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AFRICAN HIV PREVENTION HANDBOOK

*Putting The Knowledge, The Will
and The Power into practice*

**for the National African HIV
Prevention Programme (NAHIP)**

Sigma
RESEARCH

 **African**
HIV Policy Network
empowering African communities affected by HIV

NAHIP 

PREFACE

In 2008 the National African HIV Prevention Programme (NAHIP) worked collaboratively on the development of *The Knowledge, The Will and The Power: a plan of action to meet the HIV prevention needs of Africans living in England* (KWP). That document described the state of the HIV epidemic among African people living in England and articulated the purpose, targets and aims involved in planning sexual HIV prevention interventions for this population. The overarching goal binding NAHIP partner agencies together is minimising the number of sexual HIV acquisitions and transmissions involving African people living in England.

The NAHIP partner organisations have worked closely with Sigma Research in the development of *The Handbook*, which is an implementation guide for KWP. It offers clear and concise descriptions of a broad array of possible HIV prevention interventions. The intended targets include African people living in England with and without HIV, as well as those who influence them, including: people planning and delivering HIV prevention interventions, community and faith leaders, education and health professionals, police, commissioners of services, charitable funders, legislators and researchers.

One of the aims of this document is to clarify concepts and the language used to describe various interventions.

It also strives to describe the component parts of interventions, and their limitations so that those people who plan, deliver, fund and research interventions can improve their activities.

The collaboration achieved throughout this process has helped to ensure a *Handbook* that offers a clear and purposeful description of a range of ongoing and future HIV prevention interventions. We are proud of the commitment to partnership that this document embodies and hope that it will support all those who are concerned with HIV infection and who have the capacity to influence it.

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Centre for African Families Positive Health
Community of Congolese Refugees in Great Britain (CORECOG)
Congolese Youth Association

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NAZ Project London

Organisation of HIV Positive African Men (OPAM)
Pan-Afrique Centre
Positively Women
Terrence Higgins Trust
Uganda AIDS Action Fund
West African Network Initiative
Youth Projects International

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1 FIRST PRINCIPLES: *THE KNOWLEDGE, THE WILL AND THE POWER*

This *Handbook* outlines the full range of interventions used in HIV prevention with African people living in England. It is a companion document to *The Knowledge, The Will and The Power: a plan of action to meet the HIV prevention needs of Africans living in England* (Dodds et al. 2008a).

The phrase **HIV prevention intervention** refers to any finite, defined and purposeful action intended to reduce the likelihood of HIV transmission.

The Knowledge, The Will and The Power (hereafter referred to as *KWP*) is a statement of intent, outlining the plans of the organisations comprising the National African HIV Prevention Programme (NAHIP) to work collaboratively towards the common goal of minimising the number of sexual HIV acquisitions and transmissions involving African people living in England. It is a document that explores the **why** and the **how**, including extensive exploration of the purpose, aims and targets of HIV intervention planning with this population.

Like *KWP*, this *Handbook* is a resource for workers, managers, policy makers, legislators, health professionals and commissioners, or anyone with an investment in reducing HIV exposure and transmission among African people in England. It is intended to facilitate action by describing **what** HIV prevention interventions targeting African people in England entail. It describes how the behavioural and bio-medical theory, ethics and aims articulated in *KWP* are embodied in the day-to-day interventions that target African people. Much of the focus is on the direct contact work that health promoters and others undertake to meet the HIV prevention needs of African people (chapters 3-13). However, attention is also paid to broader health promotion interventions that benefit African people by improving the social structures within which they live

(chapters 14-16). We document work that is already being undertaken, as well as assisting in the development of new types of activity. It is a record of what happens now, and what could happen in the future.

This document offers an array of intervention options, described concisely and directly. It offers guidance to those responsible for planning and funding HIV prevention interventions on how to ensure that selection of interventions and their design and implementation are driven by needs identified in specific target populations.

Priorities for HIV prevention planning should be set by analysing and identifying the actual gaps between the locations, scale and needs of the priority populations and the efforts that are currently under way to address these. (UNAIDS 2007)

The following sections summarise some of the core principles articulated within *KWP*, as a starting point for this *Handbook*.

1.1 FIVE NECESSARY CONDITIONS FOR THE SEXUAL TRANSMISSION OF HIV

The success of interventions that seek to minimise the sexual transmission of HIV among African people requires that those funding, planning and delivering such interventions attend closely to the five necessary conditions for sexual HIV transmission. In order for sexual transmission of HIV to take place, it is necessary that:

1. Sexual contact occurs between infected and uninfected partners (HIV sero-discordant sex);
2. which includes a sexual act that provides a route for HIV to pass from the infected to uninfected partner (often called 'unsafe sex', for example intercourse without a condom);

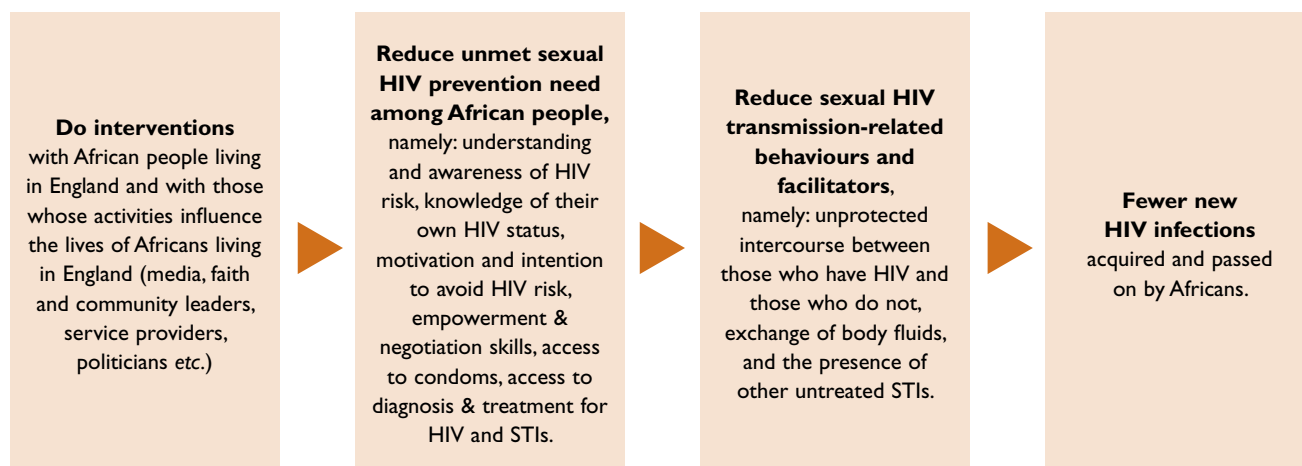
3. through which a quantity of specific body fluid (semen, vaginal fluids, anal mucous or blood) containing HIV is transferred from the infected to uninfected partner through either a mucous membrane (in the vagina, penis or anus) or directly to the bloodstream (through broken skin);
4. with a sufficient concentration of HIV particles (called viral load) in the bodily fluid of the person with HIV; to
5. an uninfected partner who is susceptible to HIV infection.

HIV prevention interventions benefiting African people in England should enable individuals considering sex to disrupt one or more of these conditions.

1.2 HIV PREVENTION CHAIN OF INFLUENCE

The ultimate goal of HIV prevention involving African people in England is fewer HIV infections. To achieve this, interventions aim to exert influence and reduce need among a broad array of individuals and structures, including African people themselves. This combined influence supports the reduction of HIV-risk behaviours and HIV transmission facilitators among African people, with a resulting reduction in HIV incidence. The chain of influence described in *KWP*, and shown here in Figure

Figure 1.2: HIV prevention chain of influence



1.2, demonstrates these relationships between action, aim and outcome. The **how** and **why** elements of HIV prevention interventions targeting African people, denoted in the second and third boxes, constitute the content of *KWP*. **What** the interventions referred to in the first box entail, is covered in detail in this *Handbook*. In this way we can see how these documents function together to support the planning and delivery of HIV prevention interventions.

1.3 FIVE PRIORITY GROUPS FOR INTERVENTIONS

In order to maximise their impact on HIV infections, interventions should prioritise the following groups of African people, in this order:

1. People with diagnosed HIV

Since they are in the minority, people with HIV have much more opportunity for HIV sero-discordant sex than people without HIV. This does not mean that NAHIP partners think people with diagnosed HIV have *more* responsibility for HIV transmission than HIV negative people, but simply that they have more opportunity for involvement in transmission. As a result, unmet prevention need (as well as unmet HIV treatment and care need) in people with HIV is more likely to result in new infections than unmet needs in people without HIV.

2. **People in sexual relationships with people with HIV**

People in relationships with someone of a different HIV status to themselves have much more opportunity for sero-discordant sex than people not in such relationships. NAHIP partners agree that it is unethical to attempt to break up relationships where one partner has HIV and the other does not, in order to reduce sero-discordant sex. Therefore it is essential that people in sexual relationships with people with HIV have their HIV prevention needs met, and have access to post-exposure prophylaxis (PEP) when exposure does occur.

3. **People with multiple sexual partners**

The more sexual partners someone has, the more likely it is one of their partners will have a different HIV status. So people with multiple concurrent sexual partners including: commercial sex workers, people in (formal or informal) polygamous relationships, and many homosexually active men, are more likely to have sero-discordant sex than those with fewer partners. NAHIP partners think it is feasible and ethical to influence people to reduce the frequency with which they have intercourse with new partners, particularly if they are already in a sexual relationship. This is to be achieved by meeting the needs associated with avoiding and declining intercourse during sexual sessions, as well as declining potential sexual partners.

4. **People who have sex with people with multiple sexual partners**

Those who have unprotected sexual intercourse with a man or woman who has multiple sexual partners (either concurrently or not) need to be aware that their partner has an increased likelihood of having HIV. This will particularly apply to homosexually active men whose male partners have multiple sexual partners, clients and other partners of commercial sex workers and those in relationships who know or think that their partner may be having sex with others. The ability to access and use condoms will be important for people in this group, as well as the ability to undertake a range of non-penetrative sexual options with partners.

5. **All other people who are or will be sexually active**

Thinking through the issues related to HIV prevention, including condom use, abstaining from or delaying sex with a new partner, or being sure of HIV concordancy are all important prevention tactics for sexually active African people. It is possible for people to choose to reduce their risk of HIV transmission by having sex only with someone they know has the same HIV status as themselves. HIV testing allows people to know *their own* HIV status. Establishing the HIV status of current and potential sexual partners is much more complex, and requires a high degree of physical autonomy and assertiveness. All of these tactics are also reliant on sound knowledge of HIV, including how it is transmitted.

1.4 VALUES AND ETHICS

NAHIP partners and other organisations seeking to reduce the number of sexual HIV acquisitions and transmissions involving African people living in England operate within an established framework of ethics and values. One of these is individuals' right to make their own choices about their own sexual and reproductive health. Health promoters acknowledge the diversity of sexual desires and practices among African people in England as individual rights and contribute to the creation of a social environment conducive to Africans taking greater control of their sexual and reproductive health. Creating such an environment will involve improving access to suitable shelter, education, food, income and ensuring peace and equality, an endeavour which requires support and action from an array of stakeholders far beyond those involved directly in sexual health promotion.

Health promotion interventions aim to help African people make informed decisions about their sexual health, while at the same time recognising that individuals make decisions for themselves. Interventions should improve people's ability to decide how, when and with whom to have sex without fear of being bullied, stigmatised or discriminated against. Therefore, health promoters should not coerce or misinform Africans to achieve a desired behaviour because that would be a

breach of their sexual rights. However, ensuring freedom of choice should not stop health promoters from being clear about proven methods of HIV risk reduction. The messages must remain unambiguous so that Africans can have the opportunity to acquire relevant skills, confidence and resources they need to take control of their sexual health.

Although African people share a continent of origin, they are not one group. Different behaviours and responses undertaken by African people will be influenced by location, age, gender, religious belief, migration history, cultural values, information and changing social and material circumstances. There is no single African cultural approach to sex. Interventions will focus on social networks, life experiences and beliefs of Africans living in England rather than assumptions about cultural backgrounds. Social attitudes towards sex and sexuality have a great bearing on interventions because they determine what is publicly acceptable among different groups and communities. In addition to this, there are clear differences between public identity and private sexual practices.

Interventions need to be sensitive to the central role played by social networks and communal ethics among many Africans. This can be described as a shared sense of mutual care, belonging and interdependence which is strengthened by extended family ties. This belief in duty of care and responsibility for each other can have a significant effect on reducing HIV transmission. However, an ethic of communal belonging can also be misused to castigate and alienate those who are made to feel they

are outsiders because of their identity, HIV status, sexual desires or attitudes or behaviours.

In order to improve sexual health and reduce HIV transmission among all African people living in England, we need to collectively improve knowledge, will and power. First they need knowledge about HIV, what they can do to reduce their risk of infection or transmitting HIV to their sexual partners, realities about living with HIV, and available treatment and care. They also need to know what can be done to improve their own health, and that of those around them. African people also need the motivation to adopt HIV-risk reduction behaviours. Health promoters support their willingness to act by clarifying the costs and benefits of various sexual behaviours, and by promoting social norms that are supportive of prevention aims. Lastly, African people need the power to take control of their actions to reduce HIV risks. This involves increasing access to material resources, skills and opportunities. However, the power to take control of one's life will depend on interpersonal, family, community and national power dynamics.

All organisations, stakeholders and NAHIP partner agencies involved in carrying out or supporting HIV prevention should find ways to influence the development of local, regional and national policies that promote equality and rights, while maintaining high ethical standards in their own practice. Finally, NAHIP partners also aim to increase the knowledge, the will and the power of all other stakeholders to play an effective role in HIV prevention for African people in England.

2 STRATEGIC INTERVENTION PLANNING

This chapter helps to situate HIV prevention interventions in their broader practical, social and economic contexts. It begins with a consideration of choices made when classifying and describing HIV prevention interventions, before moving on to discuss key findings relating to their efficacy. As a large proportion of funding provided for targeted HIV prevention interventions in England comes from the NHS, the last section of this chapter describes how new policy directions (particularly those relating to commissioning and procurement) are likely to impact upon the expectations of commissioners and service providers.

2.1 CLASSIFYING HIV PREVENTION INTERVENTIONS

One of the central aims of this *Handbook* is to describe HIV prevention interventions in the most basic terms possible – so that each element of activity can be clearly defined, and so that strengths, weaknesses and outcomes can be clearly described. The production, marketing and distribution of resources focused upon a particular theme (typified by the national NAHIP campaigns, for instance) is an important element of the direct contact interventions that occur with individual African people. However, it is necessary to understand the array of interventions that can comprise such campaigns – by starting to describe each of their parts in detail. A good way to begin breaking down interventions into their base elements is to pay close attention to the core aspects of the activities.

Different agencies and researchers describe and name interventions in different ways, with some focusing on settings (such as ‘schools work’), or target groups (‘sex worker project’), outcomes (‘empowerment intervention’) or activities (‘counselling’). There are also times when the same word (for instance, ‘training’) is

used to denote very different types of activity (including: an HIV seminar day for African church-goers; health promotion staff induction; or an assertiveness skills course for young women). These various ways to describe interventions make it difficult to compare, review, learn about, evaluate, or standardise activities. As a result, UNAIDS’ recommended practice is to devise concise definitions for interventions that are generated through consensus, and that are primarily defined by the **activities** or **services and commodities** provided (Sweat 2008). This enables all parties to have a shared understanding of what an intervention is, what it intends to achieve, and how it will do so.

This specificity helps to meet a range of needs:

- funders will be clear what exactly is expected from a particular set of interventions in order to ensure value;
- planners and steering group members will be able to give adequate focus to each intervention, with detailed consideration about the most appropriate means of achieving a particular set of aims; and
- workers and volunteers will know how best to use different resources and skills in different contexts.

Direct contact interventions are those which communicate specifically with people whose behaviour puts them at risk of HIV exposure or transmission.

In order to maintain the principles of simplicity and direct description recommended by UNAIDS, the **direct contact intervention** chapters of this document (chapters 3-13) are classified according to their most basic common elements. Classifying interventions in this way allows us to consider the modes of delivery and skills required for different activities.

- *Talking and listening* relates to the activities through which health promoters, trainers or counsellors directly engage with service users to direct them toward resources, ideas, skills, and personal development goals that are most appropriate to their needs.
- *Reading and writing* helps us to consider both the process of developing useful text, as well as its appropriateness and utility for readers.
- *Giving and taking* helps to guide attention toward the activities that ensure that resources are given to, and received by those who can use them.
- *Clinical interventions in the community* relates to the clinical services, such as STI and HIV testing, pre-test and post-test counselling, and clinical referrals that can be undertaken outside of the hospital setting in community-based venues, facilitated by partnerships between clinical and non-clinical providers.

Different interventions will meet diverse aims, for different people, in a variety of settings. Most interventions can be bundled together to maximise their impact within programmes (Sweat 2008). While bundling of interventions may arise from pragmatism, or a desire to build a multi-component response to meet complex sets of need, in other cases there are ethical mandates to bundling discrete interventions, such as the provision of psycho-social care and support for people who have attended for voluntary counselling and testing and who have been diagnosed with HIV. In each of the substantive chapters of this document, attention is given to the ways in which specific interventions are often bundled together with others in a programme of service delivery.

The final three chapters describe interventions that are not undertaken directly with African people in HIV prevention need, but instead, which those who have influence over this population. We consider such interventions to be structural.

Structural interventions are undertaken with those who have influence over the target population. These can also be called *facilitation interventions*.

Just as the direct contact interventions are undertaken across a broad range of agencies in diverse settings, so too are structural interventions. It is through working in partnership that the impact of all of our activities is multiplied. Therefore, agencies working to implement KWP should regard themselves as part of a network of mutually beneficial relationships with others working on a variety of levels. In the main, central coordination, support and standardisation is provided by the National African HIV Prevention Programme (NAHIP), and participation with this programme is a collective effort. Those who join in the collaborative spirit of this endeavour take part in a range of consultation exercises, and in return receive both sector development interventions, national campaigns, and access to the outputs of other agencies.

The NAHIP partners acknowledge that no single organisation can undertake all interventions, nor will one intervention be appropriate for all African people.

2.2 EVIDENCE OF EFFECTIVENESS

Effectiveness refers to the achievement of the desired outcomes among the population to whom the activity was directed. The limited evidence about the effectiveness of direct contact interventions suggests:

- interventions undertaken with groups, such as cognitive behavioural therapy, skills development and relapse prevention can influence the sexual behaviours of black and minority ethnic (BME) adults;
- information and advice provided by peers, and interactive condom distribution in community settings influence behaviour among BME women, heterosexual men and adolescents; and,
- culturally-grounded interventions (that account for cultural norms, rather than just being about visual representation of BME people) can increase information uptake in the target population. (Downing *et al.* 2006)

This evidence was primarily collected in the United States, from interventions undertaken with African Americans, and we must be cautious about the successful transfer of interventions with BME

community members in one cultural context (African Americans) to another (such as African migrants in the UK). However, the US Centres for Disease Control and Prevention have identified 18 best practice interventions (Lyles *et al.* 2007) and the most common elements shared by these interventions were:

- a clearly articulated reliance on a social theory or behavioural change model;
- facilitator characteristics that were shared with the target population;
- more than a one-off interaction, with many falling somewhere between 9 and 18 hours in duration; and
- a focus on skills-building including correct condom-use, communication, decision-making and interpersonal skills.

Reviews of best-practice therefore suggest intensive interactions that offer opportunities for sustained engagement and skills development. These findings offer promise for the development of such interventions in the UK, although maximising the utility, acceptability and efficacy of interventions in this context will require ongoing evaluation and careful planning. No intervention occurs in a vacuum. Even where it may be difficult to demonstrate that a one-off intervention (such as a mass media advert, or the provision of face-to-face information and advice in community settings) has a direct impact on behaviour change, all of these activities are likely to contribute to the broader aims of improved social norms regarding sexual health and sexuality, and also help to build the brand recognition of agencies whom service users may approach for further interventions.

There is also evidence regarding the effectiveness of structural interventions. A recent review (Bauermeister *et al.* 2009) found interventions offering technical assistance to HIV organisations that utilised multiple interactive education approaches, and those aiming to increase internal communication processes in organisations were most effective. The same reviewers also found that partnership working to reduce duplication of effort and link existing resources into bundles were successful.

2.3 POLICY CONTEXT

The white paper *Choosing Health: making healthy choices easier* (Department of Health 2004) identifies improving sexual health among its six key priorities. Its implementation strategy, *Delivering Choosing Health* (Department of Health 2005) does not set out any specific aims relating to HIV, although it does point to the economic benefits of reducing HIV transmission, and endorses standards for HIV services including HIV prevention interventions (MedFASH 2003). The absence of national targets for the reduction of HIV incidence indicates that HIV prevention is not a domestic priority in the UK (National AIDS Trust 2007).

However, shifts in service commissioning and procurement offer opportunities for locally funded HIV prevention interventions. *World Class Commissioning* (Department of Health 2007), aims to increase the quality and value of all NHS services and services commissioned from community-based agencies. Central to this approach is the development of core competencies among those commissioning services, articulation of priority health aims within each Primary Care Trust (PCT) based on assessment of local need, and closer attention to the measurable outcomes of service provision. Some of the commissioning competencies that will have a key influence on working to strengthen the commissioner and HIV service-provider relationship are:

- close collaboration with community partners;
- knowledge management and local needs assessment;
- prioritisation of investment according to local needs;
- promotion of continuous improvements in quality and outcomes of service provision; and
- contract management that ensures compliance and continuous improvements in quality and outcomes.

Familiarity with *World Class Commissioning* documentation (Department of Health 2007, 2008) will increase service providers' understanding of the drivers of innovation in commissioning, and will explain the need for outcome-based planning. Intervention descriptions in *The Handbook* that are likely to receive local authority or Primary Care Trust funding if they

include a clear description of outcomes and strengthen the connection between local need, intervention activities and proposed outcomes.

2.4 BUILDING AN INTERVENTION PLAN

Planning an HIV prevention intervention is not simply about determining what *can* be done. Instead, assessment of the context in which the work is to be carried out helps planners to determine what *should* be done in order to have the greatest impact. The remainder of this chapter outlines a model (summarised in Figure 2.4a overleaf) for planning that begins with consideration of local need and available resources before determining whether an intervention should involve **direct contact** or **structural** activity. Furthermore, there is a requirement that planners clearly identify:

- WHO the target of such an intervention will be, and;
- WHAT particular need the intervention aims to meet; prior to specifying
- HOW a particular intervention will best meet that need for a specific sub-group of African people, or those providing services to them.

The following sub-sections outline key considerations for each stage of the planning process, from initial needs and resource assessments; to specifying target groups, intervention aims and selection of an intervention. The remainder of this *Handbook* is designed to support those who have chosen an intervention to plan and implement it.

2.4.1 Assessing the local situation

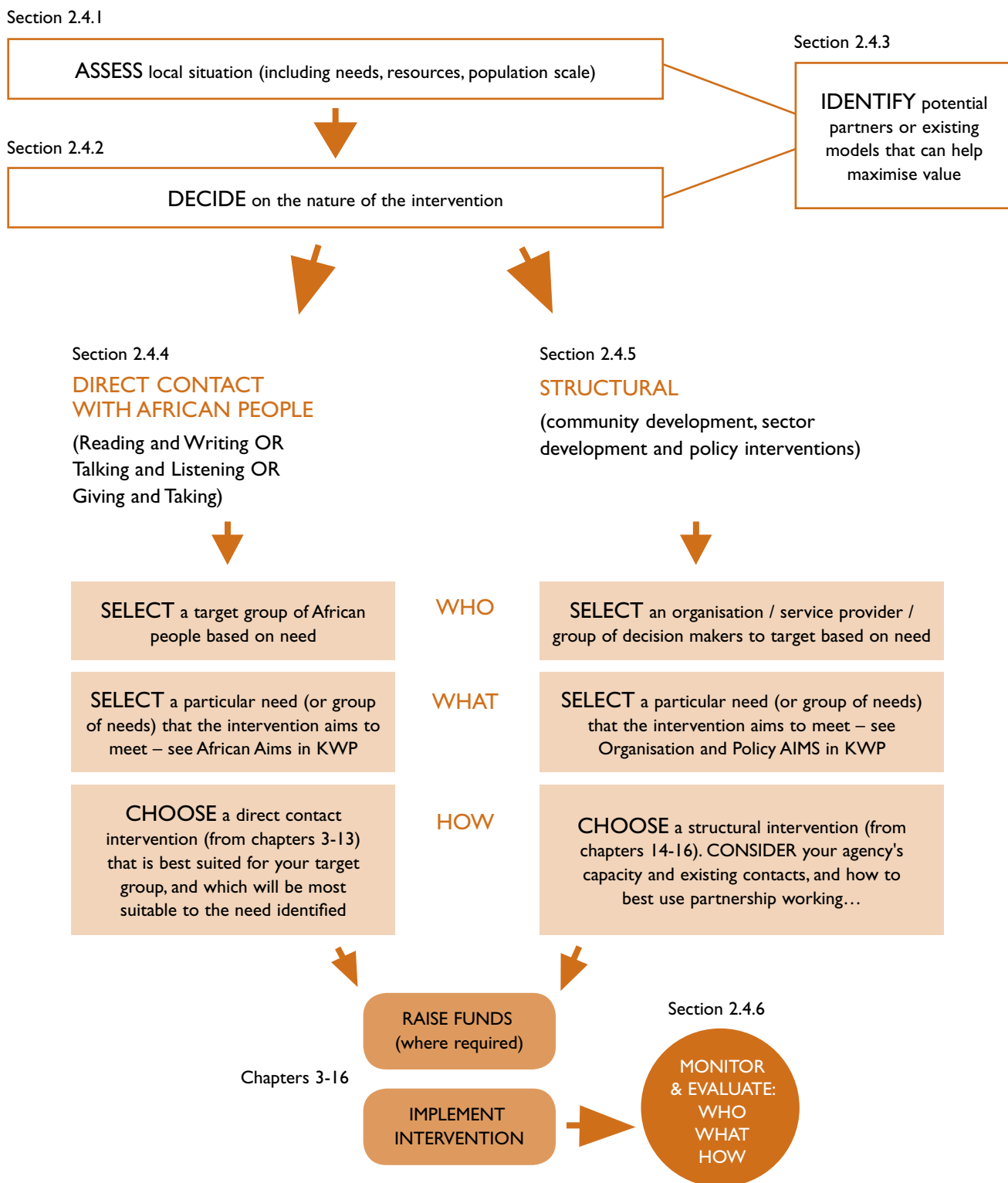
In the past, it has been assumed that HIV prevention interventions benefitting African people should begin with extensive needs assessments and consultations with local people. Such needs assessments were often seen as a prerequisite for work, but paradoxically, often served as delays or major obstacles. The development of national data sources and frameworks makes far-reaching local enquiry largely unnecessary. The survey data collected through *Bass Line* (Dodds et al. 2008b, Hickson et al. 2009); *Mayisha* (Mayisha II Collaborative Group 2005, Elam et al. 2006); *Padare* (Chinouya & Davidson 2003); *What do you need?*

(Weatherburn et al. 2009); and a large scale survey undertaken with users of clinical HIV services in London (Elford et al. 2007) offer sufficient information on UK-resident African adults' HIV risk behaviours and needs. Additional qualitative and quantitative data among somewhat smaller subsets of the population further illuminate key areas of need (see for instance, Dodds et al. 2004, Flowers et al. 2006, Doyal et al. 2007) and offer insight into the specific contexts and drivers of individual behaviour, including sexual risk assessment and service use. As a result, we recommend the comprehensive use of national resources along with limited local needs assessment prior to initiation of local work with African people at risk of involvement in the sexual transmission of HIV.

The local area can be assessed by undertaking the following actions:

- *Estimate* the size of the local population of African adults (see text box on page 10).
- *Estimate* the proportions of your local population in the key target groups (ie. African people with diagnosed HIV, etc.).
- *Gather* information on HIV risk behaviour and needs from research. **Bass Line national and local area data reports** should not be considered as being representative of all African people, so we encourage you to be looking for patterns of need, as highlighted in *Part Two* of the *Bass Line* national reports.
- *List* the local policy makers and commissioners, as well as statutory and voluntary service providers concerned with the health and social care of African people.
- *List* the local commercial and community venues that serve African people.
- *List* the expatriate African social groups or networks within the area and establish the extent to which these are utilised by various sub-groups of African people.
- *List* the local commercial and community venues that disproportionately serve young people and establish what proportion of their service users are African.
- *List* the lesbian, gay, bisexual and transgender (LGBT)

Figure 2.4a: Planning HIV prevention interventions



social groups or networks within and adjacent to the area and establish the extent to which these are utilised by African people.

- Obtain figures on the current statutory spend in the areas of sexual health, STI and HIV prevention for your local area.
- Obtain strategy documents – particularly the local outcome measures as specified within the *Commissioning Assurance Handbook* (Department of Health 2008)

Estimating the size of a local African population – how to use the Census

Using the data provided by the 2001 National Census, it is possible to estimate the current African population in your local area. Given the increase of net migration from Africa to the UK over the past decade, it is likely that the results will provide an underestimate of your local population, however, having some sense of the size of the population is useful for funding applications and planning.

1. Go to the Office of National Statistics website: <http://www.statistics.gov.uk/default.asp>
2. In the menu running across the top of the screen, click NEIGHBOURHOOD.
3. On the subsequent page, give a postcode or area name for which you want data, and click on the 'Local Authority' statistics option, and press SEARCH.
4. You can choose from an array of topics on the next page. We suggest you select the second topic in the list: '2001 Census: Key Statistics (31 datasets)'. Detailed information across more areas (without percentage summaries) is available from the first topic in the list '2001 Census: Key statistics' (61 datasets)
5. A range of basic demographic areas will be listed in these topic pages. *Ethnic group* and *country of birth* categories will probably be of greatest use.

Knowing the overall size of the population is a start. If you want to find out about Census information in greater detail, call the helpful ONS staff on 0845 601 3034 or email info@statistics.gov.uk

2.4.2 Deciding on the nature of the intervention

The local assessment exercise outlined above is primarily a desk-based activity. It does not involve research fieldwork or community consultation. It is an exercise that leads neatly into drafting a plan for local work, starting with a decision on whether it is best to undertake an intervention that directly targets African people, or one which operates to boost the infrastructure which supports African people.

In some cases, making enquiries about local spending priorities and policies can be structural interventions in themselves, given that such activity can help raise the profile of sexual health and HIV at a local level. Before initiating direct contact work with African people, the most appropriate use of limited local resources might involve attempting to bring about changes in service delivery and community infrastructure to facilitate service improvement and social networking for local African people.

In other cases, identified needs and assessments of local resources and opportunities will point toward direct contact interventions with African people in the community. Such interventions will aim to increase some element of African people's knowledge, will and power to avoid involvement in HIV exposure and transmission.

2.4.3 Identifying partnership opportunities

The local assessment should help planners to identify existing local HIV prevention interventions (provided by voluntary and / or statutory organisations). Not only will this help to avoid replication of local services, but it will also identify opportunities for working collaboratively with other organisations to achieve shared goals. For instance, those providing generic social services for African people, or clinical service providers seeking to increase uptake from African service users may benefit from partnership working with agencies with African community expertise. Working in partnership can help to increase reach, improve acceptability and increase the likelihood of achieving sustained funding for an intervention.

The Knowledge, The Will and The Power target groups (Dodds et al. 2008a)

1. **People with HIV**
2. **People in sexual relationships with people with HIV.**
3. **People with multiple sexual partners.**
4. **People who have sex with people with multiple sexual partners**
5. **People who are or will be sexually active.**

Groups with disproportionate HIV prevention need in Bass Line 2007 (Dodds et al. 2008b)

People with diagnosed HIV – Key issues: condom failure; confidence to use condoms; confidence to avoid risk.

Men who have sex with men and women – Key issues: basic HIV knowledge; condom access; confidence about others knowing they carry condoms.

Teenagers – Key issues: multiple sexual partners; basic HIV knowledge; condom and sexual health service access; confidence about avoiding transmission.

People with little or no formal education – Key issues: STIs; HIV testing; basic HIV knowledge; condom access; condom failure; confidence about avoiding transmission.

A different way of considering partnership-working is to seek out best practice examples of interventions beyond the locality in order to determine if they might be feasible locally. Working together with others who have already devised successful interventions will help limited resources to go much further, as there will be less trial-and-error with support from experts who have already undertaken similar work elsewhere.

2.4.4 Direct contact intervention planning

For those who have identified direct contact interventions with African people as the desired course of action, careful consideration must be given to the particular sub-group of African people that will most benefit (WHO), the specific need that an intervention aims to meet (WHAT), and the intervention that is best suited to meet that need (HOW). This section provides details about each of these considerations.

WHO will benefit from the direct contact intervention?

Not all African people in England are equal in their degree of HIV prevention need nor are all interventions useful or acceptable to all people. Each intervention requires identification of the particular group of African people for whom it will be designed. Although the target groups listed in the text box above have arisen from different sources, there is also considerable overlap. When selecting a target group for an intervention, consider:

- which groups demonstrate greatest need when considering national and local data,

- which groups are immediately accessible,
- which community leaders / gatekeepers / or venues might be able to assist in accessing a particular target group.

WHAT is the aim?

The following list of behavioural aims for African people from *KWP*, helps planners consider the specific HIV prevention need that interventions are intended to meet.

Africans aim 1: Africans reduce sexual HIV risk behaviours in a range of possible ways.

Africans aim 2: Africans decline unwanted sex or have non-penetrative sex.

Africans aim 3: Africans correctly use male and/or female condoms for intercourse.

Africans aim 4: African couples establish and maintain HIV concordancy.

Africans aim 5: Africans with undiagnosed STIs get them diagnosed and treated.

Africans aim 6: Africans who have unprotected intercourse practice withdrawal before ejaculation when partners are not confident they have the same HIV status.

Africans aim 7: Africans without HIV who are sexually exposed to HIV take post exposure prophylaxis (PEP).

Africans aim 8: African couples with HIV who want to conceive reduce HIV risks in doing so.

Figure 2.4b: Cost, efficacy and scope of an array of direct contact interventions



Each one of the aims listed here will require a considerable number of needs to be met, and an intervention may be designed to focus on a particular sub-aim of one of these larger aims. For instance, in order to reduce sexual HIV risk behaviours (African aim 1), African people will need to know that HIV exists, the harm it can cause, and how to reduce risk; they will need the motivation to reduce the risk of transmission, and the power to act to reduce HIV transmission risk (see chapter 6 of *KWP* for greater detail on all of these aims and their related needs).

HOW will the aim be achieved?

Chapters 3-13 of this document offer a wide array of direct contact interventions to meet HIV prevention need among African people. Determining which intervention to use will depend in large part on who is being targeted, and the aim of the intervention. For instance, aiming to improve confidence in using condoms among young African people probably needs an intervention that occurs face-to-face, involving *Talking and listening*, perhaps in group settings.

Evaluations of direct contact HIV prevention interventions have routinely found that face-to-face,

prolonged, skills-related, culturally appropriate and theoretically-grounded interventions were most likely to demonstrate impact on HIV prevention need (see section 2.2). Although it is feasible for every intervention to adopt this format, planners have an obligation to consider impact in relation to cost per intervention delivered.

Figure 2.4.b illustrates the relationship between cost, efficacy and likely reach of the different types of direct contact interventions described here.

Reading and writing interventions are likely to have a less impact than other interventions but they reach the largest number of people, and have the capacity to reach those who will not attend more intensive interventions in person. They probably have the lowest per person cost (although often a high overall spend), and should form part of national or regional programme. They can also help build service recognition, and may draw users into face-to-face or telephone contact with a provider.

At the other end of the scale, *Talking and listening* interventions that aim to achieve therapeutic change, or build skills, are necessarily resource intensive and are

among the most costly to deliver per person. It is therefore vital that high unit-cost interventions such as these are carefully targeted to ensure that those in greatest need access them. In the main, the aim of targeting at this end of the spectrum is to ensure that limited resources are not spent on intensive interventions for people whose needs could be met with less intensive interventions.

These considerations help to underline the added value of partnership working (achieving outcomes such as cross-referrals, shared expertise, and shared use of resources). Selection of an intervention for a particular sub-set of African people, to meet a specific HIV prevention need, should never be undertaken in isolation. Direct contact interventions are planned and delivered within the context of an array of activities undertaken by the same agency, and by others in the local area. Bundling of interventions into programmes helps to increase uptake by improving people's capacity to select the most appropriate intervention for them. It also ensures that interventions are not contradictory and that referral pathways are clear.

2.4.5 Structural intervention planning

Deciding to work at the strategic level, by strengthening the formal and informal structures that support African people in their daily lives, requires no less planning than the provision of direct contact interventions. In addition, such work can be difficult to evidence, so attainment of funding can be challenging. Structural interventions are

almost always more likely to achieve success through partnership working, whether it involves the targeting of a organisation that you aim to influence by working with them, or by joining together with other agencies to advocate for policy change.

WHO is the target of structural interventions?

Not only is it necessary to identify specific organisations, services and people that will be the targets of strategic interventions, the local assessment should also indicate the individuals and particular post-holders who will provide an immediate point of contact. Identification of the target will be closely tied to the resources available. Although it can provide widespread impact, seeking to achieve national change can require long-term commitment and the capacity to network and meet with other advocates from distant places. On the other hand, sometimes local issues can be addressed with swift and persuasive interventions. Identification of the targets for a strategic intervention are closely tied to the needs identified and the type of intervention that is planned.

WHAT is the aim?

Chapters 7 and 8 of KWP provide detail relating to an array of community development, sector development and policy aims. The text box below offers some examples of such aims under their relevant headings, but this is by no means a complete list.

Community aims

Increasing the extent to which African and HIV specific organisations work in partnership with generic service providers.

Improve the extent to which Africans are able to find formal and informal sources of social support.

Organisation aims

Ensure that all workers and volunteers have the knowledge, skills and openness to deliver interventions effectively.

Increase the collection and use of research evidence in planning and delivery of interventions.

Organisations increase their local leadership profiles, and gain the capacity to influence local policy developments.

Policy aims

Harmful asylum policies such as dispersal and disallowal of employment are re-considered.

HIV prevention, testing, support and care needs of Africans are better met through NHS primary and secondary care services, especially for all those in detention.

Anti-racist and anti-homophobic education initiatives are strengthened in schools, colleges and universities.

Prior to implementation, it will be necessary to articulate what specific aim will be central to success. It is critical to establish concrete outcomes that will serve as markers to indicate how much progress toward an aim has been made.

HOW will the aim be achieved?

Chapters 14-16 of this document offer a wide array of structural or facilitation interventions that will help to establish an environment in which African people are more likely to have their HIV prevention needs met. Determining the style or approach of a strategic intervention will depend in large part on who is being targeted, and the selected aim of the intervention. Community development (such as resource and skills sharing) and sector development interventions (such as the provision of newsletters, email updates, training, conferences or briefing papers) are most likely to be selected and planned based on what is uncovered in the local assessment. However, sometimes the outcomes of policy interventions can be externally shaped, as they may occur in direct relation to a critical event, or because of a consultation process that is driven by others. However, the identification of key strategic aims and objectives in organisational planning can improve the extent to which the decision to participate in (or respond to) external events is in accord with an agency's overall vision.

Targeted structural interventions are never undertaken in isolation, because they usually relate to a particular social, economic and political context shared by many stakeholders. Therefore, the identification of those working toward shared goals can be vital in shaping how structural interventions are devised, as well as ensuring their ultimate success.

2.4.6 Monitoring and evaluation

Monitoring and evaluation activities help to establish the extent and scope of interventions, as well as providing evidence of their feasibility and efficacy.

Monitoring activity records the number of times an intervention is done, where and when, and keeps track

of who is doing the interventions and the number of people that receive them. The NAHIP partnership has a unified national system for monitoring interventions, which means that organisation managers and those managing their contracts know who is doing what.

Sometimes monitoring forms require information about the basic demographics (age, gender, ethnicity, etc.) of those encountering interventions. Analysis of these data allow **access evaluation** to take place, in order to establish if the people encountering interventions are the intended targets. Where access evaluation demonstrates that people accessing an intervention are not those intended to, modifications can be made to improve the targetting of the intervention.

Evaluations relating to the **feasibility and acceptability** of interventions usually happen during the pre-testing or piloting phases of their development. Developmental versions of an intervention are used or discussed with members of the target population to assess the degree to which it appeals to them, and whether or not the language and pitch used are appropriate. Cognitive face-to-face interviews, focus groups, and questionnaires can all be used to collect this type of data, depending on the focus of the evaluation.

Evaluating **efficacy** helps to determine how well an intervention meets its aims. This usually requires a high level of research skill, as it needs careful design and analysis that pays close attention to the aims and outcomes of an intervention. Efficacy evaluation might involve the use of questionnaires before and after an intervention of a set duration (such as a group seminar) in order to determine if participants' needs were met. Other formats can include the use of focus groups, in-depth interviews with those who participate in or encounter an intervention. Sometimes, comparable data is collected from those who did not encounter the intervention, in order to demonstrate whether there are any differences in behaviour, knowledge, motivation or power between participants and similar other people.

INFORMATION AND ADVICE DELIVERED ONE-TO-ONE

3.1 WHAT IS THE ACTIVITY?

Information and advice interventions typically offer individuals the opportunity to discuss sexual health concerns, such as sexual safety, negotiating relationships or sexual dysfunction, one-to-one. However, HIV prevention need reaches beyond access to adequate sexual health information, and includes needs related to security, safety, productivity and freedom from discrimination. The provision of information and advice on welfare benefits, immigration, housing, employment and training are also interventions that help to reduce HIV prevention need among African people in England.

Engaging individuals in discussion, listening to their experiences and feelings, and offering information and advice is at the centre of many activities undertaken by agencies delivering HIV prevention interventions. Although the contexts through which individual service users come into contact with such services vary widely, many core principles of information and advice provision remain the same, regardless of the setting in which it is offered. One-to-one advice is typically client-led and should be easily accessed. Many agencies tend to focus on their detached or outreach work as the main way of giving information and advice, but we also include centre-based services (offered on a drop-in or appointment basis) and helpline (offered by telephone) and chat-room interventions (on the internet), although the latter two intervention types do not occur face-to-face.

3.2 STRENGTHS AND LIMITATIONS

The highly personalised delivery of one-to-one talking interventions means they can be responsive to service users' needs, in ways that are not possible in written interventions.

One of the most significant challenges in the provision of one-to-one advice and information (particularly

through outreach or detached work), is the recruitment, training and retention of people willing to work unsociable hours who also have excellent communication skills and sufficient sexual health expertise to deliver the intervention.

Outreach and detached work is notoriously difficult to monitor and evaluate, and there can be resistance among some workers to use of monitoring tools in the field. Similarly, service-users' interactions in settings outside of the agency may be fleeting, making monitoring and evaluation challenging.

3.3 WHERE DOES ONE-TO-ONE INFORMATION AND ADVICE PROVISION HAPPEN?

During detached work or outreach interventions, advice sessions can occur in public, private and commercial spaces where African people socialise, including markets, pubs, clubs, places of worship, schools, colleges, universities, businesses and community centres. Access is therefore immediate, and interactions tend to be short (typically 5 – 15 minutes). Workers generally operate in pairs in settings other than their agency, in order to ensure their own safety, and also to protect themselves against accusations of misconduct. Advice is usually information-based, and the session can be used as a means of referring individuals to other services, and distributing HIV prevention resources (such as leaflets and condoms).

Centre-based information and advice interventions lack the immediacy and coverage of outreach interventions. The self-referral demanded by such services means that individuals have identified a need (knowledge), decided to act to get it met, found out where to go, planned a time to attend, and had the capacity to act. People using such services demonstrate motivation (will) and the capacity to seek support in meeting their needs (power). Drop-in sessions at centres may either require follow-up or referral on to other services (offered inside and outside

the agency) where appropriate. Wherever possible, centre-based drop-in should take place in an area away from other service users and staff, offering people privacy while discussing personal issues. There should be a secure area for keeping confidential records, and private rooms may be equipped with a panic button system to be used if there is a physical danger.

Telephone helplines and web-based personal support interventions provide users with direct, one-to-one information and advice, at times and in settings that are most comfortable for them. Once again, they often demand self-referral, although accessibility is much increased compared to centre-based interventions, and is in the control of the user. Such interactions do not require an appointment, and can be of varying durations and intensities. In such interventions, the technology affords relative anonymity to the user, while the provider can tailor the information and advice offered to the needs of individuals accessing the service. Telephone and web-based information and advice require less overhead than face-to-face provision.

3.4 ISSUES TO CONSIDER

Providers of one-to-one information and advice should be knowledgeable about a range of sexual health issues such as the transmission, prevention and treatment of sexually transmitted infections (including HIV). Beyond this, they also require familiarity with related issues, in order to identify acute needs (relating say to domestic violence, homelessness, or non-consensual sex) and to be familiar with an array of services to which they can make appropriate referrals. Positions demanding this type of expertise and experience are ideally paid as it is difficult to ensure adequate quality of provision by volunteers. Workers providing information and advice should have proven listening and communication skills. Agencies could consider pooling their sessional outreach staff in order to ensure high quality provision, as well as ensuring that there is enough work to keep individuals in post. It is essential that workers display a professional, non-judgmental, knowledgeable and reliable persona while communicating with service users.

Agencies will need to have procedural and boundary guidelines for one-to-one workers, and will need to ensure that these are built into staff inductions, and are

regularly revisited. These should aim to maximise the physical safety and comfort of workers while also ensuring a standardised and reliable service. The providers' credibility is paramount to the success of these interventions, therefore workers will need training about personal, professional and social boundaries during work (and about contact with clients outside of work).

Outreach workers will generally need to be equipped with:

- identification cards;
- relevant written resources and other materials such as condoms / femidoms;
- contact details for other services;
- monitoring instruments;
- mobile phone; and
- a letter on agency-headed paper explaining their presence.

Making arrangements to gain access to community and commercial venues can be time-consuming, but careful preparation and community consultation will help agencies to successfully identify appropriate venues.

Key to the intervention

Providing information and advice to individuals requires a good understanding of their needs and concerns. Listening in an open, non-judgmental way helps those providing this intervention to get a better sense of how to tailor information and advice in ways that best suit people's needs.

Frequently delivered alongside ...

Information and advice delivered to groups (chapter 4)

Therapeutic change and skills development delivered one-to-one (chapter 6)

Therapeutic change and skills development delivered to groups (chapter 7)

Interactive distribution (chapter 11)

Clinical interventions in the community (chapter 13)

3.5 OUTCOMES

The outcomes from this intervention are primarily information based, and the list below offers some examples of outcomes, but is not exhaustive. Outcomes among African people receiving one-to-one information and advice can include:

- knowing HIV exists, and understanding the harm it can cause (see KWP 6.1.1, page 32).
- Having a clearer understanding about how and why different sexual acts carry differing risks of HIV transmission (see KWP 4.2, page 18).
- Knowing how to correctly use male and female condoms, and feel more confident introducing condoms with sexual partners (see KWP 6.4, page 36).
- Understanding the benefits of knowing their own HIV status (see KWP 6.1.2, page 32 and 6.5, page 37).
- Increasing the extent to which they consider that the sex they have could risk HIV transmission (see KWP 6.1.2, page 32).
- Knowing about the HIV prevention options for conception in couples where a partner has diagnosed HIV (see KWP 6.9, page 38).
- Knowing more about other services that they can access to better help them meet a range of needs, including HIV prevention need.
- Increased confidence and motivation to openly discuss sex and sexuality, as modeled by the provider of a face-to-face intervention (KWP 6.1.2, page 32 and 6.1.3, page 34).

3.6 MONITORING AND EVALUATION


It is most common for one-to-one information and advice to be delivered alongside resource distribution, and for that reason it is generally subject to monitoring as well as access evaluation which collates information about service users' basic demographics (age, ethnicity, gender etc.) in order to assess if the intervention is reaching the desired targets.

It is possible that innovative and lower-cost evaluation models such as *mystery-shopping* or the use of *peer evaluation* would contribute to the monitoring and evaluation of this HIV prevention activity.

CASE STUDY »

Love Safely – Youth Projects International and Embrace UK Community Support Centre

The Love Safely programme is an intervention which focuses on an initial information needs assessment, undertaken with individuals to help determine what they already know about HIV prevention, what their referral needs may be, and what further interventions may be of use to them. Agency staff or volunteers administer a face-to-face questionnaire relating to topics such as maintaining sexual health and avoiding HIV transmission. The 45 minute questionnaire is then followed-up by a detailed discussion on areas where information is lacking. An information sheet covering the topics discussed is left with participants for them to consider in greater detail, and where relevant, appropriate referrals are made (in particular, referrals for HIV testing). Those providing the service find that the intensive approach brings great rewards for individuals. Participants are also encouraged to help recruit others who might benefit from taking part.

 www.embraceuk.org

CASE STUDY »

Community Outreach – Pan Afrique

Pan Afrique employs full-time and part-time outreach staff, supplemented with volunteers who provide information and advice in a broad range of community settings. Health promotion training of all outreach staff and volunteers is provided externally, and ongoing development is ensured through African health promotion training courses provided by Naz Project London. Staff and volunteers visit a broad range of social events in four cities and towns in South Yorkshire. Examples of settings include: local football matches, drama and other cultural events and parties. As well as ensuring the distribution of sexual health resources such as condoms and small media, outreach workers directly engage African people in discussions about sexual health and HIV (often using written media as ice-breakers) in order to establish and meet their information and motivation needs with regard to avoiding HIV transmission.

 www.panafrique.org.uk

4 INFORMATION AND ADVICE DELIVERED TO GROUPS

4.1 WHAT IS THE ACTIVITY?

Information and advice interventions directed at groups can stand alone or be part of a larger event. During a fixed time slot, participants hear about HIV prevention from trained health promoters, and gain advice regarding specific HIV and sexual health issues that arise as a result of the interaction (for instance, during a Question and Answer session). Information is imparted in an engaging format. Depending on the setting, group facilitators should also be able to signpost relevant services, provide sexual health resources, and provide one-to-one information and advice where required (or make arrangements to do so at a later time).

Groupwork interventions and support groups offer a more therapeutic and developmental approach over longer periods of time. These are discussed separately in chapter 7.

4.2 STRENGTHS AND LIMITATIONS

Educational events with a large audience help to give a sense that sexual health is an issue for open discussion among African people.

Hearing information from a trusted expert, and having an opportunity to ask questions can increase motivation to seek further interventions and services.

The administration, advertising and delivery of events require considerable time, effort and skill. For these reasons they can be cost intensive, yet their unit cost (cost per service user) can be lower than many other face-to-face interventions because many more people can benefit.

These interventions are topic-led rather than client-based. Therefore, some people in any given group will hear things they already know, and some will miss out on things that they would have liked to have known.

Information-giving on its own does not meet all HIV prevention needs. In particular, it does not help to address situations where a person's limited power prevents them from avoiding HIV transmission.

4.3 WHERE DOES GROUP-BASED INFORMATION AND ADVICE PROVISION HAPPEN?

These interventions are often delivered face-to-face by facilitators who can speak to large or small groups. They usually last an hour or two, and can be part of a larger event. Such events may require the organisation of formal venues and catering, whereas smaller informal settings, such as family homes can also be used.

Settings include (but are not limited to):

- cultural and community venues (such as town halls, libraries, cultural festivals, church halls, conference spaces);
- commercial venues (such as pubs, clubs, hotels or conference facilities);
- the offices of other service providers (including NHS and voluntary sector services);
- one-to-many media platforms such as radio and television.

Key to the intervention

The responsibility for sexual decision-making belongs to the people who have sex. Talking interventions delivered to groups are usually educational, and encourage people to examine the potential consequences of their choices rather than telling them how to behave.

4.4 ISSUES TO CONSIDER

Those with the greatest social skills, confidence and interest in a topic are the most likely to want to increase their knowledge. This can lead to a pattern where repeat attendees are the ones who fill available spaces, rather than those in greatest need. Carefully considered advertising and interventions that take place as a part of broader events, in partnership with other service providers, can help such interventions to reach those in greatest need.

Self-referral is often the key to such interventions. This means they require that African men and women recognise their information deficits and have sufficient motivation to engage in addressing them. This motivation is more likely when the person and / or agency providing the intervention is trusted, and also when potential participants are aware of the likely benefits.

Facilitators will require training and experience with a variety of communication techniques. Knowledge on its own is not sufficient, as facilitators will need to deliver the intervention in a way that is engaging and non-judgmental, and which recognises the (sometimes diverse) values and learning styles held by participants.

CASE STUDY »

Seminars – Pan Afrique Centre

Pan Afrique delivers information and advice sessions for groups identified to have specific HIV prevention needs. Rather than advertising health seminars for anyone who wants to come, they work in partnership with other service providers to target groups that meet regularly, or have shared issues. This allows facilitators to tailor the content to best suit the specific needs of different audiences (such as: younger people, single parents, people with diagnosed HIV, social enterprise collectives etc.). This approach allows for a focus on wider issues relating to the audience, with a subsequent move into the topic of sexual health. This method overcomes the need for self-referral to a separate event at an unknown location, as talks can be hosted by agencies with which the participants are already familiar.

 www.panafrique.org.uk

4.5 OUTCOMES

As with one-to one information and advice interventions, the outcomes are primarily information based. The list below offers some examples of outcomes among African people receiving information and advice in groups (depending on the content of the intervention):

- knowing HIV exists, and understanding the harm it can cause (see KWP 6.1.1, page 32).
- Having a clearer understanding about how and why different sexual acts carry differing risks of HIV transmission (see KWP 4.2, page 18).
- Knowing how to correctly use male and female condoms, and feel more confident introducing condoms with sexual partners (see KWP 6.4, page 36).
- Understanding the benefits of knowing their own HIV status (see KWP 6.1.2, page 32 and 6.5, page 37).
- Knowing more about other services that they can access to better help them meet a range of needs, including HIV prevention need.
- Possessing increased confidence and motivation to openly discuss sex and sexuality, as modeled by the providers of group interventions (KWP 6.1.2, page 32 and 6.1.3, page 34).
- Increased desire to contribute to the health and well being of their community (see KWP 5.4, page 25).

Frequently delivered alongside ...

Information and advice delivered one-to-one (chapter 3)

Targeted cultural programming (chapter 5)

Interactive distribution (chapter 11)

4.6 MONITORING AND EVALUATION

The use of access evaluation tools can provide agencies with a basic demographic profile (age, ethnicity, gender, area of residence) of the people using information and advice interventions for groups.


Short self-completion questionnaires may also be used to help determine the effectiveness of interventions. These may ask users to fill in some questions prior to the intervention, and again afterwards in order to assess changes in knowledge, beliefs or attitudes. Support from researchers is useful in order to ensure that such tools are used effectively.

More complex research techniques (for instance, in-depth interviews) can be used in order to undertake longer-term follow up. However, the cost and commitment required is considerable, and the collection and management of individual service users' personal details is necessary.

CASE STUDY »

Radio broadcasts – Black Health Agency

A youth group hosted by Leeds Skyline was invited by a local radio station to produce a talk show on sexual health. It was such a success, they were asked to broadcast more shows. In addition to this, a different local radio station in Manchester approached Black Health Agency to deliver sexual health and HIV information to its listeners. In return, staff were offered broadcasting and radio training, which has proven very popular. In each case, the unexpected benefits for those involved in delivery include new skills and increased confidence. These relationships benefit local radio stations as well, given their constant demand for content. The time and cost commitment on the part of the service provider in these partnerships is relatively low, when compared to the reach that some local African broadcast media have.

 www.blackhealthagency.org.uk

5 INFORMATION AND ADVICE DELIVERED THROUGH TARGETED CULTURAL PROGRAMMING

5.1 WHAT IS THE ACTIVITY?

Information and advice about preventing HIV transmission can be delivered through a range of creative events. Carefully structured cultural productions (including those which use dance, art, music, poetry and drama) provide a multi-sensory means through which observers and participants can gain new insights into their existing experience and knowledge. It is an approach which encourages people to explore their emotional responses to sexuality, HIV and risk (including anger, pleasure, happiness, sadness, indifference, fear), while also enabling people to consider the different outcomes of behavioural choices.

5.2 STRENGTHS AND LIMITATIONS

Innovative and creative interventions that use a range of cultural media can create unique opportunities to help people explore difficult and complex issues. The dynamic and often informal environments which such approaches help to create are likely to engage those who are not drawn to more traditional health promotion interventions (such as seminars, written information, etc.).

Narratives are an important means of conveying meaning. Through the development of an empathetic response, creative cultural events can provide a powerful medium through which individuals begin to consider their own responses to HIV. The use of oral, visual and kinetic expression improves accessibility for those with difficulties with spoken English. Furthermore, the use of modern and traditional African art-forms can engender an immediate sense of welcome, belonging and recognition, although targeting must be carefully considered, as regional, generational, linguistic, and religious diversity means that not all interventions will be appropriate or acceptable for all African people.

Cultural exhibits and displays will be limited in the scope of information they can convey, and will not be particularly responsive to the needs of individuals. They are best used to express simple ideas.

5.3 WHERE DOES CULTURAL PROGRAMMING HAPPEN?

Cultural programming can be devised as an event in its own right, or it can comprise one element of a larger public gathering, display, or transmission.

Examples include:

- generic community events such as independence day celebrations, religious occasions, World AIDS Day events, health fairs, conferences;
- specially convened community events such as art, poetry, dance or music competitions;
- broadcasts on African-targeted radio and television stations or programmes, usually as a dramatic series or in musical form.

Key to the intervention

In order to maximise the HIV prevention benefits of cultural programming events, it is necessary to extend the outcomes beyond raising awareness. Powerful imagery and narrative can be put to use in ways that challenge an audience to reflect directly on the likelihood that they may be involved in HIV transmission, as well as considering what changes they can make to avoid that risk.

Frequently delivered alongside ...

Information and advice delivered one-to-one (chapter 3)

Information and advice delivered to groups (chapter 4)

Interactive distribution (chapter 11)

5.4 ISSUES TO CONSIDER

Creative cultural interventions have the capacity to go far beyond raising HIV awareness. Where the intention is to reduce HIV prevention need, then planning must incorporate elements that aim to increase participants' knowledge, will and / or power to prevent HIV transmission.

Effective interventions will require both health promotion and artistic expertise. Often, this will require collaboration between these diverse and contrasting disciplines.

5.5 OUTCOMES

The outcomes from this intervention are primarily information-based, but can also include attitude change. The list below offers some examples of possible outcomes but is not exhaustive.

Outcomes among African people exposed to targeted cultural programming can include:

- knowing HIV exists, understand the harm it can cause, and will be better equipped to reduce the risk of transmission (see KWP 6.1.1, page 32).
- Understanding the benefits of knowing their own HIV status (see KWP 6.1.2, page 32 and 6.5, page 37).
- Increased confidence and motivation to discuss sex, sexuality, and sexual health, as modeled within cultural programmes (KWP 6.1.2, page 32 and 6.1.3, page 34)
- Increased desire to contribute to the health and well being of their community (see KWP 5.4, page 25).
- Feeling that their cultural, religious, tribal and ethnic attributes and values are recognised as being part of the rich mosaic of pan-Africanism in the UK (KWP 5.3, page 24).


5.6 MONITORING AND EVALUATION

In the development stage, *peer review* and *pre-testing* of the proposed programmes' form and content is important to ensure that the aim and the content are unified, that the essential information is clear, and that the design ideas are acceptable and attractive to viewers and listeners. Follow-up *questionnaires*, or end-user *focus groups* can be used to assess if the aims were met among those exposed to the programme.

CASE STUDY »

Kobana stories – NAHIP partnership


As a part of the national *Do it Right* campaign developed and delivered by NAHIP in 2008, the campaign working group commissioned four short fictional films (of three or four minutes each) focusing on matters regarding family dynamics, masculinity, femininity, culture and sexual relationships and centering around the life of the central African character, Kobana. The films are accompanied by group exercises, and are designed to be used in an array of settings in order to instigate facilitated discussions that help participants to explore these issues and reflect on their own experience. The way in which the films are used can vary broadly, depending on how they are bundled with other interventions (for instance, they could be used in a family counselling setting, within groupwork sessions, or in classrooms).

 www.nahip.org.uk

CASE STUDY »

Using drama with groups – Embrace UK Community Support Centre

In order to challenge prevalent myths about HIV and its transmission, Embrace UK devised a live dramatic presentation that can be used in a wide array of settings, including at community events, in distribution venues, or at information and advice interventions for groups. The agency finds that drama is also a useful starting point for much of its work in schools.

 www.embraceuk.org

6 THERAPEUTIC CHANGE AND SKILLS BUILDING DELIVERED ONE-TO-ONE

6.1 WHAT IS THE ACTIVITY?

Counselling is an in-depth, personalised intervention that aims to help individuals, couples and families achieve greater psychological well-being through reflection and discussion. Counsellors may be voluntary or paid, with a minimum qualification of a *Diploma in Counselling* (or equivalent). On-going supervision contributes to counsellors' professional development, and provides monitoring and support for their ethical judgements and well-being.

Over a period of time (typically 6 to 12 weeks), counsellors and clients build up a trusting relationship. Sessions typically last for 45 to 60 minutes, within which clients are supported in their exploration of feelings, experiences, traumatic life events and goals in order to encourage emotional and behavioural stability. Where families and couples take part in counselling together, aims often include strengthening relationships and communication strategies.

6.2 STRENGTHS AND LIMITATIONS

Therapeutic interventions have a significant advantage over more immediate interventions (such as written materials or face-to-face information and advice provision) because their duration enables identification of personally-relevant issues, reflection on these factors, and support in finding solutions. This means that the potential for behaviour change resulting from therapeutic interventions far exceeds other types of interventions (see section 2.2).

Participation in a therapeutic programme of counselling requires that service users commit to a long-term intervention. This requires a significant degree of motivation, trust in the service provider, and the resources and social capacity to take part. Attending counselling also requires that participants recognise the

potential benefits, including identifying and prioritising their HIV prevention needs. It is possible that those in greatest need of therapeutic interventions may be least able to access them because they may feel alienated from them, or are unsure of their outcomes, making engagement unlikely.

6.3 WHERE DO ONE-TO-ONE THERAPEUTIC AND SKILLS INTERVENTIONS HAPPEN?

In the main, counselling occurs on the premises of a provider agency. This arrangement helps to ensure the security of both clients and counsellors. Counselling requires a private room with few distractions, with phones (including clients' mobile phones) switched off or silenced for the duration of the session. Some agencies install a panic button in counselling rooms so that other staff members can be alerted in case of physical danger. Counselling staff require the time, space and resources to keep adequate notes on client sessions, and notes must be handled in accordance with the Data Protection Act 1998.

Key to the intervention

Counselling interventions are facilitated by qualified professionals who help clients to identify desirable outcomes during the therapeutic process (these could be as diverse as sexual behaviour change, improved communication, or increasing self-confidence). The immediate establishment of a trusting, confidential relationship between service user and provider is essential to their success.

6.4 ISSUES TO CONSIDER

In the context of scarce resources, one-to-one therapeutic interventions should be targeted at those in greatest psycho-social support need.

Confidentiality and its limits must be clearly communicated with service users.

Keeping coherent, accurate notes of counselling sessions can be a key tool for the counsellor, but raises acute data protection and confidentiality issues. As a result, records kept in relation to counselling sessions should be carefully attended to within each agency's confidentiality policy, and in accordance with obligations under the Data Protection Act 1998. These record-keeping practices should be subject to regular review.

The use of full-time qualified staff in the provision of counselling can be prohibitively expensive for some service providers. Many agencies circumvent this problem by recruiting voluntary specialists offering psycho-social support to service users. Of course, this can mean challenges in coordination and commitment.

Social stigma continues to be attached to psycho-therapeutic and counselling activity. Agencies that have successfully offered these services to those who would not usually take them up of their own accord have found innovative means of challenging that stigma, sometimes by enabling familiarity with counselling staff through diverse service provision contexts.

6.5 OUTCOMES

The outcomes from this intervention tend to focus on people's possession of the requisite motivation and skills to avoid participating in HIV transmission. The list below offers some examples of outcomes (dependant on the content of the therapeutic intervention), but is not exhaustive.

Outcomes among African people participating in therapeutic interventions can include:

- increased control over HIV transmission in their lives (KWP 5.2, page 24 and 6.1.3, page 34).
- Having the skills to actively manage anxiety and depression (KWP 6.1.2, page 32).
- Possessing increased confidence and motivation to openly discuss sex, sexuality, and sexual health with sexual partners and in social networks, as modeled and rehearsed within the intervention (KWP 6.1.2, page 32 and 6.1.3, page 34).
- Increased likelihood of establishing and maintaining sero-concordancy with sexual partners (KWP 6.5, page 37).
- Joint assessment of HIV prevention options for conception in couples where a partner has diagnosed HIV (see KWP 6.9, page 38).

6.6 MONITORING AND EVALUATION

Therapeutic interventions aim to meet an extensive range of needs tailored to individual service users, but the effects may not be immediately apparent. *Questionnaires* aimed at those who use and do not use the service can help to assess perceptions about recruitment to the service, access challenges, and to identify key areas for change in delivery. *Reviews* of anonymised case notes can be used to assess short-term changes noted by practitioners. However, longer-term follow-up – through repeated *interviewing* – is perhaps the best way to evaluate longer-term benefits to individuals, couples and families.

Frequently delivered alongside ...

Information and advice delivered one-to-one (chapter 3)

Interactive distribution (chapter 11)

Static distribution (chapter 12)

Clinical interventions in the community (chapter 13)

CASE STUDY »

THT counseling services

The Terrence Higgins Trust have found that in order to better accommodate the needs of their African service users, it was necessary to change some of the routine elements of their counseling service. In recognition of the fact that few young people will self-refer to counseling, THT's Youth Counseling Service devised a street-to-counseling intervention whereby trained counselors interact with young people in non-therapeutic settings in order to become known and trusted. Once relationships are built, and where counseling need is identified, young people can meet with counselors in more formal settings.

In addition, THT has amended its attendance policies in the London-based African adult and youth counseling programmes, in order to better accommodate those whose employment responsibilities, or access to transport and childcare, make it difficult to attend routine sessions. Whereas many organisations may be quite strict about missed appointments and locations for sessions, THT has found that increased flexibility that accounts for individual needs, with the addition of an informal drop-in element to the counseling service helps African service users with busy lives or conflicting priorities to benefit from therapeutic interventions.

 www.tht.org.uk

THERAPEUTIC CHANGE AND SKILLS BUILDING DELIVERED TO GROUPS

7.1 WHAT IS THE ACTIVITY?

There are two basic models for the provision of therapeutic change and skills-building with groups, known as group-work interventions and as support groups. We describe them each separately here.

Group-work interventions target and recruit members of sub-groups within a population that are likely to share specific sets of HIV prevention need (such as those with multiple concurrent sexual partners, or people in sero-discordant relationships for example). Meeting over a pre-determined course of time (for example, one weekend plus four week nights spanning a six week period), the group is facilitated by qualified counsellors and / or trainers. The aims of group-work interventions should be clearly articulated at recruitment stage, and will involve some mixture of all of the following elements: information-giving, skills development, resolution of psycho-social conflict, and an increase in social capacity. Such activities may be regarded as short intensive courses that help people to kick-start broader reflective processes regarding specific behaviours that relate to their sexual health.

Support-group interventions offer diverse groups of service users safe space to exchange experience and ideas with others in a similar position. Sharing concerns and challenges can help people to begin processes of problem-solving in their own lives. Although the ethos of self-help and empowerment pervades such interventions, it is critical that professional facilitators with at least some training in counseling skills are present at each session. Support-groups can provide a vital life-line for those who feel socially and emotionally isolated. Although support-groups may operate weekly or monthly over very extended periods of time, those attending will vary, so the content-related aims are likely to be much less defined than they would be for group-work, for example. However, they will also include some elements of:

information-giving, skills development, resolution of psycho-social conflict, and an increase in social capacity – but these will be delivered using relatively informal methods. Facilitators may help to stimulate discussion and personal development by hosting a variety of speakers on topics that will be of interest to attendees.

Groups that provide social or community infrastructure (such as youth, social or interest groups) and therefore contribute to the aims of *community development* are discussed in chapter 14.

7.2 STRENGTHS AND LIMITATIONS

Due to the high cost of delivery, short-course therapeutic interventions are unlikely to meet the needs of more than a very small proportion of African people. This means that careful consideration should be given to recruiting *only* those whose unmet need has the greatest impact on the epidemic.

Attending groups requires that participants self-refer, meaning that they have to identify and prioritise their HIV prevention needs. It is possible that those in greatest need of group interventions may be least able to access them because they may feel alienated from them, are unsure of their outcomes, or have other obligations or resource limitations that make engagement unlikely.

Evaluation has demonstrated that these interventions are likely to have a significant advantage over other less intensive interventions (such as written materials or face-to-face information and advice provision) because their duration encourages identification of detailed personally-relevant issues, reflection on these factors, and support in finding acceptable solutions. This means that the potential for behaviour change resulting from skills-based and therapeutic interventions for groups far exceeds what can be expected from some other forms of prevention activity (see section 2.2).

7.3 WHERE DO GROUP-BASED THERAPEUTIC AND SKILLS BUILDING INTERVENTIONS HAPPEN?

Group-work and support-groups are usually centre-based activities. Where agencies lack the necessary facilities, accessible locations (such as church halls, or community centres) can be hired. Selection will need to prioritise users' needs to feel welcomed and safe, as well as attending to privacy and confidentiality. To this end, user consultation prior to naming and siting of groups will help to determine their acceptability. Reception staff should be briefed on the discreet handling of attendees, and a private area off the main room might be useful for those who require one-to-one support or space to themselves after an emotive or provocative session.

7.4 ISSUES TO CONSIDER

Whereas support groups are traditionally regarded as being the model of service provision for people with diagnosed HIV, many more groups of people likely to be involved in HIV transmission can benefit from their provision. Consideration should be given to broadening out support groups for others such as behaviourally bisexual African men or partners of people with diagnosed HIV.

Groups of all kinds are most effective when their identity and role are clear. As such, members should be aware of a group's function, and can be asked to contribute to the development of its identity.

Where interventions have an extensive therapeutic element, it is ideal that they are convened by those with professional training, accreditation and supervision.

Frequently delivered alongside ...

Information and advice delivered to groups (chapter 4)

Targeted cultural programming (chapter 5)

Interactive distribution (chapter 11)

7.5 OUTCOMES

The outcomes of this intervention tend to focus on participants' motivation and skills to avoid participating in HIV transmission. The list below offers some examples of outcomes (dependent on the content of the therapeutic group intervention), but is not exhaustive.

Outcomes among people participating in therapeutic and skills building group interventions can include:

- Increased confidence and motivation to openly discuss sex, sexuality, and sexual health with partners and in social networks, as modeled and rehearsed within the intervention (KWP 6.1.2, page 32 and 6.1.3, page 34).
- Increased likelihood of establishing and maintaining sero-concordancy with sexual partners (KWP 6.5, page 37).
- Increased control over involvement in HIV exposure and transmission in their lives (KWP 5.2, page 24 and 6.1.3, page 34).
- Better management of anxiety and depression due to less social isolation (KWP 6.1.2, page 32).
- Increased desire to contribute to the health and well-being of their community (see KWP 5.4, page 25).
- Feeling that their cultural, religious, tribal and ethnic attributes and values are recognised as being part of the rich mosaic of pan-Africanism in the UK (KWP 5.3, page 24).

Key to the intervention

Therapeutic and skills-based group interventions attend closely to the skill-levels and needs of those attending the intervention. They facilitate development over time through reflection, openness and exploration in a trusting environment. The people who attend provide essential resources for the dynamic and interactive process of change, they are not simply intervened upon, nor are they passive recipients of knowledge.

7.6 MONITORING AND EVALUATION

Access evaluation can be undertaken alongside monitoring activities, to determine the profile of people attending therapeutic and skills-based interventions for groups. While this does not assess effectiveness, it can be compared with needs data from broader research samples in order to establish whether those sub-groups most in need are accessing the intervention.

Evaluating the effectiveness of support group attendance could be garnered through face-to-face *interviewing* or *focus groups* with current, past and non-attendees in order to determine reasons for attendance and attrition, and to gain input into future planning.

In the case of group-work, *questionnaires* distributed at the outset of the intervention should clearly articulate the outcomes. Attendees can add information about how they came to hear about the group, and what motivated them to attend. As soon as the intervention is complete, they can also be asked to complete a satisfaction questionnaire.

A more costly, but more useful means of evaluating group-work would be to follow-up attendees through face-to-face or telephone *interviews* (after say, three or six months) to determine what they found to be of continuing use to them from the intervention, and what further needs they may have identified as a result.

CASE STUDY »

Monya Project – NAZ Project London and Newham PCT

Monya in Swahili means strength. African men who have sex with men (MSM) living in London are faced with a number of problems, often including HIV, immigration, education and employment, isolation, fear and hate crime. The project aims to enable African MSM to face up to these challenges which HIV, sexual health and homophobia can present. Facing these issues requires not just the strength of African MSM, but also of their friends, family and loved ones to bring an end to the stigmatisation.

Naz Project London (NPL) outreach workers engage with MSM in their local communities, and often inform them about the Monya Project by word-of-mouth. The support group element of Monya enables African MSM to meet once a month, sharing stories with other men about their lives and how they meet various challenges. Ultimately, knowing others who have made the decision to be more open about their sexuality can help to support service users who would like to do the same. NPL believes that men who are more confident and open about their sexuality are able to exercise greater control over HIV transmission when having sex with other men. There is also explicit HIV prevention activity which takes place within the project, as men are given information about sexual health, and are encouraged to test for HIV so that they are aware of their status.

 www.naz.org.uk

8 SMALL MEDIA INTERVENTIONS

8.1 WHAT IS THE ACTIVITY?

Small media are written and printed resources usually intended to be taken away by members of the target audience. They include text-based interventions such as magazines, newsletters, booklets, leaflets, posters or cards, and are designed to meet HIV prevention need. They come in a variety of shapes and sizes with variable amounts of text. They are usually made available, or actively distributed to African people in social or service settings.

Alternatively, newsletters or magazines are sometimes mailed (or emailed) directly to users on a mailing list. There is some overlap between small media and mass media, which becomes apparent when considering how the setting can change the name of an intervention. For example, health promotion information displayed in a barbershop may be called a 'poster' and considered small media, but a similar product from the same campaign in the African press is called a mass media 'advert'.

8.2 STRENGTHS AND LIMITATIONS

Where funds are very limited, leaflets and other written small media help to ensure that a comprehensive source of information on a topic exists.

As a part of a HIV prevention campaign, different types of small media can draw service users from initial interest (perhaps through a poster), to picking up a leaflet (which enables them to gain more detailed information), to making a decision to seek further interventions, or perhaps to alter their behaviour.

Written interventions cannot be expected to meet complex social needs or address interpersonal problems. Instead, they are best used to convey information, and to raise awareness. In addition, small media can offer information about organisations and their services, thereby promoting other interventions.

8.3 WHERE DO SMALL MEDIA INTERVENTIONS HAPPEN?

Detailed information on the settings for distribution interventions are described in chapters 11 and 12 (*Giving and taking*). Small media interventions may be encountered in generic or African-specific public settings, or private settings. The choice of setting for the placement or display of written interventions will be influenced by its appropriateness for the chosen intervention. Challenging or complex content needs careful placement consideration, as some may feel exposed or stereotyped by targeted material placed in a public setting. In this way, consideration of the potential settings can influence small media development, just as the content of small media may influence the selection of locations for distribution.

8.4 ISSUES TO CONSIDER

The production of high-quality, well evidenced written resources is relatively costly, despite the fact that the cost per unit delivered to an end user is relatively low. With this in mind, smaller agencies may choose to distribute interventions produced by others (see Chapter 11 and 12) rather than devoting their own resources to their development and production. Partnership-working enables the collaborative production of small media resources between agencies. Micro-printing technologies also allow, for instance, for one page of local contact details in a national resource, while still undertaking a large print-run.

'Support media' can help to draw service users into conversation with those distributing small media. These items might include hats, pens, stickers, button badges, key-rings, sweets, etc. carrying a campaign's key message and perhaps some contact details. Front-line staff find that such items can be vital as icebreakers for verbal interactions, or a useful tool to close a conversation during outreach or detached work.

Complex messages often take time to assimilate, and as a result, may be more suitable to portable (leaflet) rather than fixed (poster) written formats, so that they can be kept and read more than once.

Small media development must be carefully managed, from the creation of aims, the collection of relevant evidence, to the publication of the final product. 'Mission drift' is most likely where clear lines of leadership and responsibility are lacking, and where external agencies hired to deliver design services are allowed to take control of the health promotion content.

Small media interventions can be designed and delivered to almost any target group, but this does not mean that it is right for them to exclude others. As such, all HIV prevention interventions should ensure that they are inoffensive to people with diagnosed HIV, even in materials intended for those who have never tested. Similar attention should be paid to matters of gender, age, ethnic and national identity, sexuality, and educational background. It is important to account for differences in value systems and personal priorities among those who may come across these written resources. Peer review and pre-testing campaign ideas and text in the development stage is essential in order to ensure that the aim and the content are unified, that the essential information is clear, and that the design ideas are acceptable and attractive to readers.

Key to the intervention

Less is more when it comes to small media. It is likely that only the first eight words of a headline ever get read. Sentences should never be more than thirteen words long. Seventy words constitutes long copy. Posters should only seek to make one point.

Frequently delivered alongside ...

Mass media (chapter 9)

Websites (chapter 10)

Interactive distribution (chapter 11)

Static distribution (chapter 12)

8.5 OUTCOMES

The outcomes of small media interventions are primarily information-based, and the list below offers examples of outcomes depending on the content of the intervention:

- Knowing HIV exists and understanding the harm it can cause (see KWP 6.1.1, page 32).
- Having a clearer understanding about how and why different sexual acts carry differing risks of HIV transmission (see KWP 4.2, page 18).
- Knowing how to correctly use male and female condoms, and feeling more confident introducing condoms with sexual partners (see KWP 6.4, page 36).
- Understanding the benefits of knowing their own HIV status (see KWP 6.1.2, page 32 and 6.5, page 37).
- Increased consideration that the sex they have could risk HIV transmission (see KWP 6.1.2, page 32).
- Knowing more about other services that can help to meet a range of needs, including HIV prevention need (see KWP 6.6, page 37).

CASE STUDY »

NAHIP campaigns planning process – ANPN and NAHIP partnership

One of the key roles of the NAHIP partnership is its identification, planning and production of written HIV prevention interventions including small media, mass media and dedicated websites. All these interventions are then released across England, with local support for their use from NAHIP partner agencies in various cities and areas. This support is strengthened by NAHIP partner agencies' participation in the choice of intervention topics, and in their development. The text box in chapter 9 describes how NAHIP campaign development occurs. At the outset of each three year cycle of NAHIP planning, key strategic areas are identified by the programme leader, in consultation with key stakeholders in the sector. These form the basis of the NAHIP partnership strategic plan.

 www.nahip.org.uk

8.6 MONITORING AND EVALUATION

A key element of monitoring the production of small media interventions is ensuring that an archive of interventions at various phases of their development is kept for future reference. This allows agencies, partners and researchers to trace the history of small media production, as well as keeping account of which ones were produced in each calendar or contract year.

During various phases of small media development, the ideas, design and language used in the intervention should be pre-tested with people in the target population. This helps agencies to determine if the meaning they intended to convey is clear and unambiguous. Pre-testing can be undertaken as short cognitive interviews with individuals or in focus group settings – comprised of members of the target audience with no professional or personal connection to those developing the intervention. Similarly, focus groups among those in the designated user group can be undertaken after an intervention has run, in order to assess the acceptability of small media interventions, and in order to improve future campaigns. Peer review of interventions at all phases of design is also likely to be beneficial.

The extent to which small media have reached those in specific settings or geographical areas can be assessed by coverage surveys, where individuals are asked if they recall seeing a particular item. Coverage questions can be included in broader surveys, which reduces costs, and also facilitates statistical analysis that includes other demographics, leading to a greater understanding about which sub-groups of the African population are most (and least) likely to have seen the intervention.

It is possible to evaluate the effectiveness of small media interventions at a population level, although this can be a complex and expensive undertaking. It requires an agreement on the appropriate indicators used to measure the desired change, for instance, knowledge of a particular fact, awareness of a new prevention technology – whatever it is that is the subject of the intervention. The level of these indicators then need to be established before and after an intervention, so they can be compared to measurements taken with a comparable population at the same intervals, but who were not exposed to the intervention. Nationally, this might mean comparing those in cities where a written intervention occurred, with in cities where it was not.

9 MASS MEDIA INTERVENTIONS

9.1 WHAT IS THE ACTIVITY?

Mass media interventions usually involve developing and placing advertising in a range of text-based and visual media (such as newspapers, magazines and the internet) to give information about a particular HIV topic or service. Such activities are frequently part of campaigns that can incorporate the key messages and imagery used in associated small media. In this way, mass media and small media complement one another, helping to increase recognition among the target population.

9.2 STRENGTHS AND LIMITATIONS

Mass media advertising extends the reach of interventions to those who are not likely to come into contact with outreach staff or service providers. Also, those who see such advertising can do so in their own time and space, without worrying about who may have seen them picking up a leaflet in a public space.

Reading about HIV in everyday contexts (when flicking through a community newspaper, or when browsing the internet, for instance) can help people to consider that the issues might affect them. This helps HIV to be regarded as an issue that should not be stigmatised.

Carefully considered placement in publications that are designed to reach a clearly articulated target audience makes mass media advertising more cost effective. The use of targeted publications also means that interventions can be tailored for specific audiences.

On their own, mass media adverts cannot be expected to result in behavioural change. However, they are an essential part of the environment within which HIV prevention need can be met. An advert can only expect to achieve a moment's glance from most people that encounter it.

9.3 WHERE DO MASS MEDIA INTERVENTIONS HAPPEN?

Mass media adverts are usually placed in media targeting African people in the UK including language- or nationality-specific newspapers, websites and magazines; and in media targeting young people and people with diagnosed HIV. Printed posters, of mass media adverts, can also be displayed in HIV or African service settings and commercial venues where a large proportion of the clientele are African. In the NAHIP partnership such venues include specific hairdressers, nail bars, barbers, cafes and some shops.

9.4 ISSUES TO CONSIDER

In order for a mass media advert to gain readers' interest and trust, it must be well designed, and submitted as a high resolution digital image to the specification of the publisher.

Although placing adverts in magazines can cost very little for each person who might see it, the total cost of developing, testing, designing, and placing a mass media advert is often quite high. All costs should be established well in advance of development, and investment shared between several partner agencies can help to defray cost.

Significant research should be undertaken to ensure that identified publications have the reach and the audience that is required for a particular intervention. Publishers hold detailed information on their readership, and this should be investigated closely before time and money is wasted in the wrong location. For instance, although many BME-targeted publications claim that people of diverse ethnicities are included in their readership (which is likely to be the case), the proportion of African readers would have to be quite high in order to reach desired saturation for an African HIV prevention mass media intervention.

Key to the intervention

As with small media, less is more when it comes to mass media advertising. Only one piece of information should be conveyed in an advert.

Frequently delivered alongside ...

Small media (chapter 8)

Websites (chapter 10)

Interactive distribution (chapter 11)

Static distribution (chapter 12)

9.5 OUTCOMES

The outcomes of mass media interventions are primarily information-based, and examples include:

- Knowing HIV exists and understanding the harm it can cause (see KWP 6.1.1, page 32).
- Having a clearer understanding about how and why different sexual acts carry differing risks of HIV transmission (see KWP 4.2, page 18).
- Knowing how to correctly use male and female condoms (see KWP 6.4, page 36).
- Understanding the benefits of knowing their own HIV status (see KWP 6.1.2, page 32 and 6.5, page 37).
- Increased awareness of other services that they can access to better help them meet a range of needs, including HIV prevention need (see KWP 6.6, page 37).
- Increased consideration that the sex they have could risk HIV transmission (see KWP 6.1.2, page 32).

9.6 MONITORING AND EVALUATION

A key element of monitoring the production of mass media interventions is ensuring that an archive of interventions at various phases of their development, as well as an archive of final products is maintained for future reference. This allows agencies, partners and researchers to trace the history of mass media production, as well as keeping account of which ones were produced in each calendar or contract year. Monitoring of mass media placement requires ensuring that all paid advertisements are placed, keeping dated copies of print publications that hold the advert, as well as requesting that website providers give a breakdown of page impressions and click-through rates.

As mass media interventions are likely to be developed alongside small media and other associated interventions, similar forms of evaluation will apply. Along various phases of mass media development, the ideas, design and language used in the intervention should be pre-tested with people in the targeted population. Devising a variety of possible executions at this time enables those engaging in pre-testing to articulate which particular aspects of different executions they prefer.

The extent to which mass media adverts have reached those in specific settings or geographical areas can be assessed by coverage surveys, where individuals are asked if they recall seeing a particular item. Coverage questions can be included in broader surveys, which reduces costs, and also means that other demographics can be cross-tabulated so that there is a greater understanding about which sub-groups of the target population are most likely to have seen (or not seen) the intervention.

In addition, focus groups or cognitive one-to-one interviews among those in the desired target group can be undertaken after an intervention has run, in order to assess its acceptability, and its perceived impact.

CASE STUDY »

NAHIP campaigns development process – AHPN and the NAHIP partnership

At the outset of NAHIP campaign development, a core group is assembled to agree the intervention, including: aim, setting, targets, objectives and resources. A summary of these issues is compiled and circulated to key stakeholders, including members of the NAHIP Advisory Group, and partner agency representatives. After a period of consultation and feedback regarding these broader considerations, the task of devising interventions is assigned to a small writing group. Small media and mass media text is composed and a design brief is prepared, and several potential approaches are presented to the designer.

An array of design options and executions are then mocked up – so that the campaign team can make decisions about which option is most suitable for the aims and objectives of the intervention, taking into account the target audience and the settings where they are to be used. At this stage, further consultation may be undertaken with partner agencies – in preparation for pre-testing with the target audience. Pre-testing of the various executions helps to establish if language and imagery work together to clearly communicate information to the intended readers. The results of the pre-testing are then used to make revisions, and the small media and mass media resources are prepared for production and dissemination.

 www.nahip.org.uk

10

WRITING AND READING

WEBSITES

10.1 WHAT IS THE ACTIVITY?

Many agencies delivering HIV prevention interventions to African people have a website that describes their work and promotes the agency. More recently, dedicated websites targeting Africans have been developed as an intervention in themselves or as an element of a particular campaign or resource. Good online interventions aim to make the most of the setting, by providing appropriate hyperlinks and facilitating referrals. This means they are much more than simply a repeat of text that is already available in small media or mass media interventions.

10.2 STRENGTHS AND LIMITATIONS

One of the major benefits of any website is that it extends the potential reach of interventions beyond what face-to-face interactions can achieve. The potential to offer people up-to-date, relevant referrals to other sources of information and services is vast, and can be tailored specifically to their own needs. Also, those who may be less likely to approach workers or services directly (due to embarrassment or concerns about stigma) may be more likely to access information in the relative anonymity of the internet.

Online resources can be interactive, and are also not necessarily linear. This means that people can directly access an element of an intervention that is of greatest use to them personally.

Internet-based interventions will not reach those without computer skills, or who lack consistent access to the internet. However, among African respondents to the *Bass Line 2007* survey, two thirds said they used the internet at their own home in the past three months, and more than a quarter had done so at a friend's home, as well as many who used internet cafés, places of employment, libraries or educational institutions to go online (unpublished data, Bass Line 2007, Sigma Research).

With careful attention to design, the needs of people with diverse linguistic and disability access requirements can be met online at a comparatively low cost.

10.3 WHERE DO WEB-BASED INTERVENTIONS HAPPEN?

Web-based interventions take place on the internet. What requires close attention, however, is what particular websites or web-searches will encourage the target audience to visit the site. Even the best websites will be of limited value if there is little attention paid to their promotion.

10.4 ISSUES TO CONSIDER

Simply placing materials designed for a print-based (small or mass media) campaign on the internet is not necessarily effective. Playing to the strengths of the medium will mean that interactive websites add value and will attract users.

Exciting and innovative websites are of no use if the target audience is not aware of their existence. Careful attention must be paid to recruitment and motivation to spend time on the website. This will require an advertising strategy that is diverse, carefully targeted, and that occurs mainly online, as people click-through to websites rather than remembering to follow-up on websites that they have heard about through printed (offline) media. This will require extensive research about the internet habits and most popular sites among the target group before planning promotion. Where funding means that the target audience covers only a very small geographic area, a dedicated website is unlikely to be the best means of reaching people.

Website hosting and webmaster arrangements must be in place for the duration of an intervention, and planned clearly from the outset. Systems for error reporting are also essential.

10.5 OUTCOMES

The outcomes of online interventions are usually information-based, but they may help to alter attitudes and perceived norms of behaviour. The list below offers some examples of outcomes depending on the content of the online intervention:

- knowing HIV exists and understanding the harm it can cause (see KWP 6.1.1, page 32).
- Having a clearer understanding about how and why different sexual acts carry differing risks of HIV transmission (see KWP 4.2, page 18).
- Knowing how to correctly use male and female condoms (see KWP 6.4, page 36).
- Understanding the benefits of knowing their own HIV status (see KWP 6.1.2, page 32 and 6.5, page 37).
- Increased awareness of other services that they can access to better help them meet a range of needs, including HIV prevention need (see KWP 6.6, page 37).
- Increasing the extent to which sexually transmitted infections are diagnosed and treated (see KWP 6.6, page 37).
- Increased requests for (and uptake of) PEP following sexual exposure to HIV (see KWP 6.8, page 38).
- Increased consideration that the sex they have could risk HIV transmission (see KWP 6.1.2, page 32).

CASE STUDY »

Do it Right website – AHPN and NAHIP partnership

In spring 2008 NAHIP launched the *Do it Right* website, designed to accompany a national small and mass media campaign focusing on gender issues and their role in HIV prevention need. An essential element of the website was *Kobana's Stories* – a set of short dramatised videos highlighting the complex interactions between gender norms, social and familial expectations of behaviour and sexuality. The website also included a discussion forum for visitors to express their responses to the Kobana stories, as well as further information and films from other sources. The promotion of an intervention-related website, and the use of audio-visual and participatory technology to engage visitors was innovative for NAHIP.

Do it Right printed materials (which focused mainly on informing readers about accessing HIV and sexual health screening services) all promoted the website address. However, traffic to the website was low and attempted remedies such as boosted mass media advertising have failed to improve the numbers visiting the website.

Some of the reasons for the low numbers of visitors might include:

- Lack of audience testing to determine how traffic to the site might be generated, and what the most valued elements of a health promotion website might be.
- Planning that did not include realistic cost estimates for maintaining a website, including the provision of ongoing adaptations in response to audience feedback.
- Too few funds to scale up online advertising meant that promotion was almost entirely dependent on printed materials or word of mouth promotion.
- Lack of a clear connection between the information expressed in the print materials, and that available from the website.

 www.doitright.uk.com

10.6 MONITORING AND EVALUATION

Traffic to a website can be monitored, and it is also possible to keep track of what referring / advertising partner websites the user arrived from. Funders will want evidence that website users are within a specific geographic area, meaning that recording numbers of visitors, or page views, alone is probably not sufficient. Site traffic can also be monitored in relation to particular distribution spikes pertaining to different forms of promotion (such as online, face-to-face or small media interventions).

Simple online evaluation tools can be used to ask a random (or purposefully sampled) selection of visitors to the website about their views on the site, and what they found to be of most and least use. Results can be viewed and analysed immediately, and can feed into ongoing development of the intervention – as sites can be continuously updated and improved.

Key to the intervention

Web-based interventions should be designed so that they have more to offer targeted users than can be delivered in print. Use of audio, video and interactive elements, as well as simple to use indexing and click-through links will make online interventions more useable and acceptable.

Frequently delivered alongside ...

Small media (chapter 8)

Mass media (chapter 9)

Interactive distribution (chapter 11)

Static distribution (chapter 12)

Sector development (chapter 15)

INTERACTIVE DISTRIBUTION OF RESOURCES

11.1 WHAT IS THE ACTIVITY?

Sexual health resources are items which help to meet HIV prevention need such as printed small media (booklets, leaflets, cards) and associated support materials (pens, stickers, button badges, key-rings, sweets, etc.) and male and female condoms and water-based lubricant.

Interactive distribution of resources usually involves passing things from hand-to-hand when engaging with individuals in a range of locations. It is generally accompanied by some degree of talking and listening with the people to whom the materials are being distributed.

Interactive distribution may be **proactive**, where a health promoter cold-sells a resource. This can involve making a direct approach to a specific individual or a group in a community setting and handing out materials. Alternatively, interactive distribution may be **reactive**, which means materials are given when an individual makes a request, or on the basis of a particular need identified by the health promoter when talking and listening with a client.

Static distribution refers to leaving materials in a location for people to pick up on their own, and is described in chapter 12.

Key to the intervention

By initiating engagement (proactively) or listening out for needs as they emerge (reactively) health promoters can better target their resources through interactive distribution.

11.2 STRENGTHS AND LIMITATIONS

Interactive distribution allows providers to be strategic about the targeting of material resources (for instance, to those attending specific services, or those of a particular ethnicity or age range).

Interactive distribution serves to strengthen the client's association with an issue and/or with the provider. This connection will increase the likelihood of an individual's uptake of future interventions.

Interactive distribution of material resources ensures that stock use and popularity of particular resources can be monitored, and there is little wastage.

From a staffing point of view, interactive distribution is time and cost intensive, but is likely to be more effective than static distribution.

11.3 WHERE DOES INTERACTIVE DISTRIBUTION HAPPEN?

Interactive distribution (both **proactive** and **reactive**) can happen in almost any setting where African people congregate in sufficient density, including:

- cultural and community events, and college fairs, sometimes accompanied by a stall where resources can be browsed, and which also draws people into discussions.
- Other community settings such as migrant and African cultural and support centres, HIV service provider offices, support groups, and any place where and HIV prevention talking and listening interventions are provided.
- On foot during face-to-face outreach or detached work at business venues (such as clubs, shops, restaurants, and hairdressers) and in marketplace locations.

- Given that **reactive** distribution is about directly responding to requests for resources, this can happen almost anywhere, and it includes requests to be included on mailing lists.

11.4 ISSUES TO CONSIDER

Interactive distribution requires staff or volunteers with strong communication skills, as well as specific knowledge about the best use of the resources. For instance, in the case of condom distribution, a short discussion about condom failure will increase the likelihood that condoms are used effectively. Staff will also require the ability to make referrals where appropriate.

Access to business premises and community venues will require advance negotiation with organisers and venue owners. This requires diplomacy and creativity since the existence of an ideal setting does not automatically ensure access to it. Particular locations will attract service users of a certain age, gender, ethnic background, etc. Careful attention must be paid to ensure that selected sites for interactive distribution are best suited for the intended target audience. Consideration should also be made about how materials will best reach those in need who do not frequent locations selected for distribution.

Interactive distribution during outreach work is generally delivered by pairs of workers, and in isolated or potentially dangerous areas, additional equipment (such as mobile phones and alarms) will be required.

Frequently delivered alongside ...

- Information and advice delivered one-to-one (chapter 3)
- Information and advice delivered to groups (chapter 4)
- Small media (chapter 8)
- Static distribution (chapter 12)

11.5 OUTCOMES

The outcomes of interactive distribution depend crucially on what is being distributed and the extent to which it is accompanied by talk and listening interventions. Overall the outcomes are likely to be information-based, and the list below offers some examples:

- Having a clearer understanding about how and why different sexual acts carry differing risks of HIV transmission (see KWP 4.2, page 18).
- Knowing HIV exists, and understanding the harm it can cause (see KWP 6.1.1, page 32).
- Increased consideration that the sex they have could risk HIV transmission (see KWP 6.1.2, page 32).
- Understanding the benefits of knowing their own HIV status (see KWP 6.1.2, page 32 and 6.5, page 37).
- Increased confidence and motivation to openly discuss sex and sexuality, as modeled by the worker undertaking interactive distribution (KWP 6.1.2, page 32 and 6.1.3, page 34).
- Increased belief that avoiding HIV transmission is a positive and beneficial social norm shared by prospective sexual partners (KWP 6.1.2, page 32).
- Knowing how to correctly use male and female condoms, and feeling more confident introducing condoms with sexual partners (see KWP 6.4, page 36).
- Access to quantities of free or affordable condoms (see KWP 5.5.3, page 28 and 6.4, page 36)
- Knowing more about other services that can help to meet a range of needs, including HIV prevention need (see KWP 6.6, page 37).

11.6 MONITORING AND EVALUATION

Interactive distribution is a means of ensuring that sexual health resources are effectively and efficiently distributed to their target population. Assessing outcomes for this type of intervention extends beyond monitoring the number of items distributed.

The use of short questionnaires by outreach workers can enable interveners to assess the demographic profile of the people receiving resources. The use of talking and listening interventions in conjunction with interactive distribution enables informal and formal needs assessments to be undertaken, which enhance the possibilities of outcome evaluation.

Survey methods can assess awareness of the products and means of accessing them within the target population. Interviews or focus groups may be used to examine the value that such resources carry, and how people prefer to access them.

CASE STUDY »

Street outreach – West African Networking Initiative (WANI)

An essential element of the work undertaken by WANI is its street outreach, led by a well-known and well-respected community member. His approach is direct. He engages people in discussion about their lives and their interests, wherever he finds them, be it the shopping in the street markets, catching the tube, or waiting in a mini-cab office. He finds that by quickly establishing a clear rapport, and making it clear that he is able to provide a supply of free condoms, people are often interested to hear more about what he has to offer. He always has an ample supply of sexual health resources, including condoms, a broad array of leaflets, booklets and fliers advertising health seminars and local cultural events in the small case that rarely leaves his side. He finds that interactive distribution helps him to refer people to other interventions, including making arrangements for home visits to discuss HIV prevention with the entire family.

12 STATIC DISTRIBUTION OF RESOURCES

12.1 WHAT IS THE ACTIVITY?

Sexual health resources are items which help to meet HIV prevention need, including small media, male and female condoms, and water-based lubricant. Static distribution involves placing free resources in locations and leaving them there for people to take. For instance, leaflet racks and condom dispensers can be used to provide users with easily identifiable locations where they can get written resources and condoms. Posters may also be used to alert potential users about available resources.

Distribution occurring hand-to-hand or via mailing lists is called interactive distribution, and is described in chapter 11.

12.2 STRENGTHS AND LIMITATIONS

This method of distribution requires no physical contact with the target population, meaning the time and skill required are relatively low.

Those who are too shy to request resources may be better able to collect items for themselves. However, the lack of interaction will leave other needs unmet.

The open provision of free condoms increases the visibility of condoms and probably increases the acceptability of condom use among African people.

In areas with a small or dispersed African community infrastructure, there will be a restricted number of settings for the static distribution of targeted resources.

Taking a resource is not the same as using it (or using it effectively, in the case of condoms).

12.3 WHERE DOES STATIC DISTRIBUTION HAPPEN?

Static distribution can happen in almost any (usually permanent) location where African people congregate in sufficient density. These do not have to be exclusively African spaces, however, some thought needs to go into the likely outcomes of the provision of targeted resources in generic settings. **Tailoring** resources (ensuring they are appropriate and appealing to those for whom they are designed) and **targeting** resources (ensuring they are located in places where the population for whom they are intended are most likely to see and take them) should increase uptake of interventions for specific sub-populations of African people in England. All interventions should aim to minimise the likelihood of further HIV-related stigma.

Settings include:

- commercial African venues such as shops, restaurants, barbershops, clubs and pubs;
- churches and mosques serving African people;
- African community centres, cultural groups and youth clubs;
- health service centres such as GUM and HIV clinics, GP surgeries, and HIV charities.

Key to the intervention

Ensuring that sexual health resources are seen in a variety of venues increases their acceptability and can support their use. However, the HIV prevention needs of each person are complex, and static distribution can only have a limited impact on any given person. Therefore, static distribution is a foundation upon which other interventions can build.

12.4 ISSUES TO CONSIDER

Establishing and maintaining a strong relationship with venue owners is central to the success of static distribution. Early approaches require the skills of expert health promoters who can help owners to understand the array of benefits associated with such schemes. Established static distribution sites can be maintained by less skilled workers or volunteers.

Wastage is a key issue. Venue staff may discard written resources, other materials may crowd them out, and some will be spoilt. These problems can be minimised by undertaking regular stock checks, ensuring there is a specified fixture (a rack or dispenser) to hold resources, and maintaining a strong relationship with venue owners and employees.

Keeping stock in order requires organisation. Re-stocking routines need to be clarified with venues in advance. When re-stocking, workers may require: monitoring forms, written resources, condoms, lubricant, cello tape, blue tac, etc.

CASE STUDY »

Safe Houses Scheme – Health Action Charity Organisation (HACO)

With combined funding from the local Primary Care Trust and the Cooperative Group in 2007, HACO set up a static condom distribution scheme in Medway, using local African businesses as distribution points. The easy availability of free condoms was intended to increase condom use among Africans in the area, and also to improve the social acceptability of condoms among this population. Service monitoring was undertaken in the six distribution centres, and lower-performing distribution points were replaced with those that proved to have a higher uptake. A service user questionnaire about the scheme's acceptability and usefulness was completed by more than 200 users of the scheme. As a result of information gained during this evaluation, the project steering group decided to increase the number of condoms provided in each pack. Otherwise, most respondents found the scheme to be highly accessible, and felt that it increased the likelihood of condom use during intercourse.

 www.healthaction.co.uk

12.5 OUTCOMES

The outcomes of static distribution depend crucially on what is being distributed. Overall the outcomes are likely to be information-based, and the list below offers some examples:

- knowing HIV exists, and understanding the harm it can cause (see KWP 6.1.1, page 32).
- Having a clearer understanding about how and why different sexual acts carry differing risks of HIV transmission (see KWP 4.2, page 18).
- Knowing how to correctly use male and female condoms, and feeling more confident introducing condoms with sexual partners (see KWP 6.4, page 36).
- Understanding the benefits of knowing their own HIV status (see KWP 6.1.2, page 32 and 6.5, page 37).
- Increased consideration that the sex they have could risk HIV transmission (see KWP 6.1.2, page 32).
- Access to quantities of free or affordable condoms (see KWP 5.5.3, page 28 and 6.4, page 36)
- Knowing more about other services that can help to meet a range of needs, including HIV prevention need (see KWP 6.6, page 37).
- Increased desire to contribute to the health and well being of their community (see KWP 5.4, page 25).

12.6 MONITORING AND EVALUATION

Judging the uptake and success of static distribution often goes no further than monitoring how many resources leave the office, yet this tells agencies very little about what happens to materials. Further information can be gained by monitoring the popularity of particular resources in different venues by keeping track of how often they require re-stocking.

A relatively simple, and informative means of assessing the utility of static distribution is time-sampled observation. Simply watching the resources at a selected venue for an hour at a different time every day will give insight into how they are used, who is drawn to them, and how the intervention might be improved.

Surveys can be used to assess awareness of the products and means of accessing them within the target population and people's preferences for different locations for distribution.

Frequently delivered alongside ...

Information and advice delivered one-to-one (chapter 3)

Small media (chapter 8)

Interactive distribution (chapter 11)

CASE STUDY »

Static distribution – African Institute for Social Development (AISD)

AISD has sourced a sustained and reliable supply of male condoms and water-based lubricant through the Primary Care Trust sexual health programme. AISD ensure these resources are distributed via local African businesses by identifying potential distribution points and providing startup support for those that can be persuaded to participate in their static condom distribution scheme. Skilled team members negotiate the idea of condom distribution with the venue owner, explaining that it can help to draw people into the premises. Usually written resources are also made available in the same locations.

Owners place a notice that free condoms are available from behind the counter upon request. Once the system is stabilised and running well, owners are encouraged to directly contact the NHS condom suppliers when stocks need replenishing. This reduces the need for AISD to stuff condom packs, or to physically re-supply locations. However, AISD undertakes regular checks on distribution locations, to check distribution is still occurring, and to help with any problems.

Amdani Juma from AISD says: "Our aim is to decentralise our own role in the process, and ensure that African people and businesses are being brought into contact with the mainstream services and interventions that they have a right to access."

13 CLINICAL INTERVENTIONS IN THE COMMUNITY

13.1 WHAT ARE CLINICAL INTERVENTIONS IN THE COMMUNITY?

Clinical (NHS) interventions have been undertaken in community settings almost as long as the NHS has existed – for example, blood donation sessions in workplaces. However, since the publication of the *National Strategy for Sexual Health and HIV* (Department of Health 2001) they have become much more common in HIV and sexual health promotion. Many charitable organisations now host clinical sexual health interventions, including chlamydia screening, hepatitis B vaccination, HIV testing and other screening for sexually transmitted infections. Others provide fast-tracked referrals into HIV testing services, or even chaperone their clients into standard NHS environments and provide informal interpretation.

Of particular interest here, are HIV testing services coordinated by community or charitable organisations. The actual counselling and testing in these interventions is usually provided by staff from local genito-urinary medicine (GUM) or sexual health services, with the charitable organisation collaborating to provide the venue, the reception staff and promoting the intervention to potential users. Effectively clinical governance remains with the organisation providing the nursing and health advising staff, and they also provide the bridge back into mainstream HIV services, which is especially important when someone receives a positive HIV diagnosis.

Testing and counselling should be undertaken by fully qualified staff in rooms appropriately equipped and adequate supervision, clinical governance and insurance should be in place. While it is feasible for charitable organisations to directly employ staff qualified to provide HIV testing and other clinical interventions, this is complex, and there will rarely be sufficient demand for the services to make such appointments worthwhile.

Community-based HIV testing services frequently use rapid testing technologies, also commonly known as point-of-care testing (or POCT). Testing kits such as the Abbott HIV 1&2 test kit require a finger-prick of blood applied directly to a small, plastic, disposable testing device. These kits are also used in clinical environments where rapid testing is the goal and are considered sufficiently sensitive and specific for a preliminary HIV diagnosis. The kits themselves are relatively inexpensive, and give an antibody test result in about ten minutes. Where HIV infection is indicated by the rapid test kit, a full blood test is recommended to provide confirmation.

13.2 STRENGTHS AND LIMITATIONS

People who are wary of interacting with standard NHS services – such as GP surgeries, hospitals etc. – may feel more comfortable in a community setting where there is a pre-existing relationship of trust.

Making HIV testing – or any other clinical intervention – easily accessible in community venues increases their acceptability to many users. Evaluation data (Weatherburn *et al.* 2006a, 2006b) suggests users particularly welcome services that are accessible outside core hospital hours (9am-5pm) and where no appointment is necessary.

Clinical sessions can be used as a means of referring individuals to other services, as well as a means of promoting particular written interventions and distributing HIV prevention resources (such as leaflets and condoms).

Because of the relatively high cost of staffing, sessions tend to be short (typically 2-3 hours during which 8-12 people might be tested) and only occur once a week. However, substantial effort might be needed to ensure service uptake, so promotion of the service will be required.

Most clinical interventions in the community test for one specific infection (eg. HIV). People attending standard genito-urinary medicine (GUM) services might expect to receive a battery of screening tests that could identify a much larger range of infections.

13.3 WHERE DO CLINICAL INTERVENTIONS IN COMMUNITY SETTINGS HAPPEN?

Clinical interventions can occur in public, private and commercial spaces where African people socialise or use other services, including clubs, places of worship, schools, colleges, universities, businesses and community centres. In reality, clinical interventions in the community tend to occur in the main offices of the host charities themselves, because of the specific demands of a clinical intervention.

The host charity must provide a waiting or reception area; at least one private room and ideally two, each with comfortable seating for up to 3 people; a sink (for hand-washing); a hard floor (in case sample spillage); and sharps-boxes for the disposal of clinical waste. There should be a secure area for keeping confidential records, and rooms should be equipped with a panic button system to be used if there is a physical danger.

Centre-based interventions lack the immediacy and coverage of outreach interventions. The self-referral demanded by such services means that individuals have identified a need (knowledge), decided to act to get it met, found out where to go, planned a time to attend, and had the capacity to act on it. People using such services demonstrate motivation (will) and the capacity to seek support in meeting their needs (power).

Key to the intervention

Access to clinical interventions in community settings tends to be immediate, often after-hours and with no appointment necessary. Where HIV testing is the goal it is imperative to have clear and swift referral pathways into mainstream HIV (and GUM) out-patients services.

13.4 ISSUES TO CONSIDER

Providers should be conversant with a range of sexual health issues such as the transmission, prevention and treatment of sexually transmitted infections (including HIV). Beyond this, they also require familiarity with services to which they can make appropriate referrals. Workers providing information and advice should have proven listening and communication skills.

Agencies will need to have procedural and boundary guidelines for one-to-one workers, and will need to ensure that these are built into staff inductions, and are regularly revisited. These should aim to maximise the physical safety and comfort of workers while also ensuring a standardised service. The providers' credibility is paramount to the success of these interventions, therefore workers will need training about personal, professional and social boundaries during work (and about contact with clients outside of work).

The Sigma Research evaluation of Terrence Higgins Trust's fasTest pilots of HIV testing in the community (Weatherburn *et al.* 2006a; 2006b) concluded that the success of the fasTest interventions was a function of: their promotion; a need to establish HIV status in the local population; and pre-existing service provision in the locality of the site (ie. the availability and accessibility of comparable HIV testing services). The evaluation demonstrated that it was feasible to recruit black African migrants into fasTest services, though promotion to African and other black and minority ethnic populations needed specific interventions.

This same evaluation (Weatherburn *et al.* 2006a; 2006b) demonstrated that:

- more than half of all people using fasTest reported that their main reason for choosing fasTest over other options for HIV testing was because the test result was available at the same visit.
- Another third stated that it was more convenient because of the after hours nature of the service and the absence of any need for an appointment.
- None of the clinics ran at full capacity for the entire pilot period but managing (over)demand was problematic at times in all sites. Overall, on average

1 HIV test was delivered for every 41-53 minutes of clinical staff time.

- Promotion of the service affected uptake but more expensive methods of promotion (including outreach) did not appear to have a disproportionate impact on uptake.

13.5 OUTCOMES

The outcome of this intervention is primarily diagnostic. The goal is to “reduce the length of time between HIV infection and diagnosis” (see KWP 4.6.1, page 22).

A variety of other claims are made about the utility of clinical interventions in community settings – most common among these are the assertion that the population of people testing for HIV in community settings is different from those that test at GUM clinics, GP surgeries or elsewhere. Most commonly it is claimed that the population using community testing sites will be younger, more recent migrants and / or more recently infected with HIV. None of these claims are proven but none are necessary to justify the intervention since HIV testing in community environments expands HIV testing capacity in a locality and improves patient choice, so long as it does not replace pre-existing HIV testing services.

13.6 MONITORING AND EVALUATION

Clinical interventions in community environments are generally subject to monitoring and access evaluation exercises which collate information about service users’ basic demographics (age, ethnicity, gender, geographical location) and their expected and actual test results. These details will enable some assessment of whether the intervention is reaching the desired targets.

Evaluating the impact of such interventions will require specific funding and research expertise.

Frequently delivered alongside ...

Information and advice delivered one-to-one (chapter 3)

Therapeutic change and skills development delivered one-to-one (chapter 6)


Interactive distribution (chapter 11)

Static distribution (chapter 12)

CASE STUDY »

HIV testing and clinical access – Embrace UK (formerly ECCUK)

Embrace UK hopes to reduce the length of time between HIV infection and diagnosis by encouraging HIV testing with users of their Pan African and Caribbean Sexual Health Project (PACSH). PACSH has formed a partnership with St. Anne’s Hospital (Haringey) called *Time to Know* (T2K) to enable easy access to HIV testing services. PACSH staff make clinic appointments on behalf of their service users and issue the service users with T2K cards. Because St. Anne’s Hospital staff know about T2K cards, those who present the card at the clinic are directly taken in for HIV counselling and testing. To monitor the uptake, PACSH workers go to the clinic regularly to collect and count the T2K cards. In this way, they are able to determine the numbers who have actually gone for testing and follow-up those who have not. In a different initiative, staff encourage HIV testing through a partnership with the Town Clinic in Enfield. They send service users’ contact details to the clinician who then calls the service users to make an arrangement for an HIV test.

 www.embraceuk.org

CASE STUDY »

Community Doctor – Community of Congolese Refugees in Great Britain (CORECOG)

Funding from the Big Lottery enables CORECOG to provide an innovative community doctor service. Individuals bring their confidential questions and health issues to a multi-lingual African trainee doctor during drop-in surgeries. Although no medication or treatment is dispensed, the doctor can offer advice and referral information to the agency’s mainly Francophone service users. The service also extends beyond the agency, as the doctor will accompany some service users to clinical appointments (chaperoning), and may help to interpret if they have difficulties with spoken English – all as a means of bridging the distance between the individual and mainstream NHS services. Given that doctors are frequently afforded a great deal of respect among African community members, the resources, advice, information and support offered by the community doctor are likely to be received with a high degree of trust.

14 COMMUNITY DEVELOPMENT

14.1 WHAT IS COMMUNITY DEVELOPMENT?

The term community is often used to describe those who may share a range of characteristics such as race, ethnicity, culture, sexuality, age or geographical location. Community development describes a process of supporting active and sustainable social networks based on social justice and mutual respect. It is about enabling people to directly influence the things that affect their lives. *The Knowledge, The Will and The Power* (Dodds et al. 2008a) asserts that interventions that work to improve networks of social support among communities will help to reduce power inequalities, which in turn reduces the likelihood of HIV exposure and transmission.

HIV prevention interventions do not occur in a vacuum, and it is vital to connect programme aims and objectives with local realities. The local knowledge possessed by community groups of African origin is a key tool in shaping the context of local HIV prevention interventions. Helping to ensure that those who are the targets of future HIV prevention activities are part of their development and evaluation will improve their feasibility and acceptability.

Key to the intervention

At the heart of community development is a commitment to equality. Accessible formal and informal networks of social, physical and emotional support provide the foundations upon which HIV prevention interventions for African people in England are built.

14.2 PROVIDING RESOURCES FOR THE DEVELOPMENT OF COMMUNITY GROUPS

Five key elements of successful community development (from Rifkin et al. 1988) are:

- recognition and assessment of need in the population group,
- leadership,
- organisational infrastructure,
- resource mobilisation, and
- management.

New and developing community groups will often require support in one or more of these five core areas. The aims of such support include: fostering the skills, interests and desires among individuals within community groups that help them to thrive (this is sometimes called *social capital*); sustaining social networks within which African people in England can flourish; and establishing a norm of collaborative, partnership working within a sector that can sometimes be fraught with competition for scant resources. As such, resource provision may include financial support, and is also likely to include the use of meeting space, sharing of office equipment and infrastructure (such as photocopiers, telephones or internet access), or the sharing of human resources and expertise. In this way, provision of advice on a broad array of activities (such as project management, drawing up budgets or establishing charitable status) helps to increase the stock of social capital within community networks and organisations. However, different community groups will vary in their ability to utilise such resources to the maximum potential due to their level of capacity.


Community groups with few resources are more likely to actively seek external support than those with greater capacity. This can lead to adverse selection of community groups because it is not necessarily the community groups that have the most impact or reach that seek or receive support. In the main, selection happens coincidentally, or can be based on historical or personal relationships between individuals. To avoid such trends, it is worth considering the following competencies before making a decision about resource provision for a group:

- clear articulation of aims informed by demonstrable local need,
- proven leadership or leadership potential,
- willingness to engage with HIV prevention aims and interventions,
- the capacity and interest to work with other organisations to develop interventions and programmes,
- capacity to respond to changing needs and policy environments.

CASE STUDY »

The Crescent Support Group and Community Empowerment Trust

The Crescent is a generic HIV/AIDS support organisation in Hertfordshire that provides sexual health promotion and HIV prevention services in addition to provision of support and social care for people affected by HIV. Community Empowerment Trust (COMMENT) is a community group that provides support services for all people of African origin in Hertfordshire. The Crescent identified the key local role played by COMMENT among African people in the county, and undertook to provide it with resources such as funds, equipment and expertise for some of its targeted work in churches and African associations. This process increases the capacity of existing community groups while increasing the coverage of HIV interventions in Hertfordshire.

 www.thecrescent.org.uk

14.3 PROMOTING COMMUNITY INPUT INTO PLANNING AND DELIVERY

Intervention planning that takes a top-down, unilateral approach is generally controlled by those with the relevant resources. Recent increases in training provision and skills development for those involved in planning may contribute to an increase in professionalism and technical proficiency, but does little to increase interaction between funders, providers and beneficiaries. For example, health promoters may develop HIV prevention interventions using the latest technology or psychological models, but may be surprised if their interventions are unfamiliar or impracticable to those in the target population (say because of literacy levels or cultural considerations). Feasibility and acceptability are therefore best ensured when members of groups intended to benefit from interventions are involved in the process, from development to implementation. This holds not only for direct contact interventions, but also for structural interventions including policy development.

Enabling and supporting community members to voice their opinions with decision-makers at local, regional and national levels helps to build confidence among individuals, proactively decreases social marginalisation and exclusion, and helps to make services and policies more relevant to needs. Direct input ensures that lessons can be taken from people's experiences of previous intervention successes and failures, as well as increasing community ownership of interventions. This helps to maximise the use of limited resources, while also helping to encourage social learning, whereby partnerships help providers and beneficiaries learn from one another.

Interventions to ensure direct service-user input can help individuals gain technical and interpersonal skills that will help to increase personal control in other areas of life. Thus, for some people the skills acquisition and experience processes can result in voluntary and paid involvement in the HIV prevention sector. Community development therefore also contributes to sustaining a vital, skilled and personally engaged workforce.

In this way, community members are empowered to become the subjects rather than the objects of HIV interventions. The following considerations have been suggested as useful for those aiming to promote community input into intervention planning and delivery:

- Facilitating a range of stakeholders' input requires mutual trust, which can be enabled through the use of fair, step-by-step participatory approaches accompanied by scope for flexibility.
- A careful balance between generating robust content, and establishing an inclusive process.
- Demonstrating appreciation and encouragement to those who participate helps to develop a sense of belonging, which in turn helps to sustain communal activity (Rifkin & Pridmore 2001).

CASE STUDY »

Love Train – Organisation of Positive African Men (OPAM)

Love Train is an event organised by OPAM, in partnership with other agencies that support men and women with diagnosed HIV. The aim is to facilitate people with HIV meeting in a comfortable and safe social space – which can ultimately lead to dating and the formation of relationships. Love Train events involve going to and from a destination together by train, with the sustained period of close proximity on the train designed to foster social interactions among a large number of diverse service users. Although this appears to be quite different from many other community development interventions, it is premised on the same basic goals. Essentially the agency devises a setting whereby people with diagnosed HIV are able to establish emotional and social support networks that (among other things) help to meet their HIV prevention needs.

14.4 OUTCOMES

Stronger links with sustainable grass-roots community groups, identification and strengthening of informal support networks, and evidence of community members' input into decision-making processes are all significant outcomes resulting from community development interventions.

Community participation reinforces the community ethic discussed in *The Knowledge, The Will and The Power* (Dodds et al. 2008a: page 25). This is rooted in the mutual care, belonging and interdependence that is initially fostered within extended families and can be broadened to one's community.

14.5 MONITORING AND EVALUATION

Monitoring involvement in community development interventions, by keeping an up to date record of current and past activity, enables agencies to monitor their level of capacity to engage in similar activities in the future. Participant observation and process evaluation of community development interventions will help to ensure that outcomes are understood.

15 SECTOR DEVELOPMENT

15.1 WHAT IS SECTOR DEVELOPMENT?

Sector development, also called capacity building, refers to the provision of information, knowledge and skills to improve an organisation's or individual's ability to deliver interventions. In terms of HIV prevention, 'capacity' refers to the ability of an organisation to deliver a range of interventions in a seamless manner within the context of the broader HIV sector.

Due to relatively high staff turn-over and re-current restructuring within many organisations serving African people, there is a requirement for continuous development of an ever-changing workforce. To address these challenges, organisations need the ability to operate reactively as well as proactively to shape HIV prevention processes and outcomes.

Sector development is important in helping organisations and individuals to assess their needs, improve intervention design, monitoring and evaluation, create a more enabling environment and increase the efficiency with which they use their limited resources.

15.2 WHOSE CAPACITY NEEDS TO BE DEVELOPED?

The African HIV prevention sector includes anyone who delivers, funds or supports the development of interventions aimed at reducing HIV exposure and transmission involving African people in England, and various stakeholders will have different levels of need.

Those who commission HIV prevention interventions targeting African people require up-to-date information about prevention need and other issues affecting service users and providers to enhance their commissioning decisions. Commissioners should ensure an enabling environment for organisations to develop and to deliver programmes, through mutual communications and

interactions. This requires an open and trusting relationship between commissioners and providers, grounded in shared values that prioritise evidence, ethical approaches and collective problem-solving.

All staff in voluntary sector organisations should attend training events and courses, seminars, conferences and workshops that equip them with relevant knowledge and skills about HIV prevention among African people, technical skills, and information about the work of other service providers. The development needs of board members, directors and managers, front-line staff and volunteers will not all be the same, but all will have some. There should also be effective communication and feedback systems in place so that information is shared with the rest of the team where only some individuals can be supported to attend such events.

Researchers require ongoing information about emerging service delivery and community-related issues, in order to ensure that their approaches are relevant and acceptable. This is not only achieved through formal processes, it also requires ongoing dialogue between community organisations and researchers. Increased understanding and appreciation for the daily pressures, priorities and working practices of those on each side of this relationship contributes to the development of a robust research agenda, and helps to increase the likelihood that research outputs will be useful to those whose needs they are designed to meet.

15.3 WHAT DOES SECTOR DEVELOPMENT INVOLVE?

15.3.1 Gathering and applying evidence

Managers, staff and volunteers often have important roles collecting data from their own service users, or functioning as gatekeepers for research and evaluation activities. This may involve: participant recruitment, hosting

research activity, publicising research to service users or being a research participant. In addition, there are often decisions to be made regarding how to prioritise requests for agency participation in research and evaluation activity.

Organisations also play a leading role in the development of research agendas by identifying areas requiring further investigation among those whose needs they aim to meet. This requires commitment to research processes, from start to finish, in consultative roles, through steering group membership, or project management. This helps to shift the focus from being a passive recipient of changes imposed to active involvement in shaping research and policy directions.

As part of gathering and applying evidence, organisations should also ensure that intervention planning and delivery is accompanied by the thoughtful use of needs assessment, monitoring and evaluation. These activities help providers to measure success, identify weaknesses, plan for future programmes and feedback to commissioners on how resources have been used.

15.3.2 Acknowledging failure

If organisations do not acknowledge and share information about challenges and failures, then success will be difficult to assess. Sector development includes a willingness to discuss failures, mistakes and challenges for the benefit of those planning future interventions.

15.3.3 Ongoing professional development

All new staff and volunteers should undergo a comprehensive induction to organisational policies and ethics, as well as statutory requirements on equality, rights and confidentiality. This requires genuine workplace compliance backed-up by accessible resources on such policies for all.

In addition, managers, staff and volunteers of organisations should establish and adhere to professional development plans. This should include assessments of need in a variety of skill and resource areas, and followed up with an agreed action plan which may include attending further training, seminars, or conferences; keeping up-to-date with research briefing papers, newsletters or email updates; job shadowing; or mentoring. Team activities such as away days and staff social events can be useful in developing and improving motivation in a team.

Where capacity allows, many organisations have a significant role to play as providers of information and training to staff and volunteers from other agencies. Such activities can be diverse, and may include: provision of print or electronic resources that collate developments in the field; compiling and delivering extensive packages of training for those who specialise in HIV as well as non-specialists; or hosting stakeholder seminars and conferences.

15.3.4 Ensuring coherence and collaboration in service delivery

The diverse nature of HIV work requires collaborative working to provide: opportunities for combining resources, cross-referrals, developing long-term joint goals and building professional support networks. Partnership effectiveness will depend on good leadership, service users' involvement, political will and genuine cooperation towards a common goal.

Partnerships should also extend beyond community-based organisations to include relevant private and statutory sector organisations. In forming partnerships, organisational similarity should be taken into account including a careful analysis of values, desired outcomes, and available resources to ensure best fit for all involved.

15.4 ENSURING ORGANISATIONAL STABILITY

Managers, staff and volunteers should strive for stability and longevity of their organisations. Managers require extensive fund-raising skills and familiarity with the funding environment so that their time is not overly committed to chasing unlikely opportunities. They should also oversee organisation-wide accountability policies and practice, in addition to strong commitment to monitoring and evaluation because evidence of accountability will be useful in securing future funding.

All personnel should be skillful and approachable, promoting a receptive image to potential service users. Where possible, staff and volunteers should have a cultural background similar to the service users. This will create trust among potential service users who might prefer to be served by people with similar cultural characteristics to them. To reduce high staff-turnover, managers should ensure a working environment conducive to personal and professional development.

15.5 OUTCOMES

Sector development interventions should provide staff members, volunteers, and board members of statutory and voluntary sector organisations with the necessary resources, skills, knowledge and understanding of the activities of other agencies to adequately contribute to HIV prevention involving African people in England. The specific content of these types of capacity-building activities will necessarily have to be tailored to the needs of those across a variety of contexts.

Examples of sector development outcomes may include:

- increased understanding and application of research evidence;
- improved ability to raise funds necessary to sustain existing and future interventions;
- increased understanding of interventions and services offered by other service providers; and
- improved service provider / commissioner relationships, evidenced by regular update meetings and ongoing communication.

Key to the intervention

Sector development interventions should be flexible enough to enable participants to share their experience and expertise with one another, while also facilitating their acquisition of new skills and relevant information.

Sector development resources

The following websites provide useful information in this area:
www.bvsc.org/development
www.cabinetoffice.gov.uk/third_sector.aspx
www.traintogain.gov.uk/
www.cass.city.ac.uk/cce/
www.aidsmap.com/cms1038779.asp

15.6 MONITORING AND EVALUATION

Monitoring involvement in such interventions (by keeping an up to date record of current and past activity) enables agencies to assess their capacity to meet future demand. Sector development interventions can be evaluated through the use of needs assessment questionnaires

administered before and after a particular intervention (such as a training session or a conference).

More detailed process evaluation or end user evaluation can be undertaken using follow-up interviews undertaken some time after the intervention.

CASE STUDY »

Health Promotion Diploma – National Institute of African Studies

Affiliated with Thames Valley University, NIAS offers a fully accredited diploma course in Health Promotion Theory and Practice. Six modules, each lasting 10-12 weeks can be taken as stand-alone units, or they can be combined to constitute the taught component of the diploma course. In addition, students commit to 100 hours of voluntary or community work with agencies undertaking health promotion interventions (including HIV prevention), both in the UK and abroad. NIAS seeks to increase the extent to which the learning and skills development that it provides is utilised by NAHIP partner agencies, while also seeking to increase the number of student placements in these same organisations.

 <http://africanstudies.org.uk>

CASE STUDY »

Taking Part – Positively Women

Positively Women established Taking Part, in response to the belief that women with diagnosed HIV were under-represented in terms of input into HIV policy development. It is a long-term intervention to improve the skills and confidence of women who want their voices heard on policy that affects them. One of the specific prompts for the creation of the programme was the development of patient forums (now called LINKs) within the NHS. Positively Women's director and other staff work with women who have a desire to influence policy. Over time, they work together on skills such as: dealing with the media, speaking publicly on policy matters, digesting and responding to policy documents, and making the most of conference and meeting attendance. The tangible outcomes include group members' attendance and participation within local (for instance, Primary Care Trust) and national (for instance, the All Party Parliamentary Group) policy bodies, and extensive participation in government consultation processes. Many of the group members also move into paid employment in the HIV sector.

 www.positivelywomen.org.uk

16 POLICY INTERVENTIONS

16.1 WHAT ARE POLICY INTERVENTIONS?

Policy interventions are strategic interactions that aim to influence those people at local, regional and national levels who make decisions that affect the lives of others, in this case African people in England. Policies that help to reduce HIV prevention need among African people in England can cover a vast number of areas, including decision-making on health, education, social care provision, housing, racial equality, criminal justice, welfare benefits, and immigration and employment. Policies that foster well-being, attend to human rights, and ensure appropriate access to services from the voluntary and statutory sectors will contribute to an environment where African peoples' HIV prevention needs are better met. Whether we work in the statutory or voluntary sectors, part of our mandate is to be involved in the relevant policy development processes that our democratic society affords, functioning as advocates for those whose interests we serve. That means becoming active within the policy environment that surrounds our work.

16.2 WHAT DO POLICY INTERVENTIONS INVOLVE?

Whether policy interventions are local, regional or national, success requires a strategic, pro-active approach. It is impossible to influence all policy, all of the time. This means that organisations should prioritise the issues they want to focus upon, devise a plan of action, identify and build partnerships, and review progress on a regular basis.

The form that policy interventions take can be influenced by existing structures for input. For instance, many significant policy changes instituted by central or local governments are subject to a formal consultation, based on written responses to a draft document. Knowing about such consultations, and having the

capacity to respond to them requires capacity with organisations, and supporting infrastructure between them. However, policy interventions are not always so formalised. Sometimes, they involve becoming familiar with the core documents that help to form a particular policy landscape, attending and introducing oneself at planning meetings or public events, exchanging emails, collating and sharing case studies, making phone calls, or preparing press briefings.

Sometimes, those responsible for making decisions (particularly those who are not specialists in migration, ethnicity, sexual health or HIV) will have significant deficits in information and awareness. One simple, yet direct means of influence is to offer oneself as an information resource to such individuals, helping them to gain a fuller regard for the issues that are most pressing to African people at risk of HIV transmission.

Partnership-working on a carefully selected policy agenda can prove to be particularly powerful, as evidence can be collated across agencies, and innovative approaches to exercising influence can be strategically applied by different actors, with a diverse range of targets. These might include, but are not limited to:

- Members of Parliament (individually, or through groups such as the All Party Parliamentary Groups on AIDS or the All Party Parliamentary Groups on Refugees).
- Those presiding over and consulting upon policy, legislative and regulatory change through relevant government departments, including but not limited to: Treasury, Home Office; Ministry of Justice; Office of the Third Sector (Cabinet Office); Department of Health; Department for Children, Families and Schools; and the Department for Communities and Local Government.

- Local Involvement Networks (LINks) that now cover most publicly funded health and social care services, no matter who provides them.
- Housing Associations.
- PCT and Local Authority commissioners and other resource allocators.
- Sexual Health Commissioners Group for England.
- Police, prison and probation services.
- Leaders of faith-based organisations.
- Professional associations and trade unions (including, but not limited to: health, media, education).
- School governors.
- Equality organisations, including the Equality and Human Rights Commission.

Whatever the activity or the audience, success will hinge not only on the persuasiveness of the argument, but also on incisive use of evidence. This means it is essential to be well-prepared with data and examples that help to support a particular approach to change.

16.3 STRENGTHS AND LIMITATIONS

Policy interventions can result in change that dramatically alters the conditions of life for people likely to be involved in HIV transmission. Their strength should not be underestimated, given that it has been widely argued that key players in policy have the greatest influence on (and therefore responsibility for) HIV incidence (UNAIDS 2002, Barnett & Whiteside 2002).

Involvement in policy interventions requires exposure to connections between the HIV sector, statutory agencies and government. This offers opportunities to identify and establish partnerships that might traditionally fall outside an organisation's immediate contact base, thus also helping to further develop the sector.

Intervening in the policy field can require significant effort, sometimes for little tangible gain, making it difficult to secure discrete funding to support such activities. Also, those in direct contact services will sometimes be forced to choose whether to prioritise

the pressing needs of individual service users, or following up on the complex documentation and attention to detail that policy interventions can involve. In the face of such pressures, it is useful to remember that achieving policy changes improve outcomes for whole populations, not just individuals.

Those with little experience of direct participation in policy advocacy (perhaps due to experience of different forms of governance in other countries, or because of pervasive social exclusion experienced in this country) may find such activities daunting. With appropriate support and guidance, those who are enabled to deliver a petition to a CEO of a Primary Care Trust, attend council meetings, write a letter to the editor of a newspaper, or make a visit to the Houses of Parliament will ultimately find that familiarity with the 'rules of engagement' for each of these different activities improves their subsequent capacity to provoke change.

CASE STUDY »

Advocacy Event on World AIDS Day 2008 – African HIV Policy Network (AHPN)

The AHPN organised a training event that aimed to familiarise participants with key issues and approaches to advocacy. This was followed by an Advocacy Day which focused on a AHPN campaign called *Destination Unknown*. Meetings were arranged with MPs and their constituents while others could join AHPN representatives to visit the Houses of Parliament and arrange future meetings with their MPs. An exhibition with videos and photos was complemented by a speakers' hour with key politicians, clinicians, sector experts and people living with HIV. The event was attended by religious leaders, international and national media, human rights advocates and doors were open to the public all day. The events raised the profile of AHPN and the *Destination Unknown* campaign, and led to ongoing dialogue and cooperation among attendees. Following the event, AHPN has received requests for assistance from individual MPs on issues of HIV and continues to inform national and international policies by accumulating support and evidence to challenge policies that are detrimental to African people affected by HIV in the UK. Engaging members in practical advocacy and approaches to policy is essential to the work of AHPN.

 www.ahpn.org

16.4 ISSUES TO CONSIDER

At the moment, policy work within the sector tends to be significantly under-valued, making it difficult to prioritise its development in work-plans. The best means of circumventing this problem is to identify what core issues are most relevant to a particular agency's work, often led by the most pressing needs displayed by service users, and to begin devising a policy action plan with a few key targets in mind. The current Labour government aims to support policy interventions from community-based groups. The recent document, *Communities in control: real people, real power*, released by the Department of Communities and Local Government (2008) contains a number of initiatives and ideas to help boost community development with the aim of increasing participatory democracy and direct advocacy. This is just one example of the many resources that can help inform and guide policy intervention planning.

National agencies (such as the African HIV Policy Network or the National AIDS Trust) cannot prioritise, collect evidence for, execute and evaluate their policy interventions in isolation. The success of larger-scale interventions are reliant on information collated on the ground and passed on. This is greatly assisted when there is at least one identified individual within agencies who acts as a liaison on policy issues, and who can maintain ongoing contact with the policy officers in national support organisations. As a part of this infrastructure, agencies also need to consider devising ways for front-line staff to communicate their experiences and feedback into an organisational policy intervention plan. In the same way that there is a need for information to flow downwards with regards to campaigning strategies and support, there is also a need for a significant flow of information upwards. The documentation and sharing of information about policy intervention successes will increase success across the sector through sharing of best practice. This also helps to feed a dynamic process whereby those working on HIV policy issues at national level get to hear about the impact of their work, while those delivering services are also better able to inform future areas of policy intervention.

Given the extensive range of individuals and organisations that can become targets of policy interventions, it is also important to have a means of identifying local and national partners who will be able to collaborate. This often means looking for potential partnerships outside of the African HIV sector and collaborating with migrant, LGBT, and a range of long-term disability and equality interest groups.

16.5 OUTCOMES

Outcomes relating to policy interventions will be linked very specifically to the policy area that is targeted. The following activities may help agencies unfamiliar with this type of work to begin to engage with local and national policy developments.

- Develop and maintain an up to date contact list of: local MP's constituency office and surgery times, key local councillors, PCT sexual health and / or HIV commissioning leads, Local Authority contacts regarding social services and housing policy, LINKs contact details, and contacts in the local press.
- Maintain records of involvement in local and national policy consultations and their results, and share these with AHPN and NAT.
- Document full participation in devising any local and regional sexual health and/or HIV strategies.

Key to the intervention

Influencing policy requires recognition at individual and agency level that if you feel something would be better if it were changed, you need to commit to being a force toward that change.

16.6 MONITORING AND EVALUATION

Monitoring involvement in policy interventions (by keeping an up-to-date record of current and past activity) enables agencies to monitor their level of capacity to provide future delivery.

Evaluation of policy interventions can take on a number of forms, from desk research to action research alongside those who have undertaken interventions. Document analysis can be undertaken with a discrete number of policy and other related documents (such as newspaper coverage, minutes of public meetings, or Hansard reports, for instance) covering a specified period of time. The purpose is to assess changes in the approaches or narratives used to address a particular issue before, during and following a specific intervention.

Data can also be collected from those who commission, support, and deliver interventions in order to assess reasons for and impacts of shifts in particular policy areas.

Finally, ongoing process evaluation undertaken throughout the life of a policy intervention can help those involved to determine the extent to which the intervention is worth continuing, what opportunities might have been missed, and to amend the intervention's design and targets where this is necessary.

CASE STUDY »

Policy network consultation updates – National AIDS Trust (NAT)

Knowing about national consultations in advance is key to preparation of a thoughtful response, a need which has been identified and largely met by the regular emails distributed to members of the National AIDS Trust's policy network. Relevant government consultation documents and information about response processes across the sector, as well as opportunities for the submission of joint consultation responses are shared by email with the members of this network (who represent more than 80 agencies across the sector). Recently, feedback from network members has resulted in NAT including information about the outcomes of consultation processes, so that members are able to follow up and see the impact of their participation. To become a member of NAT's policy network, email: policyandcampaigns@nat.org.uk


 www.nat.org.uk


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