly those men who had experienced it as both a child and an adult. Men who had experienced abuse as children or as adults had higher levels of need around assertiveness and expressed concerns about sexual safety than men who had never experienced these. However, it was men who had experienced unwanted sex as both children and adults who showed greatest levels of need on these indicators (although this was a small group overall, see section 2.10). Access to condoms and lubricant also seem problematic for this group.

Knowledge items show proportion who did not know or were unsure.	**Sexual assault history**			
	never	**before 16 only**	**both before & since 16**	**since 16 only**
"I'd expect a man with HIV to tell me before sex."	45.8	50.9	42.9	38.8
"I'd expect a man with HIV to tell me before fucking."	53.4	56.8	47.6	45.3
"If partners don't mention HIV I assume they are positive."	19.8	17.9	16.7	27.4
"[Not] always as safe as I want to be."	9.3	10.7	21.4	17.6
"I find it hard to say 'NO' to sex I don't want."	12.5	19.6	31.0	18.4
"Find it difficult to talk about my HIV status."	24.7	32.4	28.6	27.0
"Have problem getting extra strong condoms."	15.7	18.6	41.5	19.8
"I'm [not] happy with what I know about HIV."	5.3	6.3	7.1	5.4
• Men can have HIV without knowing it.	1.7	5.3	2.4	2.1
• There is no vaccine against HIV.	2.3	2.7	0.0	1.3
• There is no test to tell whether someone is immune.	24.1	30.6	28.6	23.4
• Can pick up HIV by fucking.	3.7	8.0	2.4	2.1
• More likely to pick up HIV getting fucked.	14.9	15.3	9.5	13.1
• Can pass on HIV without ejaculating.	13.6	16.8	9.5	10.5
• More likely to pass on HIV infection if ejaculate.	7.6	11.6	4.8	7.1
"Water-based lubricant hard to get hold of."	10.6	12.4	29.3	18.8
• Condoms less likely to break with water based lubricant.	4.4	4.4	4.9	2.9
• Two condoms increase breaking.	68.4	60.4	58.5	61.5
• Oil lubricants increase breaking.	7.3	9.9	9.8	5.0
• Can go to any sexual health / GUM clinic.	17.5	19.5	17.1	14.3
• Gonorrhoea is caused by a bacteria.	43.5	44.2	41.5	32.9
• Men can have gonorrhoea without knowing it.	36.5	35.7	36.6	30.8
• Gonorrhoea is easily treated with antibiotics.	19.7	20.4	17.1	15.3
• No one is immune to gonorrhoea.	30.7	21.2	26.8	26.2
Verbally abused in last year	26.2	43.1	54.8	38.1
Physically assaulted in last year	3.3	10.6	22.0	8.0
"I sometimes feel lonely."	67.4	76.1	76.2	78.6
"I sometimes worry about how much I drink."	33.6	38.1	42.9	43.3
"I'd like more control over my recreational drug use."	13.2	22.0	25.6	22.5

5.6.11 Use of recreational drugs, injecting and variations in needs

There was little variation across drug user groups in knowledge about HIV, condoms or gonorrhoea. Not surprisingly, men who had not used drugs were least concerned about their drug and alcohol use. On the other hand, naivete about HIV disclosure was more common among men who had not used drugs or had used alcohol only. Although finding it hard to say no was associated with poppers use, it was men who used class A drugs who identified the sex they have as not being as safe as they want it to be most commonly. Homophobic verbal abuse was also more common for men who took class A drugs or cannabis, although we are curious as to why this might be the case (verbal abuse occurs on leaving gay clubs, which may be more frequently used by drug users.)

Knowledge items show proportion who did not know or were unsure	none	alcohol	poppers (+/- alcohol)	cannabis (+/- alcohol & poppers)	any class A
Sexually assaulted in last year	3.7	2.8	3.7	2.4	3.2
Raped in last year	3.7	1.7	2.0	1.2	2.8
"I'd expect a man with HIV to tell me before sex."	53.3	56.3	41.2	38.7	40.9
"I'd expect a man with HIV to tell me before fucking."	59.8	61.5	49.8	47.1	48.2
"If partners don't mention HIV I assume they are positive."	23.6	15.2	23.0	20.0	22.5
"[Not] always as safe as I want to be."	8.4	5.0	10.6	8.2	15.9
"I find it hard to say 'NO' to sex I don't want."	14.0	9.4	18.4	12.5	16.2
"Find it difficult to talk about my HIV status."	29.6	23.2	32.5	24.2	24.5
"Have problem getting extra strong condoms."	11.2	17.0	21.0	17.3	16.5
"I'm [not] happy with what I know about HIV."	6.5	4.4	4.5	5.5	6.6
• Men can have HIV without knowing it.	2.8	2.2	1.6	1.2	2.3
• There is no vaccine against HIV.	1.9	2.8	3.3	0.4	1.7
• There is no test to tell whether someone is immune.	25.2	24.3	25.0	26.7	24.3
• Can pick up HIV by fucking.	4.7	4.4	4.1	2.7	2.3
• More likely to pick up HIV getting fucked.	15.0 1	6.6	18.8	11.0	12.9
• Can pass on HIV without ejaculating.	18.7	15.7	15.1	12.9	10.0
• More likely to pass on HIV infection if ejaculate.	2.8	8.3	9.8	7.5	7.7
"Water-based lubricant hard to get hold of."	8.6	11.9	13.6	13.3	12.5
• Condoms less likely to break with water based lubricant.	7.5	4.7	4.5	4.3	3.1
• Two condoms increase breaking.	63.2	70.2	63.5	65.9	66.3
• Oil lubricants increase breaking.	9.5	7.4	8.2	5.9	6.8
• Can go to any sexual health / GUM clinic.	19.6	19.6	14.7	13.8	17.8
• Gonorrhoea is caused by a bacteria.	41.1	44.4	43.0	43.9	39.4
• Men can have gonorrhoea without knowing it.	38.3	36.4	36.3	35.2	34.7
• Gonorrhoea is easily treated with antibiotics.	23.4	21.0	18.4	14.6	18.7
• No one is immune to gonorrhoea.	30.8	32.6	26.9	28.9	28.3
Verbally abused in last year	27.4	24.7	25.0	35.5	33.4
Physically assaulted in last year	6.5	3.9	4.1	6.3	5.4
"I sometimes feel lonely."	75.7	66.2	66.8	73.8	70.5
"I sometimes worry about how much I drink."	10.7	33.1	36.2	37.3	40.5
"I'd like more control over my recreational drug use."	2.3	12.1	12.3	15.6	20.3

6 The link: Need informing interventions

6.1 PRIORITISING NEED

If there is more need than resources available to address it, then we require a way of deciding which needs to address. The end point of mapping and prioritising need is a priority list of needs to address. Two principles can be applied to the needs map in order to prioritise which needs to address with finite resources. Needs are aims which are unmet for particular groups. Hence, priority needs can be defined by their aim, or their population group or both. *Making It Count* suggests two principles for prioritising need.

6.1.1 Prioritise aims which are poorly met for a large proportion of the population

This principle should increase the efficiency of programmes. Common unmet aims require fewer resources to address per head of population than the same unmet aim among fewer men. The data described in the previous chapter suggest that few HIV prevention needs are unmet for large proportions of men across most demographic groups. An exception is expectation of disclosure of HIV status by men with HIV. In order to have control over sdUAI, men need to know that many men with HIV do not know they are infected, and that many of those who do know do not tell their sexual partners (even if they engage in UAI with them). Many men did not know these facts. Addressing this need without demonising men with HIV is a challenging and pressing need for HIV prevention. A second HIV prevention need that was poorly met for a very large proportion of men was social support, evidenced by the proportion of men who say they sometimes feel lonely. This need is also a challenge to health promoters, especially in a large metropolitan city like London, where a commercial gay scene is often mistakenly thought to replace a gay community.

6.1.2 Prioritise population groups for whom many of the aims are poorly met

This second principle should increase the equity of programmes as well as increase their impact on incidence. The point is to identify 'vulnerable' groups: those who have little or no control over HIV in their everyday lives.

It is clear that if London's HIV prevention programme for gay men is both to have the greatest possible impact on HIV incidence, and is to disproportionately benefit those in most need, then all interventions should be designed (in setting and objectives) to disproportionately benefit men with lower education rather than men with higher education.

It is also clear that if London's HIV prevention programme for gay men is to disproportionately benefit those in most need, then the majority of interventions should take place in settings which younger men are most likely to use and if not appropriate and acceptable to all men, should be biased toward younger men.

Overall, the needs data here does not suggest any one ethnic group should have their needs prioritised over any other groups. It may be that a case can be made for ethnic group specific interventions (or organisations) to address the HIV prevention needs of specific ethnic groups of gay men. However, this case is probably best made on the basis of the qualities of those interventions rather than on a greater level of need among their target groups. It is also very likely to be the case that the demographic variations found in other sections are the case among the ethnic groups

individually. This suggests that agencies or interventions whose target groups are minority ethnic groups should be biased towards those members of that group who are younger, less well educated or who have larger numbers of sexual partners.

6.2 SETTINGS FOR HIV HEALTH PROMOTION

Men were asked how recently they had been to nineteen settings in which HIV prevention activity may occur. The following figure shows the proportion of men using each setting in the last year, and the proportion of those who used and those who did not use, who had unknown or discordant UAI.

Unknown or discordant UAI by setting use		% used setting in the last year	% who had unknown or discordant UAI		p
			Those who used setting in last year	Those who did not use setting in last year	
Looked at a publication	The gay press	99.1	33.8	26.7	ns
	The HIV positive press	80.4	35.1	28.7	<.04
Went to a commercial scene venue	Gay pub	97.5	34.0	24.4	ns
	Gay club	86.8	35.2	23.0	<.001
	gym/fitness club	55.6	33.1	34.9	ns
Went to a sex venue	cruising ground	55.1	39.2	26.9	<.001
	backroom/sex club	49.3	40.0	27.9	<.001
	Gay sauna	51.9	37.8	29.5	<.001
	cottage	31.8	41.8	30.0	<.001
Approached a service	Went to your GP	77.6	32.8	37.2	ns
	Went to a sexual health clinic	54.8	38.9	27.8	<.001
	Went to an AIDS organisation	16.6	37.4	32.7	ns
	Phoned a Gay help-line	15.2	36.8	33.1	ns
	Phoned an AIDS help-line	8.5	43.4	32.9	<.02
Attended a community event	Gay social group	30.3	29.5	35.9	<.02
	Gay community centre	14.4	34.5	33.6	ns
	Gay Pride/Mardi Gras type event	63.5	35.7	30.4	<.03
Used the internet		76.6	34.4	31.6	ns
Volunteered for a Gay or HIV/AIDS organisation		26.5	34.7	33.3	ns

It should be asssumed that, for example, because men who used cruising grounds or backrooms were more likely to have had sdUAI than men who did not use them, that the sdUAI they had occurred at the cruising ground or backroom (although it may have). Men who attended a GUM clinic or Gay Pride event were also more likely to have sdUAI than those who did not. This does not mean their sdUAI occurred at the clinic or at Pride (although it may have).

GUM based researchers Dodds and Mercey (1997; 1998; 1999; 2000) have found that men who attend GUM clinics are more likely to have been involved in sexual HIV exposure than men who do not attend GUM clinics. They conclude that clinics are good places to do HIV prevention interventions because they will be encountered disproportionately by men involved in HIV exposure. The current survey found the same association: those who had been to a sexual health clinic in the last year (54.8% of men) were more likely to have had unknown or known discordant UAI (38.9% had) than men who had not been to a sexual health clinic in the last year (of whom 27.8% had unknown or known discordant UAI).

We also found that men who had read the HIV press, been to a gay club, been cruising or cottaging, been to a sex club or gay sauna, been to an AIDS organisation, phoned a gay or AIDS helpline or been to a Gay Pride event, were more likely to have had unknown or known discordant UAI than were men who had not used each of these settings. The only setting for which we found evidence in the opposite direction were gay social groups: men who went to one in the last year were less likely to have unknown or known discordant UAI than men who did not go to one.

This suggests that the majority of settings in which gay men's HIV prevention work can occur are suitable for interventions and that it is the diversity of settings used that will be important in the coverage of the target group.

6.3 THE RELATIONSHIP BETWEEN HOW HIV IS ACQUIRED AND HOW HEALTH AUTHORITIES SPEND HIV PREVENTION MONIES

Decisions about how HIV prevention monies are spent are made by health authorities, the idea being that local variation in epidemiology can be taken into account. Figure 6.3 illustrates the association between how individual London health authorities spend HIV prevention monies and how HIV is acquired in that district. The data was taken from 1997/98 AIDS Control Act Reports and reported by Fitzpatrick (1999). Each dot represents one health authority (there are thirteen, the other three being missing from the data set). Along the bottom axis is the proportion of cumulative HIV infections diagnosed in that HA that were acquired during sex between men. Up the side is the proportion of HIV prevention expenditure on the needs of gay and bisexual men.

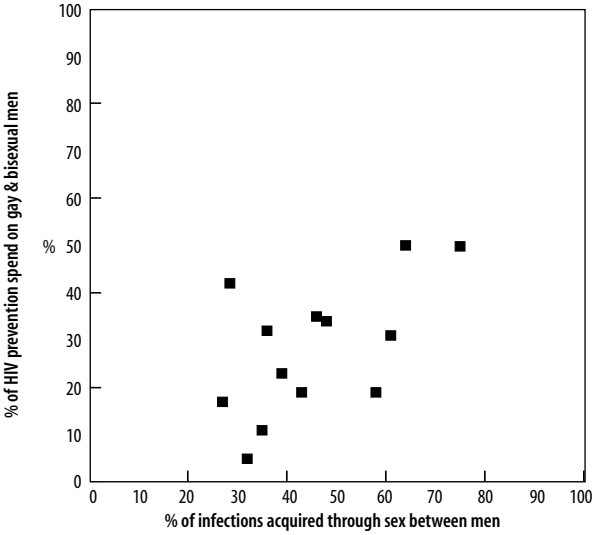

Figure 6.3: How HIV is aquired and how health authorities spend HIV prevention monies in 13 London HAs (source: Fitzpatrick, 1999)

There is an overall pattern of the dots falling on a line from bottom left to top right. This suggests that there is a relationship between how infection is acquired and how HAs spend HIV prevention monies. Or to put it another way, it appears that the proportion of HIV prevention monies health authorities spend on interventions for gay and bisexual men is relative to the contribution they make to the local epidemic.

6.4 MUCH ARE LONDON HEALTH AUTHORITIES SPENDING ON REDUCING HIV PREVENTION NEED AMONG GAY AND BISEXUAL MEN?

Health Authority expenditure on HIV prevention is reported in AIDS (Control) Act reports. The following is taken from the reports submitted to the Department of Health by London Health Authorities for the financial year 1998/99. Information regarding Brent and Harrow and East London and The City is excluded, since it was missing from the original submissions to the Department of Health.

Health Authority	Number of HAM aged 16+	Prevention allocation (£000's)	% of total London allocation	Spend on gay men (£000's)	% of allocation spent on gay men
Barking & Havering	2729	297	1.8	192	64.6
Barnet	2125	435	2.6	114	26.2
Bexley & Greenwich	13797	494	3	192	38.9
Brent & Harrow	3251	712	4.3	Missing	Missing
Bromley	2156	292	1.8	86	29.5
Camden & Islington	11168	1846	11.2	1000	54.2
Croydon Merton, Sutton & Wansworth Kingston & Richmond	2290 11053 2197	506 1392 430	14.2	630	27.1
Ealing, Hammersmith & Hounslow	8552	1877	11.4	425	22.6
East London & The City	17746	1817	11.1	Missing	Missing
Enfield & Haringay	3376	898	5.5	183	20.4
Hillingdon	1728	323	2	41	12.7
Kensington, Chelsea & Westminster	10934	1924	11.7	1100	42.7
Lambeth, Southwark, Lewisham	22610	2574	15.7	1000	38.9
Redbridge & Waltham Forrest	3200	606	3.7	145	23.9
Total	**118912**	**16423**	**100**	**4783**	**Average 33.5**

Figure 6.4: Health Authority HIV prevention allocations and spends on gay men, 1998-1999

Collectively, the Health Authorities claim to spend over £4.7 million on HIV prevention activity with gay and bisexual men, which is approximately one third of the HIV prevention allocation for London collectively. This is considerably more than we were able to identify in interventions in the health promotion map in Part Two. The basis for calculating current spends on gay men is unclear and the development of a coherent pan-London programme provides an opportunity to revisit and consolidate allocations.

Part II

Health promotion activity map 2000-2001

7 The agencies and type of health promotion they do

This second part of the report documents the activity intended to meet HIV prevention need described in the first part, as well as other need not described here. The methods for this section are described in Chapter 1. Chapter 7 gives an overview of the agencies involved in HIV prevention work with gay and bisexual men in Greater London and the types of health promotion they carry out. Chapter 8 sets out in detail the interventions of agencies known to be planning within *Making It Count*.

7.1 THE AGENCIES

Figure 7.1 shows the agencies carrying out HIV prevention commissioned by the 16 health authorities, by the type of agency (columns).

HIV health promotion provider				
	statutory sector			
voluntary sector	London Borough	Health Authority	NHS Community Trust	NHS Primary Care Trust
• Big Up • GMFA • HGLC • LLGS • Naz London • PACE • Streetwise Yth • THT • The Metro • LEAN‡	• Hammersmith • Hillingdon • Hounslow • Brent ‡ • Harrow‡	• Barking, Havering and Brentwood • Bromley • ELCHA • Enfield and Haringey • Merton, Sutton and Wandsworth** • Barnet AEU‡ • Brent and Harrow‡ • SHOC‡	Clinical (as 1999) • Barking • Bart's • Bart's same day testing • Beckenham • Central Middlesex • Charing Cross • Clare Simpson House • Ealing • Greenwich • Hillingdon • Homerton • John Hunter Clinic • King's College • Kingston • Lewisham • Newham • Oldchurch • Queen Mary's • Royal Free • St Ann's • St George's • St Helier • Town Clinic • West Middlesex • Whipps Cross • Whittington **Clinical (more detail)** • Guy's * • Mayday • Mortimer Market Centre • Northwick Park • Royal London • St Mary's • St Thomas's* • Victoria Clinic **Non-clinical** • Camden and Islington HPS • Croydon Community Health • Health First	• Hackney‡ • Newham‡ • Tower Hamlets‡

* Both Guy's and St. Thomas's reported changes in their clinics but no additional HIV health promotion activity. They do not appear in subsequent figures of activity.
** Relevant in 1999, no response in 2000. ‡ New to map in 2000.

Figure 7.1: Agencies relevant activity is occurring in

7.2 HIV HEALTH PROMOTION TO BE PLANNED

Some interventions remained unplanned at the time of interview, although they were funded to occur in 2000-2001. Interventions were unplanned for a variety of reasons: organisation restructure meant some staff were changing both location, role and management structures and no clear picture of the new role could yet be established; new and vacant posts were described, the intention being that the worker recruited would plan the activity of the post and; new interventions were described that still had the detail to be planned.

To be planned	Cost
• WAD activity (Croydon CH)	500 *
• Sero-discordant Relationships Groupwork (GMFA)	NA
• Outreach Health Advisor (Northwick Park Hospital)	NA
• Couples Same Day HIV Testing (Mortimer Market)	NA
• Health Promotion Team (ELCHA HA)	NA
• Health Promotion Advisor (Newham PCT)	NA
• Health Promotion Advisor (Hackney PCT)	NA
• Health Promotion Advisor (Tower Hamlets PCT)	NA
• Health Promotion Advisor (Healthy Hillingdon)	30000
• Community development worker (Barnet AEU)	40000

Figure 7.2: Breakdown of interventions to be planned

7.3 THE TYPES OF INTERVENTIONS DELIVERED AND THE AMOUNT OF SPEND ON EACH

For the purposes of this map, agencies were asked to categorise their interventions according to the following six types of health promotion:

- 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 health promotion. Activities which reduce discrimination by influencing and using local and national policies. Also known as developing healthy public policy.

Agencies were asked to identify for themselves which types of health promotion activity they carried out. Figure 7.3 shows the types of interventions done by each agency in the table above. When an agency's name is in a box, that agency indicated that it carried out activity of that type. See Abbreviations (at the beginning of the document) for those in this table.

	health promotion provider					agency spend
	voluntary sector	statutory sector				
		local authority	NHS health authority	NHS community trust	NHS primary care trust	
direct contact	• Big Up • GMFA • HGLC • LEAN • LLGS • Naz London • PACE • Streetwise Yth • THT • The Metro	• Brent Yth • Hammersmith Yth • HarrowLBG Yth • Hounslow CSCPU • Hounslow Yth	• BHB HP • Bromley HP • EH HIV/AIDS SCHP	SCHP Clinical • Northwick Park Hospital • Royal London Hospital • St Mary's Hospital • Victoria Clinic • Mortimer Market **Non-clinical** • C and I HPS • Croydon CH		2,391,518 94/138 interventions fully costed
social diffusion	• Big Up					na 0/1 interventions fully costed
community	• HGLC • LEAN • Naz London • The Metro	• Brent Yth • HarrowLBG Yth	• BHB HP • Barnet AEU • BH CIHP • Bromley HP	Non-clinical • C and I HPS • Croydon CH		93,572 6/19 interventions fully costed
facilitation	• Big Up • GMFA • HGLC • LLGS • Naz London • THT • The Metro •	Brent Yth • Harrow LBG Yth • Hounslow CSCPU	• BH CIHP • ELCHA PH	Clinical • Mayday Hospital Non-clinical • C and I HPS • Croydon CH • Health First		367,264 8/19 interventions fully costed
organisational	• HGLC • Naz London • The Metro	• Brent Yth • Hounslow CSCPU • Hounslow Yth	• BHB HP • BH CIHP • Bromley HP • ELCHA PH • SHOC	Non-clinical • C and I HPS • Croydon CH • Health First		50,704 26/37 interventions fully costed
equality						no interventions
to be planned	• GMFA	• Healthy Hillingdon •	ELCHA PH • Barnet AEU •	Northwick Park Hospital • Mortimer Market • Croydon CH	• Hackney • Newham • Tower Hamlets	70,000 2/10 interventions fully costed
HA spend	1,333,153 9/10 agencies fully costed	296,934 6/6 agencies fully costed	160,000 3/7 agencies fully costed	860,774 3/9 agencies fully costed	na 0/3 agencies fully costed	agency spend 2,900,058 HA spend 2,650,861

Figure 7.3: Types of interventions delivered

The agency spend is greater than the HA spend in the Figure above because several agencies support the delivery of their interventions with funding from other sources. Department of Health funding for CHAPS augments several of THT's interventions. Other monies come from private charitable trusts such as The Elton John AIDS Foundation and from community fundraising activities of the agencies concerned.

8 Interventions in a potential collaborative programme

This section provides an overview of the HIV health promotion activity of the 35 agencies (other than GUM clinics) that were interviewed. Activities categorised under each of the six types of health promotion are outlined in separate sections below. For direct contact health promotion development and delivery of interventions are separately described as there is agency specialisation whereby some develop interventions, others deliver them and some do both.

8.1 THE AGENCIES DESCRIBED AT THE INTERVENTION LEVEL

In this map all agencies with relevant activity were asked to describe it at the level of the intervention. Last year only 9 agencies were asked to do this (Hartley *et al.,* 1999). During this year's mapping exercise we asked these 9 to review the activity they had described last year. The 9 agencies were: Big Up, Camden & Islington HPS, GMFA, Health First, HGLC, PACE, RS Health Ltd., THT and The Naz Project, London.

RS Health Ltd. was closed between reporting cycles and no data could be collected regarding their activity. Health First did not report on this aspect of the mapping exercise. The remaining seven agencies described 113 interventions last year of which 7 subsequently did not receive HA funding and are therefore not part of the review process. Agencies were asked whether interventions had been delivered in full or not, and if not, whether interventions had been partially delivered, not delivered or something else delivered instead.

Number of interventions in receipt of HA funding	106	(100%)
Delivered in full	84	(79%)
Not delivered in full	22	(21%)
Of those not delivered in full:		
Delivered in part	14	(64%)
Not delivered	6	(27%)
Something else delivered instead	1	(9%)

Figure 8.1: Review of the activity of 7 agencies described in the 1999 activity map

This figure shows that the majority of interventions commissioned by the health authorities in London are fully delivered, with the majority of the remainder being partly delivered.

8.2 DIRECT CONTACT HIV HEALTH PROMOTION: CLINICAL INTERVENTIONS

There are 34 GUM and HIV testing services in the map. Eight clinics responded when asked if either their clinic intervention had changed since the previous year or if they had relevant planned activity for the coming year. Of those, seven were reporting (new) relevant planned activity and one reported a temporary but significant change in the clinic services. Those reporting relevant activity are documented below.

As before, a clinic visit 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; access to the gay and 'positive' press, extra strong condoms and lubricant and information leaflets and other small media. In most clinics, most of these services are offered to all clients. Face-to-face health advice and then Hepatitis A and B vaccinations are those services most frequently offered only to some clients. Five clinics did not offer Hepatitis A vaccinations, one did not provide lubricant but advised on its use. No changes in this pattern were reported.

In 1999-2000 five clinics reported services specifically targeting gay men. An additional 16 clinics reported actively promoting their service by advertising in the gay press, in other gay resources, in gay venues, by liaising with (gay) voluntary agencies. This year, one of the clinics for gay men has been made a male only clinic as a temporary measure in response to funding shortages. As a rule, the targets for clinical interventions are men who come through the door of the clinic.

8.3 DIRECT CONTACT HIV HEALTH PROMOTION: NON-CLINICAL DEVELOPMENT

Figure 8.3 identifies the number of resources in development to be used in direct contact HIV health promotion. Whilst the production of many of these resources is embedded in intervention descriptions that also describe the mechanism by which they reach gay men, 21 discrete units of activity were described, whose sole purpose was development (and not distribution) of mainly written resources.

In this Figure, and all those that follow the agency spend is given as a full costing (only a number is given) or as a part costing (a number is given and there is an asterisk) or none was available (in which case *NA* appears in the column).

	News-letter	Single image/text	Postcard	Leaflet	Service adverts/cards	Other
Update & print/ produce				• Men Get Yourself Checked Out (8,000, C and I HPS) • 3 leaflet reprints (60,000, C and I HPS) • 6 leaflet reprints (22,000, HF)	• PSE helpline stickers (100*, Metro)	
Develop & print/ produce	• MetroNews (2,500*, Metro)	• It's Not Unusual press ads and posters (na, GMFA) • Invisible Men press ads and posters (na, GMFA) • Nurse The Screens press ads and posters (na, GMFA) • Love and Respect 5 press ads and posters (na, GMFA) • Why Bother? press ads and posters (na, GMFA) • Ain't Necessarily So press ads and posters (na, GMFA) • I've Got Limits press ads and posters (na, GMFA) • Black Gifted and Gay 2 (na, Big Up) • Exposure risks press ads (na, THT) • Transmission risks press ads (na, THT) • Assumptions of status press ads (na, THT) • Commercial sex venue press ads (na, THT) • Power and Sex press ads (na, THT)	• It's Not Unusual small media (na, GMFA) • Invisible Men small media (na, GMFA) • Nurse The Screens small media (na, GMFA) • Love and Respect 5 small media (na, GMFA) • Why Bother? small media (na, GMFA) • Ain't Necessarily So small media (na, GMFA) • I've Got Limits small media (na, GMFA) • Cruisecards (8,500, GMFA) • Agreements in Relationships Campaign (10,000, C and I HPS)	• The Works (40,000, C and I HPS) • Positive Futures Shared Futures (40,000, C and I HPS) • Positive About Sex (10,000, HF) • Sero-discordant Couples (10,000, HF)	• Training brochure (6,000 C and I HPS) • LBG service leaflet (544 *, Bromley HP) • Press ads to publicise activities (20,000, HGLC) • Promoting use of direct services press ads (na, THT) • Nice 'n' Easy card (na, Big Up) • Nice 'n' Easy – Positively Black card (na, Big Up) • Nice 'n' Easy – young men card (na, Big Up) • Telephone helpline card and press ad (na, Big Up) • Basement Sessions card (na, Big Up) • PACE workshop programme cards and press ads (na, PACE) • Outzone card and press ad (na, EH HIV/AIDS SCHP) • Workshops card and press ad (na, Metro) • Identity card and press ad (na, Hounslow Yth)	• Condom pack inserts (na, Big Up) • Outreach resource development (9,000*, Metro) • Quickbites (25,000, C and I HPS) • Switch The Groove CD (12,000, C and I HPS) • Development of 2 resources (6,500, Naz) • Naz Latina resources (2,000, Naz) • GP resource pack (5,000*, SHOC) • Small media (7,000, HGLC) • Outreach resource (na, Streetwise Youth) • Young men's press insert (na, C and I HPS) • Big Love radio ad (na, Big Up) • Freedoms condom wrap (na, C and I HPS and HGLC) • Man2Man condom packs (na, Bromley HP)

Figure 8.3: Breakdown of direct contact development (continues over)

	News-letter	Single image/text	Postcard	Leaflet	Service adverts/cards	Other
		• Self-development press ads (na, GMFA) • Chatblack (10,000, C and I HPS) • Gimme 5 Minutes press ad (12,000, Victoria Clinic) • Sorted press ad (na, Victoria Clinic)			• Out on Thursday card and press ad (na, Hammersmith Yth) • Practical support card and press ad (na, Streetwise Youth) • Drop-in card and press ad (na, Streetwise Youth) • 1-2-1 card and press ad (na, Streetwise Youth) • Dost card (na, Naz) • Dost Positive card (na, Naz) • Masala card (na, Naz) • Schools work brochure (na, Naz) • Pau Brasil card (na, naz) • 4Ever Spirit card and press ad (na, LEAN) • Cool Fever card and press ad (na, LEAN) • Fever Pitch card and press ad (na, LEAN) • Gay men's group card and press ad (na, Bromley HP) • Space card (na, Harrow LBG Yth) • Relationships groupwork press ad (na, GMFA) • Bondage for Beginners press ad (na, GMFA) • Skills for Gay Life press ad (na, GMFA) • SM sex press ad (na, GMFA) • Cruising Skills press ad (na, GMFA) • Time to Take Control press ad (na, GMFA) • Assertive Action ad (na, GMFA) • Skills for Safety press ad (na, GMFA) • Negotiation skills workshop ad (na, Bromley HP) • Gimme 5 Minutes small media (12,000, Victoria Clinic) • Sorted small media (na, Victoria Clinic) • Working Men's Project ad (92,500*, St Mary's Hospital)	

8.4 DIRECT CONTACT HIV HEALTH PROMOTION: NON-CLINICAL DELIVERY

Direct contact interventions are sub-divided into static and interactive. 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.

The following two figures (8.4a and 8.4b) identify what direct contact interventions were planned to occur in 2000-2001. They include the setting in which the interventions were planned to occur (rows) and the method used (columns). An intervention described by an agency may appear in more than one box, because it is undertaken in multiple settings or uses multiple methods. In this Figure (and all those that follow) the agency spend is given as a full costing (only a number is given) or as a part costing (a number is given and there is an asterisk) or none was available (in which case *NA* appears in the column).

Static			
	audio broadcast	**single image display**	**resource distributor**
Radio	**Educational broadcast** • Big Love part 2 (na, Big Up) • Telephone Helpline ad (na, Big Up)		
Press and listings		**Educational adverts** • Black Gifted... and Gay part 2 (4,000, Big Up) • Exposure Risks (90,000 *, THT) • Transmission Risks (90,000 *, THT) • Assumptions of Status (27,500 *, THT) • Commercial Sex Venue (27,500 *, THT) • Power and Sex (27,500 *, THT) • It's Not Unusual (12,000, GMFA) • Invisible Men (12,000, GMFA) • Nurse the Screens (12,000, GMFA) • Why Bother? (12,000, GMFA) • Ain't Necessarily So (12,000, GMFA) • I've Got Limits (12,000, GMFA) • Love and Respect 5 (14,000, GMFA) • Self-Development (21,000, GMFA) **Service adverts** • Promoting Direct Services (22,500 *, THT) • Negotiation Skills (na, Bromley HP) • Telephone Helpline (na, Big Up) • PACE Workshops (na, PACE) • Adverts to publicise activities (20,000, HGLC) • Outzone (45,000, EH HIV/AIDS SCHP) • Workshops (0 *, Metro) • Identity (26,648, Hounslow CSCPU) • Out on Thursday (29,800, Hammersmith Yth) • Service Information (na, Streetwise Yth) • Relationships Groupwork (9,000 GMFA) • Bondage for Beginners (9,000, GMFA) • Skills for Gay Life (11,000, GMFA) • SM Sex (11,000, GMFA) • Cruising Skills (11,000, GMFA) • Time To Take Control (11,000, GMFA) • Assertive Action (11,000, GMFA) • Skills for Safety (11,000, GMFA) • Telephone Helpline (91,000, LLGS) • Dost (2,520, Naz) • Masala (2,340, Naz) • Dost Positive (2,100, Naz) • Gimme 5 Minutes (12,000, Victoria Clinic) • Sorted (na, Victoria Clinic) • Working Men's Project (92,500, St Mary's Hospital) • East London Skills Initiative (10,000, Royal London Hospital)	**Educational inserts** • Young Men's press insert (7,000, C and I HPS)

Static			
	audio broadcast	**single image display**	**resource distributor**
Gay pub / non-sex club		**Educational posters** • Exposure Risks (90,000 *, THT) • Transmission Risks (90,000 *, THT) • Assumptions of Status (27,500 *, THT) • Commercial Sex Venue (27,500 *, THT) • Power and Sex (27,500 *, THT) • Love and Respect 5 (14,000, GMFA)	**Service information** • Space (2,000 *, Harrow LBG Yth) • Nice 'n' Easy (na, Big Up) • Nice 'n' Easy-Positively Black (na, Big Up) • Nice 'n' Easy – Young Men (na, Big Up) • Basement Sessions (na, Big Up) • Telephone Helpline (na, Big Up) • Workshops (0 *, Metro) • Identity (26,648, Hounslow CSCPU) • Out on Thursday (29,800, Hammersmith Yth) • Service Information (na, Streetwise Yth) • 4Everspirit (780 *, LEAN) • Fever-pitch (100 *, LEAN) • Cool Fever (100 *, LEAN) • Gay Men's Group (3,000 *, Bromley HP) • Sorted (na, Victoria Clinic) • East London Skills Initiative (10,000, Royal London Hospital) **Condom packs** • Freedoms (190,000, C and I HPS and HGLC) • Man2Man (na, Bromley HP)
Sex-on-premises venue		**Educational posters** • Exposure Risks (90,000 *, THT) • Transmission Risks (90,000 *, THT) • Assumptions of Status (27,500 *, THT) • Commercial Sex Venue (27,500 *, THT) • Power and Sex (27,500 *, THT) **Service posters** • Promoting Direct Services (22,500 *, THT)	**Condom packs** • Freedoms (190,000, C and I HPS and HGLC)
Sauna		**Educational posters** • Exposure Risks (90,000 *, THT) • Transmission Risks (90,000 *, THT) • Assumptions of Status (27,500 *, THT) • Commercial Sex Venue (27,500 *, THT) • Power and Sex (27,500 *, THT) **Service posters** • Promoting Direct Services (22,500 *, THT)	**Service information** • East London Skills Initiative (10,000, Royal London Hospital) **Condom packs** • Freedoms (190,000, C and I HPS and HGLC)
PSE		**Stickers** • PSE Stickering (100 *, Metro)	
Gym			
Other community setting (Including: private parties, youth federation, community groups, The Metro, gay events)		**Educational posters** • Exposure Risks (90,000 *, THT) • Transmission Risks (90,000 *, THT) • Assumptions of Status (27,500 *, THT) • Commercial Sex Venue (27,500 *, THT) **Service posters** • Promoting Direct Services (22,500 *, THT)	**Service information** • Nice 'n' Easy (na, Big Up) • Nice 'n' Easy - Positively Black (na, Big Up) • Nice 'n' Easy - Young Men (na, Big Up) • Basement Sessions (na, Big Up) • Telephone Helpline (na, Big Up) • Workshops (0 *, Metro) **Condom packs** • Freedoms (190,000, C and I HPS and HGLC)

Static			
	audio broadcast	**single image display**	**resource distributor**
Outdoors public		**Educational posters** • Exposure Risks (90,000 *, THT) • Transmission Risks (90,000 *, THT) **Service posters** • Promoting Direct Services (22,500 *, THT)	**Service information** • Space (2,000 *, Harrow LBG Yth) • Service Information (na, Streetwise Yth) **Condom packs** • Mardi Gras Milleniman pack (15,000, EH HIV/AIDS SCHP)
Other (Including: street, brothel, sex worker workplace (including their home), GPs, libraries, youth centres, schools, colleges, London listings, youth service, CAB, Asian press listings, Latin American local press, gay event)		**Service information** • Masala (2,340, Naz) • Naz Latina Amigos (1,820, Naz) • Naz Latina Pau Brasil (3,926, Naz) • Naz Latina Drop-In (3,926, Naz)	**Service information inserts in Freedom packs** • Getting The Sex You Want (8,000, C and I HPS) • Sex Positive (8,000, C and I HPS & Mortimer Mrkt GUM) • Talking It Through (8,000, C and I HPS & Mortimer Mrkt GUM) • Crossroads (8,000, C and I HPS & Mortimer Mrkt GUM) **Service Information** • Space (2,000 *, Harrow LBG Yth) • Outzone (45,000, EH HIV/AIDS SCHP) • Gay Men's Group (3,000 *, Bromley HP) • Young HIV-Negative Men's Therapy Group (1,250, Victoria Clinic)
Provider's centre		**Educational posters** • Exposure Risks (90,000 *, THT) • Transmission Risks (90,000 *, THT) • Assumptions of Status (27,500 *, THT) • Commercial Sex Venue (27,500 *, THT) • Power and Sex (27,500 *, THT) **Service information** • Promoting Direct Services (22,500 *, THT)	**Leaflets** • LGB Youthwork (21,000, HGLC) **Service information** • Nice 'n' Easy (na, Big Up) • Nice 'n' Easy - Positively Black (na, Big Up) • Nice 'n' Easy - Young Men (na, Big Up) • Basement Sessions (na, Big Up) • Telephone Helpline (na, Big Up) • Workshops (0 *, Metro) • Identity (26,648, Hounslow CSCPU) • Out on Thursday (29,800, Hammersmith Yth) • Service Information (na, Streetwise Yth) • Relationships Groupwork (9,000 GMFA) • Bondage for Beginners (9,000, GMFA) • Skills for Gay Life (11,000, GMFA) • SM Sex (11,000, GMFA) • Cruising Skills (11,000, GMFA) • Time to Take Control (11,000, GMFA) • Assertive Action (11,000, GMFA) • Skills for Safety (11,000, GMFA) • Dost Positive (2,100, Naz) • 4Everspirit (780 *, LEAN) • Fever-pitch (100 *, LEAN) • Cool Fever (780 *, LEAN) • Gimme 5 Minutes (12,000, Victoria Clinic) • Young HIV-Negative Men's Therapy Group (1,250, Victoria Clinic) **Condom packs** • Freedoms (190,000, C and I HPS and HGLC) • Man2Man (na, Bromley HP) • LGB Youthwork (21,000, HGLC)

Static			
	audio broadcast	**single image display**	**resource distributor**
GUM clinic		**Educational posters** • Exposure Risks (90,000 *, THT) • Transmission Risks (90,000 *, THT) • Assumptions of Status (27,500 *, THT) • Commercial Sex Venue (27,500 *, THT) • Power and Sex (27,500 *, THT) **Service posters** • Promoting Direct Services (22,500 *, THT)	**Service information** • Space (2,000 *, Harrow LBG Yth) • PACE workshops (na, PACE) • Workshops (0 *, Metro) • Service Information (na, Streetwise Yth) • Relationships Groupwork (9,000 GMFA) • Bondage for Beginners (9,000, GMFA) • Skills for Gay Life (11,000, GMFA) • SM Sex (11,000, GMFA) • Cruising Skills (11,000, GMFA) • Time To Take Control (11,000, GMFA) • Assertive Action (11,000, GMFA) • Skills for Safety (11,000, GMFA) • Gimme 5 Minutes (12,000, Victoria Clinic) • Young HIV-Negative Men's Therapy Group (1,250, Victoria Clinic) • East London Skills Initiative (10,000, Royal London Hospital)
Mailing list			**Service information** • Negotiation Skills (na, Bromley HP) • Nice 'n' Easy (na, Big Up) • Nice 'n' Easy - Positively Black (na, Big Up) • Nice 'n' Easy - Young Men (na, Big Up) • Basement Sessions (na, Big Up) • PACE Workshops (na, PACE) • Relationships Groupwork (9,000 GMFA) • Bondage for Beginners (9,000, GMFA) • Skills for Gay Life (11,000, GMFA) • SM Sex (11,000, GMFA) • Cruising Skills (11,000, GMFA) • Time To Take Control (11,000, GMFA) • Assertive Action (11,000, GMFA) • Skills for Safety (11,000, GMFA) • EHH Assertiveness Course (11,750, GMFA) • 4Everspirit (780 *, LEAN) • Fever-pitch (100 *, LEAN) • Cool Fever (100 *, LEAN)
Internet		**Educational Posters** • Exposure Risks (90,000 *, THT) • Transmission Risks (90,000 *, THT) • Assumptions of Status (27,500 *, THT) • Commercial Sex Venue (27,500 *, THT) • Power and Sex (27,500 *, THT) • Venue Outreach (8,000 *, Metro) • It's Not Unusual (12,000, GMFA) • Invisible Men (12,000, GMFA) • Nurse The Screens (12,000, GMFA) • Why Bother? (12,000, GMFA) • Ain't Necessarily So (12,000, GMFA) • I've Got Limits (12,000, GMFA) • Love and Respect 5 (14,000, GMFA) • Self-Development (21,000, GMFA) **Service posters** • Promoting Direct Services (22,500 *, THT) • Relationships Groupwork (9,000 GMFA) • Bondage for Beginners (9,000, GMFA) • Skills for Gay Life (11,000, GMFA) • SM Sex (11,000, GMFA) • Cruising Skills (11,000, GMFA) • Time To Take Control (11,000, GMFA) • Assertive Action (11,000, GMFA) • Skills for Safety (11,000, GMFA) • Gay Men's Group (3,000 *, Bromley HP)	**Leaflets** • Love and Respect 5 (14,000, GMFA) **Websites** • LGB Youthwork (21,000, HGLC) • Space (2,000 *, Harrow LBG Yth) • Website (15,000 *, Streetwise Yth) • Outzone (45,000, EH HIV/AIDS SCHP) • Workshops (0 *, Metro) • Identity (26,648, Hounslow CSCPU) • Out On Thursday (29,800, Hammersmith Yth) • Service Information (na, Streetwise Yth) • Website (na, GMFA)

Figure 8.4a: Direct Contact Delivery - Static Interventions

INTERACTIVE PUSH							
	face-to-face						
	one-to-one meetings			group meetings		mixed/clinical	telephone
	resource distributor	session limited	ongoing	session limited	ongoing		
Gay pub/ non-sex club	**Outreach** • Community Outreach (na, Big Up) • Outreach – pubs and clubs (143,594, HGLC) • Venue Outreach (8,000*, Metro) • Community Outreach (20,000, Hounslow CSCPU) • Outreach (65,000, Streetwise Yth) • Love and Respect 5 (14,000, GMFA) • Off The Hook (6,000, C and I HPS) • CLASH (112,000, C and I HPS) • Pubs/Clubs (na, Naz) • Community Cruising Initiative (10,000 *, BHB HP) • Gay Pub (0 *, Bromley HP)	**Outreach** • Community Outreach (na, Big Up) • Outreach – pubs and clubs (143,594, HGLC) • Venue Outreach (8,000 *, Metro) • Community Outreach (20,000, Hounslow CSCPU) • Outreach (65,000, Streetwise Yth) • Love and Respect 5 (14,000, GMFA) • MI - sexual strategies (9,000, GMFA) • MI - relationships (9,000, GMFA) • Off The Hook (6,000, C and I HPS) • CLASH (112,000, C and I HPS) • Pubs/Clubs (3,607, Naz) • Community Cruising Initiative (10,000 *, BHB HP) • Gay Pub (0 *, Bromley HP)		**Q and A session** • Meet The People (8,000, C and I HPS)			
Sex-on-premises venue	**Outreach** • Outreach – PSV (47,709, HGLC) • CLASH (112,000, C and I HPS)	**Outreach** • Outreach – PSV (47,709, HGLC) • CLASH (112,000, C and I HPS)		**Workshop** • Outreach – PSV (47,709, HGLC)			
Sauna	**Outreach** • Outreach – PSV (47,709, HGLC) • CLASH (112,000, C and I HPS)	**Outreach** • Outreach – PSV (47,709, HGLC) • CLASH (112,000, C and I HPS)		**Workshop** • Outreach – PSV (47,709, HGLC)			
PSE	**Outreach** • Outreach – PSE (47,709, HGLC) • Outreach (65,000, Streetwise Yth) • Love and Respect 5 (14,000, GMFA) • CLASH (112,000, C and I HPS) • Community Cruising Initiative (10,000 *, BHB HP) • Hampstead Heath (na, GMFA) • Finsbury Park (na, GMFA)	**Outreach** • Outreach – PSE (47,709, HGLC) • Outreach (65,000, Streetwise Yth) • Love and Respect 5 (14,000, GMFA) • CLASH (112,000, C and I HPS) • Community Cruising Initiative (10,000 *, BHB HP) • Hampstead Heath (na, GMFA) • Finsbury Park (na, GMFA)					

INTERACTIVE PUSH							
	face-to-face						
	one-to-one meetings			group meetings			
	resource distributor	session limited	ongoing	session limited	ongoing	mixed/clinical	telephone
Gym	**Outreach** • CLASH (112,000, C and I HPS)	**Outreach** • CLASH (112,000, C and I HPS)					
Other community setting (Including: private parties, youth federation, community groups, The Metro, gay events)	**Outreach** • Community Outreach (na, Big Up) • Love and Respect 5 (14,000, GMFA)	**Outreach** • Community Outreach (na, Big Up) • Outreach (65,000, Streetwise Yth) • Love and Respect 5 (14,000, GMFA)					
Internet							• Website (15,000 *, Streetwise Yth)
Other (Including street, brothel, sex worker workplace (including their home), GPs, libraries, youth centres, schools, colleges, London listings, youth service, CAB, Asian press listings, Latin American local press, gay event)	**Outreach** • Outreach (65,000, Streetwise Yth) • Roadshow (12,000, C and I HPS) • Male Sex Worker Outreach (na, Naz) • Community Cruising Initiative (10,000 *, BHB HP)	**Outreach** • Outreach (65,000, Streetwise Yth) • Roadshow (12,000, C and I HPS • Male Sex Worker Outreach (2,100, Naz) • Community Cruising Initiative (10,000 *, BHB HP)					**Outreach** • Outreach (65,000, Streetwise Yth) • Male Sex Worker Outreach (2,100, Naz) • Working Men's Project Outreach (92,500 *, St Mary's Hospital)
Provider's centre		**Assessment** • 1-2-1 assessment (20,170, HGLC)	**Counselling** • 1-2-1 ongoing (3,879, HGLC) • 1-2-2 ongoing (7,758, HGLC) • Identity 1-2-1 (4,441, Hounslow CSCPU) **Support** • 1-2-1 (74,000, Streetwise Youth) • 1-2-1 Advice and Support (5.766, Naz)	**Workshops** • Negotiation Skills (na, Bromley HP) • Centre-Based Workshops (15,904, HGLC) • LGB Youthwork (21,000, HGLC) • Workshops (0 *, Metro) **Closed groups** • Life Begins @40 (14,850, PACE) • Out In The World (2,475, PACE) • Status Symbols (6,435, PACE) • Positively Speaking (19,830, PACE) • Let's Talk About Sex (8,940, PACE) • Sexual Healing (4,455, PACE) • Listen To Me (4,950, PACE) • Games People Play (7,425, PACE)	**Drop-in** • Space (2,000 *, Harrow LBG Yth) • Drop-in (73,000, Streetwise Yth) • Naz Latina Drop-In (3,926, Naz) **Open groups** • Groups (31,806, HGLC) • LGB Youthwork (21,000, HGLC) • Outzone (45,000, EH HIV/AIDS SCHP) • Identity (26,648, Hounslow CSCPU)	• Practical Support (74,000, Streetwise Yth) **Clinical Session** • CLASH Rent Boy's Clinic (2,500 *, Motimer Market)	**Helpline** • Telephone Helpline (na, Big Up) •Telephone Helpline (91,000, LLGS) **Support** •1-2-1 Advice and Support (5,766, Naz)

INTERACTIVE PUSH							
	face-to-face						
	one-to-one meetings			group meetings			
	resource distributor	session limited	ongoing	session limited	ongoing	mixed/clinical	telephone
Provider's centre continued				• Trouble and Strife (2,475, PACE) • It Takes Two To Tangle (4,950, PACE) • Sorted (4,950, PACE) • Groups (31,806, HGLC) • EHH Assertiveness Course (11,750, GMFA)	• Out On Thursday (29,800, Hammersmith Yth) • Dost (2,520, Naz) • Dost Positive (2,100, Naz) • Naz Latina Amigos (1,820, Naz) • Naz Latina Pau Brasil (3,926, Naz) • Friday Afternoon Group (4,240 *, LEAN) • Gay Men's Group (3,000 *, Bromley HP)		
GUM clinic		**Outreach** • Outreach (65,000, Streetwise Yth) **Assessment** • 1-2-1 assessment (20,170, HGLC)	**Support** • 1-2-1 Advice and Support (5,766, Naz)	**Closed groups** • Getting The Sex You Want (8,000, C and I HPS & Mortimer Mrkt GUM) • Sex Positive (8,000, C and I HPS & Mortimer Mrkt GUM) • Talking It Through (8,000, C and I HPS & Mortimer Mrkt GUM) • Crossroads (8,000, C and I HPS & Mortimer Mrkt GUM) • East London Skills Initiative (10,000, Royal London Hospital)	**Therapy Group** • Young HIV-Negative Men's Therapy Group (1,250, Victoria Clinic)	**Clinical Session** • Sorted (na, Victoria Clinic) • Working Men's Project (92,500*, St Mary's Hospital)	
Scene			**Support** • 1-2-1 Advice and Support (5,766, Naz)	**Closed groups** • Relationships Groupwork (9,000 GMFA) • Bondage for Beginners (9,000, GMFA) • Skills for Gay Life (11,000, GMFA) • SM Sex (11,000, GMFA) • Cruising Skills (11,000, GMFA) • Time To Take Control (11,000, GMFA) • Assertive Action (11,000, GMFA) • Skills for Safety (11,000, GMFA) • Survival Guide (10,000, C and I HPS)	**Open group** • 4Everspirit (780 *, LEAN) • Fever-pitch (100 *, LEAN) • Cool Fever (100 *, LEAN)		

INTERACTIVE PUSH							
	face-to-face						
	one-to-one meetings			group meetings			
	resource distributor	session limited	ongoing	session limited	ongoing	mixed/clinical	telephone
Community group meeting				**Workshops** • Negotiation Skills (na, Bromley HP) • Sexual Health Work With LBG Yth (1,500, Croydon CH)			
Internet							**Outreach** • Outreach (65,000, Streetwise Yth)
Other (Including: schools, colleges, commercial gay and black friendly spaces, cottage, cruising ground, restaurant and Soho health centre)			**Support** • 1-2-1 Advice and Support (5,766, Naz)	**Workshops** • Schools Work (0 *, Brent Yth) • Schools Work (0 *, Harrow LBG Yth) • Identity Schools Work (8,883, Hounslow CSCPU) • Schools Work (4,363, Naz) • Colleges Work (3,000, BHB HP) • Colleges and university work (0 *Harrow LBG Yth)	**Open groups** • Nice 'n' Easy (na, Big Up) • Nice 'n' Easy – Positively Black (na, Big Up) • Nice 'n' Easy – Young Men (na, Big Up) • Basement Sessions (na, Big Up) • Masala (2,340, Naz)		

Figure 8.4b: Direct Contact Delivery: Interactive Interventions

8.4.1 The settings of direct contact interventions

Many of these interventions occur in multiple settings. What follows (Figure 8.4.1) is a ranked list of settings used for these direct contact interventions. The first list is of the settings used to advertise or promote interventions, the second list is of the settings used to deliver interventions. Each list has two sections, the first section is a ranked list of those settings offered to providers at the time of data collection and the second list is of the 'other' settings identified. The two sections cannot be collapsed as they are not directly comparable. That is, if we had offered some of the settings we were given as 'other' settings to all providers during data collection, we would have seen more interventions reported to occur there.

Settings used to advertise and promote interventions (and number of interventions using each setting).		**Settings used to deliver interventions (and number of interventions using each setting).**	
gay press	35	agency/ service centre	43
GUM/ HIV/ STD clinic	30	gay pub	29
other providers	28	gay club	21
at home (i.e. in a mailing)	26	GUM/ HIV/ STD clinic	19
gay pub	17	gay press	18
agency/ service centre	16	internet	17
HIV positive press	14	HIV positive press	16
internet	14	other providers	15
gay club	13	community group	10
workplace setting (i.e in a mailout)	11	sex club or backroom	9
community group	7	sauna	8
gay event	5	telephone	7
conference	3	cruising ground	6
professional forum	2	cottage	5
sauna	1	gay event	4
		outdoor site	3
		at home	1
		gym	1
		workplace	1
other settings used to advertise and promote interventions (and number of interventions using each setting).		**Other settings used to deliver interventions (and number of interventions using each setting).**	
through other interventions	20	commercial Black gay friendly spaces	4
London listings	10	schools	4
Black commercial venues	5	street	4
local Latin American press	3	colleges	3
youth service	3	brothel	2
colleges	2	youth centre	2
schools	2	And one each of: arts centre, Black press, commercial space, client's flat, radio, private parties, youth federation.	
libraries	2		
And one each of: Asian press listings, Citizens Advice Bureau, GPs, radio, referral.			

Figure 8.4.1: The settings used to advertise, promote and deliver interventions

8.4.2 The targets of direct contact interventions

Of the 138 direct contact interventions reported, 117 were delivery interventions and 21 were development interventions. By definition, and in practice, each of the delivery interventions targets gay men or sub-groups of them. Of those 117, 60 interventions are restricted to the target group only and these are predominantly the interactive interventions.

Thirty-five interventions targ*et al*l gay men and the rest target sub-groups of them. These sub-groups can be broken down by age, ethnicity, life event, lifestyle or context, setting use and HIV testing status.

The age groups and number of interventions targeting each age group are as follows: young men (2), men aged 15 to16 (1), men aged 15 to19 (1), men aged under 18 (1), men aged under 20 (5), men aged 16 to 21 (1), men aged 16 to 25 (1), men aged under 25 (6), men aged under 26 (3), men aged under 40 (2) and men aged over 40 (1).

The ethnicities and their sub-groups targeted and number of interventions targeting each are as follows: Black community (1), Black gay and bisexual men (9), HIV positive Black gay and bisexual men (1), Black gay and bisexual men aged under 25 (1), South Asian gay men (1), South Asian men aged 16-26 (1), South East Asian gay men (1), South Asian/ North African/ Horn of Africa/ Middle Eastern gay and MSM men (3), HIV positive South Asian/ North African/ Horn of Africa/ Middle Eastern gay and MSM men (1), Latin American gay and MSM men (2) and HIV positive Brazilian or Portuguese speaking men (2).

The life event by which men are targeted and the number of interventions using each grouping are as follows: men coming out (1), men in relationships (9), men with a lower educational qualifications (7), men new to gay 'scene' (1) and men who have been abused or fear abuse (1).

The lifestyle or life context by which men are targeted and the number of interventions using each grouping are as follows: men with self-identified drug or alcohol problem (1), men with 10 or more partners (10), men in cities (2), men who sell sex to men (8), men into SM sex (1), men not sticking to their own safer sex rules (2), men who have sexual agreements in relationships (1) and men in sero-discordant relationships (1). All the men using certain settings are also targeted, as follows: commercial sex venue user (4) and cruising ground user (1).

The HIV testing status target groups and the number of interventions that target each grouping are as follows: untested (6), untested and aged under 25 (1), HIV negative or untested (2), HIV negative (4) and HIV positive (18).

8.4.3 The aims of direct contact interventions

When informants described direct contact health promotion they were asked to nominate the primary aim of the intervention, from a list of the 11 aims of the first edition of *Making It Count* (with an 'other' category). Of the 117 direct contact interventions described: 11 had no stated aim, 68 had a *Making It Count* aim as their primary purpose and 48 interventions had other stated aims, or multiple aims where none took priority.

Figure 8.4.3 below shows the broad mix of *Making It Count* direct contact aims that interventions list as their primary purpose. The lack of consistency in intervention description makes any direct comparison of this kind difficult but it demonstrates the broad priority attached to achieving each of these aims.

Aims of *Making It Count* (first edition, 1998)

AIM 1 Men are able to choose who they have sex with and what kind of sex they have.

AIM 2 Men are equipped and competent to negotiate sex.

AIM 3 Men are knowledgeable about HIV, its exposure, transmission and prevention .

AIM 4 Men are aware of the possible HIV related consequences of their sexual actions for themselves and their sexual partners.

AIM 5 Men are free to choose whether or not to test for HIV.

AIM 6 Men are knowledgeable about HIV testing and the meaning of HIV test results.

AIM 7 Men have access to quality HIV testing services.

AIM 8 Clear and unambiguous naming & labelling of condoms and lubricant.

AIM 9 Men are knowledgeable about STIs, their transmission and prevention.

AIM 10 Men are knowledgeable about clinical sexual health services.

AIM 11 Men have access to quality clinical sexual health services.

A further 39 interventions were described using multiple aims where no priority could be established, or which used a single aim - not directly comparable to *Making It Count* aims (see below).

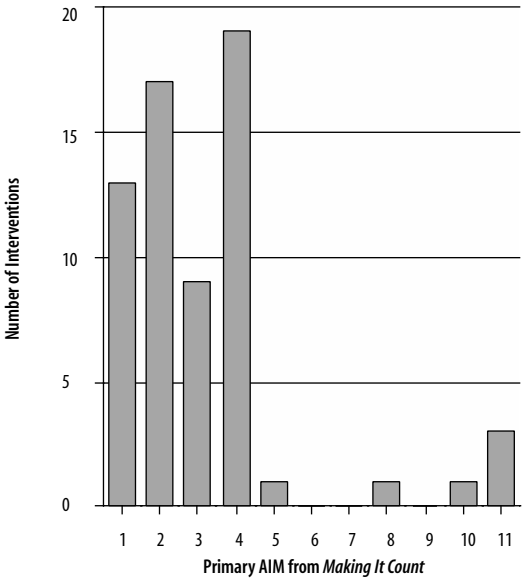

Figure 8.4.3: Number of direct contact interventions by *Making It Count* primary aim

For the 48 interventions that had multiple or other aims the level of description varies substantially. The majority have multiple aims which are either a collection of *Making It Count* aims, none of which could be said to be primary, or a mixture of *Making It Count* and other aims.

Some interventions have specific single aims that are closely related to *Making It Count* aims, for example: 'men know about the range of sexual health services in London' or 'men are aware of (named specific service)'. Others have far more general but solitary aims, such as 'to provide information, care and support' and 'to address the physical, mental and social well-being of gay men and bisexual men (in specific HA)'. Interventions addressing people with diagnosed HIV are especially common in this generic category, and while most interventions probably have a 'HIV prevention' function this is rarely their primary aim (for example, 'to address the HIV prevention, social and support needs of HIV positive gay men'). Interventions addressing specific Black and minority ethnic populations are also common in these categories. Where these are also interventions for people with HIV the aims are especially difficult to categorise (for example, 'to provide emotional and culturally appropriate social care for people infected and affected by HIV').

8.5 COMMUNITY HIV HEALTH PROMOTION

Community HIV health promotion seeks to support, or bring into existence social networks in which health promotion can occur, including the social networks in which social diffusion HIV health promotion may take place (setting up a youth group for example). Outlined below are the 19 community health promotion interventions planned for 2000-2001.

8.5.1 The targets of Community health promotion

The targets of this activity varies between 'professionals' and gay men. The interventions with professionals intend to influence service funders, HIV prevention workers, gay youth workers and additionally community leaders, volunteers and staff in Black and Latin American organisations.

Activities for gay men serve a specific range of sub-groups of them. Most target younger gay men by offering social groups. The age ranges these groups are restricted to vary and the following were documented: under 16, 16-21, 16-24, 21-25, under 25 and under 26. Three of these groups are for young lesbian, gay and bisexual people, lesbians and bisexuals are therefore also targets of this activity, as are people exploring their sexuality. One community group targets gay men with diagnosed HIV.

8.5.2 The settings of Community health promotion

When professionals are the targets of this activity, they both find out about, and do, the intervention in their agencies or workplaces.

Gay men find out about the interventions targeting them in the gay or HIV-positive press, on the gay scene, at (other) community groups and in GUM clinics or from other providers of HIV health promotion. Several of the interventions are also

Community HIV health promotion	
Community group support	
• Societal development, young gay men (HGLC)	15,788
• Community development (Croydon CH)	5,000 *
• Small grants scheme (BH CIHP)	6,000 *
Groups	
• Youth and group work (Metro)	2,000 *
• Black men's seminar (C and I HPS)	NA
• First Move (Barnet AEU)	20,000
• Naz Latina workshops and talks (Naz)	3,780
• Romford Gay Youth (BHB HP)	4,000 *
• GRAB (BHB HP)	8,000 *
• SNAP (Bromley HP)	7,000
• Mosaic (Brent Yth)	1,300 *
• BreakOut (Harrow LBG)	0 *
• Interact (Harrow LBG)	0 *
Special events	
• Mardi Gras event (Metro)	3,000 *
• Club Fever (LEAN)	NA
Volunteering	
• Volunteering (Metro)	8,000 *
Mailings	
• Mailings (Metro)	NA
Training	
• Training (HGLC)	4,540
• Advice and consultancy (HGLC)	5,164

Figure 8.5: Community health promotion interventions

advertised on the internet or through direct mailing to men who belong to a mailing list. The men do the interventions in a range of settings including gay pubs, clubs and events, 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.

8.5.3 The aims of Community health promotion

The 19 community HIV health interventions that were described have 42 aims in total. Eight of these relate directly to the provision of space in which social networks can form. These aims also proscribe the nature of the space to be created, such as safe and supportive or free from prejudice and discrimination.

Another 8 aims relate to how the men who get the intervention might be changed as a result of their participation. Along with increases in consciousness, it is aimed for the men's physical, social and mental well-being to be improved and for their capacity to make choices and to express themselves to be increased. These aims are predominantly empowerment aims.

Another 7 aims describe the sexual and general health information these interventions hope to impart (but one aims to impart HIV/AIDS awareness among Latin American community based organisations). Several other aims describe the outcome that is intended either as a result of creating more extensive social networks for gay men or as a result of these men's participation in the delivery of the intervention. These outcomes include: maintaining the norm of the safer sex culture amongst gay men, empowering men to shape local services and increasing effectiveness through volunteer participation. The remaining aims describe an intention that participation in community health promotion may lead to participation in other, more direct, health promotion.

8.6 SOCIAL DIFFUSION HIV HEALTH PROMOTION

Social diffusion HIV health promotion 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). Only one such intervention was described as planned to occur in 2000-2001.

This intervention, by Big Up, targets black gay and bisexual men in London with training and supervision to become a volunteer health promoter. Men are recruited from the gay and Black press, on the gay scene, at community groups, by other providers and via a mailing list. The training and supervision happens in the agency's offices. The aim is for these men to be knowledgeable about STI's (including HIV), their transmission and prevention, and to be knowledgeable about health promotion practice.

8.7 ORGANISATIONAL / INSTITUTIONAL HIV HEALTH PROMOTION

Organisational/ institutional health promotion seeks to contribute to a reduction in HIV incidence by increasing the capacity of agencies or competencies of individuals to impact on HIV prevention need amongst gay men. It differs from facilitation of health promotion in that it occurs with individuals and agencies whose primary purpose is not HIV health promotion (GPs for example).

8.7.1 The targets of Organisational/ institutional health promotion

This activity aims to influence professionals, most commonly primary care staff including GP practice and GUM clinic workers. The next most common targets are education staff such as school teachers and college lecturers. The remaining targets are from a broad range of sectors and include local authority workers, the Police, social services, local service providers and the catch-all target 'those who work with gay men'.

8.7.2 The settings of Organisational/ institutional health promotion

Most of this activity occurs in the workplaces of those professionals targeted. This is also where these people find out about the activity. A few interventions take place in agency or service centres (which are effectively workplaces) and several happen in local colleges. Community Health Council (CHC) buildings are used for one intervention, and a GP practice for another.

Organisational HIV health promotion	
Resource provision to other agencies	
• Resource dissemination (Croydon CH)	500 *
• GMPI statutory sector small media distribution (HF)	4,000
• Gay men's resources in primary care (HF)	6,500
• Resource dissemination (SHOC)	0 *
• Resource distribution (C and I HPS)	NA
• Resource dissemination (BH CIHP)	4,000
Collaborative planning forums	
• Health and sexuality forum (Brent Yth)	0 *
• Strategic development (BH CIHP)	10,000 *
Consultancy	
• Policy briefings for local authority and non-specialist services (HF)	4,000
• Police liaison (Bromley HP)	0 *
• Advice and consultancy (HGLC)	5,164
Education & training of staff	
• Training (BHB HP)	1,000 *
• Training (Croydon CH)	1,000 *
• Training for social workers (Bromley HP)	0 *
• Training and development programme (Health First)	7,000
• Training (HGLC)	4,540
Joint Working	
• Joint Working (Metro)	0 *
Colleges work	
• Colleges Work (BHB HP)	3,000
• Colleges and university work (Harrow LBG Yth)	0 *

Figure 8.7: Organisational/ institutional interventions

8.7.3 The aims of Organisational/ institutional health promotion

Of the 19 interventions, only 2 had no aim. The others had 38 aims which can be split into five categories: aims about improving knowledge; about changing the attitudes or improving the skills of other professionals; about disseminating resources; about administering the dissemination of resources and about influencing local and national policy.

The knowledge these interventions are trying to impart to other professionals is predominantly accurate and up-to-date sexual health and HIV/ AIDS information, often in the context of being sensitive to the broader needs of gay men. Additional aims concern the promotion of homophobic violence monitoring schemes and of agencies that work with the range of gay men's needs. One intervention was concerned with facilitating the involvement of service users in this process of education (and its aim was gay men using a service).

Skill and attitude-based interventions focus on raising awareness about HIV, sexuality, homophobia, heterosexism and the discrimination routinely faced by gay men. Some interventions explicitly state that this is to improve the ability of services to work with and be sensitive to, gay men; others leave this as implicit. One aim summed up the goal of most of these interventions: 'increased confidence of staff to work with (young) gay and bisexual men'.

Whilst some were concerned with improving the equity of access to resources for gay men – that is, making sure (written) resources are available in as many sites/ venues as possible across the capital – others were concerned with making sure other professionals had the right resources to do their job. Other resource administration aims concern collating and disseminating good practice, improving referral processes and informing ongoing needs assessment.

The final set of aims articulated for this activity were policy based. They seek to ensure the inclusion of, and sensitivity towards, gay men's needs in local authority policy and to ensure gay men's sexual health does not suffer as a result of prejudicial legislation or practice.

8.8 FACILITATION OF HIV HEALTH PROMOTION

Facilitation health promotion seeks to contribute to a reduction in HIV incidence by increasing the capacity or competencies of health promoters or agencies to develop and implement interventions. Thirty-seven such interventions were described as due to occur in 2000-2001.

8.8.1 The targets of Facilitation interventions

By definition, facilitation HIV health promotion seeks to influence HIV health promotion professionals and it is therefore no surprise that the main targets of this activity are HIV prevention workers and GUM clinic staff. Other, less common, targets of this activity are service managers and commissioners, volunteers, professionals who work with gay men, HIV planners and researchers, youth workers and other workers involved in HIV.

8.8.2 The settings of Facilitation interventions

The majority of this activity happens in agency or service centres and in the workplace. GUM/HIV/STD clinics are also used as a setting, as are the internet, telephone, gay pub, community group and gay press, although these are used far less frequently and most commonly when the targets are volunteers involved in prevention. HIV health promotion

Facilitation HIV health promotion	
Collaborative planning forums	
• GMPI planning fora (HF)	6,000
Consultancy and support	
• Support for local LGB youth workers (BH CIHP)	3,000 *
• Evidence facilitator consultancy (HF)	10,000
• Voluntary sector consultancy programme (HF)	10,000
• Individual & organisational learning needs assessments (HF)	5,000
• GU consultancy (HF)	12,000
• Appreciative enquiry learning project (HF)	8,000
• Advice and consultancy (HGLC)	5,164
• EHH GM Project Provider Development (Hounslow CSCPU)	25,000
Mentoring	
• HIV health promotion practitioners mentoring scheme (HF)	6,000
Pilot projects	
• HGLC session (Mayday Hospital)	NA
• HIV positive gay & bisexual men's HP specialist (Hounslow CSCPU)	35,000
Research investigations	
• Young gay & bisexual men's needs assessment (Brent Yth)	2,000
• Action research (Big Up)	NA
Resource distribution to health promoters	
• Resource distribution (Hounslow CSCPU)	25,000
• GUM resource service (HF)	3,000
• Resource distribution (C and I HPS)	NA
• Resource dissemination (BH CIHP)	4,000

professionals find out about this activity, without exception, through the post in their workplace, although a small number of interventions additionally use both 1-2-1 outreach and websites to promote their activity.

8.8.3 The aims of Facilitation interventions

One intervention had no aim and one had an objective as its aim (that is, a description of what would be done rather than what would change as a result of what is done). The other 35 interventions had 76 aims.

Sixteen of them are about improving the practice of health promoters and they include increasing reflective practice, improving supervision and management skills, understanding health promotion theories and their implementation and how to support the choices of clients. A further 14 are concerned with increasing the knowledge and basic skills of health promoters by offering educational courses or seminars: the topics include gay men and mental health, post-exposure prophylaxes (PEP), the impact of class and education on HIV incidence amongst gay men, gay men's sexual behaviour and sexually transmitted infections (STIs). Ten aims address improving the evidence-base of health promoters and a further 9 are about providing various support mechanisms for workers. Improving information dissemination (7), developing strategy (6) and increasing service acceptability were the next most important aims. Fewer aims (4 each) related to the development and dissemination of pilot projects and to establishing the training needs of health promotion agencies and individual health promoters.

Resources for health promoters	
• Developing GUM standards for work with gay men (Croydon CH)	500 *
• F***sheet newsletter (GMFA)	13,500
Seminars	
• Practitioner development seminar programme (HF)	7,000
• Mental health, depression and gay men (THT)	1,800 *
• PEP – What do we tell gay men? (THT)	1,800 *
• Homophobia and working class gay men (THT)	1,800 *
Strategy work	
• Strategy (Hounslow CSCPU)	57,000
Training	
• Sexual health training for volunteers (LLGS)	200 *
• Evidence based gay men's health promotion (HF)	5,000
• Supporting behaviour change in gay men (HF)	8,000
• Health promotion theory and gay men (HF)	7,000
• Harm reduction course (HF)	7,000
• An introduction to working with gay and bisexual men (HF)	8,500
• Back to source (HF)	8,500
• Time Gentlemen (C and I HPS)	8,000
• Professional Training (C and I HPS)	NA
• Consultancy and Training (Naz)	5,000
Volunteer development	
• Volunteer support (GMFA)	67,000
Joint Working	
• Joint Working (Metro)	0 *

Figure 8.8: Facilitation interventions

8.9 EQUALITY HIV HEALTH PROMOTION

Equality interventions are those activities whose aims are to contribute to a reduction in HIV incidence by reducing discrimination that either makes health promotion activity more difficult (or impossible), or that makes the impact of discrimination on individuals or groups less common by making discrimination less common. None were funded by a London Health Authority to occur during 2000-2001.

References

Dodds J & Mercey D (2000) *Monitoring high risk sexual behaviour amongst gay men in London, 1999*. London; University College Medical School Department of Sexually Transmitted Diseases (020 7380 9879).

Fitzpatrick J (1999) *Are Health Authorities failing gay men?* London; National AIDS Trust (020 7814 6767).

Hartley M, Hickson F, Warwick I, Douglas N & Weatherburn P (1999) *HIV health promotion activity map for Greater London, 1999-2000*. London; Sigma Research (020-7737 6223).

Hartley M, Hickson F & Weatherburn P (2000) *Scene It? Done It? Who had contact with gay men's HIV prevention in London in 1999?* London; Sigma Research (020-7737 6223).

Hickson F, Reid D, Weatherburn P, Henderson L, Stephens M (1998) *Making data count: findings from the National Gay Men's Sex Survey 1997*. London; Terrence Higgins Trust (020-7831 0330).

Hickson F, Weatherburn P, Reid D, Henderson L, Stephens M (1998) *Evidence for change: findings from the National Gay Men's Sex Survey 1998*. London; Sigma Research (020-7737 6223).

Hickson F, Nutland W, Doyle T, Burbidge N, Burnell C, Cadette M, Henderson L, Ward M, Wools C, Weatherburn P. (2000) *Making it count: an ethics, theory and evidence based health promotion framework to reduce the incidence of HIV infection through sex between men* (2nd Edition). London; Sigma Research (020-7737 6223).

Hickman M, Bardsley, De Angleis D, Ward H & Carrier J (1997) *A sexual health ready reckoner: summary indicators of sexual behaviour and HIV in London and south east England*. London; The Health of Londoners Project (020 8983 2936)

Johnson A, Wadsworth J, Wellings K, Field J, Bradshaw S (1994). *Sexual attitudes and lifestyles*. Oxford; Blackwell Scientific Publications.

Kelley P, Pebody R & Scott P (1996) *How far will you go?* London; Gay Men Fighting AIDS (020 7738 6872).

Keogh P, Weatherburn P, Stephens MS (1999) *Relative safety: risk and unprotected anal intercourse among gay men diagnosed with HIV*. London; Sigma Research (020-7737 6223).

McGarrigle CA & Nicoll A (1998) Prevalence of HIV-1 among attenders at sexually transmitted disease clinics: analyses according to country of birth. *Sexually Transmitted Infections, 74(6),* 415-20.

PHLS (1999) *Survey of Prevalent Diagnosed HIV Infection* (SOPHID). Public Health Laboratory Service in collaboration with the Scottish Centre for Infection and Environmental Health <www.phls.co.uk>.

National AIDS Manual (1999) *Nambase*. London; NAM Publications (020 7627 3200).

National Statistics (1998) *1991 Census Local Base Statistics: London.* London; National Statistics.

Weatherburn P, Davies P, Hickson F & Hartley M (1999) *A class apart: the social stratification of HIV infection among homosexually active men*. London; Sigma Research (020-7737 6223).

Weatherburn P, Stephens M, Reid D, Hickson F, Henderson L, Brown D (2000) *Vital Statistics: findings from the National Gay Men's Sex Survey 1999*. London; Sigma Research (020-7737 6223).