

# Making it count

*A collaborative planning framework to  
reduce the incidence of HIV infection  
during sex between men*

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# Foreword

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Towards the end of 1996 a number of agencies doing HIV prevention with gay and bisexual men in England, came together to collaborate on the development of a national programme of prevention work, funded by the Department of Health and co-ordinated by the Terrence Higgins Trust under the name of CHAPS. In its first year, this partnership developed and published *Making It Count* (March, 1998). This document set the targets for that collaboration and outlined a framework to help plan how to achieve them.

In the last two years, that document has been put to many uses. The framework is being used to plan, deliver, monitor and evaluate the national HIV prevention work within CHAPS. It has been used both by the CHAPS agencies and other health promoters to develop local planning consortia and prevention programmes. It has provided a commissioning framework for a number of health authorities and the basis for a number of investigations by researchers who share the overall goal of reducing HIV incidence during sex between men.

This second edition of *Making It Count* serves the same purpose as the first: it is a planning framework for collaboration in HIV prevention. The main changes have been in structure and clarity rather than substance. The overall goal, behavioural targets and aims of interventions are all similar to the last edition. Structurally, the values on which the framework is built have been brought to the front of the document, the health promotion aims have been grouped under the behavioural targets they are related to, and the descriptions of interventions has been standardised and clarified.

The agencies and authorities involved in HIV prevention in the UK have diverse histories, structures and purposes. We feel that the first edition of *Making It Count* fostered an unprecedented sense of common purpose among this extremely diverse group. We hope this second edition continues to contribute to this developing consensus.

**Ford Hickson**  
on behalf of the *Making It Count* Development Group  
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# 1 Introduction and overview

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## 1.1 PURPOSE

This document is a formal statement of the aspirations of a range of organisations who are engaged in HIV prevention with gay men and other homosexually active men in England. It does not encompass all the concerns or all the activities of those agencies but articulates our common purpose in reducing HIV incidence. The document describes a framework for planning activity intended to contribute to a reduction in the incidence of HIV infection during sex between men. It has been developed in consultation with many other stakeholders (see Acknowledgements). The purpose of the document is to increase our collective capacity to reduce HIV incidence, by describing:

- a model of HIV infection in a population of homosexually active men;
- an explicit and ethically acceptable approach to influencing HIV incidence in that population;
- a system of prioritisation of need (and hence resources), which attends to both equity and impact on incidence;
- a strategic planning framework for building collaborative HIV prevention programmes at national, local and agency levels. This includes an examination of the range of interventions currently available to address need and a template for the evaluation of interventions and programmes.

## 1.2 VALUES

This is a framework for planning HIV health promotion. Health promotion is 'the process of enabling people to increase control over, and to improve, their health' (WHO, 1996). The two broad categories of activity by which this process occurs are health education (for example, of gay men, health practitioners or the media) and healthy public policy making (for example, about education in schools, HIV testing or public involvement in programme planning) (Tones & Tilford, 1994).

A central principle of health promotion is that the promotion of one person's health must not be at the expense of another's. So, not all activities that could prevent HIV infection can be considered HIV health promotion. For example, detention of people with HIV may (or may not) reduce the number of exposures that occur in the population. Yet it cannot be considered health promotion even if it does because it involves damaging the health of people with HIV to 'protect' the health of those without infection.

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

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

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

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

### **1.3 AIMS**

The document outlines a series of aims that we aspire to meet for all gay men and other homosexually active men. We recognise the aims as situations we are always working towards but which are unlikely to ever be met for all men. Taken together, the aims can be summarised as:

- ▶ **An HIV and STI educated, aware, empowered and equipped population of homosexually active men who have access to clear, accurate and credible information and quality services.**

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

As men themselves are the largest human resource and many of our aims can best be met by them, we also aim to ensure:

- ▶ **The peers of homosexually active men can be involved in meeting the needs of the men they know.**

Because peer interventions are only able to occur in places where men meet and socialise, we are more likely to achieve the above aims if we also ensure:

- ▶ **There exist places where men can encounter interventions and each other, including project centres and community meeting places.**

Many aims we try to meet for homosexually active men also fall within the interest or remit of other organisations and services. The activity of other bodies also affects our activities. So we also aim for:

- ▶ **Organisations that share our overall goal of reducing HIV incidence to plan within this framework collaboratively.**
- ▶ **Organisations with an interest, concern or responsibility for the education, health or sexual behaviour of gay men and other homosexually active men to be able to carry out HIV health promotion as appropriate to the organisation's role and responsibilities.**
- ▶ **Other organisations and institutions to facilitate, or at least not impede, HIV prevention activities.**

All of the above aims exist within a national and local context of heterosexism and discrimination against people with HIV. Not only does this make all of our work to achieve these aims more difficult (Piot & Aggleton, 1997) but it also directly impacts on the mental health of many homosexually active men in many ways (Otis & Skinner, 1996; Cole *et al.*, 1996). Although significant change has been achieved in these areas in recent years, inequality between sexual minorities and the sexual majority exist in every area of life and HIV continues to be a stigmatised disease. We therefore finally aim for:

- ▶ **The absence of policy and practices that unfairly discriminate against homosexually active men and people with HIV, and that make HIV prevention interventions less possible.**

Any intervention that contributes towards meeting any of the above aims is recognised in this framework as a valid HIV prevention activity. So having interventions that make a significant contribution to reducing HIV incidence without mention of HIV or condoms is possible.

## **1.4 SCOPE AND EQUITY**

We are concerned with all gay and other homosexually active men (and those who wish to become so) inclusive of perceived, actual or diagnosed HIV status, sexual identity, ethnic group, age, social class, area of residence, educational qualifications and disability.

The framework does not address HIV infections occurring through routes other than sex between men, or other health concerns of homosexually active men except as they relate to HIV incidence. We focus on reducing the rate at which uninfected men are becoming infected with HIV and suggests this goal be approached primarily by enabling all men to avoid involvement in sexual HIV exposure (whether they already have HIV or not). The framework is therefore concerned with the sexual health of both HIV infected and uninfected men but not the other health issues faced by either group.

For men with HIV infection, having little or no control over exposing their infection to others probably means having little or no control over being exposed to further infections themselves. In other words, many of the unmet needs that contribute to men with HIV sexually exposing their infection to uninfected men probably also contribute to poor sexual health for themselves. Increasing the control men with HIV have over their involvement in sexual HIV exposure should contribute to both lower incidence and the health of people with HIV infection. However, as the

HIV prevention needs of people with HIV are *additional* to their own sexual health needs, meeting their HIV prevention needs (as defined in this document) does not mean we will have met all their HIV related sexual health needs.

How far away a man is from having all the above aims met is viewed as a marker of their needs. We define need as an absence of an aim being met. This should suggest any man's potential to benefit from a single intervention or programme of work. Rather than equality of input (each group getting the same resources regardless of need) we call for equality of aims (that all men are educated, aware, empowered and equipped about HIV and other STIs). Given finite resources and potential infinite need this is a call for effective targeting to reduce both health inequalities and incidence.

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

Many homosexually active men live with discrimination in addition to heterosexism and HIV prejudice. Important among these are racism, ageism and ableism. These needs are *additional* to those outlined above (Fenton *et al.*, 1999). As well as attending to prioritisation based on differences in incidence and/or need, all organisations should consider the equity of access to their interventions concerning these differences. This means expecting interventions to be equally accessible to all groups unless stated otherwise and where this is not so, to instigate interventions specifically targeted at those groups. In practice we have found that different groups of men require varying degrees of intervention depending on their personal and collective capacity to engage with service provision.

## **1.5 ETHICS, THEORY AND EVIDENCE**

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

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

Similarly, our decisions about which interventions to adopt cannot be solely based on whether they 'work' (ie. contribute to a reduction in incidence). They must also be judged on how they work. Some interventions may be effective but are entirely at odds with the notion of the promotion of health and would be entirely unacceptable to health promoters and the men they are attempting to influence (for example, segregating people with diagnosed HIV infection).

## 1.6 INDIVIDUAL AND PUBLIC INTERESTS

Superficially there is a tension between our values that assert the rights of the individual, and our shared goal – which is essentially the public health goal of reducing HIV incidence for the whole population. We reconcile this tension by recognising that how we achieve the public health goal is as important as achieving it. If we can imagine a world in which no HIV transmission occurs, which is a worst world to live in than one in which it does, then we must recognise that we are not willing to do *anything* to reduce incidence. In other words the process is as important as the outcome. For example, we reject the criminalisation of sexual transmission of HIV as an intervention to reduce HIV incidence. We also reject any legislation that contradicts the HIV and human rights aims in section 5.7.

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

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

## 2 Context

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Advances in highly active anti-retroviral therapy (HAART) for HIV infection (Alcorn, 2000) have done much to improve the health and well being of many people with diagnosed HIV infection (Anderson & Weatherburn 1998; 1999; Anderson *et al.*, 2000). They have also substantially reduced the death rate associated with HIV. However, HIV infection remains a serious, life long and primarily life-threatening infection. Despite treatment advances, prevention of primary HIV infection remains a central pillar of a comprehensive national response to HIV.

HIV continues to affect gay men disproportionately to any other group in the population. The Department of Health, health authorities and HIV prevention organisations all agree that 'targeted' spending is necessary. However, evidence suggests that nationally there continues to be *no relationship* between how HIV is being acquired within health authority areas and how health authorities spend their HIV prevention budget (NAT, 1999). Guidance from the Department of Health (UK Health Departments, 1995) states that 'gay men are the primary group to be targeted for HIV health promotion' and that 'HIV health promotion will need to be developed further at both national and local levels'. The Government has been in the process of developing a strategic response to HIV for some time. It has recently been subsumed within the strategy to reduce all sexually transmitted infections and unwanted conception/birth. *Making It Count* is a contribution to that development.

The 'evidence-base' for HIV health promotion is dispersed and unsystematic. Although there is increasing consensus on the meaning of success in HIV health promotion, what counts as acceptable, equitable, effective and efficient interventions remains to be agreed. This problem is magnified when we consider the interaction of interventions in a programme. Some advances are being made in evaluating several interventions and the effectiveness and efficiency of programmatic approaches (Hartley *et al.*, 1999).

Sexual health promotion can be difficult in many settings in which other health promotion is not. These problems are severely compounded when addressing sex between men due to the social taboo of homosexuality generally and discrimination against gay men in particular. Sex between men continues to be subject to discriminatory laws and prosecutions of men for consensual sex continue to occur. Conversely, few sexual assaults of men (including rape) are prosecuted (Hickson *et al.*, 1997a).

Department of Health guidance (UK Health Departments, 1995) states 'personal, social and health education (including sex education) in schools is a key element in HIV prevention'. However, schools are not required to address homosexuality in secondary school sex education so that it is supportive of gay and bisexual young men. Current evidence suggests the extent and quality of education about homosexuality is low (Douglas *et al.*, 1998). This is due to several factors including teachers' perceptions of parental disapproval and lack of training on and confidence to educate young people about diversity.

These barriers are compounded by Section 28 of the Local Government Act 1988 (which prohibits the promotion of homosexuality and its acceptability by local authorities but has no bearing on what can be legally taught about homosexuality within school sex education). The British Medical Association (BMA, 1997) have stated that Section 28 has 'proved positively

harmful in ensuring that issues of sexuality are responsibly addressed within schools (and) ... should be repealed'. While efforts to repeal Section 28 are ongoing it remains on the statute book at the time this document goes to press.

Local authorities' central HIV and AIDS responsibilities concern assessment for, and provision of, care for people diagnosed with HIV. In addition, the Health of the Nation points out that local authorities "are also employers and through contacts with the community are well placed to develop interventions which aim to raise awareness" (Department of Health, 1994). It continues "Local authorities may wish to strengthen their corporate response by contributing, through social services and other departments, to the development of coherent overall strategic plans for sexual health". In one study (Moran, 1996), 79% of local authorities surveyed stated that health promotion was recognised as a specific activity within the authority. We do not know how much HIV health promotion with gay men (and other homosexually active men) is currently occurring in local authorities and their services.

The workplace has been identified as a productive site for general health promotion, which can include sexual health promotion if carried out appropriately. However, research (Snape *et al.*, 1995) also suggests that two thirds of gay men willing to take part in research conceal their sexuality from all or some people they work with and a fifth have experienced harassment at work because of their sexuality. Anti-discriminatory workplace policy has become increasingly common over the last ten years although the impact of these policies on everyday working life is largely unknown.

Most people are exposed to health related information and opinion through television and newspapers, and the media has played a central role in the HIV epidemic in Britain. The National Union of Journalists has issued guidelines for reporting on HIV and AIDS in the media (NUJ & HEA, 1993). Clause 10 of the NUJ's Code of Conduct states that a person's race, nationality or sexual orientation should be mentioned only if strictly relevant to a story. There is no published research on adherence to these guidelines.

# 3 Factors contributing to incidence

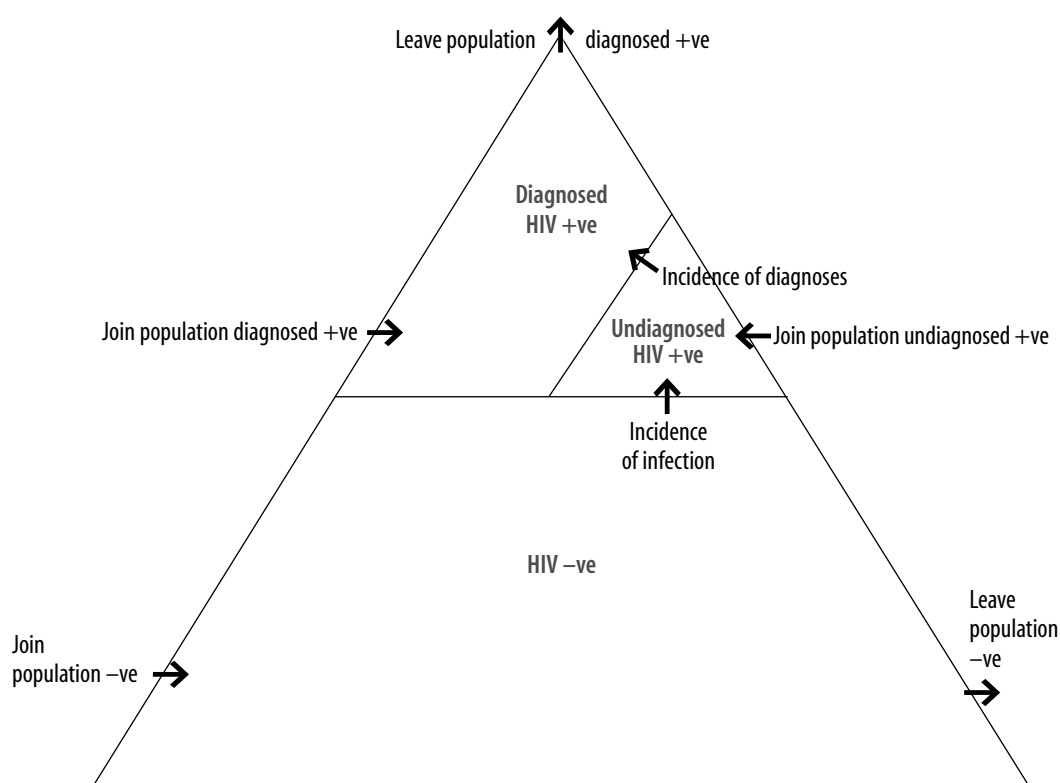
## 3.1 HIV PREVALENCE AND INCIDENCE

Figure 3.1a illustrates HIV prevalence and HIV incidence in a population. The large triangle represents the entire population with which we are concerned. The smaller triangle on top are those who have HIV infection (+ve, positive), the remainder on the bottom are those who do not (-ve, negative). Those who do have HIV are split into those who have had their infection diagnosed, and those who have not (undiagnosed, the smallest triangle).

A review of evidence (Hickson *et al.*, 1997b) suggests there are between 200,000 and 800,000 homosexually active men in England. National monitoring systems suggest that (at the end of 1999) approximately 12,000 of these men had diagnosed HIV infection, and an additional 6,000 had undiagnosed infection (PHLS, 2000).

HIV prevalence is the proportion of the entire population who currently have HIV, whether their infection has been diagnosed or not. On the above figures, this would mean an overall prevalence of between 2% (if there are 800,000 homosexually active men) and 9% (if there are 200,000). Prevalence goes up as men with HIV join the population (for example, as men with diagnosed or undiagnosed infection move to an area) and as uninfected men become infected (incidence of infection).

Figure 3.1a: HIV prevalence and incidence in a population



If HIV infection could be cured, prevalence could be reduced by diagnosing and treating infection. As HIV infection remains incurable, prevalence only decreases as people with HIV die (or leave the population of concern). The introduction and uptake of highly active anti-retroviral therapy (HAART) has extended the life of many people with HIV and had caused a corresponding increase in HIV prevalence. That is, the very desirable change that fewer people are dying with HIV disease is reflected in an overall increase in prevalence.

HIV incidence is the rate at which people in a population are becoming infected with HIV. In Figure 3.1a it is represented by movement of people in the 'negative' section into the 'undiagnosed positive' section (all infections must be acquired before they are diagnosed). As incidence is a rate, it is the proportion of negative people who become infected in a given period. Incidence refers only to the number of uninfected men becoming infected and not the number of men infections come from.

Incidence of infection should not be confused with diagnoses of infection, represented by movement from 'undiagnosed positive' to 'diagnosed positive'. Reports of diagnoses of infections present a partial picture of new infections because of the variable time between infection and diagnosis. However, over time, almost all HIV infections will be diagnosed, giving a partial picture of recent incidence. For the past ten years, there have been approximately 1,500 new diagnoses per year, where HIV has been thought to have been acquired during sex between men.

This framework is concerned with the incidence of infection. The shared goal of those planning within this framework is to slow the flow of men from the negative into the undiagnosed positive section of the figure.

**Shared Strategic Goal:  
A reduction in the incidence of HIV infection during sex between men.**

The rate at which homosexually active men are becoming infected is the outcome of the interaction between many factors. Incidence may rise and fall independently of either the sexual behaviour of the population or HIV health promotion activities. While a decrease in incidence is the goal we share, our collective and individual success cannot be judged on changes in incidence.

The rest of this chapter presents a model of the factors influencing the incidence of HIV infection through sex between men. The model is represented schematically in Figure 3.1b

Two events are necessary and sufficient for primary HIV infection to occur:

- (i) exposure of an uninfected man to an infected man and
- (ii) transmission of the virus (or sero-conversion of the uninfected man).

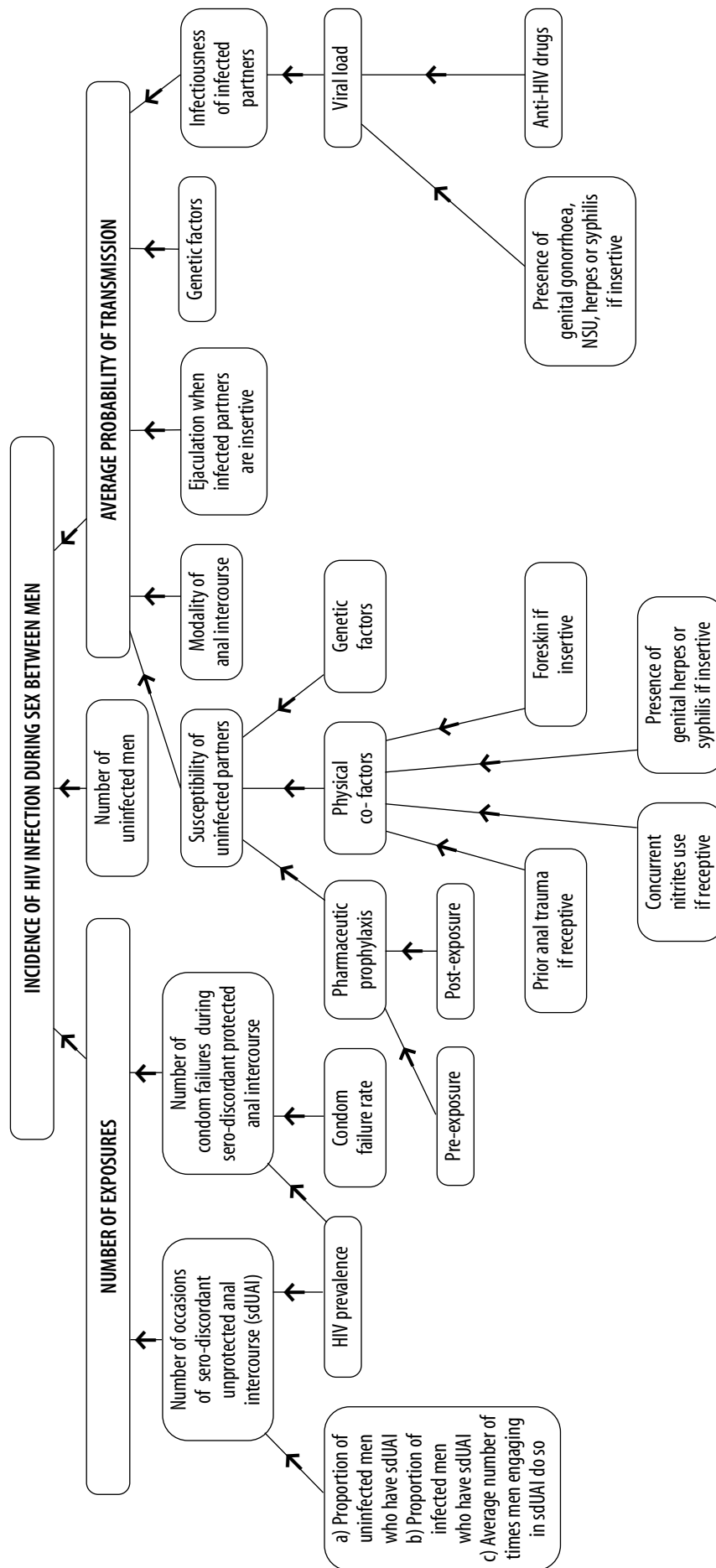


Figure 3. 1b: Factors contributing to HIV incidence

### 3.2 PRIMARY EXPOSURE TO HIV

What counts as exposure of an uninfected person to an infection is not fixed but is determined by our knowledge of the characteristics of infectious agents and our understandings of risk. Current evidence (Caceres & van Griesven, 1994) suggests that among homosexually active men, the vast majority of HIV exposures (and so transmissions) occur during unprotected anal intercourse.

HIV transmission can occur during oral sex especially when the infected man is insertive. Most, but not all, documented cases suggest that oral transmission will only occur if there is ejaculation into the mouth and possibly requires another cofactor, such as throat infection, oral ulceration or recent dental work (UK Chief Medical Officers' Expert Advisory Group on AIDS, 2000). While educating men about oral transmission is an important part of an HIV health promotion programme, even large scale changes in the patterns of oral sex between infected and uninfected men are unlikely to have a significant impact on HIV incidence.

For the purposes of this framework, exposure occurs whenever an uninfected man engages in anal intercourse without a condom with an infected man, irrespective of the modality of anal intercourse (ie. irrespective of which partner is receptive or insertive during anal intercourse). We use the term sero-discordant unprotected anal intercourse (sdUAI) to describe this activity.

HIV exposure in a population of homosexually active men can be expressed as the absolute number of times sdUAI occurs. The absolute number of times sdUAI occurs is dependent on the number of infected men in the population and is thus related to HIV prevalence. The absolute number of times uninfected men engage in sdUAI must be the same as the number of times infected men do so.

However, as some men have sex with more partners than others, the numbers of uninfected men and infected men engaging in sdUAI are likely to be different. Similarly, as the size of the uninfected and infected populations differ, the proportion of infected men engaging in sdUAI will be much higher because the population is much smaller.

As noted above, a reduction in HIV prevalence could only be achieved through a cure for infection or infected men leaving the population. No cure is available and removing infected men from the population is not acceptable. Currently then, reducing prevalence in order to reduce exposure is not an option.

Finally, even if all sero-discordant anal intercourse featured condoms, HIV exposure would still occur due to condom failure. The precise number of exposures that occur in this way is unknown. However, evidence suggests that condom failure (slippage and breakage) is not an isolated event with 10%-20% of users experiencing some failure within a year period (Hickson *et al.*, 1999; Weatherburn *et al.*, 2000). The number of HIV exposures that occur because of condom failure is influenced by both the number of times sero-discordant protected anal intercourse occurs (which is related to the prevalence of HIV) and by the rate of condom failure.

So the rate of primary exposure will decline if there is a reduction in:

- HIV prevalence; and / or
- the proportion of uninfected men engaging in sero-discordant unprotected anal intercourse (sdUAI); and / or
- the proportion of infected men engaging in sdUAI; and / or
- the average number of times those who engage in it do so, and / or
- the rate of condom failure during sero-discordant *protected* anal intercourse (sdPAI).

### 3.3 PRIMARY TRANSMISSION OF HIV

Not all exposures to HIV result in infection, and incidence is not simply a function of the number of exposures. What proportion of HIV exposures do result in transmission of the virus remains largely unknown but it is probably a minority. The probability of a man who is sexually exposed to HIV becoming infected is determined by many factors and the very complex interrelationships between them. The boxes in Figure 3.1b that lead into 'average probability of transmission' box represent a range of factors currently thought to influence whether or not transmission occurs when exposure does. These risk factors are only relevant to HIV incidence when they accompany exposure.

The modality of intercourse (who is insertive, who is receptive) influences the likelihood of transmission occurring. Transmission is much more likely if the infected man is insertive and the uninfected man is receptive than vice versa (Caceres & van Griesven, 1994). If the infected man is insertive, ejaculation is not necessary for transmission to occur. However, transmission is more likely if ejaculation in the rectum occurs than if it does not.

The strain of HIV involved may influence the likelihood with which it will be transmitted although evidence for this is conflicting (Mastro *et al.*, 1997).

The susceptibility of uninfected men exposed to HIV varies dependant on several factors. These are grouped into three categories: genetic factors, physical co-factors, and pharmaceutical prophylaxis. Genetic factors influence susceptibility to HIV (O'Brien & Dean, 1997) and remain constant throughout an individual's life. It is likely that some people are genetically immune to HIV, although no way exists to tell who is and who is not.

The presence of certain physical co-factors increase the probability of transmission when exposure occurs. These factors help transmission by providing or enhancing a route by which HIV can enter the body. If the uninfected man is receptive, these include activities which results in rectal trauma (eg. being 'fisted') before sdUAI (Coplan *et al.*, 1996) and inhaling nitrites ('poppers') during sdUAI (Seage *et al.*, 1992) which dilate the rectal membrane. If the uninfected man is insertive in sdUAI, having a foreskin appears to increase the likelihood of transmission (and being circumcised appears to decrease it, Moses *et al.*, 1994), as does having an ulcerative or exudative utheral infection such as herpes or syphilis (Dickerson *et al.*, 1996).

The third set of factors that influence the probability that a man who is sexually exposed to HIV becomes infected is the presence of pharmaceutical prophylaxis. While the use of pharmaceutical prophylaxis to prevent sexual transmission of HIV remains rare in the UK, they have the potential to decrease the likelihood of transmission when exposure occurs.

Prophylaxes could be administered either pre-exposure (possibly through taking anti-HIV drugs when uninfected or a vaccine if one becomes available) or post-exposure (taking anti-HIV drugs shortly after exposure) (Katz & Gebberding, 1997).

The more infectious the infected man is, the more likely transmission is to occur. The body fluid in which HIV is transmitted during sex is seminal fluid when the infected partner is insertive and blood when the infected partner is receptive. The infectiousness of the body fluids of infected men is mediated by viral load (Operskalski *et al.*, 1995). A higher viral load indicates greater infectiousness and plasma viral load can differ from seminal viral load. Viral load is influenced by several factors: the use of anti-retroviral drugs (HAART) reduces viral load in both plasma and semen (Vernazza *et al.*, 1997); and genital infections appear to increase seminal viral load independently of plasma load (Atkins *et al.*, 1996).

### **3.4 THE OUTCOMES: HIV INFECTION AND HIV INCIDENCE**

Whether or not HIV infection occurs during sex between men is the outcome of the above factors and their interaction. Obviously, for primary exposure to occur one partner must be infected and the other must be uninfected (ie. sero-discordant for HIV). Whether transmission occurs during any one occasion of sdUAI is not determined by any single factor. So for example, an HIV-uninfected man with genital syphilis, engaging in insertive UAI with an HIV-infected man with a high viral load may be much more likely to become infected than an HIV-uninfected man engaging in receptive UAI with an HIV-infected man with a low viral load who does not ejaculate.

At the population level, HIV incidence depends on how much exposure is occurring and the levels and combinations of all transmission factors in all occasions of sdUAI. There exists a continuing need for evidence regarding the behavioural and biological factors associated with HIV infection. This includes more detailed knowledge of the range of factors involved, the contribution to incidence each makes and the relationships between them. This need is international and, in the UK, is the responsibility of the Department of Health and the Medical Research Council.

Based on the above model, we can identify several changes, any of which would reduce incidence if all other factors remained constant. Not all factors are equally amenable to change and there are many ways of influencing those that are. The next chapter describes the targets we are attempting to change in the population, and the aims of interventions we carry out.

# 4 Population targets and health promotion aims

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## 4.1 INTRODUCTION

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

This chapter considers the potential of each factor in Figure 3.1b as 'targets' for an HIV health promotion programme. For each factor, we ask: is it *possible* to reduce its contribution to incidence; is it *ethical* to do so; and is it practically *feasible* to do so. In answering these questions we draw on theories about why each factor occurs, and consider how interventions may influence that factor.

Ultimately this framework articulates three 'strategic targets' which it considers possible, ethical and feasible. These three targets are intended to contribute to the overall strategic goal of '*a reduction in the incidence of HIV infection during sex between men.*'

This chapter also introduces the *aims* of health promotion interventions proposed and endorsed by the agencies planning within this framework. The aims of intervention are derived and determined by the approaches outlined in Chapter 1. The aims are ambitious. They do not relate to what men do, but to what they are able to do. They concern the information men have, the meaning of that information to their lives, their personal and social resources and their interpersonal skills. They also concern the availability and quality of clinical services and control over condom failure.

The aims are what we aspire to. They are statements of the situation towards which we are working. Our aims are identical for all homosexually active men, although the extent to which they are currently true varies greatly across different groups (Hickson *et al*, 1999; Weatherburn *et al.*, 2000). All men have an equal right to have all of the aims met irrespective of their perceived or actual HIV status, sexual identity, ethnic group, age, residence, disability or other characteristics.

## 4.2 INFLUENCING BEHAVIOUR

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

Approaches to influencing what people do can be thought of as sitting somewhere on a *We Decide/You Decide* axis. This axis concerns who decides what people do, the people doing the influencing or the people they are attempting to influence. We can imagine the axis starting with '*You will do what we say*' through '*Well, you should do this really*', to '*Do what you think best*'. Figure 4.2 illustrates a number of approaches to influencing what people do.

The behaviour could be, for example, a sexual act, having blood taken for an HIV test, the use of lubricant with a condom, or having asymptomatic gonorrhoea diagnosed. We can think about using any (or each) approach to making that behaviour more likely. We can also think about each approach for making the behaviour less likely.

*We decide* approaches are those that value the behaviour above the individuals own choice. While it is preferable that individuals voluntarily 'do' the behaviour, that is less important than the behaviour being done. The meaning of success in *we decide* approaches is that the behaviour is done (or not done). It is defined on the 'end', not the 'means'.

*You decide* approaches are those that value the behaviour of an individual for that individual. Since benefit is ultimately defined by the individual, it is pointless making someone do something against their will, because we judge it 'for their own good'. This does not remove changes in the behaviour from the meaning of success, but adds whether they are voluntary. It is defined on both the 'end' and the 'means'.

**Figure 4.2:**  
**Approaches to influencing behaviours**

We decide	You decide
physical intervention	removing barriers
misinformation	education
limit opportunity	awareness raising
instruction giving	skills development
banning	responsibility giving

The approaches we adopt are informed by who 'we' are, who 'they' are, the relationship between us, and how much power we have to compel them, which is related to our relative numbers (how many of us and them are there). The agencies collaborating on this framework adopt *You Decide* approaches. We believe that raising awareness and empowering men through clear, accessible information and facilitating the development of the skills to carry out their choices is the most ethical approach to reducing HIV incidence among homosexually active men.

### 4.3 REDUCING THE NUMBER OF OCCASIONS OF sdUAI

Influencing whether or not men engage in sdUAI has been the central target of HIV prevention since the beginning of the epidemic. This is based on the belief that human behaviour is not inevitable, and that influencing it is possible. While there are undoubtedly unethical ways of influencing whether men are involved in sdUAI, there are also ethical ways of doing so. Sufficient UAI is currently occurring both between pairs of men who know they are sero-discordant for HIV and between those who do not know their sero-concordancy (Hickson *et al.*, 1999; Elford *et al.*, 1999; Weatherburn *et al.*, 2000) for it to be feasible to reduce the contribution sdUAI is making toward incidence. The first target we share is therefore:

**Strategic Target One:**  
**A reduction in the number of occasions of sdUAI.**

Men engage in sdUAI for multiple and complex reasons. The reasons on any one occasion differ markedly for different pairs of men, and between the infected and uninfected men involved (Henderson *et al.*, 1998; Keogh *et al.*, 1999). Many factors differentiate those men more likely to be involved in sdUAI from those who are less likely to. The first explanatory factor is *opportunity*. For example:

- ? where men live;
- ? whether they have HIV infection or not;
- ? how many different men they have sex with;
- ? whether they regularly have sex with someone who is HIV sero-discordant to themselves.

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

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

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

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

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

We deem it possible for ethical interventions to alter all of these factors, and for there to be sufficient evidence of need to make this feasible (Hickson *et al*, 1998; 1999; Weatherburn *et al*, 2000). The agencies planning within this framework are using the following approaches to influence the proportion of (both uninfected and infected) men who engage in sdUAI and/or the number of times they do so:

- ✓ Reduce barriers to sexual choices and increase the control men have over the sex they have;
- ✓ Increase men's sexual negotiation skills and their access to condoms and lubricant;
- ✓ Educate men about HIV, its exposure, transmission and prevention;
- ✓ Raise men's awareness of when their engagement in UAI might be sero-discordant.

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

The first four health promotion aims shared by agencies planning within this framework relate to Target One, the number of occasions sdUAI is occurring.

First, to decide about sex men must have choices, so our first aim is:

**AIM 1 Men have control over the sex they have.**

Some of the components of this aim are:

- 1.1 Men are able to choose who they have sex with and what kind of sex they have.
- 1.2 No man is raped or otherwise sexually assaulted.
- 1.3 No man is sexually exploited.
- 1.4 No man's sexuality is a problem to him.
- 1.5 No man's sexual behaviour is a problem to him if his sexual behaviour is not a problem to his sexual partners.
- 1.6 No man engages in sexual activity he does not want because he feels it is expected of him.
- 1.7 Men can envisage a future for themselves and a means to achieve it.

While having control in sex is necessary, it is not sufficient to have control over sdUAI. The ability to negotiate sex depends on the possession of personal resources and interpersonal skills. If men engage in anal intercourse they require access to condoms and lubricant and the practical skills to use them. In addition to control, we also want men to have abilities. Our second aim is therefore:

**AIM 2 Men are equipped and competent to negotiate sex.**

Some of the components of this aim are:

- 2.1 Men have the self-confidence to negotiate sex.
- 2.2 Men have the interpersonal skills to negotiate sex.
- 2.3 Men have easy access to appropriate condoms and water-based lubricant.
- 2.4 Men have the skills to use condoms and lubricant correctly.

Autonomy and abilities are prerequisites of control, but are only useful if men also have knowledge. HIV education involves imparting understanding as well as supplying information and should be tailored to a man's ability to understand. The aim of education is not that men know the 'safer sex rules', but that they understand the process and consequences of HIV infection. Our third aim is:

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

Some of the components of this aim are:

- 3.1 Men know that HIV is a virus that can result in AIDS, a serious, incurable and often fatal disease.
- 3.2 Men understand how HIV is and is not transmitted and the difference between exposure and transmission during sex.
- 3.3 Men know that anal intercourse is by far the most common and easiest route of HIV transmission and understand how the use of a condom prevents HIV exposure.

- 3.4 Men know and understand the differences between condoms and between lubricants and their relationship to condom failure.
- 3.5 Men know that incorrect use of condoms increases the rate at which they fail.
- 3.6 Men know that condoms can fail, even if they are correctly used.
- 3.7 Men are able to access and understand further information about HIV, its transmission and prevention should they wish to do so.

Abstract knowledge about health is not acted upon unless a hazard is perceived. That is, knowledge is of little use unless men are aware of the need for that knowledge. We aspire to increase the likelihood that men who engage in sdUAI, *recognise that is the case before doing so* by raising men's awareness of HIV infection in their own lives. While Aim 3 concerns this abstract knowledge, our fourth aim concerns the actual situation gay men face concerning HIV.

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

Some of the components of this aim are:

- 4.1 Men know there are both HIV-uninfected and HIV-infected homosexually active men in all areas of Britain and in every country in the world.
- 4.2 Men know that a man's appearance, age, ethnic group, life experience and behaviour are neither accurate nor reliable ways of telling whether they are infected with HIV or not, and that men can have HIV without experiencing any symptoms.
- 4.3 Men are aware that some men have undiagnosed HIV infection.
- 4.4 Men are aware that some men believe their HIV status to be other than it actually is.
- 4.5 Men are aware that some men who do not know their HIV status will engage in UAI without revealing that they do not know their status.
- 4.6 Men are aware that some men who know they are not infected with HIV will engage in UAI without revealing their negative status.
- 4.7 Men are aware that some men who know they have HIV will engage in UAI without revealing their positive status.
- 4.8 Men are aware that the more men they engage in UAI with, the more likely it is that they will be involved in HIV exposure.
- 4.9 Men understand that having HIV infection does not depend on whether that infection is diagnosed or not.

To meet Aim 4, men may wish to know whether they are infected with HIV or not. Men knowing their own and their partners HIV status is not necessary to avoid HIV exposure during sex and knowing their HIV status does not mean men will not engage in sdUAI. However, if men wish to engage in UAI and be confident that HIV exposure will not occur, a knowledge of their sero-concordance is essential. HIV testing is by far the most sensitive and specific way in which men can know their HIV status.

The following three health promotion aims relate to HIV testing, and the control testing gives men over their involvement in sdUAI. HIV testing, alone, is not a target within this framework. We do not share a desire to change the overall proportion of men who have tested or the proportion who test each year. It is the knowledge from tests that informs men of the potential for HIV sero-discordancy with their sexual partners, not the process of testing itself. Simply

encouraging or dissuading men to test for HIV contributes nothing to a reduction in HIV incidence. In addition, people's use of HIV testing covers more areas of their life than sexual decision making. The decision to test should always rest with individual men. So our aims concern whether men can access voluntary, quality HIV testing. The first aim related to HIV testing is therefore:

**AIM 5 Men are free to choose whether and when to test for HIV.**

Some of the components of this aim are:

- 5.1 No man is tested for HIV without his informed consent.
- 5.2 Men can discuss HIV testing without feeling obliged to take a test.

To decide about testing (and to give informed consent to a test) men must know about tests and the meaning and possible implications of different test results. Our second aim relating to HIV testing is therefore:

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

Some of the components of this aim are:

- 6.1 Men know that a medical test exists which can determine whether they are infected with HIV or not.
- 6.2 Men know that the HIV antibody test has a window period when their recent infection may not be detected, and understand what that means for them.
- 6.3 Men know that a test result applies only to the person taking the test and not to any of their sexual partners.
- 6.4 Men understand that a negative test result, if the person has not been exposed to HIV in the last three months, means a person is almost certainly not infected with HIV, and does not mean a person is immune, even if they *know* they have been exposed to HIV.
- 6.5 Men know that taking an HIV test means a person may face discrimination in some areas of their lives solely because they have tested for HIV.
- 6.6 Men know that a positive test result means a person will face discrimination in some areas of their lives, solely because they are infected with HIV.
- 6.7 Men understand that a positive test result means a person is infected with HIV and can pass their infection on.
- 6.8 Men know that a positive test result means a person may benefit from health monitoring, medical treatment and support services that would be unavailable if their infection remained undiagnosed.
- 6.9 Men can access and understand further information about HIV testing should they wish to do so.

For men to be able to access HIV testing, HIV testing services must exist and meet certain minimum practice standards. Moreover, men must be knowledgeable about their existence, and feel comfortable accessing them. The following aim being met is therefore dependent on the characteristics of services as well as the men who need them. Our third HIV testing aim, and the final aim concerning sdUAI is:

#### **AIM 7 Men have access to quality HIV testing services.**

Some of the components of this aim are:

- 7.1 There are testing services that are free and confidential at the point of delivery and are accessible both geographically and in terms of clinic times.
- 7.2 NHS testing services meet minimum practice standards.
- 7.3 Men know which HIV testing services exist and are aware of where they can access them.
- 7.4 Men know that HIV tests are available free and confidentially on the NHS
- 7.5 Men feel able to approach testing services and can talk honestly about their sexual behaviour with clinic staff if they wish to do so.
- 7.6 Men understand what happens when they visit an HIV testing service and why.

This concludes the aims of intervention about sdUAI. We judge that men are *less likely* to engage in sdUAI if these aims are true than if they are not. We recognise that, because choice remains with men themselves, some men will still choose to engage in sdUAI even when they know that is what they are doing, they understand what the consequences may be, and they can do otherwise. To *ensure* men do not engage in sdUAI requires the removal of their autonomy, which the agencies collaborating on this framework deem unethical. However, the proportion of sdUAI where this is true appears small. We therefore judge it feasible to influence the number of sdUAI occasions by addressing these aims.

#### **4.4 REDUCING THE CONDOM FAILURE RATE**

Condoms provide a very effective barrier to HIV exposure during sdUAI. Given the extent of UAI, the vast majority of sdUAI is probably a result of not using condoms rather than condom failure. However, condoms do fail and some men are exposed to HIV as a result. Evidence suggests that 10%-20% of condom users experience some failure (slippage and breakage) within a year period (Hickson *et al.*, 1999; Weatherburn *et al.*, 2000). Hence, condom failure is adopted as the second target within this framework. As it is not always possible for men to identify which occurrences of protected anal intercourse are HIV sero-discordant and selectively reduce condom failure on these occasions, we propose a reduction in condom failure during all instances of protected anal intercourse. Therefore, our second target is:

##### **Strategic Target Two: A reduction in the condom failure rate among all users.**

Whether or not a condom fails in use is related to many factors:

- ? the way it was manufactured;
- ? the age of the condom and the condition it has been kept in;
- ? the way it is used;
- ? the type and quantity of lubricant; and
- ? the strength of the condom.

The quality of condoms in the UK is high, and manufacturers have a clear interest in reducing what failure occurs through manufacturing error. We judge health promotion efficiently expending resources in this area to be unfeasible. However, there continues to be confusion about the naming and labelling of condoms, which it would be possible, ethical and feasible to

change. This limits the accuracy with which men can choose appropriate condoms. We suggest that the condom failure rate can be reduced by employing the following approaches:

- ✓ Increase the clarity of naming and labelling of condoms and lubricant
- ✓ Increase men's access to appropriate condoms and water-based lubricant;
- ✓ Develop men's skills in the use of condoms and appropriate lubricant;
- ✓ Educate men about differences between condoms and between lubricants;

Knowledge about, access to and the skills to use, appropriate condoms and lubricant feature in Aims 2 and 3 above, about whether men engage in sdUAI or not. They are repeated here because they are also important to condom failure. In addition, there are further sub-aims about condom failure but not sdUAI. The aims of interventions to reduce condom failure are brought together in our eighth aim. This aim is concerned both with homosexually active men and with the manufacturers and distributors of condoms and lubricants.

#### **AIM 8 Men have maximum control over condom failure.**

Some of the components of this aim are:

- 8.1 Condoms and lubricant are clearly and unambiguously named and labelled
- 8.2 Men have easy access to appropriate condoms and water-based lubricant.
- 8.3 Men have the skills to use condoms and lubricant correctly.
- 8.4 Men know that anal intercourse is by far the most common and easiest route of HIV and understand how the use of a condom prevents HIV exposure.
- 8.5 Men know and understand the differences between condoms and between lubricants and their relationship to condom failure.
- 8.6 Men know that incorrect use of condoms increases the rate at which they fail.
- 8.7 Men know that condoms can fail, even if they are correctly used.
- 8.8 Men can access and understand further information about condoms should they wish to do so.

### **4.5 REDUCING THE PROBABILITY OF HIV TRANSMISSION WHEN EXPOSURE OCCURS**

#### **4.5.1 Most factors cannot be targets**

We currently have little evidence about the proportion of HIV exposures that result in transmission. We also know little about which factors are the most important in determining whether or not transmission does actually occur. The average probability of HIV transmission among all exposures could, theoretically, be reduced by influencing the factors that contribute to transmission identified in Figure 3.1b. However, we judge most of these factors to be currently either impossible, unethical or unfeasible to influence. This section looks at each factor in turn, before turning to the group of factors we think may be adopted as a target, other sexually transmitted infections (STIs).

In assessing the contribution of each factor to the overall probability of transmission, it is important to distinguish between their influence on the probability of transmission and their actual contribution to overall incidence. For example, a factor may greatly increase the probability of transmission but be unsuitable as a target because it is very rare.

The vast majority of homosexually active men with HIV infection (in the UK) are infected with HIV-1. It may be the case that different subtypes of HIV-1 are differentially infectious, but effecting a change in the strains of HIV involved is not possible.

A reduction in the proportion of sdUAI where the uninfected man is receptive without a change in the number of exposures would require uninfected men exchanging one exposure for another. Therefore, attempting to increase the insertive:receptive ratio of all sdUAI is both unethical and unfeasible in practice. Similarly, reducing the percentage of sdUAI (in which infected men are insertive) that results in ejaculation is also felt to be unfeasible.

There exists no preventive vaccine against HIV infection - the main way in which an increase in pre-exposure prophylaxes could be achieved. Obviously the development of a vaccine would require a substantial addition to our targets and the approaches we adopt to pursue them (Dickerson *et al.*, 1996).

Although the Department of Health has issued guidelines for post-exposure prophylaxis (PEP) for health workers exposed through needle-stick injury (Chief Medical Officer's Expert Advisory Group on AIDS, 1997) no guidance has been given for its use following sexual exposure. The efficacy of PEP for sexual exposure is still unclear. We currently assume that the proportion of sdUAI in which uninfected men know they are being exposed to HIV is low and that self-nominated PEP would reduce transmission in a small proportion of exposures. At a population level then, reducing transmission through an increase in post-exposure prophylaxes is currently felt to be unfeasible. However, as an option for individual men we believe it should be available. In the continuing absence of guidance or policy on this factor contributing to incidence, we propose consideration by all of: *Men who have been sexually exposed to HIV have access to post-exposure prophylaxis.*

Our current knowledge about the following three factors and approaches to influencing them precludes their adoption as targets: an increase in the proportion of uninfected men (exposing themselves to HIV through insertive sdUAI) who are circumcised; a reduction in rectal trauma among uninfected men before receptive sdUAI; or a reduction in nitrite inhalation by uninfected men during receptive sdUAI.

Improvements in the efficacy of anti-retroviral therapies and/or an increase in successful anti-viral drug uptake among those infected men (who have had their infection diagnosed) who are exposing HIV to uninfected men would probably reduce the likelihood of transmission when exposure occurs. However, this is not an ethically acceptable approach to reducing incidence, given the current uncertainty about the long-term efficacy and side-effects of anti-HIV drugs. The health of infected men must always be the central concern in decisions about anti-HIV drug use.

#### **4.5.2 Reducing the presence of other sexually transmitted infections (STIs)**

The presence of STIs facilitate HIV transmission when exposure occurs in several ways and may therefore be a more significant factor than others. A comprehensive strategic review from the USA's Institute of Medicine concluded 'improved prevention of STIs should be an essential component of a national strategy for preventing sexually transmitted HIV infection' (Institute of Medicine, 1996).

The key difference between HIV and other STIs for prevention is that most other STIs can be cured or effectively treated and some can be vaccinated against. However, not all STIs are important to HIV transmission during sex between men in England (Weatherburn *et al.*, 1999).

We consider reducing the contribution of syphilis to be unfeasible as it is not sufficiently common (Lamagni *et al.*, 1999) to be making a significant contribution to incidence. Similarly, we judge HIV uninfected men engaging in sdUAI with (first attack) herpes on their penis to be uncommon, and therefore unfeasible as a target. Gonorrhoea and non specific urethritis (NSU) are the most common STIs among homosexually active men that may be playing a part in HIV transmission. This leads us to adopt a third target:

**Strategic Target Three:  
A reduction in the prevalence of gonorrhoea and NSU infections.**

The role of gonorrhoea and NSU in HIV transmission probably varies, especially in relation to their incidence, in various areas of the country. This Target should take more or less prominence besides Targets One and Two, according to the prevalence of gonorrhoea and NSU in that area (which is concentrated in large urban areas, especially London).

Barriers to gonorrhoea and NSU being treated include men being unaware of them or their symptoms, them having no symptoms, or they may be uninformed or misinformed about what services are available. Absent, inaccessible or unacceptable clinical services also reduce the likelihood gonorrhoea and NSU will be treated. This suggests that the prevalence of gonorrhoea and NSU could be reduced by employing the following approaches:

- ✓ Educating men about gonorrhoea and NSU, their transmission, detection and treatment.
- ✓ Educating men about clinical sexual health services.
- ✓ Increasing the accessibility and acceptability of clinical sexual health services to men.

How often gonorrhoea and NSU are present when sdUAI occurs is determined by the prevalence of these infections among all homosexually active men. Men with diagnosed HIV infection continue to acquire gonorrhoea (Sadiq *et al.*, 1998) and we have no evidence to suggest men with undiagnosed HIV infection are less likely to do so than HIV-uninfected men.

To reduce the presence of gonorrhoea and NSU when sdUAI occurs, we advocate a reduction in the prevalence of gonorrhoea and NSU among all homosexually active men, through prompt diagnosis and treatment. The last two health promotion aims concern this third strategic target. This first extends Aim 3 of the framework to include gonorrhoea and NSU as well as HIV.

**AIM 9 All men are knowledgeable about gonorrhoea and NSU, and how to prevent them, including their transmission, detection and treatment.**

Some of the components of this aim are:

- 9.1 Men know that sexual contact can transmit bacterial, viral and parasitic infections that can cause serious diseases as well as unpleasant and inconvenient ones.
- 9.2 Men know that gonorrhoea and NSU are more easily contracted than HIV.
- 9.3 Men know that the greater a man's number of sexual partners, the greater his possible exposure to gonorrhoea and NSU.
- 9.4 Men know that gonorrhoea and NSU can be cured.
- 9.5 Men know that a man's appearance, age, ethnic group, life experience and behaviour are neither accurate nor reliable ways of telling whether they are infected with gonorrhoea or NSU, and that men can have gonorrhoea and NSU without experiencing any symptoms.

- 9.6 Men know that the use of a condom reduces the likelihood of infection with gonorrhoea and NSU if they have intercourse with someone who is infected.
- 9.7 Men know that the longer gonorrhoea and NSU remain untreated, the more physical damage and disease they are likely to cause.
- 9.8 Men can access and understand further information about STIs, their transmission and prevention should they wish to do so.

In order for men to have infections diagnosed and treated, clinical services must be available. Moreover, men must be knowledgeable about their existence, and feel comfortable accessing them. As with Aim 7, this aim being met is dependent on the existence and characteristics of services as well as the men who need them.

**AIM 10 All men have access to quality sexual health clinical services.**

Some of the components of this aim are:

- 10.1 There are sexual health clinical services that are free at the point of delivery and are accessible both geographically and in terms of clinic times.
- 10.2 Sexual health clinical services meet minimum practice standards.
- 10.3 Men know which clinical sexual health services exist and are aware of where they can access them.
- 10.4 Men know which sexual health clinical services are available free and confidentially on the NHS.
- 10.5 Men feel able to approach sexual health clinical services and can talk honestly about their sexual behaviour with clinic staff if they wish to do so.
- 10.6 Men understand what happens when they visit a sexual health clinical service and why.

This concludes the description of the three targets our HIV prevention programmes are attempting to influence and the aims of our interventions within such programmes. The targets are properties of populations, not individuals. The aims are for interventions whose targets are homosexually active men. They are expressly chosen on their relationship to the targets.

# 5 HIV health promotion interventions

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## 5.1 STARTING POINT FOR THE CHAPTER

HIV health promotion is the process of enabling people to increase their control over HIV in their everyday lives. It attempts to ensure that men have the necessary resources for everyday living with HIV, whether they are infected or not. Hence, our overall aim is an HIV and STI educated, aware, empowered and equipped population of homosexually active men who have access to clear, accurate and credible information and quality services.

Within this approach we recognise as HIV health promotion any activity whose purpose is to increase the likelihood of achieving any of the health promotion aims (for one or more men) without reducing any other (for the same or other men). As many obstacles impede individuals making and implementing informed decisions, HIV health promotion also involves removing individual, community and societal barriers to choices and their accomplishment.

Central to this planning framework is the notion that the settings and objectives employed should be determined by the desired outcome in relation to an assessment of need. In other words, the decision about the objectives (eg. leaflet, outreach, community mobilisation, policy development, lobbying) does not come first in the planning process.

The starting point for this chapter is that what interventions are collectively trying to achieve is a reduction in unmet HIV prevention need, as defined by the aims in Chapter 4. What follows is a generic description of all the interventions known to us, through our own practice and that of others, which may contribute to a reduction in HIV prevention need.

## 5.2 TYPES OF HIV PREVENTION INTERVENTIONS

Although HIV infection is viral and the virus infects individual men, not all health promotion activity is intended to influence individuals directly and the probability they are involved in HIV exposure. We group HIV health promotion activities into five 'types' depending on how the activity contributes to a reduction in incidence. The five types of (HIV) health promotion intervention are:

- Direct contact health promotion interventions
- Community health promotion interventions
- Organisational / institutional health promotion interventions
- Health promotion facilitation interventions
- Equality interventions

Community health promotion can be further divided into building community infrastructures; social diffusion projects and community involvement structures. While the aims of most community health promotion interventions are mixed, separate representation here is intended to clarify the ways in which they are thought to 'work' (ie. contribute to a reduction in HIV prevention need among homosexually active men).

Health promotion interventions can contribute to a reduction in need among homosexually active men without making direct contact with them. They can do so by intervening on people who meet homosexually active men, for example their peer group (community health promotion interventions) and other service providers (organisational health promotion interventions). Activities that increase health promoters' ability to carry out quality interventions indirectly contribute to need being met among homosexually active men. Equality work addresses discrimination that makes all HIV prevention activity with gay men and other homosexually men less possible.

Of course, it is possible for a single intervention to use a range of activities which contribute to the primary HP aims 1 to 10 in a number of ways. So the boundaries between interventions are not always sharp. However, while the aims, targets, objectives, settings and resources of different types of intervention vary all should be describable (Hartley et al., 1999; Reid *et al.*, 2000; Henderson *et al.*, 2000). The rest of this chapter describes currently available interventions in greater detail.

### 5.3 DIRECT CONTACT INTERVENTIONS

Direct contact (DC) health promotion interventions are the most common of all HIV prevention interventions. Some can be done by anyone, others require considerable skill and resources; everyone can do some of them, all can be done by someone. They include all the interventions which gay men and other homosexually active men encounter, whose aim is to meet their HIV prevention needs.

DC interventions use many tangible objectives and settings, and are often tailored to specific population groups. There is no one-to-one relationship between the objectives, including methods, and the aims. However, some objectives and methods are obviously more appropriate to certain aims than others and far more evaluation evidence is needed about which best meet which aims.

Most objectives and methods can be used in a variety of settings. The method used to bring about the aim should not be confused with the setting in which it occurs. For example, 'gay scene work' and 'PSE work' are settings, not methods. Some objectives and methods are much more suited to certain settings than others and *vice versa*.

Direct contact intervention	<b>Target</b>	Homosexually active men (and sub-groups of them)
	<b>Aim</b>	Reduce primary HIV prevention need (ie. increase one or more sub-aims of the ten primary health promotion aims described in Chapter 4.)
	<b>Objectives</b>	HIV prevention service delivered usually involving one or more of: <ul style="list-style-type: none"> <li>• Display of printed materials in the mass media, on posters, and by distributing leaflets and cards;</li> <li>• Display of text and image through other media including the Internet and film;</li> <li>• Telephone discussion and information giving;</li> <li>• Face to face discussion, counselling and therapy between two people either as a single encounter or as an on-going activity;</li> <li>• Discussion, counselling and therapy carried out in groups either as a single session or an on-going activity;</li> <li>• Clinical services, including HIV testing;</li> <li>• Condom and lubricant distribution and sales.</li> </ul>
	<b>Setting</b>	Places where men can encounter interventions, including: <ul style="list-style-type: none"> <li>• Schools;</li> <li>• Universities and colleges of further education;</li> <li>• Social groups including young men's groups;</li> <li>• Work-places;</li> <li>• Social settings such as pubs and clubs;</li> <li>• Gyms and other leisure facilities;</li> <li>• Public and semi-public places where sex or sexual contacts occur;</li> <li>• Shops and other business services;</li> <li>• On telephone information and helplines;</li> <li>• In (and on) the mass media;</li> <li>• At designated HIV health promotion service sites;</li> <li>• GUM clinics/HIV testing services;</li> <li>• Other health service settings including: GPs; in-patient and out-patient services; day care services; home care services</li> </ul>

The settings in which direct contact health promotion is carried out should not be confused with the target group for the intervention. Although population groups are sometimes defined by a setting (eg. PSE users) they are usually independent of settings (such as men with diagnosed HIV, Black Caribbean men, men with 'large' numbers of partners, or young men). Different population groups differentially use different settings. In programme planning (see Chapter 6.3) attending to how population groups and settings overlap is important.

Many (but not all) DC interventions can be made by other services, and, importantly, by peers of the target group. It is these interventions that community and organisational interventions seek to increase.

## 5.4 COMMUNITY INTERVENTIONS

Community health promotion includes all activities that engage with and develop community infrastructures. This type of intervention covers the range of activities whose objectives are to encourage social, physical and political environments in which the health promotion aims are more likely to be met. Community health promotion is divided into two areas, with the interventions contained within them concentrating on more or less of each.

### 5.4.1 Social diffusion interventions

Social diffusion interventions are those that target people in the social networks of homosexually active men. They aim to increase those people's abilities to make interventions with others in their networks that reduce their HIV prevention need. Social diffusion projects also aim to meet the HIV prevention needs of the people they target and as such function as direct contact interventions as well. A generic name for some such interventions is peer-led education.

Social diffusion intervention	<b>Target</b>	Homosexually active men
	<b>Aim</b>	Increase HP aims 1 to 10 during social interaction
	<b>Objectives</b>	Peer makes intervention
	<b>Setting</b>	Social networks
	<b>Target</b>	Peers of homosexually active men
	<b>Aim</b>	Increase HP aims 1 to 10, and increase ability to make direct contact interventions.
<b>Objectives</b>	Facilitating community involvement, training	
<b>Setting</b>	Project centre and community meeting places	

The largest human resource in reducing HIV incidence is gay men, other homosexually active men and their social networks. Many aims can be brought about by men interacting with each other and with women. Some cannot. We recognise (as valid HIV health promotion) activities that increase the contribution individuals make to meeting the health promotion needs of gay men and other homosexually active men. The key means of social diffusion include critical consciousness raising and community mobilisation.

### 5.4.2 (Building) community infrastructure

Much health promotion activity is only possible because of the existence of a gay community infrastructure including meeting places, 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 building a community infrastructure is the existence of community infrastructures. As such, the target is not individuals, but the relationships between them. The objectives are less tangible and predetermined than those of DC interventions, and include establishing, facilitating or supporting the functioning of community groups. The existence of such structures reduces social exclusion and increases the range of settings in which direct contact and social diffusion health promotion can occur. Community infrastructures are not an end in themselves, but desirable to the extent that they benefit their members.

Social infrastructure intervention

<b>Target</b>	Places where men can encounter interventions, project centres and community meeting places
<b>Aim</b>	Their existence
<b>Objectives</b>	Facilitating and maintaining community structures, training
<b>Setting</b>	Community

## 5.5 ORGANISATIONAL / INSTITUTIONAL INTERVENTIONS

Direct contact interventions can be made by a wide range of organisations and institutions whose prime goal is not reducing HIV incidence but who wish to contribute towards it. Organisational interventions increase their ability to do so. These interventions include those that facilitate organisational development.

Organisational interventions are those that influence the policy and practice of organisations and institutions to enable them to increase the contribution they make to the ten HIV health promotion aims being met for the men they encounter. We recognise (as valid HIV prevention) interventions that increase the contribution of organisations and institutions to the achievement of the aims. The aims of such interventions vary by the target organisation.

Organisational HP intervention	<b>Target</b>	Organisations which share our overall goal of reducing incidence	Organisations with an interest, concern or responsibility for the education, health or sexual behaviour of homosexually active men	Other organisations and institutions
	<b>Aim</b>	Collaboratively plan within this framework	Ability to carry out HIV health promotion as appropriate to the organisations role and responsibilities.	Facilitate, or at least not impede, HIV prevention activities.
	<b>Objectives</b>	Professional training, lobbying, policy making, training, facilitating community involvement		
	<b>Setting</b>	Organisational networks		

Clearly the range of organisations that touch on HIV prevention practice is enormous. Here, we distinguish three levels of organisation. First, to maintain the momentum of this collaboration, we seek to influence organisations that share our goal (reducing incidence during sex between men) to increase collaboration by planning within this framework. Secondly, we seek to influence all organisations, institutions and other services that have an investment in HIV prevention, to maximise their contribution to making the aims true for the men they encounter. Thirdly, we seek to influence all other organisations, to facilitate, or at least not impede, our activities.

## 5.6 FACILITATION INTERVENTIONS

Facilitation of health promotion includes all activities that help those engaged in HIV prevention to plan and carry out interventions. It includes teaching and learning activities designed to develop health promotion competencies. These activities are not undertaken with gay men and other homosexually active men (unless they are health promoters). However, they contribute to increasing the effectiveness, efficiency and equity of the direct contact, community and organisational interventions undertaken.

**Facilitation interventions**

<b>Target</b>	HIV health promoters
<b>Aim</b>	Increased ability to plan and carry out interventions (above and below)
<b>Objectives</b>	Training in developing and delivering direct contact, community facilitation, training and equality interventions; research and development; communications and collaboration between agencies.
<b>Setting</b>	Organisational networks

Facilitation includes all research and development intended to generate information for use by health promoters, such as needs assessments (see 6.2) and evaluation (see 6.5). Programme planning itself (see 6.3) is an activity that enables health promoters to do HIV prevention, as are communications and collaboration between agencies (eg. inter-agency fora, newsletters). Since these activities take resources and have a purpose they can be considered interventions whose targets are health promoters themselves.

### 5.7 EQUALITY INTERVENTIONS

Social justice and equity are fundamental prerequisites for health (WHO, 1996) and social exclusion has been identified as a key cause of ill health (Townsend & Davidson, 1982; Wilkinson & Marmot, 1998). While the factors that lead to HIV exposure and infection are behavioural and biological, they are not random. They involve people and are determined by social processes. Therefore, influencing the behavioural and biological factors requires influencing the social processes that lead to them and which determine their distribution.

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

Equality interventions can be defined as any activity that reduces discrimination and social exclusion by influencing local and national policies. It is also known as developing healthy public policy.

Activities that reduce obstacles to our aims being met, or barriers to direct contact health promotion activities taking place, are recognised as valid health promotion activities, in themselves. Therefore, we recognise and support activities attempting to bring about social equality for gay men, bisexual men and people infected with HIV.

**Equality interventions**

<b>Target</b>	Discriminatory policy and those engaged in discriminatory practices, which make all HIV prevention interventions with or about homosexually active men less possible.					
<b>Aim</b>	Equal recognition for young lesbians, gays and bisexuals in our schools, an end to homophobic bullying and the repeal of Section 28.	Equal treatment under the criminal law, an equal age of consent and the repeal of gross indecency.	Equal protection from discrimination in the workplace, in education and in the provision of goods and services.	Equal recognition and respect for same sex partners.	Equal recognition and respect for lesbian and gay parents and their children.	That no person is denied a right which all citizens of the UK enjoy under international law because they have HIV.
<b>Objectives</b>	Lobbying, anti-discrimination policy, training, community involvement					
<b>Setting</b>	Everywhere.					

The aims of equality for gay men and other homosexually active men adopted by agencies planning within this framework are those of Equality 2000 (Mason & Watson, 1997). This campaign is organised by Stonewall to challenge five key areas of social and legal injustice.

We assert that without the above aims being met, the effectiveness and efficacy of all HIV prevention interventions will be severely compromised. Meeting these five aims will make meeting the health promotion aims more feasible and more likely. The targets of these aims are not gay men or other homosexually active men, but the social and legal environment in which they live. These five aims are to be met in all communities, across the range of geography, social class and ethnic groups.

The aims of equality for people with HIV infection adopted by agencies planning within this framework are those of The UK Declaration of the Rights of People with HIV and AIDS, launched by The UK Forum on HIV and Human Rights (UK Forum on HIV and Human Rights, 1992). The aim of this declaration is that no person is denied a right that all citizens of the UK enjoy under international law because they have HIV. Rights that we all enjoy under international law are:

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

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

Adoption of the above aims is not simply an endorsement of the activity of *Stonewall* and *The UK Forum on HIV and Human Rights* but an active commitment to ensuring that these aims are attended to. This means including measures of discrimination and inequality in HIV prevention needs assessment and consideration of interventions to address them in programme planning.

## 5.8 THE RELATIONSHIP BETWEEN TYPES OF INTERVENTION IN A PROGRAMME

Figure 5.8a summarises an entire HIV prevention programme for a population (in a city or area). All of the activity is directed towards reducing incidence by reducing the contributory factors, by reducing need, by making interventions, which occur across cities or areas.

Figure 5.8a: A population & its HIV prevention programme

<b>POPULATION</b>	<b>Morbidity</b>	HIV incidence
	<b>Contributory factors</b>	Sero-discordant unprotected anal intercourse Condom failure Gonorrhoea & NSU
	<b>Needs</b>	Extent to which aims are unmet
<b>HIV PREVENTION PROGRAMME</b>	<b>Aim</b>	Increase HP aims 1 to 10
	<b>Target</b>	Homosexually active men
	<b>Objectives</b>	Direct contact HP interventions Community HP interventions Organisational / institutional HP interventions HP facilitation interventions Equality interventions
	<b>Setting</b>	Cities and areas

Figure 5.8b shows the same programme in greater detail and shows the relationships between the different types of interventions just described. The top part of the figure represents the population of concern, HIV incidence within that population, the behavioural targets in that population that are driving HIV incidence, and their needs to have control over those behaviours.

In the bottom part of the figure are health promotion interventions. Men themselves encounter intervention from three sources; health promoters, their peer groups, and other services. These three interventions are shown as the top tier of interventions, and are those which directly impact on men's needs.

Health promoters do activities whose aim is to support and increase the interventions made by peers (through social diffusion interventions) and other services (though organisational interventions). These activities are shown below their respective direct contact interventions, with targets of these activities as the peers of gay and bisexual men, and organisational staff respectively. Therefore both social diffusion and organisational interventions consist of two parts. Those done by health promoters with peers and organisations, and the activities those peers and organisations do with men directly.

Community infrastructure interventions are those which support direct contact and social diffusion interventions by creating or maintaining places in which direct contact can occur. In the figure they appear underneath direct contact and social diffusion interventions (but not organisational ones). While the meaning of success in community interventions is the existence of community infrastructures, these infrastructures are desirable mainly because they provide a place for social diffusion and direct contact activities.

Facilitation interventions support direct contact, social diffusion, organisational and community interventions by increasing health promoters' abilities to do each of them. Similarly, equality interventions support all of the preceding. It is likely that an optimum health promotion map for any area will contain a balance of these intervention types dependent on local need.

**Figure 5.8b: Five types of activity in an HIV prevention programme and their relationship to HIV prevention need (and hence HIV incidence)**

<b>POPULATION</b>	<b>Morbidity</b>	HIV Incidence					
	<b>Contributory factors</b>	Sero-discordant UAI	Condom failure	Gonorrhoea & NSU			
	<b>Need</b>	Extent to which aims are unmet for homosexually active men					
<b>HIV PREVENTION PROGRAMME</b>	<b>Target</b>	<b>Direct contact interventions</b>	Homosexually active men (and those who wish to become so)	<b>Social diffusion interventions</b>	Homosexually active men (and those who wish to become so)	<b>Organisational HP interventions</b>	Homosexually active men (and those who wish to become so)
	<b>Aim</b>		Increase HP aims 1 to 10		Increase HP aims 1 to 10 during social interaction		Increase HP aims 1 to 10 in course of other service
	<b>Objectives</b>		HIV prevention service delivered		Peer makes intervention		Other service delivered (eg. health service, local authority service, education service)
	<b>Setting</b>	Places where men can encounter interventions	Social networks	Other service setting			
	<b>Target</b>		Peers of homosexually active men	Deliverers of services other than HIV prevention			
	<b>Aim</b>		Increase HP aims 1 to 10, and increase ability to make direct contact interventions (above)	Increase ability to meet HIV prevention needs of their clients in course of service delivery (above).			
	<b>Objectives</b>		Facilitating community involvement, training	Professional training, lobbying, policy making, training, facilitating community involvement			
	<b>Setting</b>		Project centre and community meeting places	Organisational networks.			
	<b>Target</b>		<b>Infrastructure interventions</b>	Places where men can encounter interventions, project centres and community meeting places			
	<b>Aim</b>	Their existence					
	<b>Objectives</b>	Facilitating and maintaining community structures, training					
	<b>Setting</b>	Community					
	<b>Target</b>	<b>Facilitation interventions</b>	HIV health promoters				
	<b>Aim</b>		Increased ability to plan and carry out interventions (above and below)				
	<b>Objectives</b>		Training in DC delivery, community facilitation, training and equality.				
<b>Setting</b>	Organisational networks.						
<b>Target</b>	<b>Equality interventions</b>	Discrimination which makes all the above HIV prevention interventions less possible.					
<b>Aim</b>		Equality.					
<b>Objectives</b>		Lobbying, anti-discrimination policy, training, community involvement					
<b>Setting</b>		Everywhere.					

# 6 Needs assessment & programme planning

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## 6.1 THE MEANING OF NEED WITHIN THE FRAMEWORK

We take the health promotion aims 1 to 10 not being true as the meaning of HIV prevention need for homosexually active men. In other words, need is defined as an aim being unmet. Men have unmet need/s if they are unaware of HIV or STIs, ignorant or misinformed about them, disempowered in sexual relationships or activity, or ill-equipped to take protective action, including condom use. Men are also in need if they have little or no access to educational or clinical services, or they have access only to poor quality services. Need describes areas where a single man or group of men have the potential to benefit from an intervention or programme of work. An intervention may target the men themselves, or members of their social and sexual networks who in turn influence them.

As we are also attempting to increase the number and quality of peer-led interventions, men *not being able to make interventions with their peers* is also considered evidence of need within the framework. Since we require community infrastructures to do direct contact and social diffusion interventions, *the absence of community infrastructures* is also considered as evidence of need. As are *organisations being unable to contribute to the health promotion aims in the course of their work*.

As health promoters and researchers require organisational structures, personnel, skills and planning data, the absence of these is also viewed as an HIV prevention need within the framework. Finally, *policy and practices that unfairly discriminate against homosexually active men and people with HIV*, and which make HIV prevention interventions less possible are in themselves evidence of need. An HIV prevention needs assessment for gay and / or bisexual men could cover any or all these areas of need.

## 6.2 NEEDS ASSESSMENT

HIV prevention need cannot simply be derived from HIV incidence, STI prevalence or sexual behaviour in a population. Needs assessment involves making informed judgements about the extent to which health promotion aims are unmet in a population. Resources are likely to be most efficiently used if they are employed in areas of greatest need. Alternately, interventions may be inefficient simply because their aims are already well met for the target audience.

An assessment of need may consider:

- the extent to which a specific aim(s) is met for an entire population;
- the extent to which all of the health promotion aims are met for a specific sub-population; or
- the extent to which specific aims are met for a specific sub-population.

We can use a number of ways of defining sub-populations of homosexually active men. For example, demographically (Black Caribbean, social class, young etc.); geographically (rural, Londoners etc.); socially (opera lovers etc.); clinically (men with hepatitis or HIV); sexually (men with 'higher' numbers of sexual partners) or by another means of HIV exposure (such as injecting drug use). Of course these classifications will often overlap.

The health promotion Aims 1 to 10 described above are identical for all men but the extent to which they are met may vary between sub-populations and between individual men. A needs assessment for a population or sub-population should make an estimate of its size and relationship to other population groups.

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

All health authorities have a statutory responsibility to assess the HIV prevention needs of their resident population (UK Health Departments, 1995; Department of Health, 1999a). They also have a responsibility to use an allocated and finite amount of money on commissioning services to meet as much need as possible in the most equitable manner. However, the extent to which some health promotion aims are met, the obstacles to them being met and the health promotion initiatives that may best achieve them, transcend health authority boundaries. Some needs therefore require assessments on geographical areas larger than single health authorities.

Needs assessment is not a single activity, event or report. It is an ongoing process requiring the collation of information from a wide range of sources and cycles of review. Needs assessment and programme planning occur in parallel: health promotion should not be evaded while a needs assessment is carried out, nor needs assessment disregarded once health promotion has begun. Needs and the health promotion aims they are intended to address should be revisited throughout the planning and implementation of programmes.

### **6.3 PROGRAMME PLANNING**

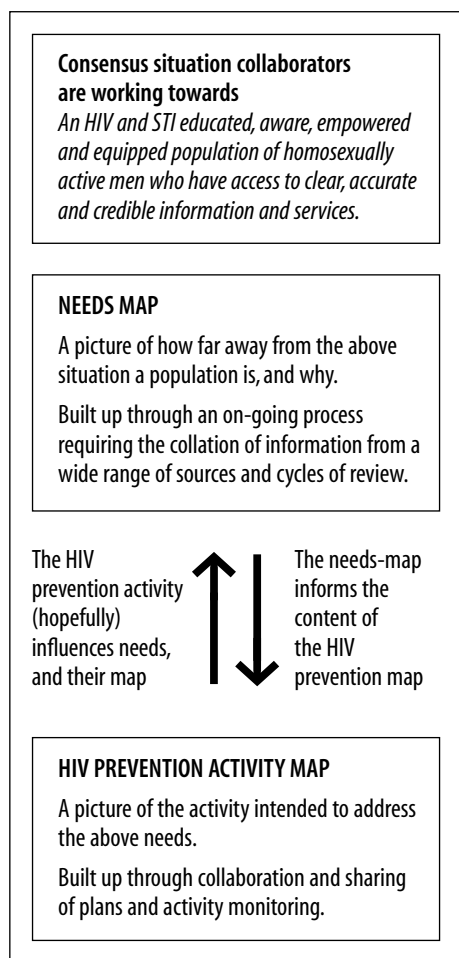
Since a programme is a set of ‘...activities designed to fulfil particular strategic goals and targets related to a ...(particular) priority’ (Simnet, 1995, p.101), any strategic combination of interventions may be thought of as a programme of work.

In any city or area with several interventions occurring, men will probably encounter more than one. Men encounter and are influenced by (and often do not distinguish between) health promotion emanating from several sources, even if those sources are unaware of each other. In short, no agency has exclusive access to any one individual. Consequently, single interventions cannot easily be independently prioritised as the desirability of each is dependent on what other interventions are occurring. The combined influence of different interventions should have a greater impact than the individual interventions encountered separately. Moreover, contradictory or conflicting interventions may cancel each other out.

Programme planning is essential to use finite resources in the most effective and efficient way to address the unmet aims identified in needs assessment. As all programmes have access to finite resources, some prioritisation of activities needs to occur.

Homosexually active men are a diverse population, who do not all go to the same places, or all know the same people. Since such diversity cannot be reflected in every health promotion activity, a successful programme must employ a variety of settings and methods. Different interventions (in either setting, objectives or both) may be required to address the same unmet aims for different groups of men. However, it is not the case that each group of men that can be identified requires its own programme (or organisation). What is important is *relevant* group differences.

Recent Department of Health guidance (Department of Health, 1999b) has emphasized the importance of moving from competition to cooperation among those involved in service planning and delivery. It is suggested that, given the complex influences on people's health, no single agency can hope to meet all the health-related needs of any population.



**Figure 6.3: The interaction between collective HIV prevention activity and need in the population**

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

The collective task of those who undertake HIV health promotion for gay men and other homosexually active men is to configure activities so they have the maximal impact on reducing need and therefore HIV incidence. In other words, it is an attempt to identify the best combination of interventions to address needs. This is represented in Figure 6.3.

Describing interventions facilitates the construction and articulation of programmes. When the interventions under consideration are described in a comparable manner, they can be collected to form a health promotion activity map (Hartley *et al.*, 1999; Reid *et al.*, 2000; Henderson *et al.*, 2000). This allows us to avoid replication and maximise impact. It also allows us to increase the equity of a programme by covering as much of the population of concern as possible.

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

HIV prevention activity is ongoing and has an impact, whether or not we can describe this impact. An activity map (Hartley *et al.*, 1999; Reid *et al.*, 2000; Henderson *et al.*, 2000) is a way of looking at the activity of organisations and groups of organisations. It is a tool for collaborative planning, that is, it can be used to facilitate the coordination of activity so it has the maximum impact with the greatest degree of equity. While health authorities have considerable influence over the content of maps (through financing), they usually only finance what providers are able and willing to undertake.

Comprehensive activity maps should include all interventions occurring in a geographic area, not only those financed by health authorities. Just as a service provider would vary the activity they undertook with a single man dependent on his unmet needs, so collaborating agencies and their commissioners can make changes at the programmatic level to match changes in the unmet needs of the population.

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

Currently, the detail of the two maps is variable and dispersed. No one has a comprehensive and detailed map of either needs or health promotion for the whole population. Large variation exists in maps for particular population groups and specific HIV prevention aims. However, health promoters and commissioners hold much information, especially for the activity map.

## **6.4 PRIORITISING INTERVENTIONS**

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

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

### **Impact on incidence**

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

### **Impact on equity of health**

Prioritise interventions encountered by population groups for whom the aims are poorly met compared with other population groups (such as men with lower educational achievement, men under 20 or over 50, behaviourally bisexual men).

### **Impact on both incidence & equity of health**

Prioritise interventions with aims that are poorly met for many of the population (such as aims 4.5 to 4.7 concerning expectation of disclosure of HIV status by UAI partners – see Weatherburn *et al.*, 2000)

In addition, prioritisation needs to attend to both the effectiveness and efficiency of individual interventions in meeting their specified aims. These requirements are taken up below.

## **6.5 EVALUATING INTERVENTIONS & PROGRAMMES OF INTERVENTIONS**

It is essential to distinguish between the effectiveness of individual interventions at influencing the HIV prevention needs of the men who encounter them, and the effectiveness of programmes of intervention at meeting the needs of a population and so influencing the strategic targets for populations.

### 6.5.1 Evaluating interventions

It is against changes in their aims that individual interventions should be judged. Evaluation of individual interventions should attend to what is done (objectives and methods), where (setting), with what (resources), to achieve what change (aims) for whom (target).

If these dimensions of interventions are specified in advance and information on their actual performance is gathered (ie. monitored), we can ask about the quality of the interventions (see Figure 6.5.1).

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

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

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

#### Impact on efficiency

Prioritise interventions that are the most efficient at reducing need.

### 6.5.2 Evaluating programmes

The effectiveness of a programme at influencing the strategic targets in a population will not be determined solely by the range of methods it includes. The fit between the needs of the population and the programme planned to address them, the range of settings health promotion is carried out in and the broader social and legal context will all be important.

**Figure 6.5.1: Qualities of an intervention**

#### Feasibility

Is it possible? Can those objectives be done in that setting with those resources?

#### Cost

How many resources does it take (eg. money, people, equipment)? How much is related to the setting (recruitment costs) and how much to the objectives (unit costs)?

#### Acceptability

What do the target think of the objectives, particularly in that setting?

#### Coverage and access

How many (or what proportion) of the target encounter the objectives in that setting and how do they differ from the people who do not encounter them?

#### Needed

Is the aim already true for the target before they encounter the objectives?

#### Effectiveness

Do the objectives bring about a change in the aim for the target? Who benefits most and who least?

#### Efficiency

Are all the resources necessary to bring about the change in the aim for this target?  
How does the intervention compare to others that bring about the same amount of change for the same people?

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

Comprehensive programmes of interventions should be judged by population level change in the strategic targets specified in Chapter 4, namely:

**Target One:** a reduction in the number of occasions of sero-discordant unprotected anal intercourse (sdUAI);

**Target Two:** a reduction in the condom failure rate among all users;

**Target Three:** a reduction in the prevalence of gonorrhoea and NSU infections.

It is unlikely that in any area a single agency can take responsibility for all men's HIV prevention needs. Hence, all the above targets cannot be expected to be achieved by any one agency. Rather, change in the targets will be a consequence of all related activity of all agencies in an area working collaboratively.

# 7 Collaborative planning & development of *Making it Count*

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## 7.1 COLLABORATIVE PLANNING

There currently exists no single organisation or institution with a responsibility for reducing HIV incidence through sex between men nor any single group of organisations commanding sufficient expertise, resources and respect to ensure it occurs. Hence, our collective success will depend on the extent of our collaboration. The framework requires championing and using by a wide range of individuals and organisations.

The framework is a means, not an end. It will only contribute to a reduction in the incidence of HIV through sex between men if it is used as a basis for collaborative planning of HIV prevention activity.

Gay men and other homosexually active men, like many population groups, are a mobile population who do not recognise health authority boundaries. Regional level initiatives will be more effective and efficient to address some needs than several independent health authority level initiatives. Adoption of this framework would facilitate national, regional, district and agency-level planning groups that can include commissioners, providers, researchers and lay people.

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

- is commissioning or carrying out HIV health promotion with gay or other homosexually active men that contributes to the achievement of our shared aims and is not carrying out activities that make their achievement less likely; and
- recognises the need for a collaborative approach to reducing HIV incidence and is committed to working in partnership with other agencies to do so; and
- can describe its activity and is willing to share intervention performance information with other agencies.

## 7.2 ONGOING DEVELOPMENT OF *MAKING IT COUNT*

This document represents our on-going strategic response to the HIV epidemic among gay men and other homosexually active men in England. While the framework is not set in stone it is intended to provide a firm foundation on which to build. There is much to be done. Only by using the framework in planning and carrying out collaborative HIV health promotion will its strengths and weaknesses, its irrelevancies and omissions, become apparent.

This document provides the planning framework for all interventions carried out as part of the Community HIV and AIDS Prevention Strategy (CHAPS), for many of the other health promotion activities of the agencies participating in that collaboration, and for several agencies outside that partnership. It also provides the basis for the planning and purchasing of a wide range of health authorities.

It is intended that this framework be reviewed every two years. The *Making It Count* Development Group of CHAPS would welcome comments and suggestions on this framework and its use in collaborative planning. These can be sent to:

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