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# THE FIELD GUIDE

Applying *Making it count* to health promotion
activity with homosexually active men

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CHAPS COMMUNITY HIV AND AIDS PREVENTION STRATEGY

# PREFACE

This *Field Guide* considers a range of methods used to carry out health promotion with homosexually active men. It is a companion document to *Making it count: a collaborative planning framework to reduce the incidence of HIV infection during sex between men* (Hickson *et al.*, 2003). Like *Making it count*, this document will be reviewed every two to three years and accompanied by training opportunities. The authors welcome comments and suggestions on this document and its use. These can be sent to: chaps@tht.org.uk or mic@sigmaresearch.org.uk. "Briefing papers" that add to the content of this guide will be produced as part of the CHAPS sector development programme. These will be available periodically from www.chapsonline.org.uk.

*Making it count* describes a co-ordinated national framework to reduce HIV incidence occurring as a consequence of sex between men. It is intended for workers, managers, policy makers, legislators, health professionals or anyone with an investment in reducing HIV incidence among homosexually active men.

This *Field Guide* is written for gay men's HIV health promoters. It places the theory, goals and strategic aims contained in *Making it count* in the context of day-to-day health promotion activity. It was developed through a range of formal interviews and informal discussion with more than 40 managers and key workers with experience and expertise in specific areas of HIV health promotion for homosexually active men. It concentrates mainly on direct contact work (Chapters 3 to 7), but also considers other types of health promotion that benefit homosexually active men by influencing the structures they live within (Chapter 8).

Section one (Chapters 1 and 2) provides an overview of *Making it count* and the relationship between this document and that main framework. It outlines the key strategic aims of *Making it count* and contextualises what follows.

Section two concerns direct contact with homosexually active men. Chapters 3, 4, 5 and 6 deal with different methods of carrying out direct contact work with this population. Chapter 7 considers the different target groups within the entire population of homosexually active men. It examines how to prioritise target groups using epidemiological and needs data and how best to target different groups in various settings.

Section three (Chapter 8) addresses other types of health promotion interventions that are necessary including policy, community and service interventions. These are the interventions needed in order to facilitate direct contact interventions and attend to the broader determinants of sexual health for homosexually active men.

It is anticipated that some (NHS) commissioners would benefit from reading this document in order to further their understanding of the range of work that they could fund. However, this document is not an implementation plan for the NHS in relation to HIV incidence among homosexually active men. Rather, Terrence Higgins Trust are currently in discussion with the Department of Health concerning further work to support the use of *Making it count* as the basis for Primary Care Trusts' planning and purchasing of HIV prevention activity for homosexually active men.

**Will Nutland**
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# ACKNOWLEDGEMENTS

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# ABBREVIATIONS AND JARGON

| Letters | What they stand for | Further explanation of their use |
|---|---|---|
| AI | anal intercourse | fucking between men |
| UAI | unprotected anal intercourse | AI without a condom |
| sdUAI | sero-discordant unprotected anal intercourse | UAI between HIV infected and uninfected men |
| ExHAM | Exclusively homosexually active men | a man that has had sex ONLY with other men and not with women (in this instance, in the last year) |
| BB | behaviourally bisexual | a man that has had sex with men and women (in this instance, in the last year) |
| STI | sexually transmitted infection | infectious agents acquired during sex (including HIV) |
| | (Statistically) significant Significantly | If we had done the survey multiple times, this difference would be observed in fewer than one in a thousand of the surveys, purely by chance. In tables significant differences are highlighted in blue and bold for the highest figure and underlining of the lowest. |
| LGBT | Lesbian Gay Bisexual Transgender | Catch-all term used to describe non-heterosexual people / communities |
| PCT | Primary Care Trust | Local Authority body managing the allocation and management of primary health services |
| GUM | Genito-Urinary Medicine | Medicine concerned with the urinary and genital organs |
| LEQ | Lower Educational Qualification | Academic qualification up to and / or including O'Level or GCSE |
| HAM | Homosexually Active Man | Man who, regardless of sexual identity, has sex with another man / men |
| CHAPS | Community HIV / AIDS Prevention Strategy | Department of Health Funded partnership of voluntary organisations delivering HIV prevention initiatives to homosexually active men in England and Wales |
| GMSS | Gay Men's Sex Survey | Survey of homosexually active men's sexual behaviour conducted by Sigma Research |
| PSE | Public Sex Environment | Public Toilet or grounds such as lay-bys and parks used by homosexually active men for sexual interaction |
| | 'Class A' drug | Term in this report to describe drugs including ecstacy, LSD, amphetamines, cocaine, ketamine, heroin, free-base cocaine and GHB |

# SCENE SETTING

# SETTING THE SCENE: MAKING IT COUNT

## 1.1 OVERVIEW

This *Field Guide* outlines a range of methods and approaches used to carry out health promotion with homosexually active men. It is a companion document to *Making it count: A collaborative planning framework to reduce the incidence of HIV infection during sex between men* (Hickson *et al.*, 2003).

*Making it count* describes a co-ordinated national framework to reduce HIV incidence occurring as a consequence of sex between men of different HIV statuses. It is intended for workers, managers, policy makers, legislators, health professionals or anyone with an investment in reducing HIV incidence among homosexually active men.

This *Field Guide* is written from the perspective of gay men's HIV health promotion workers. It places the theory, goals and strategic aims contained in *Making it count* in the context of day-to-day health promotion activity concentrating mainly on direct contact work (Chapters 3 to 7). It also considers other types of health promotion that benefit homosexually active men by influencing the structures they live within (Chapter 8).

### Strategic goal of *Making it count*

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

## 1.2 WHAT IS MAKING IT COUNT TRYING TO DO?

*Making it count* asserts that HIV incidence among homosexually active men should not be seen as solely the responsibility of gay men's HIV prevention agencies, but as a national problem, the solution to which involves the mobilisation of all members of society, all services and authorities and all levels of government. *Making it count* describes a collective, national HIV prevention response which mobilises central and local government, the media, gay community organisations, health and social services, the general public, gay men and other homosexually active men themselves.

All agencies and / or individuals working to *Making it count* share the same *goal*. To meet this goal it specifies a range of strategic aims for four specific constituencies or target groups. These are homosexually active men; policy makers and legislators; the wider population and service providers. In this chapter, we list these strategic aims and briefly explain their rationale.

### 1.2.1 *Making it count* strategic aims for interventions with homosexually active men

We can identify a number of factors which influence the probability of HIV transmission during sex between men including the amount and type of sero-discordant unprotected anal intercourse (sdUAI); the incidence of condom failure during protected anal intercourse; and the incidence of other sexually transmitted infections (STIs).

Generally speaking these factors relate to the amount of knowledge and control men have over the sex they have. The more knowledge and control they have, the more likely it is that our strategic goal will be achieved. Chapters 3 to 7 in this report explore the range of methods, targeting strategies and settings used to meet these aims.

The extent to which we achieve these strategic aims is dependent on the personal and collective capacities of homosexually active men. However, homosexually active men do not exist in a vacuum. They are influenced by their social environment. Therefore, our capacity to attain these strategic aims is dependent on the actions of policy makers and legislators who make the laws that govern them; the attitudes of the general population towards them; and the actions of service providers that serve them.

These groups (policy makers, community, services) are therefore also targets of *Making it count*. Agencies working towards the goal of *Making it count* are collectively trying to influence the actions of these groups just as much as they are trying to influence the actions of homosexually active men themselves. *Making it count* therefore lists strategic aims for these three broad groups also.

### 1.2.2 *Making it count* strategic aims for policy interventions

The actions and attitudes of the wider population and the nature of services available to homosexually active men are influenced by the policy and legal environment in which they are formed. Countries with the appropriate legal and policy environment have been shown to be far more effective at combatting HIV than those who do not (UNAIDS, 2002).

*Making it count* therefore describes strategic aims that would influence the policy and legal environment in order to facilitate the active involvement of individuals, groups and services in reducing HIV incidence among homosexually active men. These changes attend to our governments' involvement in global efforts (such as an HIV vaccine); the way in which HIV services and priorities are organised within the NHS; service policies of local, police and education authorities; repeal of various detrimental legislation and an articulated governmental response to the issue of HIV amongst homosexually active men. Ways in which we can meet these aims are explored in chapter 8.

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## Strategic aims for homosexually active men

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

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

> **Aim 2a:** Reduce the number of occasions of sero-discordant unprotected anal intercourse where the infected partner is insertive.

> **Aim 2b:** Reduce the number of occasions of sero-discordant unprotected anal intercourse where the uninfected partner is insertive.

> **Aim 2c:** Reduce the proportion of condoms that fail during anal intercourse.

> **Aim 2d:** Reduce the number of times HIV infected men ejaculate into uninfected men's rectums without condoms.

> **Aim 2e:** Reduce the number of times HIV infected men ejaculate into uninfected men's mouths without condoms.

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

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

## Strategic aims for policy makers, commissioners and researchers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Making it count* is based on the understanding that a man's general health and his sexual health cannot be seen in isolation from other social, environmental and cultural factors that may act as a barrier to choice and well-being. We must attempt to make changes on all levels, from individual sexual practices to parliamentary legislation.

### 1.2.3 *Making it count* strategic aims for community interventions

Homosexually active men are everywhere. They watch television, read newspapers, use services, conduct business, work in offices and factories, take part in education, play sports, eat in restaurants, use public transport *etc*. The way that they are treated in all these settings and the attitudes and actions of the majority population, has an impact on their health in general and their sexual health in particular. In addition, the general public's attitudes towards homosexually active men will influence the drafting and repeal of laws; the development of social policy; the allocation of resources; the education of children; the quality of health and social

## Strategic aims for communities, the media and businesses

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

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

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

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

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

**Strategic community aim 6:** Gay website managers increase features of their sites that reduce the HIV prevention need of their users.

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

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

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

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

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

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

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

**Strategic community aim 14:** Gay and bisexual men increase their lay involvement in Primary Care Trusts (PCTs) and other planning and consultation structures.

services *etc. Making it count* therefore explicitly recognises a connection between the wider social determinants of health and HIV transmission.

*Making it count* sets strategic aims to increase the capacity of the community to contribute towards homosexually active men's health and sexual health (or at least not undermine it) and therefore meet the overall goal. In this context 'community' is used in its widest sense. These are the sexual partners, partners, friends and families of homosexually active men; lesbian, gay, bisexual and transgender (LGBT) organisations; businesses targeting gay men and other businesses; employers; the gay and mainstream media; religious leaders and the wider population *etc.*

The strategic aims *Making it count* lists for the community seek to mobilise the wider population to provide support for homosexually active men. They also seek to increase homosexually active men's involvement in lesbian, gay, bisexual and transgender (LGBT) community and political activities and in service planning and consultation. In addition they seek to reduce homophobic abuse. Other strategic aims seek to foster the non-HIV LGBT community sector as well as mobilising businesses targeting homosexually active men (including scene venues, print and websites) in HIV prevention activities. These community interventions are addressed in Chapter 8.

### 1.2.4 *Making it count* strategic aims for interventions with education, health and social services

The HIV prevention needs of homosexually active men come within the remit of a large and diverse collection of public services. All services intended to address the education, health and social needs of the entire population can impact on the HIV prevention needs of homosexually active men. *Making it count* lists a broad range of service providers who have an influence over HIV incidence among homosexually active men, including schools and colleges, NHS and Local Authority-managed services, police and prison services and the voluntary sector.

The strategic aims for services are intended to ensure that: all services consult with and take into account the needs of homosexually active men at the planning stage; all services monitor and improve their capacity to do so by consultation, training and involvement in research; all targeted health promotion services are appropriate to homosexually active men (including those with HIV); all generic health services are acceptable to homosexually active men and that no homosexually active man encounters homophobia when coming into contact with any health, local authority or other statutory / voluntary service (including the criminal justice and education systems). Service interventions designed to meet these aims are addressed in chapter 8.

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## Strategic aims for education, health and social services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# FIRST PRINCIPLES

When we list the aims of *Making it count*, the range and sheer magnitude of change that we are trying to bring about seems daunting. We need to be clear therefore about how such change can be brought about on various levels. We start by stating some over-riding principles.

First, *Making it count* is a framework which describes an ideal state of affairs. The strategic aims are long-term and ambitious. Like all frameworks its purpose is to give us a commonality of purpose and direct our actions towards ultimate goals.

Second, achieving the strategic goal of *Making it count* rests on the commitment of a diverse constituency of people and organisations. As such, it demands a multi-level approach. There exists no one agency or institution with overall responsibility for reducing HIV incidence through sex between men nor any single group of organisations commanding sufficient expertise, resources and respect to ensure that it occurs. Hence our collective success will depend crucially on the degree and success of our collaboration. In other words, no one agency can or should do everything and a division of the tasks set out above will be the most efficient and perhaps the only way of achieving our common goal.

Therefore, although all who subscribe to *Making it count* share the same goal, strategic aims and aims, they will not all be engaged in the same activities. This begs the question: who should be doing what?

## 2.1  THE INTERDEPENDENCE OF ACTIVITIES AND AGENCIES

The strategic aims set out in *Making it count* are interdependent. That is, one strategic aim being met in one area will facilitate the meeting of other strategic aims in other areas. For example, methods used to meet strategic aims for homosexually active men – such as detached / outreach work at gay commercial venues and public sex environments – will not be possible unless access to such venues is ensured (thus involving meeting community aims with venue owners, and service aims with local authorities and the police). The latter will be facilitated by clear policy on behalf of the police (a service aim) and changes in gross indecency legislation (a policy aim). Likewise efforts to improve local schools' sex education (a service aim) will be facilitated by the development of training packages for teachers (another service aim) and clarification regarding legislation (a policy aim).

Since our strategic aims are interdependent, so are the agencies and individuals who are trying to achieve them. That is why *Making it count* describes a co-ordinated partnership approach. No agency exists in a vacuum and most interventions they undertake should be seen in the

context of others undertaken elsewhere. Through partnership working and interdependence, the sum total of all of our activities can be multiplied. Therefore, agencies working to *Making it count* should see themselves as part of a reciprocal network of beneficial relationships with others on all levels. However, in order to ensure that such activities are maximally efficient, there is some need for central co-ordination and central support. The Community HIV and AIDS Preventions Strategy (CHAPS) is co-ordinated by a range of mechanisms and should not be seen as a top-down hierarchy, but rather as a co-ordinated collective effort. From now on, we will refer to those mechanisms which co-ordinate CHAPS as 'The national partnership' and the individual agencies which make up that partnership as 'partner agencies'.

The relationship between the national partnership and the partner agencies is reciprocal. The partner agencies take part in a range of consultation exercises and in return receive both capacity building interventions, national campaigns and access to the outputs of other agencies.

## 2.2  COLLECTIVE DEVELOPMENT / INDIVIDUAL DELIVERY

Although meeting the goal of *Making it count* is a collective effort, the delivery of interventions is carried out by a range of different partner agencies within the national partnership. The function of the national partnership is therefore to increase the capacity of individual agencies to carry out – or participate in – interventions at all levels. The expertise and development that lies behind any intervention with homosexually active men (be it training of an outreach worker or counsellor, or development of a leaflet) is collective; the delivery is usually individual. Likewise the expertise behind and delivery of other interventions to meet other strategic aims with other groups.

In order to increase their capacity to achieve their strategic aims (and intervention aims), the partner agencies can rely on statistical data and basic research assistance, national interventions, direct contact interventions offered by other partner agencies, staff training and development. In order to design their mass media interventions, intervene with general population and lobby government, the national partnership can rely on partner agencies to: take part in national research, consult on the development of national interventions and offer specialised knowledge for integration into partnership capacity-building interventions.

## 2.3 WORKING ON A LOCAL LEVEL

Working collectively makes a big difference to the way that we initiate and carry out local work with and for homosexually active men. In the past, it has been assumed that work with homosexually active men should begin with extensive needs assessments and consultations with local men which lead to the foundation of new interventions. Such needs assessments were often seen as a prerequisite for work, but paradoxically, often served as delays or obstacles.

Although they may have been necessary in the past, the development of national data sources, frameworks and resources makes such far-reaching local enquiry and planning unnecessary. First, there is sufficient national data on homosexually active men's risk behaviours and needs. Second, there is now a national framework (*Making it count*), which gives guidance for prioritising target groups as well as establishing strategic aims and intervention aims. Instead, we recommend the comprehensive use of national resources along with appropriate but limited local needs assessment in the initiation of local work with homosexually active men. The local area can be assessed under the following headings.

### 2.3.1 Local homosexually active population

*Estimate* the size of the local population of homosexually active men (see text box).

*Estimate* the proportions of your local population that are in your key target groups (see Chapter 7).

*Gather* information on HIV risk behaviour and needs from research. Sigma Research can provide you with relevant data reports about the men in your area who responded to the *Gay Men's Sex Survey* (GMSS) from 2001 onwards <www.sigmaresearch.org.uk/reports.html>

### 2.3.2 Local service networks

List the local policy makers and resource allocators (see box, next page, for potential key players).

List the local statutory and voluntary services involved with the health and social care of homosexually active men.

List the local statutory and voluntary services involved with the education, policing or regulation of homosexually active men.

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### Local population of homosexually active men – estimating size

**1.** Establish the size of the adult male population of your catchment area/s using 2001 Census data. You should decide the age boundaries of men you seek to serve (because of the way Census data is presented it is easier to take 15+ than 16+). Data is available at www.statistics.gov.uk/census2001/

**2.** The National Survey of Sexual Attitudes & Lifestyles (Johnson *et al.*, 2001) provides an estimate for the proportion of adult males that are homosexually active (actually the proportion of sexually active males aged 16 to 49 that have had genital contact with a man in the last 5 years).

- For Greater London it is 4.2% to 7.2% of adult males.
- For the rest of Britain it is 1.7% to 2.7% of adult males.

When you apply these percentages to estimate the size of your population it is useful to present the outcome as a range.

- So, if 100,000 males live in your non-London PCT then 1,700 to 2,700 are homosexually active men. If your area is urban and has a substantial gay scene and infrastructure (such as Birmingham, Brighton, Manchester *etc.*) then the actual number of men is probably at the upper end of this range. This will be especially true if the PCT spans the 'gay commercial centre' of the city. If your area has little gay community infrastructure and is predominantly rural, then the actual number of men is probably at the lower end of your estimate.
- If your area is an inner London PCT then the actual number of homosexually active men is probably at the upper end of the range. If it is an outer London PCT then your estimate is probably at the lower end of the range.

## Local policy makers and resource allocators

- NHS PCTs
- Local authorities
- Police Authorities
- MP and other political party representatives

## Local statutory and voluntary services

- NHS managed services
- GPs and primary care teams
- GUM and HIV Clinic staff
- Health promoters
- Local Authority managed services
- Youth service providers
- Gay men's service providers
- Voluntary sector services
- Switchboards / Helplines
- Education, health & social service providers
- Schools & colleges
- Police officers

## Local providers of education, health and social services

- Schools & colleges staff
- NHS managed services
    GPs and primary care teams
    GUM and HIV Clinic staff
    Health promoters
- Local Authority managed services
    Care providers
    Youth service providers
    Gay men's service providers
- Voluntary sector services
    Switchboard / Helplines
    Gay men's health providers
- Police staff
- Prison staff

### 2.3.3  Local social and sexual networks

List the commercial gay scene venues within and adjacent to the area.

List the public sex environments (PSEs) within and adjacent to the area.

List the lesbian, gay, bisexual and transgender (LGBT) social groups or networks within and adjacent to the area.

### 2.3.4  Local service spend

Obtain current statutory spend in the areas of sexual health, STI and HIV prevention, Community Partnership funds.

Obtain local strategy documentation, spending priorities, commissioning frameworks *etc*.

The initial assessment / scoping exercise outlined above is essentially a desk-based activity consisting of the compilation of lists and the consultation of various resources. It does not involve research fieldwork or community consultation.

The assessment exercise leads neatly into drafting a plan for local work. The information gathered should be used to ensure that local statutory spend is appropriate to local epidemiology for homosexually active men and that generic local services are appropriate and accessible to homosexually active men. The first target groups for local work might be local statutory service providers, NHS commissioners in Primary Care Trusts (PCTs) and GUM clinics as well as local LGBT community organisations and scene venues. In ensuring that both spend and services are appropriate, national partnership resources (such as capacity building interventions, advocacy and representation, briefing papers and research) can be drawn upon. Before starting direct contact work with homosexually active men, the most appropriate use of limited local resources might involve attempting to bring about some changes in services and community structures to facilitate service improvements for local homosexually active men.

When starting direct contact work with local homosexually active men, national partnership resources can also be drawn upon. A wide range of general and strategic tailored mass and small media resources is available (see section 2). Training and capacity-building interventions are also available (see section 3).

# DIRECT CONTACT INTERVENTIONS

# TEXT-BASED INTERVENTIONS: WRITING AND READING

Reading and writing interventions are those in which homosexually active men interact with written (and other visual) materials. A variety of reading interventions exist and they share many of the same core characteristics.

**Core characteristics include:**
- Contain words (and pictures)
- Provide information and raise awareness
- Encourage engagement with, and contemplation of, an 'issue'
- Promote other interventions

**Interventions types & settings include:**
- Adverts in the gay and HIV-specific (and sometimes mainstream) press
- Posters in gay venues (and sometimes more general display sites)
- Leaflets and a variety of support media (postcards, cruise-cards, *etc.*) in gay venues
- Newsletters, often posted direct to men's homes
- Longer interventions which are often web-based

**Writing and reading interventions vary with regard to:**
- Their style and format
- The amount of information they contain
- The proportion of the population they are intended to address
- The setting for which they were produced

We present writing and reading interventions in five broad categories: leaflets, advertisements, support media, newsletters and longer (web) interventions. The difficulty in categorising them becomes apparent though when considering how the setting can change the name of an intervention. For example, health promotion messages stuck to walls in gay venues, GUM clinics or on 'outdoor' display are normally called "*posters*" but a similar product in the gay press is an *advert* (until you tear it out and stick it on a wall). A web-site may contain a complete reproduction of an advert (as the THT site often does) or a banner advert leading to the actual advert on another web-site. In this case, the banner advert is probably best considered a support medium or knik-knak.

The question for agencies is not whether writing and reading interventions should be deployed (because invariably they should) but whether or not the agency should devote resources to their production rather than merely facilitating access to existing interventions. Irrespective of whether an agency decides to produce its own print resources or to use those that already exist, consideration of distribution mechanisms is essential (see Chapter 4).

Generally speaking, reading interventions are useful for conveying simple information and raising awareness and less useful for meeting social needs and addressing interpersonal problems. If a man's biggest problem is finding other men to socialise with, because few opportunities exist locally, giving him a leaflet is unlikely to help. However, reading interventions are useful for raising awareness or providing information where need or salience has been identified. They can involve men in a discourse and may be used in combination with other methods to supply information at a range of levels. Reading interventions can supply role models, communicate information, strategies and solutions and even reduce feelings of isolation. They can also be sources of cross-promotion, providing contact details for more in-depth interventions and communicate the brand and ethos of the producer.

In the following sub-sections we examine the rationale for the five broad categories of writing and reading interventions. We present the intervention types in the order of least to greatest length (in words) and depth (in terms of areas / concepts covered).

### 3.2.1  Why do support media – knik-knaks?

Support media – which are sometimes known as knik-knaks – are 'teaser' products whose purpose is to promote campaigns (that probably include adverts and other written interventions) or other interventions (such as a specific clinic perhaps). Knik-knaks are especially popular among outreach / detached workers as icebreakers for verbal interactions. They typically communicate the campaign's key message, use few words, carry the producer's logo and provide contact details for further information.

A variety of items can serve as support media including stickers, (A8) referral cards or cruise-cards, (A6) postcards, button badges, lollipops or other sweets, cigarette lighters, beer-mats *etc.* The key is that they are recognisably allied to, and synergistic with, each other and the interventions they promote.

A randomized control trial has shown them to improve CHAPS national campaign recognition (Weatherburn *et al.*, 2003).

## Engaging men with support media *(knik-knaks)*

A recent CHAPS national campaign *(Biology of transmission)* included press advertising, poster and leaflet production and local face-to-face work to support the national interventions. The campaign aim was to raise awareness of the properties of the rectum which make it particularly receptive to HIV infection (fragility and absorbency) and that co-infection with another STI facilitates HIV transmission when exposure occurs.

To facilitate face-to-face work two types of *knik-knak* were produced: small (A8) cards containing the campaign images and messages for use in condom packs and a bath-sponge shaped like buttocks. The sponge was chosen because it illustrated a key campaign message (rectal membrane absorbency). It also provided referral details for further information and carried the CHAPS logo.

Detached / outreach workers noted the value of these products as tools for engaging men with the national campaign (Weatherburn *et al.*, 2003).

✍ **www.sigmaresearch.org.uk/ reports.html**

Thanks to Campbell Parker and Richard Scholey (Terrence Higgins Trust)

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### 3.2.2  Why do advertising?

Advertising includes poster displays in a variety of settings including the gay (and other) press, posters in bars and in more general (outdoor) sites and even on the web. Adverts are particularly useful for engaging clients with simple information and compelling or otherwise immediate concepts. They are not particularly suited to complex or highly challenging messages because of the settings in which they are typically encountered.

### 3.2.3  Why do leaflets?

Leaflets and booklets occur in a variety of sizes, shapes and styles. They are valuable for engaging the reader in relatively complex or lengthy discourse. They can be a useful supplement to the relatively limited level of information provided in adverts. Leaflets benefit from their portability which ensures that they can be retained for reference and read at times of the readers choosing (and in private). Finally, where funds are limited, leaflets ensure that a comprehensive source of information on a topic exists which can be applied systematically.

### 3.2.4  Why do newsletters?

Leaflets and newsletters share many core characteristics and in some respects the differences between them are marginal.

However, differences are observable across a range of characteristics: newsletters tend to be larger and usually have lower production values; they tend to include a range of types of content (more akin to a newspaper) and they also tend to be distributed directly to subscribers rather than be made available more widely. Newsletters, by definition, also appear repeatedly over time and while most remain print-based, the growth of the internet makes electronic newsletters, delivered via email, feasible.

Newsletters are a useful medium for engaging individuals with the work, services, ethos or debates of an organisation and are especially common among membership organisations and those with active volunteers. Receiving a newsletter implies membership of some kind of community and therefore newsletter production and dissemination may have a community-building function.

### 3.2.5  Why do longer (or more interactive) written interventions?

This section covers a variety of less common writing and reading interventions including books and other reference material including internet pages. Its purpose is to acknowledge that leaflets, adverts, support media and newsletters are neither the only written interventions men engage with nor the only interventions that are feasible. While a

variety of books on gay men and sexual health exist, we concentrate here on the internet as the source of the most accessible and largest variety of longer written interventions.

As a setting, the internet allows homosexually active men to access targeted HIV-prevention information anonymously and in their own time and space (including in their home). The internet is a new and multi-faceted medium. It is constantly available, has a relatively low access threshold and is gaining popularity as a means of accessing sexual interaction, thus potentially placing health promotion interventions relatively close to the point of sexual contact (Weatherburn *et al.*, 2003).

Some argue that the internet is cheaper than printed interventions but such comparisons are problematic. Web-work requires significant investment in IT skills and staff time for initial design and implementation as well as on-going maintenance. The medium has other disadvantages: web-pages have to be sought by users and often require significant promotion to ensure access; the medium may be highly accessible, but it is not portable and tends to convert poorly to print; and finally, the internet is crammed with information, much of it inaccurate and out-of-date and knowing this affects users' interactions with it.

However, internet interventions are relatively easy to update when information needs revising and they offer the possibility of designing an interactive intervention of user-varied depth from raising awareness to providing substantial information. An advantage of such layering is that users can pursue the level of information they require and links to related information can be included. In addition, chat facilities and discussion boards may provide a community / infra-structural element which facilitates social and sexual networks.

### 3.3   WHERE DO WRITING AND READING INTERVENTIONS HAPPEN?

Writing and reading interventions may be encountered in mainstream, gay-specific and private settings, or all three. Mainstream settings include any site where individuals outside the target group will be exposed to the message (for example, billboards). Gay-specific settings are still public spaces but they mainly contain individuals who share some common purpose or identity (for example, a gay bar). Irrespective of where interventions are first encountered, those that are portable (leaflets, newsletters *etc.*) will also be used elsewhere.

The choice of setting for placement or display of reading interventions is influenced by at least three over-lapping considerations. The first broadly concerns the content of the intervention and its appropriateness for the envisaged setting (and to those who will see it there). The effect of placing a contentious, personally challenging or explicit message in a

*You Choose:* **Pre HIV-test discussion at the touch of a button**

The *You Choose* website is part of a multifaceted initiative designed to reduce barriers to HIV testing for gay men uncertain of their HIV status. Led by the Victoria Clinic for Sexual Health (London), the site shows how the interactive nature of the internet can enhance reading interventions.

The website (also distributed as a miniature CD-rom) aims to increase access to information about HIV testing. Taking the form of a pre-test discussion it provides men with a (private) opportunity to make risk-assessments and to consider the personal implications of HIV testing. It also provides information about the process of testing and allows users to search a database of UK HIV testing centres. In the first year the site had 40,000 hits.

The interactive nature of the internet means that information can be provided on the basis of the user's responses and men can engage with the process at their own pace and in their own homes.

✎ **www.youchoose.org.uk**

Thanks to Dr Alan McOwan (Lead Clinician and Service Director for Sexual Health, The Victoria Clinic)

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## Obscene Publications Act (1959)

It is illegal to publish material which as a whole might "tend to deprave and corrupt [a significant proportion of] persons who are likely to read, see or hear the matter contained." NAM (2003) notes text is notoriously hard to censure: "in practice the legislation is applied by having an effective blacklist of forbidden images." The legislation also contains a caveat that a potentially obscene publication might be justifiable on the basis of being for the public good; this could be argued to apply to health promotion materials.

To stay on the right side of the law:

- Consider whether the product could be argued to deprave and corrupt those who will see it (use of explicit images if for reasonable purpose such as securing attention or graphic illustration is probably defensible);

- Targeting delivery is crucial. It could be argued that even a relatively banal written HIV prevention intervention for gay men could deprave a member of the general public.

- If you are unsure, seek legal advice.

For more information about the law, HIV and sexual health promotion read The AIDS Reference Manual from NAM (26th edition, June 2003).

✎ **www.aidsmap.com**

mainstream setting may be to alienate the intended target because he feels exposed in attending to it; for the unintended viewer, the effect may be to cause offence or to reinforce negative stereotypes. Public settings are most appropriate for broadly acceptable and non-threatening topics. By contrast, targets have a greater capacity to attend to challenging issues when they feel secure. Thus, gay-specific and private settings are more appropriate for reading about complex or challenging topics. Complex messages take time to assimilate and may need to be read and re-read and therefore portable formats may be desirable.

The second major consideration in choosing the setting for placement or display of reading interventions is: which settings give greatest access to the target group? Clearly, for an individual to benefit from an intervention he must be exposed to it. The gay scene and the gay press are usually the primary settings for distribution and display of reading interventions because they give access to a high proportion of the target group. Messages which are relevant to most men should be placed in high-traffic settings or in media which are widely available. Placement of material in high-traffic settings which is relevant to only a few of those who will see it is unlikely to be efficient and may have unintended outcomes because of non-target engagement with it.

The final consideration is broadly economic – the need to reach the largest proportion of the target group in an appropriate manner within a limited budget: cost effectiveness is key. For example, more homosexually active men watch television every day than read the gay press. However, homosexually active men probably make up less than 5% of the average television viewing audience. Hence television advertising for HIV health promotion is impractical (because it reaches a disproportionately large section of the general population) and inappropriate (because the subjects covered and the style of much HIV prevention makes it unsuitable for general viewing). Therefore, the development and placement costs for television commercials might be justified in terms of coverage but would remain indefensible with regard to appropriateness.

In summary, questions of appropriateness, access and economy limit the settings used to target homosexually active men with writing and reading interventions. The table below is intended to outline some of the more common choices made – it is neither exhaustive nor complete, but is intended to illustrate the vast array of options. The boxes with crosses are not – for the most part – impossible interventions. They are usually either inappropriate or economically unfeasible. However, the ticks denote common interventions.

|  | Service Centre | Gay scene | Public space | PSE | Gay press | Internet | Mailing list | GUM clinic |
|---|---|---|---|---|---|---|---|---|
| display (read) adverts | ✔ | ✔ | ✔ | ✘ | ✔ | ✔ | ✘ | ✔ |
| distribute (read) leaflets | ✔ | ✔ | ✘ | ✔ | ✘ | ✔ | ✔ | ✔ |
| distribute knik-knaks | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| distribute (read) newsletter | ✔ | ✔ | ✘ | ✘ | ✘ | ✔ | ✔ | ✘ |
| distribute (read) longer interventions | ✘ | ✘ | ✘ | ✘ | ✘ | ✔ | ✘ | ✘ |

It is worth noting that the majority of settings that form the downward columns can be subdivided. For example, the gay press can be split into constituent papers (Gay Times, Boyz *etc.*), or you could separate out the HIV-positive press. Alternately, you can consider other specialist media (such as specific black and minority ethnic newspapers) or even the mainstream press. Similarly the internet can be divided into health promotion websites and gay commercial websites or even into their constituent parts: the world wide web, email, web-chat *etc.*

It should be apparent from the preceding discussion that considering where written interventions should be placed is not straightforward. The following questions may, however, help you to consider which setting will be most effective:

- Who is the target?
- Which settings does the target group use? (see chapter 7)
- Which of these settings might be appropriate given the content?
- Are there risks associated with other people (non-target) seeing it?
- How much money is available for placement?
- Of the appropriate settings, which are affordable or free?
- Which combination of affordable and free settings will provide best coverage?

## 3.4  WHO ARE THE TARGET GROUPS?

Almost any group can be targeted with writing and reading interventions, although which method will be most appropriate depends on the skills of the workers and the needs and capacities of the specific target group. When considering the most appropriate method for a reading intervention it is also worth considering the demographics of the intended targets and your access to those settings which they are most likely to populate (see chapter 7).

As with all health promotion interventions, those individuals motivated to maintain or improve their health will benefit most despite, arguably, being least needy. Text-based interventions clearly favour those who read; the

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higher the word-count the greater the level of literacy required to engage with it. Moreover, CHAPS evaluation data tells us that adverts are, in general, more often recognised and recalled by men living in London; men between 20 and 40 years of age; men with higher levels of formal education and men with diagnosed HIV infection (Weatherburn *et al.*, 2003).

These biases are probably common to many writing and reading interventions, especially those planned and executed on a national basis. While we would probably want most HIV prevention interventions to be biaised towards younger men, the other biases are more problematic and need to be bourne in mind when planning and executing writing and reading interventions.

Writing and reading interventions need – at worst – to be inoffensive to men with diagnosed HIV infection, even if they are targeted at men who have never tested. If their targets are men with lower levels of education, or men from black and minority ethnic groups, they need to be culturally and linguistically appropriate. This does not necessarily mean increasing representation of certain groups, simplifying concepts or lowering the reading age, but taking into account differences in value systems and personal priorities. This requires attending to relevant qualitative research.

## 3.5 PLANNING CONSIDERATIONS

Reading interventions are considered a mainstay of HIV health promotion. They ensure that health promotion can occur without face-to-face interaction and can be accessed by a much higher proportion of all men. Some suggest that reading interventions are also more acceptable to some men than more in-depth or face-to-face interventions. The question, therefore, is not whether reading interventions should be deployed, but rather what reading interventions are required to facilitate the current aims of the agency and how they should be made available.

### 3.5.1 Resourcing / capacity

Where needs are identified which are not met by existing written interventions then individual agencies might consider producing their own. However, even when this is necessary, there must be capacity for, and expertise in, writing and resource design and production. Equally, viable distribution mechanisms should be identified so that the product reaches those for whom it is intended (see Chapter 4).

Reading interventions are most cost-effectively developed by partnerships for relatively widespread distribution and a collaborative development process is also likely to maximise the utility of the intervention. However, where information is agency or locality specific, or where no appropriate product exists, resource production may be required.

A high number of written HIV health promotion materials currently exist and very many remain in circulation long after they pass their useful life. In order for a product to compete for the target's engagement it must be at least as good as those with which it competes. Design must be engaging, content must be of interest, cogent, accurate and easily understood.

### 3.5.2  Scene size and density

In areas where the gay press is available, those who read it will be exposed to national HIV health promotion advertising which generally carries basic messages. Exposure to such information is therefore beyond the control of local providers. However, whether or not such messaging is supported at a local level is a decision for local providers.

The extent of local gay infrastructure is important since it has a bearing on the settings available for the placement of reading interventions. Furthermore, in high-density gay scenes with large numbers of men, HIV prevalence tends to be greater than in smaller and less commercial gay scenes which also tend to be less sexualised. These factors will affect the kinds of messages which will be relevant locally and, to some extent, what will be considered acceptable.

Where there is little gay infrastructure or the target group of interest do not use the gay scene, reading interventions will be harder to place effectively. Here, settings such as the world wide web and electronic and postal mailing lists may be especially important.

### 3.5.3  Infrastructure

Some production processes require specialist skills and equipment and are beyond the capacity of most health promotion agencies and must be outsourced. For example, design and typesetting requires experience, creativity and skill to help the reader to engage with the content. The value of professional design cannot be under-estimated, especially for products which will be press-printed and therefore require an understanding of how design must be made amenable to press printing specifications. Similarly, commercial printing tends to be the only viable means of producing high volume reading interventions and this requires specialist skills and equipment.

Once a (portable) item has been written, designed and produced it will require delivery – from print producer to provider agency and from the agency to the setting/s for its distribution. This will require planning and resourcing.

### 3.5.4  Staffing

Developing, designing and producing reading interventions is a skilled activity which typically involves the outsourcing of some functions. The skills required are:

- Research to investigate need in order to plan the intervention and to ensure the accuracy of the information provided
- Copy writing and editing – different products and addresses require quite different styles of writing
- Briefing designers, printers *etc.* – providing clear written and verbal instructions is essential to ensure materials are delivered to budget, on time and to the envisaged specification
- Proofing – the ability to thoroughly scrutinise text to identify poor phrasing, spelling and typographical mistakes

### 3.5.5  Practice Guidelines

Before embarking on resource development there are some key questions which should be answered.

- Is there evidence of need?
- Is a reading and writing method the best way to meet the identified need?
- Does a similar product already exist and, if so, does it meet the needs identified?

If the development of reading and writing interventions is supported by evidence of need, likely to meet that need and no existing product will suffice, then development of a new intervention may be warranted. There are no absolute rules to maximise the benefit of written interventions but the following points provide some guidance.

**Inter-agency partnership working:** involving a range of peers from different organisations who have differing perspectives and different professional remits provides valuable insight into the key issues and ways of communicating them; it also secures consensus about approaches. Thus, a useful first step in the development of reading and writing interventions is to identify partners, seek their engagement and agree the terms of the collaboration. Partnerships might share decision-making, costs, expertise, practical skills *etc.* but there is no single model for partnership working and it will depend on the individual capacities of the partners. Clarity around roles, responsibilities and powers is crucial because consensus is rare. Transparency in process and clear, predetermined involvement parameters ensure that partnerships operate dynamically and manage dissent productively.

**Scoping:** An explicit brief helps those involved in the development of an intervention to stay on track and to consider whether the prototype is meeting the needs it aspires to. The document will communicate to peers the purpose of the product and the way it will be produced and used. A good brief might describe the aim/s, objectives, content, targets and intended settings for a resource (and show evidence of need).

**Lexical choices:** Written health promotion interventions should be easy to understand without patronising the reader with over-simplifications. Some argue that jargon is unacceptable. However, much jargon exists in common parlance; it would be misguided to seek an alternative unless it is more widely understood or more appropriate. Vernacular forms can be useful for tailoring information to particular groups. However, if the resource is perceived as coming from outside the group such forms can appear awkward.

**Word count:** Health promotion is rarely sexy or interesting and some communications specialists suggest that people typically spend less than a second appraising a billboard and attend to it for only a little longer (if at all) on the basis of that appraisal. It has also been said that only the first eight words of a headline ever get read; that sentences should never be more than thirteen words long; that seventy words constitutes long copy; and that posters / advertisements should only ever seek to make a single point. Whether or not any of these maxims constitutes fact is perhaps less relevant than the point that they all make: when it comes to written interventions less is usually more!

**Accessibility / readability:** long words, multiple-syllables and complex sentences all increase the level of literacy required for comprehension. Some easy measures of readability exist and copy should always be assessed against at least one of these. Ewles and Simnett (1999) describe the *gobbledygook* test which assesses text on the basis of average sentence length and the proportion of multi-syllabic words. Alternatively, Microsoft Word can apply two American readability tests on demand. Decide on the appropriate level of readability for your product and stick to it, re-writing anything that contravenes your threshold.

**Ease on the eye:** design should always enhance the product. This sounds obvious but it is all too easy to lose sight of the purpose of a product in the quest for beauty. There is a balance to be struck between increasing the appeal using contemporary design and compromising readability with complex formats. A rule of thumb might therefore be: *aspire to cutting-edge design but not at the expense of clarity.*

**Pre-testing:** ideally all products should be tested with the intended target group(s) prior to publication. Pre-testing should assess factors such as the desirability of the product, the use of imagery, the language used (register, tone, lexicon), level of comprehension, issues raised and key messages retained following brief exposure (see Weatherburn *et al.*, 2003).

**Peer review:** provides an opportunity to draw on the expertise of professionals for what it costs to print and post drafts and perhaps also make telephone calls. Whether or not funds are available for pre-testing with the end-user, seeking the opinions of others in the field might be regarded as pre-requisite.

**Borrow:** Often other resources contain copy, design, imagery, which you might want in your own product; in such cases it makes sense to borrow. Whilst authorised duplication can be regarded as flattery, plagiarism can constitute infringement of copyright. The easy way to avoid embarrassment (or worse) is to seek permission and provide acknowledgment to the originator.

**Signpost further actions for the reader:** Having engaged with your product the user may want a number of things such as more information or specific services. Sign-posting other interventions is important and allows you to develop reciprocal cross-promotion relationships with other service providers in your field / locality.

### 3.5.6 Accessibility, promotion and marketing

Developing reading interventions is the first stage in meeting the needs addressed in the product. The second is getting it into the hands of those who might benefit from it. The intended audience must be made aware of the resource and motivated to engage with it. It is essential to establish mechanisms for exposing the target group to the intervention; its availability will determine what proportion of the target group sees it. Reaching the entire audience is unlikely, but permeation of more than 50% of the target has been achieved with some adverts and about 25% with some longer written interventions (Weatherburn *et al.*, 2001 and 2003). Maximising exposure requires knowledge of the settings used by the target (see Chapter 7), creativity and careful planning.

A common complaint about many bought-in written interventions is that whilst the content is acceptable, the referral information (or branding) is inappropriate, having been developed for a different locality. If you like the product but the referral information is irrelevant why not produce a sticker with your own details on it for placement over the inappropriate information?

Even with careful planning, producing written interventions is rarely straightforward. Below are some common problems in the development (and distribution) process.

### 3.6.1 Using sex to sell products

There is little doubt that sexualised products are highly appealing and the logic of using sex-positive images to encourage individuals to engage with sexual health information makes intuitive sense. However, there are some who suggest that there are disadvantages to such an approach. The use of sexual imagery may increase uptake of a resource but might actually reduce engagement with the message itself. Another concern about the use of beautiful bodies is that they perpetuate unhelpful stereotypes. There has been a move in recent times to seek a better balance between erotic / sexualised imagery and a fairer representation of the target group.

### 3.6.2 Model release

It is essential that agencies have the right to use the images in their publications. The photographer (or illustrator in the case of drawings) typically retains the rights to reproduce and to sell their images but the model has rights too. Models should sign a release form confirming that they are of legal age; understand what and how their image may be used and detailing any payment in lieu. It is not uncommon for models to consent to pose and then to change their minds about the photographs being used (especially if they are sexually explicit or imply something about their sexual behaviour or HIV status). Without verified consent, the model is well within their rights to seek legal recourse for "unauthorized" use of an image.

### 3.6.3 Economy of scale and limited shelf life

The set up costs for commercial design and printing are considerable but the volume printed sometimes has a marginal impact on overall cost: the higher the print run the lower the unit cost. This is a compelling argument for mass production but unless there is a demand, run-on printing is uneconomical. In addition, there are costs associated with storage of surplus items. Hence, it is essential to consider the appropriate number of

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a written intervention to produce. Over-production on the basis that materials may one-day be useful is risky since content quickly becomes obsolete as information changes. Moreover, over-stocking settings with resources does not make the products more popular. Those which are surplus to current demand take up space, get spoiled and reduce the audience's interest in other information available in the same setting.

### 3.6.4  You can't please all the people all the time

The more broadly applicable a product is the blander it tends to be; a trade-off exists between breadth of appeal and depth. Not everyone will like your intervention. It will be criticised for its style or content and many will not get from it what was intended. The aim, in written interventions, should be to ensure that the greatest number of men get the greatest value. Those who an intervention serves poorly should be acknowledged and plans should be made to meet their needs in other ways.

### 3.6.5  Consultation is a difficult process

As noted above, one-size rarely fits all and those involved in the development of reading and writing interventions may disagree about the most appropriate content and style of messages. This will mean that some of those involved in resource production will argue for the inclusion of content which is ultimately excluded and for the exclusion of that which is included. Debate about methodology is crucial to best practice; approaches should be argued through and hard won but such processes are difficult. Clarity about the roles of those involved and the power they exercise can help minimise conflict.

# DISTRIBUTION INTERVENTIONS: GIVING AND TAKING

*Distribution* interventions supply sexual health resources directly to their target group. The items distributed are usually condoms (loose or in packs, with or without sachets of lubricant) or written interventions. This can be done by placing resources for men to *take* (*static distribution*) or by *giving* them directly to individuals (*interactive distribution*). *Interactive distribution* can occur either in response to a specific request from a man (ie. *reactive distribution*) or can be undertaken using a cold-selling approach (ie. *proactive distribution*).

**Taking** → *Static distribution*
(Such as providing leaflets via a rack)

**Giving** → **Interactive distribution**
*Reactive* (such as providing condoms following a request from a man in a cottage)

*Proactive* (such as handing out condoms to all men at a cruising ground)

## 4.1.1 What is static distribution?

Static distribution involves the stocking of dispensers (for condoms and usually sachets of lubricant) or racks (for written materials) which are left unattended and used by the target group at their discretion. The items are available for collection for as long as stocks remain and irrespective of the worker's presence. The role of the worker is that of delivery person and so does not actually require a health promotion specialist.

Static distribution is a relatively cheap way to ensure resources are constantly available from a specified location. Since the target must collect the resource he is also likely to be motivated to engage with it. For men who are unwilling to make direct requests for resources (perhaps because they are shy or have no suitable postal address) racks and dispensers provide a valuable opportunity to access health promotion resources.

The main disadvantages of static distribution are that stock control is difficult and it is very hard to evaluate who is collecting what. The popularity and ultimate destination of the resources and the type of men who collect them can only be inferred from the setting in which they were made available and the frequency with which re-stocking is necessary.

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### 4.1.2 What is interactive distribution?

Interactive distribution occurs in a range of settings and is usually – but not always – undertaken face-to-face. It allows workers to engage with individual clients where they find them and provide them with resources such as a leaflets, condom packs or support media (also known as knik-knaks). Interactive distribution usually occurs as part of *detached / outreach* but can also occur as part of most face-to-face interventions that rely on talking and listening (including advice, counselling and group-work). Interactive distribution can also occur via the telephone, email or internet, although this requires postal distribution.

Interactive distribution is a means of distributing resources in such a way as the destination of each item and the demographic profile of each user is available to the provider. This means that stock-use and popularity can be monitored and access to the intervention can be assessed. The method has high appeal because uptake of, and engagement with, the product is more likely given the way it is received. The activity also serves to strengthen the client's association with an issue and / or with the provider. However, interactive distribution is relatively costly because of the worker time involved.

Within interactive distribution we differentiate *reactive* and *proactive* distribution. *Proactive distribution* involves the cold-selling of an item that a health promoter wants to distribute. The actual item may be the same but the context in which it is distributed is probably very different. *Proactive distribution* is usually prioritised at the launch of new interventions or as a tool to begin a wider-ranging discussion. In contrast, *reactive distribution* involves responding to a specific request from a client. This may be a simple request for condoms in any contact, to a more complex request for information on a specific sexual health need (the safety of sucking perhaps). The key characteristic of the interaction is: the client makes the request and the health promoter responds by giving him something (he may also talk with him and offer information or advice). Since resources are only provided on request, far fewer are probably distributed overall.

While time in the field is saved, providing a reactive distribution mechanism requires promotion of the service, user-friendly systems through which clients can request products (e.g. email, web and telephone mechanisms), a system for the monitoring of requests, the packaging of orders and (usually) their posting.

An alternative form of *reactive distribution* is the development of mailing lists of men interested in receiving information by post; this can ensure wide and broadly targeted distribution of products. However, since the item sent was not necessarily specifically requested by recipients, provision is less tailored to the particular needs of the individual.

## 4.2 WHERE DO DISTRIBUTION INTERVENTIONS HAPPEN?

A range of settings might be useful for static and interactive distribution, although not all settings will be equally appropriate for both.

Some common examples of settings are:

- The commercial gay scene including pubs, clubs, saunas and even hotels, shops and gyms
- Other community settings such as lesbian and gay centres, social and support groups, HIV care services, social events, private (sex) parties and public sex environments (PSEs)
- Health service centres such as AIDS service organisations, General Practice surgeries and GUM and HIV clinics
- Direct to men's homes by post through reactive distribution and mailing lists

Static and interactive distribution schemes can supply resources directly in almost any setting where homosexually active men congregate in sufficient density. However, consent is required from those who control the setting (bar or sauna mangers or social group co-ordinators, for example). It may not be viable to staff some of these locations; for example, GP's surgeries may be appropriate sites for leaflet racks but inappropriate for talking interventions. Reactive distribution – in response to requests by men – can occur anywhere but can also take place from a service centre direct to individuals' homes by post or collection.

In areas with a limited gay community infrastructure opportunities for static distribution are more limited. Getting products into generic public spaces may require diplomacy and creativity since the existence of an appropriate setting does not automatically confer access to it. In areas where there are few opportunities to provide static distribution, interactive schemes in less formal settings (such as PSEs) may be particularly valuable, as may be reactive, centre-based, schemes. Finally, some gay men and other homosexually active men do not make use of community settings. Providing resources to them may require static schemes in generic spaces (such as GP surgeries) and interactive approaches in settings which they do use (such as PSEs).

The settings chosen for distribution interventions will depend on:

- Those available and their amenability to different types of distribution
- The group/s for whom the resources are intended
- The practicality for the provider of servicing the setting

**Direct contact interventions**

## Static distribution racks on the gay commercial scene

TRADE, a Leicester-based gay health project, operates a static distribution scheme using designer, branded leaflet racks sited in gay venues from which men can help themselves to printed information.

The racks are maintained on a fortnightly basis. A project worker goes from site to site with a box of print resources. To ensure the racks look interesting and so that regulars see a range of materials, leaflets are sometimes withdrawn and replaced with alternatives; old and tatty products are discarded along with non-health promotion resources which have been deposited there. Not only does the intervention ensure that men have access to HIV prevention materials but also provides the scene worker with an opportunity to maintain contact with venue managers and to deliver regular supplies of free condoms to the venue.

✎ **www.gaymenstrade.com**

Thanks to Nick Broderick (Manager, TRADE)

## 4.3  WHY DO DISTRIBUTION INTERVENTIONS?

Resources are provided to homosexually active men in order to meet their sexual health needs. Distribution interventions provide a system through which resources reach the target group and as such they are a mainstay of HIV prevention. The issue is not whether to undertake *distribution* interventions, but how best to do so to ensure appropriate access in an efficient and cost-effective manner.

Broadly speaking, two types of health promotion resource are distributed: written interventions and condom packs.

Condom distribution increases access to the means of preventing HIV transmission during anal intercourse. Written interventions provide information about how to maximise health (for example, by increasing knowledge about how HIV transmission can be avoided).

### 4.3.1  Why distribute condoms?

Many HIV prevention organisations have traditionally provided free condoms and water-based lubricant. The rationale is that condoms are an extremely effective barrier to HIV transmission and, in health economy terms, represent a cost-effective alternative to treating HIV and other STIs. It can also be argued that such provision sends a 'sex-positive' message and, where appropriate products are hard to come by, ensures that men have access to supplies.

However, in recent years condoms and water-based lubricants have become far easier to buy and, since many organisations now assert that standard thickness condoms are appropriate for anal intercourse, the relative difficulty in getting "extra-strong" condoms is less of an issue than it once was. Thus, the arguments for free condom provision are now, perhaps, less clear-cut than they once were (for more information on the condom-thickness debate see www.tht.org.uk/health_workers/condom_thick.pdf).

However, there are some compelling reasons for providing free condoms and lubricant to homosexually active men. Providing condoms and lubricant to gay scene venues and public sex environments puts them at, or close to, the point of usage. Condom packs also offer an opportunity to provide additional written interventions (such as instructions on correct usage or cross promotion of other services). In addition, provision of free condoms has a public relations function for the provider, sustains HIV awareness in the community and supports a condom-use culture. Finally, condoms can be regarded as a free gift and may serve to ingratiate the provider to the client; as such they can be used to encourage men to engage with health promoters in the field.

Free *condom distribution* schemes do have their drawbacks. Condoms are a costly commodity and in some geographic areas demand may outstrip funds. Further, it has been argued that the provision of free condoms can lead to a dependency culture in which men rely on free condoms. Once such a culture has been engendered it is difficult to modify – rationing supplies or charging some individuals (or venues) often leads to resentment and accusations that the provider is failing to meet the needs of their clients. However, the market for free condoms is essentially huge and, therefore, establishing parameters around provision (who are they for, under what conditions and in what circumstances) is prudent. It can be argued that only those without access to condoms (either because they are not available or too expensive) should receive them at no cost. The decision about whether condoms should be provided at all, and if so to whom and by which methods, is perhaps best taken with regard to the aims of the programme and the capacity of the provider.

### 4.3.2 Why distribute written interventions?

For those who do not seek, or require, an in-depth or specialist intervention, provision of written interventions ensures access to health information which can be read at any time and in any place of the target's own choosing. Written interventions provide the foundation for more specialist interventions and ensure that a greater number of men than could ever be reached by face-to-face interventions receive basic information. While written interventions cannot achieve all the aims of *Making it count* (Hickson *et al.*, 2003) no method can.

### 4.4  WHO ARE THE TARGET GROUPS?

A wide range of target groups can benefit from distribution interventions. The setting for distribution and the method chosen can serve either to prioritise some groups over others or can be used to ration provision. Often, however, targeting is by proxy, with available settings dictating those receiving the items rather than the intended target driving the choice of a particular setting. When planning resource distribution it is perhaps worth considering who – ideally – the resources are intended for and, therefore, which available settings will give the best access to this group (see Chapter 7).

Health promoters might choose to target particular types of men for distinct reasons such as: their proximity to the epidemic; the availability of condoms where they choose to have sex; and the likelihood that they would deliberately seek out, or could afford to purchase the resources otherwise.

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### *Safer sex* packs

The Lesbian and Gay Foundation (LGF) is a charity based in the North West of England hosting a number of lesbian and gay health and community projects including a condom distribution scheme. The scheme buys in branded packs for delivery to a wide range of settings used by homosexually active men. Distribution settings include the gay scene, GP surgeries, colleges and hairdressers.

The packs contain two condoms, two (8ml) sachets of lubricant and usage instructions and are delivered to venues for *static distribution* in dispenser boxes. Packs can also be ordered online or by telephone and received by post (*reactive distribution*).

The scheme is funded with HIV-prevention monies under contracts with local PCTs to supply 500,000 condoms and sachets of lubricant per annum; an allocation which matches demand. The success of the scheme is measured in terms of the number of packs distributed.

✍ **www@lgfoundation.org.uk**

Thanks to Alistair Gault (Manager, The Lesbian and Gay Foundation)

Many HIV infections amongst homosexually active men are associated with commercial gay scene engagement. Thus, by targeting users of the scene those men most likely to be involved in HIV exposure are reached. However, such men are also more likely to be prepared for and knowledgeable about reducing HIV transmission risks. By contrast, public sex venues (PSVs) and public sex environments (PSEs) may also attract men who do not use the social gay scene. Such men may be non gay-identified, in relationships with women or closeted and have less access to health promotion resources. Therefore, some users of PSEs and PSVs may be less likely to know the risks associated with homosexual activity and / or less well prepared to manage them. They may also be unwilling to retain condoms for fear of being found out. Deciding who to target (and therefore which settings might be used for condom distribution) will depend on the aims of the intervention.

### 4.5 PLANNING CONSIDERATIONS

Any health promotion organisation that works directly with homosexually active men should make available to them some basic printed information. Whether they should also distribute condoms and lubricant will depend on other local provision and on available funds. The issue then is not whether to undertake distribution interventions, but how?

### 4.5.1 Resourcing / capacity

For static distribution to work via 'leaflet' racks, they must be serviced regularly and consistently and the relationships with those who manage the setting in which the rack is fixed must be maintained. Maintaining a rack demands field-work which often co-exists with detached / outreach provision. However, in the absence of other field-based activity, maintaining a rack requires scheduled out-of-office time which accords with the opening hours of the rack's host. If a number of racks are to be serviced, resources will have to be carried in number, perhaps requiring a vehicle for transportation.

Centre-based reactive distribution demands client-friendly systems through which resources can be requested such as on-line and telephone ordering mechanisms. Requests must then be actioned with resources sourced, packaged for delivery and then posted / delivered. In order for such a mechanism to provide acceptable coverage it must be widely promoted, which is likely to have cost implications.

Field-based interactive distribution is generally delivered by pairs of workers and requires significant investment of staff time, both in preparatory work and subsequent delivery. If it is to take place in isolated, potentially dangerous areas (such as some PSEs), workers may require additional equipment. More detailed information about detached / outreach interventions appears in Chapter 5.

### 4.5.2 Scene size and density

A large gay scene will provide a variety of opportunities to disseminate resources using static and interactive methods. However those with most connection to gay infrastructure (regular scene users) may be those in least need of HIV prevention resources. Where there is little gay infrastructure, or the intended target of interventions do not use such venues, alternative settings will have to be explored.

Resource provision in public sex environments affords the opportunity to engage non-scene using men with health promotion materials. However, their readiness to accept printed material may be limited. If the aim of an intervention in a PSE is solely to provide condoms this could be done using a static dispenser.

### 4.5.3 Approaches

Choosing between interactive and static distribution methods will depend on the aim of the intervention, the perceived value of the resource to the target and the capacity of the provider. Where the aim is entirely focused on distribution of desirable items the most cost-effective method is likely to be static distribution. However, interactive distribution provides the opportunity for a short talking intervention and also to put into men's hands materials they might not pick up otherwise. Nonetheless, interactive approaches are costly in terms of worker time. Fewer resources are typically taken from racks and dispensers than might be given out during an interactive intervention. However, if left to help themselves, most people tend to take what they feel they need, although it is unlikely to make much impact on those who are actively avoiding their concerns about HIV transmission. Therefore, a key benefit of interactive distribution is the opportunity it affords to engage ambivalent men.

In addition to the aims of the intervention, other considerations which will affect the choice of approach are: the resources of the agency; the settings available for distribution; how tightly the agency wish to control distribution; the skills and number of staff available; and the infrastructure of the provider.

### 4.5.4 Infrastructure

All distribution interventions require sufficient quantity of the materials (condoms, leaflets *etc.*) and sufficient space for their storage. Most will also require some form of porterage to get them to the site of distribution. In some interventions this may include use of a vehicle for transporting materials and perhaps the workers who will distribute them interactively. In interactive distribution the workers will require bags for carrying materials and sometimes a stall or display-table to attract attention to their intervention once on-site. Static distribution interventions will also require racks (for leaflets) and / or dispensers for condoms.

**Direct contact interventions**

If materials are being distributed direct to clients through the mail then agencies will require systems to manage such distribution and will be required to manage clients' address details within the Data Protection Act, 1998.

### 4.5.5 Staffing

For static distribution, the main challenges arise in establishing the scheme and building the relationships necessary to make it work. This will require management and public relations skills, and sufficient grasp of likely demand to set up systems for stock purchasing and control, packing and delivery. The challenge of running the intervention thereafter requires less specific capacities, although diplomacy is important in on-going relationships with rack and dispenser hosts. Some venues are likely to be accessible only during their opening-hours and these may not be office hours. Delivery to a number of venues or over significant distances may also require dedicated transport.

Interactive distribution usually occurs as part of detached / outreach work. This is generally delivered by pairs of workers. Interactive distribution in informal settings (such as PSEs) is labour-intensive and is usually combined with talking interventions. More detailed information about detached / outreach interventions appears in Chapter 5.

If materials are being distributed direct to clients through the post then agencies will require staff and systems to manage the enquiries and subsequent distribution. This may include a dedicated point of contact for orders, packaging and posting *etc.*

### 4.5.6 Practice Guidelines

Commercial scene venues are businesses and may have concerns about allowing health promoters access to their customers – especially if this is assumed to have a negative effect on profits. In order to facilitate access to commercial venues some agencies organise schemes in which participation explicitly confers advantages to both the business and the agency and which are bound by explicit written agreements (see text box on page 75). Thus, for example, the agency might agree to provide financial support in the promotion of special nights at which the agency will have workers present; the idea being that the night will increase profits at the same time as allowing access to customers. Alternatively, the agency might agree to supply free condoms to venues which agree to host fund-raisers or to host information racks and condom dispensers. Such schemes involve venue managers in the process of health promotion and may provide the opportunity for the agency to devolve some functions (such as rack / dispenser maintenance) to venue staff. However, managing and maintaining such schemes requires investment and also reduces the opportunities of the provider to monitor and control stock.

Guidelines for maintenance of static distribution interventions are less straightforward since a lot will depend on the available sites and the agencies relationships to those who own or administer them. Condom distribution requires decisions about the acceptability and efficacy of loose supplies versus packaged portions (usually one or two condoms and sachets of lubricant) and strategies to ensure proper storage and prompt re-stocking of dispensers. Rationing of free condom supplies is also a real challenge – no free scheme has unlimited funds and in many geographic areas demand will out-strip supply. Manipulating the number of outlets distributing condoms and / or reducing the quantities supplied to each, requires careful monitoring and management. Strategies to minimise wastage and reduce related litter will also be important in some sites.

The resources provided through racks should be up-to-date, verified for accuracy and of a size which is easy to slip quickly into a pocket. Information which is visually attractive and easy to read is likely to be most valued; erotic imagery can also increase uptake (although there may be moral, political or practical reasons for not supplying highly sexualised materials; see page 16). Some racks have a poster display space which allows them to function as a display site also. Stock should be refreshed regularly and defaced resources removed. It should also be varied to maintain interest and in order to meet a range of basic information needs. Products which de-stigmatise use of the rack can be useful; items such as cruise-cards (used to exchange phone numbers) and postcards can also increase appeal.

### 4.5.7 Monitoring and evaluation

Judging the success of static distribution is neither straightforward nor very often a high priority. The number and type of condoms and / or written resources which leave a rack or dispenser can be monitored to give an indication of uptake and preferred products. A compelling but relatively simple method to assess the utility of racks and dispensers is time-sampled observation. Simply watching the rack / dispenser for an hour at a different time every day will give an insight into how it is used and how the intervention might be improved.

More substantial research and evaluation methodologies can be applied to all distribution interventions but rarely are. Surveys can be used to assess men's awareness of the products or means of accessing them and can examine reported uptake and usage. More qualitative research can examine the value men place on products, the way they are made available and their preferences for accessing resources. All these methods of evaluation require considerable resources.

## The Freedoms Condom Scheme

freedoms.org.uk is a registered charity managed by Camden Primary Care Trust. The charity operates a NHS funded, pan-London intervention to make condoms and lubricant available to homosexually active men. Supplies are free in small quantities and available at low cost for larger quantities. Free supplies are provided in packs via dispensers (static distribution) in about 85 gay pubs and clubs. Each pack contains usage instructions, two extra-strong condoms and two (10 ml) sachets of water-based lubricant. Condoms and lubricant are also available loose via dispensers in 22 saunas or backrooms.

The free scheme, funded with HIV-prevention monies, is contracted to supply 1.2 million condoms and 1.3 million sachets of lubricant per annum. Since demand currently outstrips provision, each venue receives a fixed monthly allocation. However, there are plans to increase provision by raising funds through charitable fund-raising. Camden Primary Care Trust assess their success by comparing delivery with contracted outputs.

The pay scheme (*reactive distribution*) provides larger quantities of condoms and lubricant by post (via an internet ordering service) and from selected gay-friendly commercial outlets in London.

✎ **www.freedoms.org.uk**

Thanks to Michael Veale and John Collett (The Health Promotion Service, Camden and Islington Community Health Services Trust)

### 4.5.8  Accessibility, promotion and marketing

It can be argued that most distribution interventions do not require active promotion, since men encounter them in situ on the gay scene. Well placed racks or condom dispensers will soon be discovered. Similarly advertising where outreach / detached workers will visit on any given night is unlikely to be very advantageous. However, some reactive distribution interventions require promotion. If you want to deliver condoms, leaflets, newsletters or other materials to men directly through the mail, then men need to know about such a service before they can access it – such interventions are not often grossly over-subscribed. While promotion can be undertaken via specific written interventions, it is probably more important that all other local interventions are made aware of the distribution intervention and actively collaborate by referring men to it.

## 4.6   COMMON PROBLEMS IN DELIVERY

Areas without gay-specific spaces present a dilemma in terms of what information can be supplied; for example, provision of explicit materials to a venue that either has a mixed client group or at times serves other populations is problematic. Also, in mixed spaces, men who might seek information may feel exposed by doing so. In such cases, it might be more effective to supply a variety of sexual health information targeted at a range of population groups so that accessing the information rack is unlikely to identify the sexual preferences of the information seeker. This might demand the purchase of materials for individuals outside of the service provider's target or creative partnerships between various providers.

Where condoms and lubricants are provided to commercial venues free of charge and this can be argued to enhance their operation, it is not unreasonable to expect a return for your investment. Some providers who supply free condoms to commercial outlets set out criteria for such provision which require the venue to participate in other health promotion activities. Such agreements might ensure that the business co-operates in a number of ways. For example, the venue might raise funds for the provider, grant access to workers to do other interventions or even participate in jointly planned and promoted nights which have a health promotion element.

# INFORMATION AND ADVICE INTERVENTIONS: TALKING AND LISTENING

## 5.1  WHAT ARE INFORMATION & ADVICE INTERVENTIONS?

Information and advice interventions are typically one-off, solution-focused opportunities to discuss sexual health concerns such as sexual safety, sexual (dys)function and relationships. The interventions invariably occur one-to-one. Their defining characteristics include being easy to access and (usually) client-led, that is the client dictates the topics and concerns covered. Depending on the client's concerns, the session may be a sufficient intervention; alternatively it might act as a springboard to more in-depth therapeutic (counselling or groupwork) or medical interventions (such as referral to a GUM clinic).

Advice interventions differ from therapeutic interventions (such as counselling and some groupwork) in intensity (it is usually one-off) and likely focus, which is mainly informational rather than reflexive or therapeutic. Apart from this, it shares with therapeutic interventions many basic characteristics. *Advice* interventions are usually informational but can also serve to refer into other services and / or to distribute health promotion materials. Advice interventions vary in their duration and the setting in which they are delivered. Five of the most common ways in which advice is delivered are described below. They are: centre-based advice sessions, detached / outreach interventions, helpline interventions, groupwork and webchat interventions.

### 5.1.1  What are centre-based advice interventions?

Face-to-face advice is a one-to-one, (usually) one-off, centre-based intervention. Such an intervention usually requires self-referral and an appointment. The defining characteristic is the centre rather than the community setting. Sessions can be used to address more complex information needs since they are relatively long (usually 45 minutes or so) compared to other advice interventions.

Where a client requires some form of therapeutic intervention, advice sessions should serve as a gateway to them (or even pre-assessment to them if they exist in the same agency).

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### Advice – a typical session

*Fictitious vignette based on accounts of the Advice Service at Terrence Higgins Trust Midlands (Birmingham).*

New to the city and the gay scene, Elliot was excited and frightened in equal measures and was looking for someone to show him the ropes. Having summoned the courage to pick up a gay magazine he saw an advert in it for his local gay men's project's Advice Service.

Elliot spent an hour with the adviser who helped him to voice his concerns. He talked about his fears and what he wanted out of his new life. The adviser listened, acknowledging Elliot's feelings and providing practical information where necessary. They talked about the scene, about sex, relationships and health. Leaving, Elliot felt clearer about what he wanted from his new life in the city. He took away the number of a young men's group and a leaflet about safer sex. Three months on he hasn't been back to the Service, but he knows it is there if he needs it.

✍ **www.tht.org.uk/gaymen/uk.htm**

Thanks to Matthew Keogh (Senior Health Practitioner, Terrence Higgins Trust)

**Direct contact interventions**

## Male homosexual activity and the law

**The age of consent** *in England, Wales and Scotland* is 16 years (for homosexual and heterosexual sex). In *Northern Ireland* it is 17 years.

Group sex is legal between consenting adults of any gender.

**The Sexual Offences Bill** (before parliament at time of writing) is likely to become law. The Bill does not discriminate between homosexual and heterosexual sex aiming to *"protect people from being unwilling witnesses to overtly sexual behaviour that most people consider should take place in private"* (Protecting the Public, The Home Office, 2002).

The legislation will ensure that:

1. Sex in toilets is illegal.

2. Outdoors sex is not criminal if it takes place "where one would reasonably expect not to be observed". However, a defence based upon "I did not expect to be observed" would be problematic following sex in a known cruising area.

3. Sex in a backroom or sauna is not illegal since others present are unlikely to be "unwilling witnesses" (although the venue's licensee could still be prosecuted for running a disorderly house).

☞ **www.homeoffice.gov.uk/justice/ sentencing/sexualoffencesbill/index.html**

Thanks to Martin Kirk (Senior Campaigns and Parliamentary Officer, Terrence Higgins Trust)

### 5.1.2  What are detached / outreach advice interventions?

Face-to-face advice is commonly delivered in detached / outreach interventions on the gay commercial scene and in public sex environments (PSEs) such as cottages and cruising areas.

The defining characteristic of the intervention is the setting – it occurs *in situ*, in the community. One of the main benefits is the immediacy of the intervention – men receive advice on the spot. Men can also have the opportunity to address their sexual health needs while in a sexualised environment. Typically, detached advice interventions are short (usually less than 15 minutes). Advice is usually factual or informational. The intervention can also serve to promote a new service or interventions, and / or to distribute health promotion materials (such as condoms or leaflets).

### 5.1.3  What are helpline advice interventions?

Helplines have a long history in the UK HIV epidemic and the current edition of NAM lists twenty in operation (in May 2003). Some are generic sexual health advice services (such as the Sexual Health & National AIDS Helpline), while others cater for specific communities (such as the Jewish Lesbian & Gay Helpline) or specific aspects of HIV need.

Typically helpline interactions are short (usually less than 15 minutes) and in the control of the caller (who decides who and when to telephone and what to discuss). Their defining characteristic is the setting – the telephone – the benefits of which include relative anonymity, low infrastructure (housing) costs and ease of access.

### 5.1.4  What are groupwork advice interventions?

One purpose of groupwork is to deliver information and advice and in this case it can be described as training since it concentrates on learning and skills development. However, the distinction between such groups and their more therapeutic counterparts is not easy to define or maintain since most groupwork contains both elements. In short, information / skills training groups tend to be delivered by trainers (rather than counsellors); occur with larger groups of men; and are somewhat more focused on learning and less on self-development. Unlike the other information and advice methods, training tends not to be client-led but topic-based. It has pre-ordained content and is not necessarily one-off, since a group might meet more than once. Groupwork is discussed in greater detail in chapter 6.

### 5.1.5  What are chatroom advice interventions?

Advice can be delivered via the internet in encounters in chatrooms. Such interactions do not require an appointment and can be of varying

durations and intensities. Most commonly a health educator enters (sexualised) chatrooms using a name and profile which declares his background. The worker usually then addresses clients in the room en masse to solicit questions or queries and invite individuals to open private chat windows ("pvt") for one-to-one interaction. Occasionally workers may make cold contacts or re-contacts by establishing private chat windows with clients on the basis of their username and / or profile.

The defining characteristic is the setting and one of the main benefits is the relative anonymity the internet brings. Web-chat could be described as a reading / writing intervention but since it is interactive and occurs in real time it is best considered as talking and listening (as would use of minicom or talk-and-type telephone services for men with impaired hearing).

## 5.2 WHO ARE THE TARGET GROUPS?

Easy access to sexual health information and advice is particularly valuable to men with relatively simple information needs or straightforward (factual) questions. Since such interventions tend to be marketed as 'no nonsense', they may attract those who might not consider entering more *therapeutic* interventions. They may be particularly useful for men whose concerns are not related to cultural factors (which might be better addressed in a peer context). It is also believed that men with little gay community involvement and / or non-gay identified homosexually active men may find information and advice intervention more accessible than a therapeutic intervention.

Information and advice may be useful for any homosexually active man to address his basic information and support needs. To some degree, it requires that men recognise their information deficits and have sufficient motivation to engage with addressing them. While the intervention is usually cheaper than many other face-to-face interventions, being short and one-off, it remains relatively expensive in terms of the cost per man benefitting. However, its impact on individuals is likely to be substantial and it can be used to address needs that are beyond the reach of reading interventions. No access criteria should be applied to information and advice interventions, since self-referral is key and the interaction will usually be one-off.

Detached / outreach work might be appropriate to support other interventions targeting men with higher numbers of sexual partners, for example. Likewise, men who use recreational drugs might well be targeted in certain venues. However, it remains important to consider detached / outreach work as a multi-faceted intervention whose role is to support other interventions (such as distribution or advice interventions).

## Good Practice for Helplines

**Training:** All operators should have basic counselling and information-giving skills and know how to begin and end calls. Training should also provide practice guidance and explain policy.

**On-going support:** Some calls can be very difficult. Regular, on-going (and compulsory) support and supervision sessions facilitate professional competence. Group sessions are effective and can be led by a peer or external supervisor.

**On-call support:** Having a list of staff available for emergency de-briefing / supervision following particularly challenging calls is useful.

**Boundaries around meeting callers:** It is unwise for operators to meet callers outside the service no matter how well intentioned meeting might be. To do so could compromise the safety of the operator and/or caller and damage the organisation's reputation.

**Confidentiality of calls:** There are different levels of confidentiality between operator and caller, operator and support systems and agency-wide. These need to be considered when formulating policy so that staff understand when it is and is not appropriate to share information.

**Dealing with abuse and other challenges:** It is up to organisations to determine their position on derogatory calls (e.g. verbal abuse), masturbatory calls and callers who disclose abuse of others or of themselves (e.g. self-harm and suicidal intent). Organisations should decide what might be tolerated and worked with by operators, when calls should be cut short and circumstances in which disclosure to a third party might be appropriate.

**Working with regular callers:** Regulars are a feature of Helplines. Many are working through issues via repeated calls; others are isolated, lonely or simply bored. Consideration should be given to the value – to different types of caller – of repeated calling so that it can be supported or discouraged appropriately.

✑ www.helplines.org.uk/
   tha_home_page.htm
✑ www.getconnected.org.uk

Thanks to David Keenan (Therapeutic Services Co-ordinator, The Lesbian and Gay Foundation)

**Direct contact interventions**

## Webchat

*Ficititious vignette based on Neil Frost's work with Action for Men (North Essex)*

Marco is at his desk. His computer is logged in to the local chatroom, 17 men are inside. His profile explains that he is working for a sexual health agency.

**Action4Men-Marco>** Hi Guys! How's it going in here tonight? Wots the gossip?

**RandyBugger>** Hi Marco

**VWE Jim>** Hi Marco

*A 'pvt' window pops up*

**HornyJohn>** Hello. Are you the guys who give out the condoms at the WavyHedges cruising ground?

**Action4Men-Marco>** Yeah, thats us. Did we give you some?

**HornyJohn>** No, I wanted some but there were other guys around and I didn't want 2 b seen getting any – I'm a bit shy.

**Action4Men-Marco>** Yeah – u r not the only one. Do u want us 2 send u some by post?

**HornyJohn>** Well I live on my own but I am not out to anyone so I wouldn't want anything coming through the post which gave the game away.

**Action4Men-Marco>** No prob there. All our stuff goes out in plain brown envelopes.

**HornyJohn>** Kewl. Well I would like some, but the last guy who fucked me said that the thick condoms that I had were ruining it for him – they were 2 thick and 2 small 4 him and he wanted 2 do bb. R there any thinner ones that I could try 2 get guys 2 use?

*Another 'pvt' window pops up while Marco and John are talking. Marco chats to both men separately while keeping an eye on the main room.*

**Terling22>** Hi Marco

**Action4Men-Marco>** Hiya, how's it going?

**Terling 22>** Not bad. I enjoyed the Hepatitis Party at the Wolf and Beagle last week – those people from the sexual health place were really nice – I thought I would be embarrassed but I wasn't.

**Action4Men-Marco>** Has it made you change your opinion about going to the sexual health clinic?

✎ **www.action4men.org**

Thanks to Neil Frost (Team Leader, North Essex Health Promotion)

### 5.3.1  Resourcing / capacity

Information and advice interventions should be considered viable where more basic written interventions already exist. Although they are usually cheaper than therapeutic interventions, they still require significant human and financial resources which typically restricts capacity.

### 5.3.2  Scene size and density

Outside major urban areas, the capacity to deliver most face-to-face information and advice interventions may be constrained by limited target population density and by the need for clients to travel to centres where the interventions can be delivered. In such cases, telephone-based services such as helpline or web-chat may be more appropriate. In certain geographical areas, detached / outreach work in PSEs might be appropriate where the range of formal meeting places for homosexually active men is very limited. Moreover, certain sites may prove complementary (for example, a cruising site which becomes active after a gay pub closes) and therefore open to joint interventions. Such an approach may benefit from the synergy created by an individual encountering a worker in different settings; although this will reduce the new contact rate and coverage of the programme.

### 5.3.3  Approaches

Information and advice interventions are usually promoted as an easy-access opportunity for confidential, responsive and tailored advice. The interventions tend to be solution-focused and information-oriented. In many cases, the practitioner / client relationship is less essential to the intervention than in more in-depth interventions (like counselling) although it draws on many similar skills.

Several of the information and advice interventions (especially outreach / detached work, helplines and webchat) can also serve to increase the profile of an agency, to market a new intervention or to draw attention to a particular problem, for example a local rise in cases of a particular STI.

### 5.3.4  Infrastructure

The infrastructure requirements of advice interventions will vary according to the specific methods employed. Some key requirements are detailed below.

1) **Centre-based advice sessions** will require a private room with few distractions, a secure filing system for confidential client records and, ideally, a dedicated client waiting area. Rooms might also have a panic button system for attracting attention in case of physical danger.

Reference materials should be at hand as should monitoring instruments. Any information gathered that could identify service-users should be securely filed. These interventions will also require active promotion and inwards referral. Public liability insurance is a prerequisite for all centre-based interventions.

2) **Detached / outreach** workers will generally need to be equipped with:

- Project identification cards
- Relevant written and other resources
- Contact details for other services
- Monitoring instruments, pens and paper
- A letter of agency headed paper explaining their presence and / or a letter from police acknowledging the work

In potentially dangerous locations (such as PSEs) detached / outreach workers will require security equipment such as mobile phones, attack alarms and torches and might also need their own transport. Some detached / outreach agencies also provide a clothing allowance (or clothing) to workers who deliver services to inhospitable environments (such as muddy parks). Detached / outreach workers should be adequately insured against personal accident and injury.

3) **Helplines** require at least one dedicated incoming line, a telephone (including headpiece facility) and an out-of-hours answering service. The system should be sited in a private area where ambient noise is minimal. Reference resources and monitoring instruments will be required. Any information likely to identify service-users should be securely filed.

4) **Groupwork / training** interventions will require most of the same infrastructure as centre-based advice sessions and the requisite tools for groupwork facilitation (such as pens, paper, post-it notes *etc.*). These interventions will also require active promotion and inwards referral.

5) **Web-chat** requires a computer connected to the internet (at least 56 bps) in a private area. Reference resources and monitoring instruments will also be required.

### 5.3.5  Staffing

Generally speaking, workers providing information and advice may be counsellors (qualified or in-training) or more generic sexual health promotion workers with skills transferred from other forms of direct contact work. They should have experience of face-to-face advice and good listening and communication skills. All workers should be conversant with a range of sexual health issues such as the transmission, prevention and treatment of sexually transmitted infections (including HIV). Since a key role for workers is as a referral point for other

services, it is important that they are aware of the range of services to which clients might require referral.

Detached / outreach work requires the skills described above and is normally conducted by pairs of workers to ensure personal safety and to protect the provider from accusations of misconduct during work in informal (and often highly sexualised) settings. In potentially dangerous locations (e.g. PSEs) adequate time must be devoted to preparatory work in order to maximise worker safety. Workers should know the area (including entrances and exits) well and have spent time observing how different parts of the site are used, by whom and for what.

### 5.3.6 Practice guidelines

Intoxication of the client is a barrier to effective work. Ideally clients should not be substantially intoxicated or under the influence of recreational drugs. As a low entry threshold intervention, a decision about whether or not to proceed with an intoxicated client could be taken on the grounds of the client's amenability to the intervention at that point.

Explicit protocol can protect both staff and users and should exist for two reasons. Firstly, effectively implemented *procedural guidelines* maximise the physical safety and comfort of workers whilst facilitating the provision of a standardised and consistent service. Secondly, *boundary guidelines* ensure that users receive a professional service that maximises therapeutic benefits and helps to maintain the credibility of the provider.

It should be recognised that specifying what is and is not appropriate service delivery in the form of guidelines can be interpreted by workers as a lack of confidence in their professionalism. It is important, therefore, that both parties recognise the position of the other. Workers should understand that the existence of policy is not indicative of a lack of trust and managers should recognise that most workers will deliver a professional and appropriate service whether such policy exists or not. Often the best way to ensure this is for workers and managers to develop or review guidelines collaboratively.

Workers should understand the potential consequences of violating guidelines. However, excessively stringent application of formal disciplinary procedures in response to one-off and relatively minor policy infringements may be unproductive since they reduce the trust between workers and their managers. This is detrimental to all parties because it compromises the likelihood of dialogue, reduces opportunities for mutual support and stands in the way of both individual and service development. It would be better that where violations are minor in nature, disciplinary procedures are informal and that safeguards are put in place to reduce the likelihood of their recurrence.

### 5.3.7 Safety procedures

Clear and strict policy should surround information and advice interventions to maximise their success and maintain the credibility of the provider. Such policy should address issues such as: necessary training and experience for advisors; the nature of appropriate relationships; ensuring the physical safety of clients and advisors; and the protection of client confidentiality.

Safety procedures are especially important in detached / outreach work where they are intended to protect workers from physical harm. Policy should cover worker numbers and general practice; procedure in case of threat of (or actual) attack; policy on recreational drug / alcohol use and the circumstances under which the session should be cancelled. Specific procedure varies from intervention to intervention depending on the operational remit of the organisation and the settings in which it operates.

### 5.3.8 Boundary guidelines

Since detached / outreach work occurs in informal settings, and often with men engaging in criminalised activity, many of the norms which would usually determine acceptable public and professional behaviour are challenged.

The purpose of boundary guidelines is to facilitate the delivery of a standardised and professional service that is consistent regardless of the worker who provides it, the user who receives it, or the setting in which the interaction occurs. Such guidelines describe the kind of relationship which should exist between a worker and user. As with procedural guidelines, the requirements of detached / outreach providers will depend on how and where interventions take place. However, the following boundaries are common across many organisations delivering detached / outreach work.

### 5.3.9 Monitoring and evaluation

Client-led and one-off interventions are very hard to evaluate since the needs addressed are hugely variable and there is usually no on-going contact. Moreover, the specification of aims for the intervention is often patchy and the criteria for success vary. Some would argue that, if primary HIV prevention is the aim of advice and information interventions, success should be measured in terms of a reduction in HIV exposure. However, since the intervention typically concentrates on one very specific information deficit, sexual behaviour change is unlikely to be a realistic outcome measure.

In the first instance, evaluation of advice interventions should probably concentrate on establishing the profile of its service users along basic

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## Worried a young person is at risk?

Taken from: Department of Health Publications (2003) *What to do if you're worried a child is being abused.* UK: Crown Publications.

The law regards under16-year-olds as incapable of sexual consent; an adult who has sex with a person under-16 is committing a criminal offence. In practice though, the law is more concerned with protecting young people from physical, emotional or psychological risk. If a young person tells you as a professional that they are having sex with an adult you need to consider whether they have done this because he feels at risk in some way. If you think that the individual is at risk you should discuss your concerns with them, seeking a strategy for their protection. If you think other agencies need to be involved you must seek the person's consent for this since the information is confidential. If the young person does not consent but you believe that disclosure is necessary for his protection discuss this with your line manager. You can contact your local Child Protection Team for guidance without breaching confidentiality by withholding the person's personal details.

Document all information as soon as possible (name(s), address(es), date of birth, details of those with parental responsibility, primary carer(s) and the nature of the allegation). Since allegations of abuse may lead to criminal investigations do not do anything that might jeopardise a police investigation (such as asking leading questions or investigating the allegation/s).

**Area Child Protection Committees run training for providers:**

☞ **www.doh.gov.uk/qualityprotects/ info/listofareacpcchairs.pdf**

☞ **www.doh.gov.uk/safeguarding children/safeguardingchildren.pdf**

☞ **https://www.nspcc.org.uk/ nspcc/helpline**

Thanks to Claudia Lank (Senior Solicitor, Childcare Legal Team, Bristol City Council)

**Direct contact interventions**

demographic lines (such as ethnicity, age and area of residence). This allows providers to establish whether clients are members of demographic groups most likely to be at risk of HIV exposure. Thereafter, more complex research techniques will be necessary to evaluate the outcomes of the interventions. If such evaluation is deemed appropriate it will require substantial and specific resourcing.

### 5.3.10  Accessibility, promotion and marketing

Two of these advice interventions (outreach / detached work and webchat) do not require any active promotion, since men encounter them *in situ*. However, the others require promotion. Due to its relatively high cost, face-to-face centre-based advice is unlikely to have sufficient capacity to benefit more than a very small proportion of the homosexually active men within their catchment area. However, due to the need for self-referral they are not often grossly over-subscribed, and many require active promotion in order to attract sufficient potential clients (the same is usually true of *helplines*). While this can be undertaken via specific mass or small media interventions, it is probably more important that all other local interventions are aware of the intervention and actively collaborate in referring men to it.

### 5.4  COMMON PROBLEMS IN DELIVERY

Men wanting directive advice may feel disappointed if information and advice interventions do not provide this. It is appropriate to make clear, early in the interaction (and in all promotional literature), what the client can expect from any specific information and advice intervention.

There is one compelling disadvantage to detached / outreach work: the settings it occurs in are, by definition, intended for other activities: drinking, socializing, entertainment and sex. Such conditions are not optimal for health promotion interventions. The setting is often not welcoming (for example, noisy clubs, cold and wet cruising sites, users who are intoxicated or in groups). Moreover, such spaces although public, are the sites of (sometimes intensely) private activities. Finally, interventions in such venues brings agencies in contact with illegal activities. This requires sensitivity and careful management. Liaison with various stakeholders will be required to gain access and manage these challenges. Liaison brings access to the setting and goes some way to ensuring the safety of workers. It might be necessary with: local police, local authority departments (licensing and environmental health), scene proprietors and staff. In planning liaison, it is worth bearing in mind that different stakeholders have different priorities (for example, venue managers are concerned with profit, police are concerned with public order, local authorities are concerned with health and safety).

# THERAPEUTIC INTERVENTIONS: TALKING AND LISTENING

## 6.1 WHAT ARE THERAPEUTIC INTERVENTIONS?

In this chapter we consider counselling and groupwork interventions designed to improve mental health using therapeutic and information / skills-building approaches.

### 6.1.1 What is counselling?

Counselling is an in-depth interpersonal intervention designed to promote psychological well-being through reflection. The intervention invariably occurs face-to-face and one-to-one, though couple counselling may involve the therapist and both people in a relationship. Among all talking interventions, counselling involves the longest and deepest interaction, in that it usually involves 45 to 60 minute sessions repeated over a period of time (6 to 12 weekly sessions as a norm). Counselling is a centre-based activity.

The role of the counsellor is to facilitate engagement with maladaptive thoughts, feelings and behaviour in a focused and productive way. In an HIV and sexual health context, most counselling interventions are broadly psychotherapeutic, but their theoretical basis varies according to who delivers them, and these variations have an impact on the interaction that occurs between therapist and client.

### 6.1.2 What is groupwork?

Groupwork describes a variety of interventions which are delivered to a collection of individuals with a common interest. Its purpose is to enhance psychological well-being through a dynamic and experiential process. Groups can be used to increase the capacity of the individual to deal with particular issues (developmental) or to reduce a psychological pathology (remedial). Groupwork is a centre-based activity.

Group processes are powered by the interaction of individuals with a common membership and varying perspectives and experience. The dynamic nature of groups affords an interpersonal environment for personal development which can be energetic, complex and challenging but also contained and supportive. The quality of the relationship between the facilitator/s, the client and the other members of the group is probably more predictive of success than any specific aim or theoretical basis for the intervention.

**Direct contact interventions**

Sexual health groupwork varies in its configuration and underlying purpose but has three main functions:

i) To impart information and skills
ii) To resolve psycho-social conflict
iii) To increase social capacity

Typically, groupwork delivers a mixture of these functions; the mix depending on the needs it has been configured to meet and the theoretical perspective of the provider. While the delineation of types of group and their purpose (that is skills building, therapeutic and / or social) is not clear-cut, this chapter considers groupwork which draws on therapeutic and training techniques. Those that provide social or community infrastructure (such as youth, social or interest groups) are discussed in chapter 8.

In practice, groupwork delivered to increase men's knowledge and skills may employ a range of therapeutic techniques. Similarly, therapeutic groupwork often involves information provision and typically also increases men's knowledge and skills. The choice, therefore, of what kind of groupwork to deliver will depend on the aims of the intervention (that is, primarily skills-building or largely therapeutic) and the background of the provider and / or facilitator. While acknowledging the lack of clear delineation between therapeutic and skills-building groups in practice, we describe them separately below to encourage providers to consider the aims and purposes of groupwork and the capacities that providers might require in order to deliver successful interventions.

*Training (information / skills) groups* aim to increase knowledge and develop skills with the group interaction animating the information to be conveyed. While they are also intended to increase the capacity of members to deal with particular issues (such as sexual negotiation, for example) the scope of any specific group is relatively narrow and explicit from the outset. These groups tend to be structured and relatively formal and can be described as training (as in *Assertiveness Training*, for example).

Such groups meet for a specified, pre-determined time before disbanding (anything from a single three hour session to several weekends and / or evenings over a period of weeks or months). They are led by a facilitator (or two) and cover a core curriculum with varying amounts of flexibility based on the facilitators' approach and the attending men's needs or desires.

*Therapeutic groups* are intended to deliver a specialised remedial intervention with the aim of reducing a psychological difficulty (or increasing the individual's ability to cope with the issue) or resolving maladaptive behaviours, thoughts or feelings. They have a closed

membership and have a large psychological component. The remit can be narrow and well-defined from the outset, but is not always.

Such groups meet for a specified, pre-determined time before disbanding (one weekend and four evenings over six weeks, for example). They are ideally led by a therapist (or two) and while they may cover a core curriculum they are relatively flexible and therefore amenable to attending men's needs or desires. They can be constructed as 'group therapy' but usually have some focus (for example, *getting the sex you want*). Some therapeutic groupwork is theorised and described in terms of 'behaviour modification programmes' and draws on cognitive behavioural models. Psychotherapeutic forms have also been advocated for changing behaviour by facilitating insight into unconscious processes.

### 6.2  WHY PROVIDE THERAPEUTIC INTERVENTIONS?

Therapeutic interventions are provided by sexual health promotion and HIV prevention agencies because they can reduce the likelihood that men are involved in HIV exposure. Such interventions are designed either to provide knowledge and skills which will enable men to avoid HIV exposure or to improve men's mental health in the belief that doing so will reduce their likelihood of engagement in behaviours which might be detrimental to their sexual health. Counselling or groupwork can be used to deliver therapeutic interventions, but groupwork may be more cost-effective for facilitating skills development.

#### 6.2.1  Why provide counselling?

Counselling is useful for working through a number of emotionally salient issues including addressing prior trauma (such as bereavement, sexual abuse *etc*); psychosexual difficulties (such as anxiety regarding sexual interaction); issues of sexual identity; desire and behaviour; and problematic drug and alcohol use.

In the context of limited funds and the range of other possible talking interventions, it is worth considering the topic areas best addressed in counselling. For example, socio-cultural issues such as the interaction between sexual identity and minority ethnicity might be better addressed in groups of individuals who share common experiences of the problem. Similarly, where psychological problems relate to extrinsic barriers (such as stigma or discrimination) there may be a trade-off between working with the individual to address his feelings about these factors and addressing the barrier directly via advocacy or policy interventions (see chapter 8).

### 6.2.2  Why provide groupwork?

Homosexually active men grow up (and sometimes continue to live as adults) as a dispersed minority spending little time with peers except in the context of a commercial and / or overtly sexual agenda. Through the facilitated sharing of thoughts, experiences and emotions, and more general social interaction with peers, groups can provide men with the opportunity to compare themselves to others; consider alternative perspectives; learn and share life and social skills and examine various ways of being.

Where groups of individuals recognise and value their affiliation, a bond of trust can develop between members and the group can become an arena within which social interactions develop and can be reflected upon and challenged in relative safety. Such experience can be valuable for psychological well-being and in particular for the formation of a positive self-identity and the amelioration of psychogenic problems related to sex and sexuality. Further, when individuals change as a result of exposure to a group process, it has been argued that the changes are likely to be stable and enduring because they are bound within multiple, supportive social relationships.

Groupwork can provide social, educational and therapeutic environments (and often delivers a mixture of these). Because groups are powered by social interaction, they are a productive forum for addressing social and / or cultural problems. Hence, groups may be useful for examining issues pertaining to sexual and cultural identity, sexuality, sex and relationships. They are also a good forum for developing communication skills (such as negotiation and assertive communication) and life-skills such as cruising, flirting *etc*. A recent review of reviews pertaining to the effectiveness of HIV prevention interventions with homosexually active men (Ellis *et al.*, 2003) found that groupwork was the only intervention with substantial evidence of effectiveness.

## 6.3  WHO ARE THE TARGET GROUPS?

Therapeutic interventions will benefit men who are motivated to engage with and work on intrinsic concerns and the relationship of these to overt behaviours. Training interventions are useful to those who perceive themselves as lacking in knowledge or skills and who are keen reduce the deficit. While all such interventions are relatively expensive in terms of the cost per man benefitting, the impact on individuals is likely to be both substantial and long-lived. Therapeutic interventions can also address needs that are way beyond the reach of reading and more fleeting talking interventions.

Given their considerable cost, some entry criteria should be applied to access to therapeutic interventions. Through assessment of each presenting man's needs and suitability for the intervention, counsellors and groupworkers should establish the likely value of the specific intervention for each man that self-refers. This will require refusing some men access on the basis of limited need.

It has been suggested that those men most in need of therapeutic interventions may be least able to access them because they may feel in some way disempowered or alienated from them, and are therefore unlikely to engage with them. It is fairly clear that men with lower educational qualifications and in 'blue-collar' occupations are likely, on the whole, to be less familiar with concepts of self-actualisation, and less likely to value it as a personal ideal. The same may also be true of men from black and minority ethnic populations. Debate also exists as to whether therapeutic interventions are culturally acceptable to such men and therefore whether efforts to increase accessibility to such groups is warranted (although this does present a substantial inequity in service).

## 6.4  PLANNING CONSIDERATIONS

### 6.4.1  Resourcing / capacity

Therapeutic interventions are usually prioritised only where more basic HIV prevention interventions already exist, because they require significant human and financial resourcing which typically restricts capacity. Where resources are scarce, interventions which reduce practical or informational need and which will benefit a greater number of men may be a higher priority.

### 6.4.2  Scene size and density

Outside major urban areas, access to centre-based services may be constrained by limited target population density and by the need for clients to travel to centres where counselling or groupwork could be delivered. In such cases other interventions may be more cost-efficient.

### 6.4.3  Approaches

To ensure equity and throughput, most free therapeutic interventions are short-term 'courses' ranging from around four to twenty-eight hours. Counselling sessions usually occur once a week and last forty-five minutes to an hour. Groupwork can also be delivered in short (weekly) sessions but is often run over one or more full days – or weekends.

Therapeutic interventions, whether one-to-one or in groups, can be envisaged as existing on a continuum from behavioural to psychotherapeutic approaches. Behaviour modification programmes

typically draw on cognitive approaches but psychotherapeutic forms have also been advocated for changing behaviour by facilitating insight into unconscious processes. However, the quality of the relationship between counsellor and client is often described as more predictive of success than any specific theoretical basis for the intervention.

Information and skills-building interventions can be conceptualised on a continuum, from approaches where knowledge flows in a single direction from the trainer to the group, to those where learning is directed by the group and knowledge is seen as a shared commodity. However, in practice the approach adopted may depend on the difficulty of the subject matter and the existing knowledge of the group. That said, it is generally recognised that adults learn most readily when they feel they have some control over the subject matter, the learning context and the pace of instruction. Further, adults learn best when they perceive the relevance of the subject matter and play an active part in the experience.

### 6.4.4 Infrastructure

Groupwork requires an appropriate and comfortable space with access to at least basic refreshment facilities. Beyond this, the specific practical requirements for groupwork will depend on the group's function/s.

Counselling requires a private room with few distractions; a locked filing system for confidential client records and, ideally, a dedicated client waiting area. Many counselling rooms have a panic button system for attracting attention in case of physical danger. As with all centre-based delivery, public-liability insurance is a prerequisite.

The resources required for therapeutic interventions will depend on the activities planned and the approaches of the therapist/s or facilitator/s.

### 6.4.5 Staffing

Paid staff or volunteers can deliver counselling interventions, although all counsellors require professional qualifications and on-going supervision. Counsellors should, ideally, have a *Diploma in Counselling* (or equivalent); this requires two years part-time training which includes practical work experience and supervision. However, with adequate supervision, interventions could be delivered by someone with a *Certificate in Counselling Skills* and / or *Theory* who is gaining work experience as the vocational component of training for the Diploma (or equivalent). Many of the core counselling skills are also valuable in other forms of talking interventions.

Paid staff or volunteers can deliver groupwork interventions. The facilitator in any groupwork is crucial to setting and maintaining the role and focus of the group and ensuring it is a safe and supportive

environment which promotes psychological well-being. Groupworkers are ideally skilled and experienced group facilitators with excellent communication skills and sensitivity to the needs of all participants and of the group itself. Those who deliver information / skills training should ideally be professionally trained, have experience of delivering training, an understanding of training methods and of theories of adult education. Groups with a largely therapeutic function should ideally be facilitated by (two) trained counsellors. In interventions where facilitators take on and work with the feelings of others, adequate supervision is important.

### 6.4.6 Practice guidelines

Intoxication of the client is a barrier to effective counselling and ideally clients should not be under the influence of recreational drugs or alcohol during sessions. However, where substance use is a presenting issue an abstinence-based approach may not be viable in every case.

Typically, consistent and timely attendance by clients is regarded as indicative of client suitability and amenability to the intervention. Individuals unable to maintain attendance may be considered less amenable (and therefore, to maximise efficiency, those more able to comply might be regarded as more appropriate candidates). Such a criterion may pose problems where chaotic behaviour is a presenting issue. Regardless of the criteria for attendance, it is clear that those most able to comply with the method and the manner in which it is applied are most likely to gain from it.

Clear and strict policy should surround counselling interventions to maximise their success and maintain the credibility of the provider. Such policy should address issues such as: necessary training and experience for counsellors; the nature of appropriate therapeutic relationships; ensuring the physical safety of clients and counsellors; and the protection of client confidentiality.

### 6.4.7 Monitoring and evaluation

Counselling interventions are hard to evaluate since the needs addressed are usually client-led. Moreover, in the context of sexual health counselling, the precise specification of aims for the intervention is often patchy and the criteria for success vary substantially. Some would argue that if primary HIV prevention is the aim, success should be measured in terms of a reduction in HIV exposure. However, since the intervention is typically holistic and the needs addressed client-led, sexual behaviour change is unlikely to be a realistic outcome measure.

Evaluation of groupwork interventions is limited by some of the issues raised above, but the aims are more likely to be specific and predetermined (especially in training groups). Hence, consideration of the

### Guidelines and boundaries for groupworkers at GMFA

GMFA recognise the importance of practice guidelines and professional boundaries for maximising the therapeutic value of their groupwork interventions. However, they also acknowledge that making stringent demands on unpaid facilitators may reduce the number prepared to volunteer and that the organisation has little power of sanction against errant facilitators (except to rescind their involvement entirely). A tension thus exists between setting down largely unenforceable policy and the need to ensure professional service delivery. However, by emphasising to groupworkers the supervisory mechanisms and organisational structures within which groupwork is provided the policy appears to facilitate professional practice without requiring threat of formal sanction (such as the disciplinary proceedings usually invoked in cases of misconduct in paid employment).

✍ www.metromate.org.uk

Thanks to James Bensley (Project Worker – Training Group, GMFA)

group process and the extent to which participant's feel it has met the stated aims is one relatively simple mechanism for evaluating the process and may be used to reflect on components of the intervention and the skills of facilitators.

In the first instance, evaluation of therapeutic interventions should probably concentrate on establishing the profile of service users along basic demographic lines (such as ethnicity, age and area of residence). This allows providers to establish whether clients are members of demographic groups most likely to be at risk of HIV exposure, and if not, for changes in the recruitment procedures to be made.

Thereafter, more complex research techniques will be necessary to evaluate the outcomes associated with the intervention. If such evaluation is deemed appropriate and desirable it will require specific resourcing.

### 6.4.8 Accessibility, promotion and marketing

Due to their high unit cost, therapeutic interventions are unlikely to have sufficient capacity to benefit more than a very small proportion of homosexually active men within their catchment area. In Greater London, for example, in any given year HIV-funded therapeutic interventions have the capacity to address the needs of 1-2% of all homosexually active men.

Due to the need for self-referral, many therapeutic interventions are not grossly over-subscribed, and many require active promotion in order to attract sufficient clients. While this can be undertaken via specific written interventions, it is probably more important that all other local interventions are aware of the service and actively collaborate in referring men into it. This includes all other talking interventions such as outreach and detached work, helplines and staff at GUM clinics.

### 6.5 COMMON PROBLEMS IN DELIVERY

Groups are most effective when their identity and role are clear. It is, therefore, important that all of the members of a group feel able to contribute to its identity and that all recognise and understand its broad function.

In the absence of experienced and competent groupworkers or counsellors, the efficacy, safety and ethics of counselling and groupwork provision can be questioned. Interventions which have a large therapeutic element are best convened by those with professional training and accreditation; while that may not be possible in all groupwork it remains the ideal.

Men wanting directive advice may feel disappointed when counselling does not provide this. It is appropriate to make clear, early in the process, what the client can expect from counselling sessions. Similar problems may arise in groupwork when facilitators do not provide answers – participants may feel that workers are abdicating their role if they are encouraged to reach their own conclusions and make judgements they do not feel equipped to make. Facilitators should be aware of this and clear with the group about what they can and cannot provide.

Since the relationship between client and practitioner is paramount, counsellors / facilitators will not be able to work equally well with all clients. Thus, when a therapeutic intervention appears unproductive it may be individual differences that obstruct success in the specific context, rather than in the intervention *per se*.

Counselling interventions are a useful way to reduce the anxiety associated with structural deficits such as a lack of family support, gay social infrastructure or appropriate health services. Indeed, where this results in or exacerbates mental health problems, counselling may be especially appropriate and valuable. However, such problems can also be addressed by structural interventions (such as policy interventions) which reduce the deficit for a larger number of men.

## Monitoring access to groupwork and counselling

Sigma Research collaborates with providers of groupwork, counselling and other face-to-face interventions to assess the demographic profile of the men receiving services through the London Gay Men's HIV Prevention Partnership (LGMHPP). The mechanism provides details on the profiles of the men who access interventions and allows providers to assess their success in targeting specific groups. The questionnaire is a small, fold-over and self-seal card which men can return via Freepost (or providers can gather up and return directly). It does not measure outcomes associated with specific interventions. The access questionnaire covers 8 core descriptive variables:

1. Local authority of residence
2. Gender of sexual partners in previous year
3. Number of male sexual partners in previous year
4. Educational qualifications
5. HIV testing history
6. Age
7. Ethnicity
8. Drug use in the last year

☞ **www.sigmaresearch.org.uk/ downloads/card01.pdf**

**Direct contact interventions**

# TARGETING AND TARGET GROUPS

**WHAT IS A TARGET GROUP?**

When we define a group of any kind, we are choosing to divide up a population according to a set of criteria that are often essentially arbitrary. It could be age (people over 65 years old), gender (women) or ethnicity (Black Carribean people), or all three (Black Carribean women over 65). An almost infinite set of criteria can be used: political party membership (Green party members), beliefs (Hindus), causes (anti-war protesters) or earnings (people on low incomes). When we divide up a population in this way, we are constructing groups.

Population groups are defined for a range of reasons. Generally speaking, they can be self-defined or other-defined. A self-defined group is one which has a consciousness of itself as different from the general population. Often this sense of difference is contextual. For example, a person belonging to a certain national, faith or ethnic group will only become sufficiently aware of and interested in his or her difference when they leave an area where they are in the majority. Ethnic minority or migrant groups are good examples of a self-defined group. An other-defined group is one which is defined solely because someone else has an interest in them. A good example of these are advertisers' target groups – DINKs (Double Incomes No Kids) – who will not self-define as such but have been created as a marketing target. Population groups are only defined when there is someone with a sufficient interest and influence to make the definition – whether they are from within the group (self-defined) or outside (other-defined). For our purposes, it is helpful to distinguish three types of population groups: *identity groups* and *interest groups* which are both self-defined and *needs groups* which are other-defined.

## 7.1.1 Identity groups

Identity groups are self-defined and consist of individuals who feel a sufficient sense of difference from others and a sufficient sense of similarity with each other so that it affects who they feel themselves to be. If this difference is ethnic or racial (as in the case of Black and minority ethnic groups), membership of the group can be a matter of birth. If it is around sexuality (as in the case of gay men), membership is a matter of feeling a sense of belonging. Identity groups also include those with certain religions and beliefs.

## 7.1.2 Interest groups

Interest groups are self-defined and consist of individuals who gather around a particular interest, grievance or concern. They invariably include

identity groups, but such groups only become interest groups when they mobilise around their commonality (therefore an interest group might be members of an ethnic minority fighting racial discrimination or gay men campaigning for partnership rights). Moreover, one does not need to share an identity to share an interest. Interest groups are also defined around political affiliations or causes (such as human rights groups) or interests and hobbies (such as the Ramblers Association).

### 7.1.3  Needs groups

Needs groups differ in that they are other-defined. They are defined by those who are interested in bringing about social change and generally relate to a perceived or assessed need among a group. A good example of this is the identification of Black Carribean boys by researchers and policy makers as being in particular need around educational attainment. Although certain boys may be aware of their own need in this respect as might certain parents, the need is articulated and addressed from without, by researchers, policy makers and leaders in Black communities. Moreover, policy makers wish to prioritise this group because they are concerned with equity and / or they know that a successful intervention will result in a greater overall improvement in educational standards than if they intervened on any other group. Therefore, although it is generally in the interests of those within the needs group, the group is identified because interventions with this group fit a broader policy imperative.

Needs groups can be coterminous with both identity and interest groups. For example, members of an ethnic minority probably constitute an identity group and may constitute an interest group when they organise politically around their identity. They may also be a needs group when government identifies, say health inequalities among different Black and minority ethnic groups and introduces policy to redress these.

The distinction between identity, interest and needs group is useful when considering gay men and other homosexually active men. Homosexually active men form a needs group in relation to HIV prevention and sexual health promotion. Although the population contains gay identified and bisexually identified men (identity groups) who may campaign around gay rights (interest groups), it is defined around a behaviour (sex between men) which has an epidemiological significance (HIV and other STIs). Moreover, the needs group contains behaviourally bisexual men with heterosexual identities who cannot be defined in terms of an identity or an interest group. Therefore, the needs group/s are identified from without in order to meet broader political imperatives, particularly the reduction in HIV incidence.

We also identify needs sub-groups within homosexually active men. For example, when we design interventions for the needs sub-group Black gay men, we are interested in them because they are more likely to be

involved in HIV exposure than other homosexually active men. This said, there are likely to be factors associated with the Black identity group and their Black interest group which will mediate their ability to determine their own sexual health or HIV prevention strategies. More often though, needs groups are defined solely in relation to the priorities of the targeter. In this case, the men in this group will have little or no sense of belonging to a group (such as men who have never tested for HIV).

In summary, a needs group has the following characteristics:

- They are *defined from without* in relation to a broader policy or practice imperative.
- They are defined because they *show greater need* or intervening with this group will bring about a disproportionate gain.
- They are defined solely in relation to an *aim*. That is, the group is defined in order to carry out an intervention with them.

*Making it count* is focussed exclusively on needs groups as opposed to identity or interest groups. That is, we target specific groups of homosexually active men not because they share an identity or even an interest, but because doing so allows us to meet our aims. In the remainder of this section, we will cover the process by which *Making it count* identifies needs groups, list the groups identified and suggest ways of prioritising them.

## 7.2  IDENTIFYING NEEDS GROUPS

Needs groups are identified through annual detailed analyses of sexual risk behaviour and HIV prevention needs in the general population of homosexually active men. Over time, a number of dimensions have been identified around which needs and risk behaviour vary. That is, men's sexual risk taking and the nature of their HIV is influenced by:

→ Their age
→ Their educational qualifications
→ Their ethnicity
→ Their HIV testing history and HIV status
→ Their numbers of male sexual partners
→ The gender of their sexual partners
→ Their relationship status
→ Their history of sexual assault/abuse
→ Their recreational drug use

The remainder of this section comprises an individual discussion of each of these dimensions, drawing on the cumulative data collected annually through the national *Gay Men's Sex Survey* since 1997. Dates in brackets refer to the year the survey was undertaken rather than the publication date of the report.

Each of the discussions that follow examines what is known about HIV risk behaviour, HIV prevention needs and factors which inform how we might go about meeting need.

In order to help health promoters consider how to target specific groups each section concludes with a listing of what is known about the setting use / activities of the group. In the setting use tables, bold cells indicate which group are most likely to use the setting and cells where the number is underlined indicate which men are least likely to use the setting. If there is no bold or underlining on a row, there is no statistically significant difference across the groups.

### 7.2.1  Age

HIV prevention need varies substantially by age. While all age groups have needs, the needs of men over 50 are very different to the needs of men under 30. For our current purposes, we divide the population into three age bands: 14-29; 30-49; and 50 or over.

The needs of men under 30 are substantial, especially in relation to sero-discordant unprotected anal intercourse (sdUAI), condom use, and knowledge of HIV risk and its management. Men under 30 have far more sex than men in other age groups and as a consequence they have more anal intercourse. As a consequence unprotected anal intercourse (UAI) and sero-discordant UAI (sdUAI) is most common among men in this group. Men under 20 are most likely to have receptive and insertive UAI with an unknown status partner and to take ejaculate in the mouth. This suggests that exposure to HIV during sex with a partner not known to be positive is more common among younger than older men (2001). This problem is exacerbated by younger men's expectations of disclosure of HIV infection. Men under 20 are most likely to expect an HIV infected man to disclose prior to sex and most likely to assume a man is HIV negative if he does not disclose he is positive (2001).

Men under 20 are most likely to wear a condom for anal intercourse but also to have engaged in most of the behaviours that contribute to condoms failing. They therefore are also most likely to experience condom failure (2001). They are also most likely to express difficulties obtaining condoms.

Men in their 20's are least likely to test for HIV. They are least likely to know about anti-HIV treatments (1997) or the range of sites for HIV testing (1997). They are also most likely to be ignorant about gonorrhoea and other STIs (2000).

Younger men are much more likely to experience hate crimes and rape than older men (1997, 1998). Also, they are more likely to report loneliness (1999) and a lack of assertiveness (2000). Finally, men under 20 are most

### Gay Men's Sex Survey

| Survey | Publication |
| --- | --- |
| 1997 | Hickson F, Reid D, Weatherburn P, Henderson L, Stephens M (1998) *Making data count: findings from the National Gay Men's Sex Survey* 1997. London, Terrence Higgins Trust. |
| 1998 | Hickson F, Weatherburn P, Reid D, Henderson L, Stephens M (1999) *Evidence for change: findings from the National Gay Men's Sex Survey* 1998. London, Sigma Research. |
| 1999 | Weatherburn P, Stephens M, Reid D, Hickson F, Henderson L & Brown D (2000) *Vital statistics: Findings from the National Gay Men's Sex Survey*, 1999. London, Sigma Research. |
| 2000 | Hickson F, Reid D, Weatherburn P, Stephens M, Brown D (2001) *Time for more: findings from the National Gay Men's Sex Survey* 2000. London, Sigma Research. |
| 2001 | Reid D, Weatherburn P, Hickson F, Stephens M (2002) *Know the score: Findings from the National Gay Men's Sex Survey*, 2001. London, Sigma Research. |

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likely to want more information about sexual health topics (2001).

The probability of involvement in sdUAI decreases with increasing age in men aged between 30 and 49 years. This may be due to increases in proportions who are testing and consequently diagnosing infections. HIV testing increases to a peak among men in their 30s (2000). Men aged 35-44 are most likely to test positive for HIV (1999) with most men acquiring HIV infection under the age of 40 (2000). Not surprisingly, for those who do not test positive, having a positive partner becomes increasingly common with increasing age as does personally knowing someone with HIV (2000). Men over 40 are most likely to report an illness, disability or health problem and are most likely to self-rate their health as *not good* (2001).

The probability of involvement in sdUAI increases again in **men over 50** (1999) whilst HIV testing becomes less common (2000). Moreover, the men in this group report finding it hard to stick to safer sex (1997) and report a need for greater sexual assertiveness (1998). General health continues to decline as men get older (2001).

The table below presents the setting use of men in different age bands.

| % done activity in the previous month (2001) | Age group | | | | |
|---|---|---|---|---|---|
| | **<20** | **20s** | **30s** | **40s** | **50+** |
| Went to a cruising ground | 18.3 | 21.8 | 28.1 | 28.8 | **31.8** |
| Went to a cottage | 7.7 | 11.9 | 16.7 | 19.7 | **23.1** |
| Went to a backroom/sex club | 5.9 | 9.8 | 14.1 | **16.1** | 14.1 |
| Went to a gym fitness/club | 29.2 | 31.6 | **34.1** | 26.5 | 17.7 |
| Went to a GP (General Practitioner) | 33.7 | 29.9 | 30.0 | 32.6 | **36.8** |
| Went to a sexual health clinic | 7.8 | 10.4 | **14.5** | 12.6 | 10.9 |
| Went to an AIDS organisation | 2.4 | 4.8 | 7.7 | **8.2** | 7.5 |
| Looked at the HIV positive press | 7.2 | 14.0 | 19.6 | **20.2** | 18.3 |
| Went to a gay Pride type event | 14.3 | **19.8** | 17.6 | 14.8 | 11.2 |
| Looked at the gay press | 55.0 | **69.3** | 69.2 | 66.9 | 67.8 |
| Went to a gay pub | 60.4 | **74.6** | 69.6 | 63.5 | 54.7 |
| Went to a gay club | 54.9 | **64.7** | 53.7 | 42.0 | 28.8 |
| Went to any gay pub or club | 64.3 | **76.8** | 71.9 | 65.8 | 58.4 |
| Went to a gay social group | 21.1 | 11.8 | 11.0 | 14.8 | **25.1** |
| Went to a gay community centre | 9.3 | 5.7 | 5.3 | 5.8 | **10.3** |
| Went to a gay sauna | 6.2 | 12.3 | 19.9 | 23.4 | **25.6** |
| Used the internet | **93.4** | 91.9 | 86.7 | 82.1 | 67.8 |
| Phoned a gay helpline | 2.8 | 3.6 | 3.1 | 2.5 | 2.7 |
| Phoned an HIV/AIDS helpline | 2.8 | 5.1 | 6.8 | 9.0 | **10.6** |
| Volunteered for a gay or HIV organisation | 1.3 | 1.8 | 1.8 | 1.2 | 1.0 |

Younger men are more likely to use non sexual commercial scene venues and the internet while older men are more likely to use commercial sex venues and public sex environments.

### 7.2.2 Education

Data regarding formal education is compelling and points clearly to elevations in need in all areas for men who have the lowest educational qualifications.

Men with less formal educational qualifications are more likely to be involved in sdUAI than men with higher educational qualifications. They are more likely to have both regular and casual AI and UAI partners (2000), less likely to have concordant UAI only and more likely to have known discordant UAI (1998, 1999).

Men with lower educational qualifications are less likely to test for HIV than their middle or higher educated counterparts. But among men testing for HIV, testing HIV positive is more common among men with lower educational qualifications (1997, 1998, 1999, 2000, 2001).

Although men with lower educational qualifications are more likely to test positive, they are not more likely to think they have undiagnosed HIV infection. However, they are less likely to know someone who has diagnosed HIV and most likely both to expect a positive man to disclose prior to sex and to assume a man is HIV negative if he does not disclose otherwise (2001).

Men with lower educational qualifications have greater problems accessing condoms (2000) and although they are less likely to use a condom, they are slightly more likely to experience failure when they do (1998). More recently however, we have found that the men in the middle education group are experiencing slightly more condom failure (2001).

Men with lower educational qualifications are in greater need of knowledge about HIV transmission, condom use and GUM access (1998). They are also in greater need as regards managing regret over homosexual attraction and having control over their drug use (1999). They also report finding it harder sticking to safer sex (1997). Finally, they are most likely to report long-term illness or disability and to self-rate their health as not good (2000).

In seeking to target men with lower educational qualifications, we are compelled to mobilise social categories such as class, gender and political identity. It is necessary to investigate how these factors relate to risk in order to make sense of this target group.

There is a long established relationship between education, poverty and health. People from lower socio-economic and educational backgrounds have higher overall morbidity and a shorter life expectancy than the rest

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of the population. This relationship has been interpreted in different ways by different political systems and governments. The current popular theory is that people from such backgrounds are socially excluded. That is, they lack the personal and collective capital to create the conditions necessary for optimising their own health. The remedial intervention is therefore twofold. First, interventions should seek to equip people with the means to increase their social capital. Second, processes of decision-making mechanisms should be changed in order to be made less exclusive.

The persistence of the relationship between ill-health and socio-educational status into gay communities challenges many of our assumptions about homosexually active men. The capacity to 'come out' and take on a gay identity is often seen as a sign that the individual has the capacity to determine his own health and well-being. That is, to be gay is to be empowered. Moreover, we tend to assume that no matter what an individual's background is, when he comes out he has access to a range of support and development services which will increase his capacity to determine and improve his health. This is clearly not the case. Less well educated men engage in more risk and are more likely to become infected when they do.

| % done activity in the previous month (2001) | Education Group | | |
|---|---|---|---|
| | Low | Medium | High |
| Went to a cruising ground | 27.4 | 21.5 | 26.5 |
| Went to a cottage | 16.5 | 12.7 | 15.7 |
| Went to a backroom/sex club | 9.7 | 9.8 | 15.1 |
| Went to a gym fitness/club | 21.5 | 27.0 | 38.1 |
| Went to a GP | 33.8 | 32.6 | 28.7 |
| Went to a sexual health clinic | 11.3 | 10.8 | 12.5 |
| Went to an AIDS organisation | 5.9 | 5.1 | 7.0 |
| Looked at the HIV positive press | 15.1 | 15.2 | 17.6 |
| Went to a gay Pride type event | 15.3 | 17.4 | 18.3 |
| Looked at the gay press | 62.4 | 66.3 | 71.1 |
| Went to a gay pub | 66.3 | 67.9 | 69.6 |
| Went to a gay club | 54.3 | 54.7 | 53.0 |
| Went to any gay pub or club | 69.3 | 70.2 | 72.2 |
| Went to a gay social group | 14.6 | 14.4 | 13.8 |
| Went to a gay community centre | 6.0 | 6.0 | 7.0 |
| Went to a gay sauna | 15.8 | 14.6 | 19.3 |
| Used the internet | 80.6 | 87.2 | 91.0 |
| Phoned a gay helpline | 4.0 | 3.3 | 2.5 |
| Phoned an HIV/AIDS helpline | 4.8 | 4.9 | 8.6 |
| Volunteered for a gay or HIV organisation | 2.0 | 1.5 | 1.4 |

The table above presents the setting use of men in education groups. Less well educated men are more likely to use public sex environments, while better educated men are more likely to use commercial sex venues. Less well educated men are more likely to use generic health services and telephone interventions, whereas better educated men are more likely to access gay and HIV organisations.

### 7.2.3 Ethnicity

The data on ethnicity is inconclusive; more investigation is required to inform our understanding. However, there are recurrent and consistent differences between all ethnic groups in terms of likelihood of involvement in sdUAI. In terms of HIV testing, Black British men (which includes Black Africans, Black Caribbeans and Black Others) are most likely to test for HIV, and in two years (1998 and 2001), more likely to have tested positive. This was observed as a non significant trend in other years (2001).

Condom use and experience of condom failure were equally common in all ethnic groups. Access to condoms was more often a problem among Asian men. This group also showed increased need for knowledge of STIs and sexual health matters. Finally, White men were most likely to report a current health problem, illness or disability and most likely to rate their health as not good (2001). In spite of the lack of conclusive needs data, there is sufficient evidence to suggest that even if ethnicity does not affect the severity of need, it is likely to affect the specific nature of need or the experience of risk; further research will inform this discussion.

Men from Black and minority ethnic backgrounds are unique among our target groups in that they are part of pre-existing highly identified groups with whom they often share a common geographical origin, a common experience of migration, common religion and language among other cultural norms. To a greater or lesser extent, they share a common experience of discrimination (homophobia and racism within their communities and homophobia and racism outside) as well as economic disadvantage and social exclusion. With the possible exception of men from Caribbean backgrounds, ethnic minority status is not associated with greater or lesser sexual risk for gay men and other homosexually active men. Therefore, our sole concerns as programmatic health promoters are: how cultural factors and economic or social exclusion mediates both the *nature* of risk behaviour and *amenability* of men from the target group to our health promotion interventions. It is beholden on us therefore to create both culturally appropriate health promotion interventions and reduce structural inequality associated with ethnic minority status which may facilitate increased involvement in sexual HIV exposure.

The table below presents the setting use of men across ethnic groups.

| % done activity in the previous month (2001) | Ethnic group | | |
|---|---|---|---|
| | **Asian** | **Black** | **White** |
| Went to a cruising ground | 25.7 | 32.3 | 27.1 |
| Went to a cottage | 14.8 | 22.5 | 9.8 |
| Went to a backroom/sex club | 16.6 | 16.9 | **20.6** |
| Went to a gym fitness/club | 35.8 | 36.2 | **48.9** |
| Went to a GP | 35.8 | 32.3 | 26.3 |
| Went to a sexual health clinic | 17.3 | 9.9 | 16.0 |
| Went to an AIDS organisation | 6.9 | 12.4 | **22.6** |
| Looked at the HIV positive press | 22.5 | 18.9 | **29.5** |
| Went to a gay Pride type event | 23.1 | 20.0 | 13.4 |
| Looked at the gay press | 72.5 | 67.2 | 73.6 |
| Went to a gay pub | 75.0 | **76.7** | 74.7 |
| Went to a gay club | 64.1 | 60.4 | **70.7** |
| Went to any gay pub or club | 77.2 | 77.6 | **80.2** |
| Went to a gay social group | 19.3 | **20.5** | 19.1 |
| Went to a gay community centre | 11.1 | 9.3 | **12.1** |
| Went to a gay sauna | 18.6 | 20.9 | 20.6 |
| Used the internet | 87.9 | 86.4 | 82.1 |
| Phoned a gay helpline | 6.0 | **6.2** | 1.1 |
| Phoned an HIV/AIDS helpline | 10.9 | 7.8 | **18.1** |
| Volunteered for a gay or HIV organisation | 2.2 | 3.1 | 0.0 |

White men were more likely to use HIV/AIDS service organisations. Asian men are least likely to use many of the settings listed.

### 7.2.4 HIV testing history & current HIV status belief

There are a variety of ways of conceptualising individual men's HIV status. The two most common are HIV testing history (whether a man has tested positive, tested negative or never tested) and current HIV status belief (whether a man *thinks* he is: *definitely negative; probably negative; probably positive; definitely positive; does not know*).

At the level of population monitoring HIV testing history is the best indicator of HIV infection status. However, at the level of individuals, HIV testing history, current status belief and actual infection status are not the same thing. Although past testing history clearly influences current status belief, it does not determine it.

HIV testing history has been a compelling and consistent relationship with sdUAI need, condom failure need and HIV prevention need. Men who have tested for HIV are more likely to engage in AI and UAI than men who have never tested (1998) and more likely to engage in UAI with men they know

to be positive (2001). Men who have tested positive are more sexually active overall than men who have tested negative and those who have never tested. They have more sexual partners overall, are more likely to have both regular and casual partners and have greater numbers of UAI partners than those who have not tested positive (1998). Men who have tested positive are more likely to be involved in sdUAI than men in the other two testing groups (1998, 2001). Men who have tested are more likely to experience condom failure than men who have not (1998) and men who have tested positive are most likely to have experienced failure (1999).

Men with diagnosed HIV infection suffer disproportionately from psychological morbidity and sexual dysfunction (Castellon *et al*, 2000). This affects their sexual health and their ability to negotiate sexual risk (Gore-Felton *et al,* 2002).

Men who have never tested for HIV are most likely to expect a positive man to disclose prior to sex and most likely to assume a man was HIV negative if he does not disclose he is positive (2001). They are also most likely to want more information about sexual health topics (2001).

The table below presents setting use by men of different testing histories.

| % done activity in the previous month (2001) | HIV testing history | | |
|---|---|---|---|
| | Never tested | Last test negative | Tested positive |
| Went to a cruising ground | 21.6 | 28.2 | 34.4 |
| Went to a cottage | 12.8 | 17.2 | 18.5 |
| Went to a backroom/sex club | 8.6 | 14.5 | 23.7 |
| Went to a gym fitness/club | 26.4 | 33.9 | 31.0 |
| Went to a GP | 27.2 | 34.6 | 41.7 |
| Went to a sexual health clinic | 3.3 | 14.7 | 65.1 |
| Went to an AIDS organisation | 2.4 | 5.9 | 43.1 |
| Looked at the HIV positive press | 9.6 | 17.0 | 71.7 |
| Went to a gay Pride type event | 13.0 | 21.0 | 23.2 |
| Looked at the gay press | 59.3 | 74.1 | 81.8 |
| Went to a gay pub | 60.4 | 76.3 | 70.8 |
| Went to a gay club | 47.9 | 59.7 | 57.0 |
| Went to any gay pub or club | 63.0 | 78.7 | 75.4 |
| Went to a gay social group | 13.6 | 14.5 | 17.0 |
| Went to a gay community centre | 5.3 | 7.1 | 10.4 |
| Went to a gay sauna | 12.9 | 20.7 | 21.8 |
| Used the internet | 89.0 | 84.9 | 81.8 |
| Phoned a gay helpline | 2.7 | 3.4 | 5.4 |
| Phoned an HIV/AIDS helpline | 3.6 | 7.6 | 22.3 |
| Volunteered for a gay or HIV/AIDS organisation | 1.0 | 1.6 | 8.2 |

Men diagnosed with HIV are more likely to use all settings except the internet and some commercial gay settings. Men who had tested negative were most likely to use these settings. Untested men were least likely to have used any settings except the internet.

### 7.2.5 Numbers of male sexual partners

Clear differences emerge depending on the volume of male sexual partners men report for the preceding year. Men who have one partner in the last year are most likely to have had a regular partner and to have had UAI with a regular partner. Those who have two, three or four partners are least likely to have a regular partner, regular AI or regular UAI. Conversely, the likelihood of having a casual partner increases with partner numbers, as does the likelihood of having casual AI and casual UAI. This means that the men who are most likely to have UAI are those with either one partner only, or a very large number of partners (2000). However, the circumstances in which they have UAI and their needs are very different.

Men with one partner are often partnered monogamously and co-habiting. Their risks are those classically related to relationships. Unsurprisingly therefore, they are most likely to expect disclosure from positive men prior to sex. They are least likely to report loneliness or regret concerning their attraction to men (1999).

Men with higher numbers of partners are most likely to have casual AI and casual UAI and UAI with more partners. They are also less likely to have only thought-concordant UAI and more likely to have thought-discordant UAI, than men with fewer partners (1998, 1999).

Incorrect use of condoms is more common among men with the largest numbers of partners (2001), and experience of condom failure is increasingly likely with increasing numbers of partners (1998, 1999). Also sexually transmitted infections (STIs) are significantly more common among men with larger numbers of partners (2000).

There is a correlation between testing for HIV, testing HIV positive and having greater numbers of sexual partners. That is, men who have tested positive have more sexual partners than men who have tested negative, who have more partners than men who have never tested (1999).

Men with between 13 and 29 partners are most likely to worry about how much alcohol they drink (1999) and men with more than 30 partners report not always being as safe as they want to be. Moreover, the likelihood of having been raped in the last year increases with numbers of sexual partners (1998). Finally, men with larger numbers of partners express more need for sexual assertiveness than those with fewer partners (1998, 2000).

Determining an exact target group for *men with higher numbers of sexual partners* is essentially arbitrary. In general, roughly 10% of men report 40 or more partners in a year and 5% report 60 or more. For our purposes, we define men with thirty or more partners (roughly a sixth of all men) as having 'higher numbers' of partners.

It is clear that men with higher numbers of partners are a priority target group because they are behaviourally and epidemiologically different from other homosexually active men. That is, their behaviour puts them at increased risk for involvement in HIV exposure. Interventions to reduce sdUAI amongst this group are therefore disproportionately likely to reduce the incidence of HIV and other STIs.

The group, *men with higher numbers of partners*, does not have a fixed membership nor does it necessarily share any obvious cultural or demographic characteristics. Their HIV prevention needs are not any different to anyone else, but are more urgent and it is this that makes them a priority for HIV health promotion. In the absence of special needs or particular cultural sensitivities the challenge is not so much to construct specific interventions but to ensure that they are reached by all interventions. This group will include commercial sex workers.

Bearing in mind that men with higher numbers of partners cannot be easily identified either socially or culturally, it is probably not appropriate to dedicate specific national mass and small media interventions to them. On the other hand, because the group is geographically clustered (in major urban gay centres) and tends to use specific venues (such as backrooms, saunas and public sex environments), face-to-face interventions are probably feasible and appropriate.

**Direct contact interventions**

| % done activity in the previous month (2001) | Male partner numbers in last year | | | | |
|---|---|---|---|---|---|
| | one | 2, 3 or 4 | 5 to 12 | 13 to 29 | 30+ |
| Went to a cruising ground | 6.4 | 14.5 | 25.7 | 40.6 | 60.2 |
| Went to a cottage | 2.1 | 8.4 | 13.9 | 27.4 | 37.7 |
| Went to a backroom/sex club | 1.4 | 5.2 | 10.0 | 21.3 | 37.7 |
| Went to a gym fitness/club | 22.4 | 28.1 | 32.3 | 35.5 | 37.9 |
| Went to a GP | 30.5 | 30.7 | 31.2 | 32.2 | 33.2 |
| Went to a sexual health clinic | 6.5 | 8.9 | 12.2 | 16.5 | 21.6 |
| Went to an AIDS organisation | 5.9 | 4.8 | 6.3 | 6.4 | 9.5 |
| Looked at the HIV positive press | 14.7 | 12.4 | 16.5 | 19.9 | 25.1 |
| Went to a gay Pride type event | 12.2 | 15.4 | 16.6 | 21.4 | 25.6 |
| Looked at the gay press | 60.5 | 62.4 | 68.7 | 76.8 | 82.1 |
| Went to a gay pub | 56.2 | 64.6 | 74.1 | 80.8 | 82.1 |
| Went to a gay club | 39.0 | 51.1 | 60.3 | 65.7 | 68.1 |
| Went to any gay pub or club | 58.7 | 67.3 | 77.2 | 82.7 | 84.8 |
| Went to a gay social group | 15.2 | 14.0 | 13.8 | 14.5 | 14.3 |
| Went to a gay community centre | 6.7 | 6.1 | 6.0 | 5.5 | 8.1 |
| Went to a gay sauna | 3.6 | 8.6 | 15.0 | 30.5 | 46.8 |
| Used the internet | 85.4 | 85.4 | 88.0 | 87.9 | 88.3 |
| Phoned a gay helpline | 1.6 | 2.8 | 3.0 | 3.8 | 4.7 |
| Phoned an HIV/AIDS helpline | 6.4 | 5.3 | 6.8 | 6.2 | 9.4 |
| Volunteered for a gay or HIV organisation | 1.6 | 1.7 | 1.3 | 2.0 | 1.5 |

Men with higher numbers of partners were significantly more likely to use all settings except for gay / HIV organisations and the internet.

### 7.2.6 Gender of sexual partners

Here we distinguish between those who are exclusively homosexually active men (ExHAM), that is, have sex exclusively with men in the previous year, and behavioural bisexuals (BBs), that is men who had sex with both men and women in that time. The distinction is made regardless of sexual identity. The needs data for the two groups is generally inconclusive but there are important differences between them.

BBs have UAI with more partners than ExHAM and are more likely to do so with partners of unknown HIV concordancy (1999). BBs are also more likely to engage in UAI with a casual partner (2000).

ExHAM are more likely to have UAI because although they are no less likely to always use a condom, they are more likely to have AI in the first place. However, when they have UAI they are more likely to be doing so with a partner of known concordant HIV status. They are also more likely

to engage in UAI with a regular partner (2000). Overall then, these data suggests little difference in the probability of involvement in sdUAI between ExHAM and BB men (1999).

Although the extent of involvement in sdUAI is similar, the needs associated are qualitatively different. BBs are more likely to expect a positive man to disclose prior to sex and to assume a man is HIV negative if he does not disclose he is positive (2001). They are also more likely to experience problems getting hold of condoms (1998) and condom failure is more common among this group (1999, 2001). BBs are also in more need of basic HIV knowledge (1998, 1999) and information on other STIs (1998, 2000). However, ExHAM are more likely to test for HIV and to test positive when they do (1998, 1999, 2000).

The table below presents the setting use of men according to the gender of their sexual partners in the last year.

| % done activity in the previous month (2001) | Gender of partners last year | |
| --- | --- | --- |
| | Sex with men only | Sex with both men & women |
| Went to a cruising ground | 25.8 | 29.6 |
| Went to a cottage | 15.6 | 16.6 |
| Went to a backroom/sex club | 12.8 | 11.5 |
| Went to a gym fitness/club | 30.2 | 33.0 |
| Went to a GP | 31.1 | 33.3 |
| Went to a sexual health clinic | 12.9 | 6.1 |
| Went to an AIDS organisation | 6.8 | 2.1 |
| Looked at the HIV positive press | 17.7 | 8.0 |
| Went to a gay Pride type event | 18.6 | 7.2 |
| Looked at the gay press | 72.4 | 36.4 |
| Went to a gay pub | 73.8 | 41.7 |
| Went to a gay club | 58.2 | 35.1 |
| Went to any gay pub or club | 76.2 | 46.2 |
| Went to a gay social group | 15.0 | 8.7 |
| Went to a gay community centre | 6.7 | 4.1 |
| Went to a gay sauna | 17.7 | 18.5 |
| Used the internet | 86.4 | 90.2 |
| Phoned a gay helpline | 3.1 | 3.4 |
| Phoned an HIV/AIDS helpline | 7.0 | 2.5 |
| Volunteered for a gay or HIV organisation | 1.7 | 1.2 |

ExHAM were more likely to use gay commercial and community venues whilst BBs are significantly more likely to use cruising areas and the internet.

**Direct contact interventions**

### 7.2.7 Relationship status

Whether or not men were in a long-term relationship and the length of time of that relationship affected the possibility of their involvement in UAI, although it did not affect their testing behaviour or the likelihood that they would test positive for HIV. Although single men were less likely to engage in AI and UAI than partnered men, those that did, did so with larger numbers of partners and were less likely to only have concordant UAI (1998). Single men are also more likely to report having experienced rape in the previous year. Single men were more likely to have acquired an STI than partnered men. This is because they have more sexual partners.

Men in relationships are more likely to have AI and those partnered for more than a year are more likely to have UAI (1998). Not surprisingly, this UAI was more likely to have been only concordant UAI (1998). Condom failure is more commonly experienced by men who are recently partnered, than among single men or those in longer term relationships.

The table below presents the setting use of men with different partnership status.

| % done activity in the previous month (1999, London residents only) | Partnership status | |
|---|---|---|
| | Does not have a current regular male partner | Has a current regular male partner |
| Went to a cruising ground | **34.9** | 26.2 |
| Went to a cottage | 19.9 | 16.2 |
| Went to a backroom/sex club | **29.0** | 21.2 |
| Went to a gym fitness/club | 39.1 | 39.0 |
| Went to a GP | 32.6 | 29.5 |
| Went to a sexual health clinic | 19.6 | 20.1 |
| Went to an AIDS organisation | 17.4 | 15.8 |
| Looked at the HIV positive press | 52.3 | 53.0 |
| Went to a gay Pride type event | 6.7 | 7.6 |
| Looked at the gay press | 94.0 | 93.5 |
| Went to a gay pub | 87.9 | 87.4 |
| Went to a gay club | **70.6** | 64.4 |
| Went to a gay social group | **22.1** | 15.8 |
| Went to a gay community centre | 9.1 | 6.4 |
| Went to a gay sauna | **26.9** | 19.7 |
| Used the internet | 63.4 | 68.0 |
| Phoned a gay helpline | 4.8 | 3.7 |
| Phoned an HIV/AIDS helpline | 2.2 | 1.7 |
| Volunteered for a gay or HIV organisation | 14.5 | 15.5 |

## 7.2.8  History of sexual assault / abuse

The needs data on sexual assault is limited, yet compelling. The relationship between assault, sdUAI and other needs is under-explored. Men who have been sexually assaulted (particularly those who were also abused as children) are more likely to be involved in sdUAI, than are men who have not been assaulted (1998). Men who have been sexually assaulted as adults also experience condom failure more often than those who have not (1998).

The need for sexual assertiveness is highest among men who have been both abused and assaulted and lowest among men who have experienced neither (1998). Sexual assault is a threat for all homosexually active men but it is relatively rare. When it does occur, it has a disproportionate effect on the life of the individual. This suggests two interventions. First, to minimise the incidence of rape and the harm it causes when it occurs. This intervention should seek to increase the knowledge and awareness of rape for all men as well as publicising services. Second, services should be available which appropriately deal with the consequences of sexual assault in the individual when it occurs.

| % done activity in the previous month (1999, London residents only) | Sexual assault group | |
|---|---|---|
| | Never sexually assaulted | Ever sexually assaulted |
| Went to a cruising ground | 29.1 | 36.3 |
| Went to a cottage | 16.8 | 21.5 |
| Went to a backroom/sex club | 23.8 | 30.1 |
| Went to a gym fitness/club | 40.9 | 33.7 |
| Went to a GP | 29.7 | 35.4 |
| Went to a sexual health clinic | 19.0 | 22.8 |
| Went to an AIDS organisation | 15.7 | 19.5 |
| Looked at the HIV positive press | 50.6 | 59.3 |
| Went to a gay Pride type event | 7.2 | 6.5 |
| Looked at the gay press | 93.8 | 94.1 |
| Went to a gay pub | 87.8 | 87.6 |
| Went to a gay club | 68.0 | 67.2 |
| Went to a gay social group | 19.1 | 19.0 |
| Went to a gay community centre | 7.5 | 8.3 |
| Went to a gay sauna | 23.8 | 22.6 |
| Used the internet | 67.5 | 60.1 |
| Phoned a gay helpline | 4.1 | 4.8 |
| Phoned an HIV/AIDS helpline | 1.7 | 2.9 |
| Volunteered for a gay or HIV organisation | 14.3 | 16.6 |

Men who have been sexually assaulted are more likely to use public and commercial sex venues.

### 7.2.9 Recreational drug use

GMSS data indicates greater need amongst those men who have taken any 'Class A' drugs in the previous year (for our purposes the category 'Class A' includes ecstasy, LSD, amphetamines, cocaine, ketamine, heroin, crack and GHB) over those who use no drugs or only alcohol, poppers or marijuana.

Men using 'Class A' drugs engage in more AI, are least likely to use a condom for AI, have higher numbers of UAI partners and are least likely to have only thought-concordant UAI and most likely to have known-discordant UAI (1999).

Men who take 'Class A' drugs are also more likely to not always be as safe as they want to be, to be lonely, regret their attraction to men, to worry about their alcohol consumption and to want more control over their drug use. However, on expectation of positive disclosure prior to sex and on various knowledge indicators, they are usually least (or close to least) needy of all groups. Rather, men who take no drugs, or alcohol only, were most in need of basic knowledge and most likely to expect disclosure from positive men prior to sex (1999).

| % done activity in the previous month (1999) | Drug user group | | | | |
|---|---|---|---|---|---|
| | No drugs | Alcohol only | Poppers +/ - alcohol | Cannabis +/ - alcohol & poppers | Class 'A' +/ - alcohol & poppers & cannabis |
| Went to a cruising ground | 31.0 | 22.9 | 39.3 | 31.9 | 36.1 |
| Went to a cottage | 18.2 | 15.0 | 22.5 | 18.8 | 19.2 |
| Went to a backroom/sex club | 10.3 | 8.5 | 21.4 | 15.3 | 19.6 |
| Went to a gym fitness/club | 28.9 | 28.6 | 30.9 | 29.0 | 35.4 |
| Went to a GP | 32.4 | 30.3 | 32.9 | 33.6 | 37.2 |
| Went to a sexual health clinic | 9.6 | 9.1 | 12.9 | 13.2 | 18.5 |
| Went to an AIDS organisation | 7.3 | 6.0 | 6.6 | 10.5 | 11.9 |
| Looked at the HIV positive press | 28.8 | 26.6 | 32.6 | 36.8 | 40.4 |
| Looked at the gay press | 85.9 | 88.3 | 90.3 | 90.8 | 88.5 |
| Went to a gay pub | 82.0 | 88.6 | 91.2 | 92.6 | 94.7 |
| Went to a gay club | 64.2 | 69.7 | 78.6 | 79.0 | 89.4 |
| Went to a gay social group | 21.9 | 24.9 | 21.8 | 23.3 | 18.3 |
| Went to a gay community centre | 9.6 | 8.8 | 8.4 | 9.1 | 9.6 |
| Went to a gay sauna | 21.2 | 15.1 | 27.1 | 20.4 | 20.5 |
| Used the internet | 49.7 | 55.4 | 55.9 | 61.4 | 58.8 |
| Phoned a gay helpline | 4.7 | 3.6 | 4.1 | 3.5 | 6.1 |
| Phoned an HIV/AIDS helpline | 1.1 | 1.2 | 1.8 | 1.9 | 3.2 |
| Volunteered for a gay or HIV organisation | 10.3 | 9.8 | 10.0 | 13.3 | 11.4 |

**Direct contact interventions**

The table above presents the setting use of men who have used various recreational drugs over the previous year.

*Making it count* uses two principles to establish its priority target groups. First, programmes should prioritise the needs of groups of men most likely to be involved in HIV exposure and second, they should prioritise target groups who have many aims poorly met relative to other groups.

Data from annual *Gay Men's Sex Surveys* between 1997 and 2001 have consistently and cumulatively indicated the following priority target groups. Because they are more likely to be involved in sexual HIV exposure, we should prioritise the sdUAI-related needs of:

→ **Men with diagnosed HIV infection**
→ **Younger men (especially those under 30)**
→ **Men with lower levels of formal education**
→ **Men who have been sexually abused or assaulted**
→ **Men with larger numbers of sexual partners**

This means that any programmatic intervention designed to reduce the incidence of sdUAI amongst homosexually active men should disproportionately benefit men in these groups.

The groups most likely to be involved in condom failure when they have protected anal intercourse are similar – but not identical. We should prioritise the condom failure needs of:

→ **Men with diagnosed HIV infection**
→ **Younger men (especially those under 30)**
→ **Men with lower levels of formal education**
→ **Men who have been sexually abused or assaulted**
→ **Men with larger numbers of sexual partners**
→ **Behaviourally bisexual men**
→ **Men who use 'class A' drugs**

This means that any programmatic intervention designed to reduce the incidence of condom failure should disproportionately benefit these men. Doing so will yield disproportionate reductions in condom failure during protected anal intercourse.

The following groups are not necessarily disproportionately likely to be involved in HIV exposure (during sdUAI or condom failure) but have substantial clusters of unmet need. Because their HIV prevention needs are poorly met, we should prioritise:

**Direct contact interventions**

→ **Men with diagnosed HIV infection**
→ **Younger men (especially those under 20)**
→ **Men with lower levels of formal education**
→ **Men with larger numbers of male sexual partners**
→ **Behaviourally bisexual men**
→ **Men who use 'class A' drugs**

If our concern is equity rather than just HIV incidence, any programmatic intervention designed to reduce HIV prevention needs should disproportionately benefit men in the above groups.

In the *Gay Men's Sex Surveys* in 1998 and 1999, Black men were significantly more likely to have ever tested for HIV. In 1998 only they were also significantly more likely to have been diagnosed with HIV. In 2000, a similar trend was observed but was not statistically significant. This suggests that HIV programmes should:

→ **Pay particular attention to the HIV prevention needs of Black men**

This leads us to a final point about targeting in the context of a programme. A programmatic approach allows us to prioritise the needs of groups *relative to each other*. The implication is that it is expedient to meet the needs of *some groups over others*. This goes against an impulse common in health promotion to attend to equity and equality over all other considerations. The point is that in attending to the needs of some groups over others, we are attending better to the HIV prevention needs of our overall target group: homosexually active men. In practice, the consequence of having such target groups is two-fold. First, all population-level interventions must disproportionately benefit men in the target groups. Second, interventions and services must also be developed specifically for men in the target groups.

# STRUCTURAL
# INTERVENTIONS

8   Supporting and developing infra-structure

# SUPPORTING AND DEVELOPING INFRA-STRUCTURE

Infra-structural support and development interventions aim to improve the environment within which we carry out direct contact HIV prevention for homosexually active men. They do this by seeking to change unhelpful policy, legislation or public attitudes. When we carry out such interventions, we are seeking to involve members of the wider population in HIV prevention and to increase the accessibility and acceptability of direct contact HIV prevention interventions to the targets themselves. These interventions relate primarily to the policy, community and service strategic aims set out in *Making it count* (and summarised in Chapter 1 of this document), rather than to interventions targeting homosexually active men directly. This section deals with the kinds of infra-structural interventions that a health promoter might consider undertaking or supporting. These are described under three different headings: policy interventions, community interventions and service interventions.

## 8.1  WHAT ARE POLICY INTERVENTIONS?

Policy interventions seek to influence decision-making on HIV prevention and ensure that policy supports or at least does not impede HIV prevention for homosexually active men. These interventions relate therefore to local and national policy makers (within governmental and statutory sectors) and local and national resource allocators (for example the Department of Health and Primary Care Trust commissioners). They can also involve seeking to influence those people or agencies charged with the production and supply of information to support policy development and resource allocation. Therefore, they might also seek to influence applied and academic social researchers, epidemiologists, policy advisors and local public health surveillance personnel (we call these collectively, the research and policy community). The following suggested target groups are taken from *Making it count*:

- Policy makers and resource allocators
- Professional Associations
- Community and service support networks
- National surveillance and information providers
- Policy and research charities
- Policy forums and networks

### 8.1.1 Interventions that impact on policy makers

These are interventions which seek to influence policy makers to draft policy and legislation which contributes to meeting the aims of *Making it count* and amend or rescind policy and legislation which is detrimental to those aims being met. Examples of interventions might include:

- Lobbying MPs to remove homophobic legislation
- Taking part in government consultation on national policy
- Joining Professional Associations (where appropriate) and lobbying for policy that supports pro-active work with homosexually active men

### 8.1.2 Interventions that impact on resource allocators

These are interventions which seek to ensure that on all levels, equitable and appropriate resources are allocated to meeting the aims of *Making it count*. Examples of interventions might include:

- Lobbying the Department of Health on its guidance to Primary Care Trusts (PCTs)
- Lobbying local PCT commissioners to fund (or increase funding of) HIV prevention to address local HIV need
- Applying for funding for HIV health promotion work from local authorities or non-health related government bodies (for example, the Home Office)

### 8.1.3 Interventions that impact on the research and policy community

These are interventions which seek to increase the capacity of the research and policy community to support the two groups above in drafting policy and legislation and allocating resources beneficial to meeting the needs outlined in *Making it count*. Examples of these interventions might include:

- Joining and supporting national fora such as the Gay Men's Health Network
- Subscribing to information sources of national policy makers and lobbyists such as Stonewall, the National AIDS Trust and THT and ensuring their work addresses the needs of homosexually active men
- Taking part in national consultation processes undertaken by policy and lobbying organisations and government
- Lobbying research bodies to ensure that research meets the needs of homosexually active men and agencies working with them

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## Working with Schools and LEAs

The Aled Richards Trust (now Terrence Higgins Trust West), working with their local health promotion service, recognised a gap in provision of health promotion and support for school children with respect to sexuality.

Having identified allies within the education service, the health promoters developed a sexuality and sexual health awareness training package for Personal Social and Health Education (PHSE) co-ordinators which was successfully rolled out across the region. However, concerns regarding legislation such as Section 28 acted as a barrier to implementation of the intervention.

For this reason the health promoters turned their attention to the Local Education Authority, working with them to develop a policy position on legislation and PHSE sexuality and sexual health needs of school children. This was then sent to all teachers in all schools throughout the region.

A conference followed and gave rise to a working party comprising health promoters, teaching staff and school managers. This party took control of the initiative and began to identify additional PHSE needs and sought novel approaches to meet them, such as initiating a theatre in education intervention to address homophobic bullying in schools.

- ✎ **www.bristol-lea.org.uk/ services/pdf/section28.pdf**
- ✎ **www.bristol-lea.org.uk/policies/ pdf/thinktank_visionandvalues.pdf**

Thanks to Berkeley Burchell (European Men's Health Forum)

**Structural interventions**

## 8.2 WHAT ARE COMMUNITY INTERVENTIONS?

In a review of national responses to HIV and AIDS, UNAIDS (2002) report that one of the ten key characteristics of effective responses was support for community-building interventions. Community interventions divide into those which seek to involve the general (heterosexual) population in HIV prevention for homosexually active men and those which seek to involve homosexually active men directly in HIV prevention activities targeting them.

Community interventions have as their target the entire population including homosexually active men, their social networks and the wider population *etc*. The following list is taken from *Making it count* and divides the whole population into meaningful targets for community interventions:

- Gay men, bisexual men and other homosexually active men
- Friends and family of homosexually active men
- Non-commercial infrastructure providers (for example, AIDS service organisation boards, volunteers and staff; community group facilitators and volunteers)
- Gay targeted businesses (for example, gay press owners, editors and journalists; bar, club, sauna and shop owners, managers, and staff; web-site owners and managers)
- Non-gay targeted business (employers, newspaper owners, editors and journalists, TV broadcasters and condom manufacturers)
- Religious and faith organisations including religious leaders
- Rest of population (the rest of the general population)

### 8.2.1 What are community interventions for homosexually active men

These are interventions which support the commercial and non-commercial local gay infrastructure in supporting homosexually active men. This consists of supporting and developing the local lesbian, gay, bisexual and transgender (LGBT) community infrastructure. Interventions might include motivating commercial gay service providers to carry out HIV prevention work or involving them in existing interventions. It can also involve increasing the capacity of individual gay men or their friends and family to increase their representation in local decision-making processes.

The HIV prevention implications of specifically social interventions are sometimes difficult for workers and potential commissioners to grasp. For the most part, interventions take the form of ongoing social groups. Such groups have a wide variety of remits but broadly aim to assist in the development of personal identity and social skills. The personal development afforded in such groups results from the evolution of relationships which develop during group interaction. These groups are regular (usually weekly), on-going, semi-structured and relatively informal. The most common

example of such a group is probably an LGBT youth group. However, the range of LGBT groups which currently exist is staggering and testimony not only to the diversity of the LGBT population, but the range of HIV prevention community interventions possible. A review of a National listings in Gay Times (March 2003) yielded the following diverse examples of gay social organisations: *Small Members* (a group for men who are not well endowed); *Pleroma* (for gay men with gnostic interests); *Ford Globe* (Ford Motor Company LGB employees group); *Closer to Heaven Club* (for fans of the Pet Shop Boys musical); *Gay Birders Club* (a Lesbian and Gay birdwatching club) and *SLOSH* (Slapstick mess with food and mud).

Interventions supporting the non-commercial LGBT community infrastructure might include:

- Hosting an LGBT coming-out or youth group
- Hosting and facilitating other social groups
- Sponsoring a local LGBT community event (such as a summer Pride party)

Gay community interventions also involve dealing with businesses specifically targeting homosexually active men. These might include gay pubs and clubs, saunas, shops and the (local) gay press. These interventions seek to actively involve businesses in HIV prevention.

Examples of interventions might include:

- Awareness raising and training among proprietors and staff
- Sponsorship of pub and club nights or other gay community events
- Gay business 'healthy accreditation' schemes

Community interventions are often formalised under the term *community development*. Community development increases the capacity of populations to identify and address their own HIV prevention needs.

Interventions can work with community members to increase their capacity to:

- Organise and form voluntary associations
- Directly address the needs of other homosexually active men in the community
- Challenge homophobia and discrimination
- Lobby policy-makers, researchers and resource allocators
- Input to service planning

Community development interventions target people in the social networks of homosexually active men (often, though not always, the men themselves) and aim to increase those people's abilities to make interventions with other men in their networks. One generic name for some such interventions is peer-led education. Other key means of social diffusion include critical consciousness-raising and community mobilisation.

## Service level agreements between health promoters and commercial scene venues

Workers at CLASH and the Healthy Gay Living Centre (London), faced difficulties accessing certain gay venues to deliver detached interventions. Some venue managers felt that such work was bad for business. However, many expected unlimited supplies of free condom packs for their venues.

In order to address the needs of both parties, the health promoters developed a service level agreement to underpin a mutually beneficial relationship. In return for involvement in the Freedoms scheme, venues must host health promotion activities such as leaflet racks and detached / outreach interventions (some of which include fund-raising).

While the agreement is not legally binding nor highly specific, it focuses negotiations and sets down a memorandum of intent. Implementing the agreement has demanded close working relationships with venue managers and good personal relationships. However, it has been largely successful: scene users now get free condoms and health promotion interventions in the vast majority of London gay commercial venues.

✎ info@tht.org.uk (for the attention of the Gay Venue Outreach Team)

Thanks to Glyn Thomas (Senior Project Worker, Healthy Gay Living Services, Terrence Higgins Trust)

## Targeting the general population to enhance the health of homosexually active men

**Terrence Higgins Trust's *Black gay equality* Campaign (2003)**

To enhance the mental health of homosexually active and gay-identified African / Caribbean men, Terrence Higgins Trust implemented a mass media intervention targeting the general Black community (that is, the parents, siblings and friends of homosexually active men). Advertisements were placed at outdoor sites in areas with large African / Caribbean communities such as Brixton, London. In addition a focussed PR and editorial campaign was implemented and flyers and posters were sent to key agencies and community groups across the country. The aims of the campaign were to challenge homophobia in the black general population and send a message to homosexually active men in that community that they have rights to equal treatment and allies in the wider gay community.

☞ **www.itstimetoaccept.org.uk**

Thanks to Simon Nelson (Black Gay Men's Development Officer, Terrence Higgins Trust)

Such interventions usually occur in two stages. The first involves recruiting homosexually active men, addressing their HIV prevention needs and training them to make similar interventions with men in their social networks. The second part of the intervention is carried out by the men recruited and involves them making interventions with other homosexually active men which decrease their HIV prevention needs during everyday social interaction. These interventions can include many of those identified in Chapters 3 - 6 above.

Some interventions address the family and friends of homosexually active men to increase the contribution they make to reducing HIV need. Others target gay-related businesses such as bars, saunas and shops to increase their contribution to meeting the HIV prevention needs of their customers and create safer environments in which to have sex. These types of interventions cover a wide range of activities whose objectives are to encourage social, physical and political environments in which the HIV prevention needs of homosexually active men are likely to be met.

Community development also seeks to bring into existence social networks and support pre-existing ones. This is beneficial in that it both increases social cohesion and creates settings in which other (HIV prevention) interventions can occur. Much health promotion activity is only possible because of the existence of a gay community infrastructure including meeting places, gay media, social networks, organised and semi-organised groups. Conversely, the lack of a community infrastructure limits the range of settings in which direct contact activities occur. The aim of community development is the existence of strong community infrastructures. As such, the target is not individuals, but the relationships between them. The objectives are less tangible and predetermined than those of services directly addressing men's HIV prevention needs, and include establishing, facilitating or supporting community groups. Community infrastructures are not an end in themselves, but desirable to the extent that they benefit their members.

### 8.2.2 What are community interventions for the general population?

These are interventions which engage the wider population in supporting homosexually active men. That is, they seek to mobilise the families, employers and friends of homosexually active men as well as the businesses that serve them.

Examples of possible interventions include:

● General population anti-homophobia campaigns
● Support groups for parents of gay children or families of gay men with HIV
● Anti-homophobia training in workplaces or a leaflet for employers

General population interventions also involve dealing with generic businesses with whom gay men come into contact. These interventions seek to reduce homophobia towards gay customers.

Examples of possible interventions include:

- A local media watch (to monitor and tackle homophobic reporting)
- A local 'bad service' reporting scheme (to monitor and tackle homophobia in local businesses and services)
- Liaising with local chambers of commerce and business associations to raise awareness regarding homophobic practices and inequality of service

### 8.3 WHAT ARE SERVICE INTERVENTIONS?

Service infra-structure interventions are any actions undertaken to improve the quality of statutory and voluntary sector services provided to homosexually active men. The targets include services which specifically (and exclusively) target homosexually active men and those which may include such men among their clients. They are sometimes called capacity building interventions.

Capacity building interventions can be undertaken by gay men's HIV prevention workers and agencies to refine their own work practices. Such interventions include:

- Reading this handbook
- Attending (accredited) training from other organisations
- Attending national and international conferences
- Reading research and briefing papers on specific health promotion needs, methods and target groups
- Offering training to other organisations on your own particular competency

In addition, gay men's agencies can undertake capacity building interventions whose target is other (generic) statutory and voluntary agencies. All services intended to address the education, health and social needs of the entire population can impact on the HIV prevention needs of homosexually active men. These include local providers of education, health and social services.

Interventions might aim to improve the quality, acceptability and accessibility of generic social and health services for local homosexually active men. We can divide these interventions into two types: those that increase the service's capacity to serve other homosexually active men and those that increase the service's capacity to listen to them.

Increasing a service's capacity to listen to homosexually active men involves increasing gay representation within consultative mechanisms (these might include user groups or patient representatives, boards, management committees *etc*). That is, ensuring that the service elicits and values the participation of homosexually active men.

## Capacity building & skills development

A number of health promotion agencies run professional development courses which provide in-service education and training to other health promoters. Courses tend to be specific and relatively short and are both less costly and have lower entrance criteria than University-based health promotion courses. Such training builds capacity on a national basis and helps individuals refine skills, enhance practice and promote career development opportunities. Where training is desirable but funds are restricted organisations might also consider developing regional skills-sharing networks in which training and development programmes are traded reciprocally (a common practice in The Wessex Gay Men's Health Forum, for example).

✏ **www.sexualhealthsheffield.co.uk**

Thanks to Rob Brown (Gay Men's Worker / Manager, Sheffield Centre for HIV and Sexual Health)

**Structural interventions**

## Satellite provision

Gay Advice Darlington, with Darlington PCT and the Memorial Hospital GUM clinic, initiated an accelerated Hepatitis B vaccination and awareness programme over a four-week period in a gay commercial venue.

The course consisted of three injections so only those who applied in the first week received the treatment (those who requested it in the following weeks were referred to the clinic which saw a subsequent increase in uptake). It was considered more practical and cost-effective to give the vaccine to any man who requested it rather than to conduct initial susceptibility screening.

The programme was widely promoted beforehand and took place in a screened-off area of a gay bar. Scene-users welcomed the intervention, many women encouraging their male friends to get the vaccination. Of the fourteen men who started the course only two failed to complete. The organisers plan to make the programme an annual event and suggest that good planning and promotion, wide consultation with scene-users prior to the event and the use of the same staff during each session, ensured the success of the initiative.

☞ **http://www.gayadvicedarlington. co.uk/**

Thanks to Barry Birch (Community Worker, Gay Advice Darlington)

Service interventions might include:

- Liaison with services to ensure that they explicitly seek the participation of gay men in consultation mechanisms (for example, in their advertising / promotional materials)
- Training with services to ensure they understand the impediments to individual gay men's involvement (such as fear of homophobia)

Increasing a service's capacity to serve gay men and other homosexually active men involves increasing its **appropriateness** and its accessibility. Interventions to improve appropriateness involve improving the service itself so that it serves gay men and other homosexually active men better.

Service interventions might include:

- Training with primary care staff, GUM staff and NHS health promotion staff
- Liaison / training with local school boards, youth services and teachers
- Liaison / policy development work with local authorities to ensure that all contractors and service areas comply with anti-homophobia guidelines
- Sitting on service boards and joint planning fora in the voluntary and statutory sectors
- Prison liaison / training

Interventions to improve the **accessibility** of a service to homosexually active men involve either endorsing a service which you are confident is already appropriate to them or acting as a community interface between them and a statutory service. Although the latter approach cannot be a long-term solution for a statutory service which is inappropriate, it can provide a stop gap and might serve to increase your involvement and trust with the service provider in order to make it appropriate in the longer term.

Possible interventions include:

- **Promotional work:** promoting an under-used service which you are confident offers an appropriate service
- **Satellite provision:** Facilitating the provision of a statutory or clinical service in a scene or community venue thereby removing it from it's statutory setting
- **Chaperoning:** Accompanying individuals into and through a service (such as a GUM visit or reporting a crime to the police)
- **Hosting:** A community worker based within a statutory service setting to 'host' homosexually active men who access the service

Clinical services and other statutory provision can be perceived by homosexually active men to be unfriendly or ill equipped to accommodate

them. While there is no substitute for the provision of appropriate services (and gay men's health projects might reasonably collaborate with statutory providers to develop such services) increasing the gay presence in a service can make a significant difference to the way it is perceived.

While some gay men's agencies offer *chaperoning* on an ad hoc basis; few formalise and promote such provision. The notion is that men who do not feel confident to access services (such as GUM, for example) are accompanied and may also have the appointment arranged for them. Such provision can help ensure that potential clients can access services. Since *chaperoning* is usually offered on an ad hoc basis an informal agreement to provide it is probably all that is required. However, if the service is to be 'sold' to men as a way of increasing the uptake and acceptability of specific services, then protocol should probably be developed in consultation with the other organisation to ensure that provision is consistent and to safeguard workers and clients alike.

Alternate approaches to improving service accessibility include *hosting* and *consultancy*. While such interventions are best thought of as short-term solutions, the collaborative relationships that they necessitate can improve service accessibility and acceptability to current gay users.

### 8.4 WHY DO STRUCTURAL INTERVENTIONS?

Gay men's health promotion agencies do not traditionally prioritise influencing the structural environment within which homosexually active men live. Those who undertake such work can find it difficult to justify to NHS commissioners. This document asserts the centrality of this type of intervention because direct contact work with homosexually active men does not take place in a vacuum. National and local policy and legislation, resource allocation and public opinion all have a direct impact on how, where and in what circumstances direct contact work can take place. Also, such policy and legislation affects the way in which individual homosexually active men are treated and valued in wider society and hence their quality of life. All these things directly affect individual men's capacity to manage sexual risk.

Service interventions are particularly needed because historically, responsibility for HIV prevention has been given to a relatively small voluntary sector who have been shackled with the entire spectrum of education, health and social service needs for homosexually active men. If HIV prevention is to be delivered in the broader context of men's individual lives, it is necessary to increase the element of HIV prevention in the broader educative, health and social service interventions received by them. Rather than dedicated HIV prevention services addressing all education, health and social needs of homosexually active men; all education, health and social services should increase their contribution to addressing HIV prevention needs. It is therefore necessary to foster a

## Hosting

As part of a service level agreement with a former London Health Authority, The Healthy Gay Living Centre (HGLC) worked with a South London GUM clinic which was not widely used by gay men.

As well as providing consultancy, HGLC provided a host who worked in the public areas of the clinic. The host welcomed gay men, offering them help and support with the registration processes as well as acting as a referral point to other gay men's services. HGLC also promoted their presence in the clinic during local outreach / detached work.

As gay men's use of the clinic increased and its staff became more adept at meeting the needs of gay clients, the requirement for a host was reduced and ultimately ceased. These interventions not only increased gay men's access to the clinic but improved the service and founded a strong working relationship between the two providers.

✎ **info@tht.org.uk (for the attention of the Gay Venue Outreach Team)**

Thanks to Robert Goodwin (Development Manager Healthy Gay Living Services, THT)

## Promotional Work

When services are based in settings near to, or within a 'gay village', direct approaches to men by health promoters can be an effective way of increasing uptake: particularly for low-threshold services.

This approach has recently been used in Soho, London, where The Victoria Clinic runs "Sorted", a satellite service providing hepatitis B screening and vaccination to scene users in the evening.

Service promotion in local gay commercial venues has been undertaken by outreach / detached workers with support from clinic staff. It has been useful in increasing awareness and uptake of "Sorted."

The promotion involved proactive distribution of promotional materials (knik-knaks) and discussion aimed at encouraging men to access the service before leaving the area. Such approaches may be particularly effective for recruiting men who might not readily use GUM services.

☞ **www.freedoms.org.uk (for contact details of the Gay Venue Outreach Team)**

Thanks to Mike Taylor (Senior Health Promotion Specialist, Central London Action on Street Health)

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greater collective responsibility: all education, health and social services must take responsibility for the HIV prevention needs of current and future generations of homosexually active men. Service interventions are vital because many statutory services are currently either inappropriate for homosexually active men or hostile towards them.

It is necessary to encourage Primary Care teams and GUM staff to offer appropriate services to homosexually active men and to encourage schools to take seriously the education and welfare of young men. This extends to providing appropriate sex education and tackling homophobic bullying. The police need to be made aware of their role in establishing an environment of civil respect for homosexually active men. They must also be encouraged to aspire to better policing standards around public order, reporting of homophobic hate crime and "gross indecency". Prison governors and officers need to be made aware of their role in reducing HIV and STI morbidity among the prison population. This includes the provision of appropriate condoms and access to HIV prevention interventions for prisoners. Finally, all public services should be encouraged to maximise the public involvement of homosexually active men in service planning.

Capacity building interventions are necessary for gay men's HIV prevention agencies. Interaction and learning between a diverse range of services is also essential for a collaborative response. That is, the impact of all services can be increased if they are aware of, and complementary to, all other services in a local area, and with national services. Ensuring this is the case can only occur with communication across services and with their active participation.

The communities which make-up and surround the population of homosexually active men are the greatest potential resource for carrying out HIV prevention interventions. Community interventions with homosexually active men increase their capacity to influence the environment in which they live. That is, to take part in political action; service consultation and planning; voluntary association and peer education and support. In order to do this, they need to be aware of problems and empowered to deal with them. They also need meeting spaces and resources.

Interventions with the community which surrounds homosexually active men are necessary to tackle the wider social determinants of health for that population. Over time, interventions can change the attitudes of the majority population to sex between men. They can also influence how people develop social policy and allocate resources as well as how people deliver education, health and social services. This will ultimately affect the way that homosexually active men feel about themselves and the world around them and this will affect their health.

**PLANNING CONSIDERATIONS**

Structural interventions are necessary to facilitate our direct contact work (for example, liaison with police and local authorities). This involves attempting to bring about slow cultural and organisational change by working with a diverse range of groups. It therefore requires considerable patience, tact and political awareness. While all workers in an organisation should be encourage to recognise the structural interventions they are involved in, it is important also to have leadership and vision within any agency. It is also important to allocate specific resources to these types of interventions.

Perhaps more than any other area, structural interventions implicate us in collaborative working. That is, local collaborations between statutory, voluntary and other agencies, but also collaboration between local and national agencies. It also requires us to think about how our own area is both similar and different to others. It is often tempting to believe that the needs of the men in our (geographical) area or sub-population are vastly different from others; in fact, research generated over the last ten years demonstrates that this is the exception and not the rule. Similarly, it is tempting to believe that the structural issues facing the men in a particular area are vastly different. The reality is, that if a structural barrier to undertaking health promotion exists in one part of the country, it is likely to exist elsewhere. As such it is important to be able to identify the needs and issues that can be best addressed on a local level or at a regional level, and those that can be better addressed at a national level.

It is also necessary to work on a local, regional and national level when attending to structural interventions. Local work involves liaison and collaboration with local authorities and voluntary sector agencies. Regional level work involves taking part (or setting up) regional lobbying and collaborative fora. However, the actions of local and regional policy makers as well as the attitudes of local and regional populations are profoundly influenced by national policy and media. Although it is neither efficient nor effective for a local project, agency or worker to be developing policy or lobbying at a national level, it is appropriate for a local worker to be influencing national policy by advocating for helpful policy and legislation within national organisations and government. This can be achieved by supporting lobbying initiatives of organisations with a national remit (such as the National AIDS Trust, Terrence Higgins Trust, and the Sex Education Forum *etc.*).

## Police liaison

When they initiated outreach / detached work in London public sex environments (PSEs) The Healthy Gay Living Centre (HGLC)* made initial contact with the Police both as a courtesy and to address some of the concerns raised by service users. In discussion with PSE users it had become clear that the police were mistrusted; users were unlikely to report cruising site crime because they feared being charged with a public sex offence.

HGLC now provide consultancy to the police on LGBT community involvement in policing initiatives and advocate for victims of crime. For them the issue is one of promoting equity in law enforcement from policing of thefts on cruising sites to issues around sexual assault and domestic abuse. They note the importance of remaining impartial and maintaining distance and have made it clear to the police that they will neither sanction nor discourage public sex.

Their advice for other agencies would be to maintain a dialogue with Police Community Liaison officers, be pragmatic and work on your local needs and agenda whilst respecting their remit to uphold the law. They note that the while the police do not make the law, they have a duty to enforce it and how it is enforced may depend upon how you work with them.

*HGLC is now Healthy Gay Living Services, Terrence Higgins Trust

✑ www.galop.org.uk/
✑ www.c21project.org.uk/
citizenship_21/information_centre/
violent_hate_crime/

Thanks to Stephen Connolly (Project Worker, Healthy Gay Living Services, Terrence Higgins Trust)

**Structural interventions**

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