

Future Commissioning of London HIV Prevention Services  
Project Steering Group

# Report on Call for Evidence

This report was commissioned by the Association of Directors of Public Health (London) and written by Dr Peter Keogh, independent research consultant



In February 2013 the Leaders' Committee at London Councils recognised the shortcomings of the Pan London HIV Prevention Programme (PLHPP) approach to HIV prevention. In response, the Association of Directors of Public Health (ADPH) London, working with London Councils, designed the Future Commissioning of London HIV Prevention Services (FCLHPS) Project to oversee a London-wide needs assessment over the summer of 2013. The FCLHPS project included six work streams:

- Epidemiological review
- Evidence review update
- A Call for Evidence
- Stakeholder engagement
- Segmented insight research
- Mapping of current HIV prevention.

The overall findings of the needs assessment are published in the report: "HIV Prevention Needs Assessment for London" (November 2013). This report is the output of one of the six underpinning work streams, and focused on the call for evidence. ADPH London and London Councils will develop an options paper for a meeting of the leaders of the 33 councils in London, due to take place in November 2013.

# Future Commissioning of London HIV Prevention Services (FCLHPS) Project: Report on Call for Evidence

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## Summary

### Process

- Directors of Public Health issued a call for evidence of 'what works' in the primary and secondary prevention of HIV. The call sought submissions of evidence to support HIV prevention interventions. Responses were limited to 500 words and a pro-forma was supplied. The closing date for submissions was 5pm 9th August 2013.
- 84 responses were received. These varied in length and whether or not the pro-forma was used. An initial analysis sorted responses into four categories.
  - a. Responses describing a pilot or intervention (N=53)
  - b. Responses that presented 'grey' literature outputs of pilots or evaluations (that is, evaluations not published in peer reviewed publications) (N=8)
  - c. Narrative responses attending to over-arching or strategic aspects of commissioning (N=18)
  - d. Responses that presented 'needs' or 'behavioural' data (N=5).
- Responses in categories (a) and (b) are covered in this report. Submissions in categories c and d are reported in a companion report (see *The Future Commissioning of HIV Prevention in London Stakeholder Engagement Report*).
- Responses describing interventions were entered into a charting framework and categorised according to intervention type. As few of the responses described evaluations and those that did were not experimental in design, the use of Cochrane or NICE tools was judged to be not appropriate for the types of evidence cited in responses. Analysis of the evidence provided showed a focus on:
  - Evidence to show that the intervention is **acceptable** to intervention users or beneficiaries.
  - Evidence to show that the intervention is **feasible**.
  - Evidence of an **outcome** (for example a behavioural change).

The 53 responses in categories (a) supported by the eight responses in category (b) were sorted into intervention types and are presented under the following five headings.

### Intervention type 1: Prevention

#### *Screening/testing Interventions*

**Community testing** – Six responses: Three are community testing sites; two describe testing in saunas; one describes HIV testing in a young person's sexual health clinic and one is a pilot to assess acceptability of testing as part of NHS Health Checks.

**Testing in Primary Care settings** – Three responses, one is borough wide sexual health training, one is a diffuse borough intervention and one is a focused intervention on four GP practices.

**Testing in other clinical settings** – Seven responses, the first is HIV testing in an acute medical unit, the second is the provision of health advisors to promote testing across a range of clinical settings. The remaining five describe pilots of interventions in various clinical settings.

**Other testing pilots**—Three responses; the first is a home-testing service; the second is an active recall to clinic intervention for MSM using a GUM clinic; the third is a pilot of a risk assessment and home testing service targeted at MSM using gay social networking sites.

- Responses describing HIV testing interventions cite evidence of acceptability, feasibility, clinical benefit and cost-effectiveness of conducting HIV testing in a range of clinical settings and community settings.
- They raise questions regarding the best ways of implementing HIV testing in primary care settings and signal caution with the recommendation that all new registrations at primary care practices should be offered testing.
- There are good models of interventions targeting primary care practitioners with strong evidence of one intervention increasing number of HIV tests carried out at GP practices overall.

#### *Condom distribution scheme*

Two responses: The first targets MSM in commercial gay venues and the second describes personalised condom and information resource dissemination targeted at African Communities.

- Condom distribution schemes show high levels of satisfaction amongst users of the scheme.

#### *Needle/syringe sharing*

One response describes a proposal for new needle exchange service targeting MSM injecting drugs in the context of sex in group situations.

### ***Intervention type 2: Support***

#### *Behavioural/therapeutic and peer /community group interventions*

Five responses: Two time-limited group work interventions aimed at sub-groups of MSM; one group interaction targeted at African MSM and two Living Well Positive self-management courses.

- Responses describing therapeutic group work cite evidence-based practice.
- Internal evaluations of interventions using before/after approaches describe evidence of self-reported change along key behavioural and attitudinal indicators.
- Similar evaluations describe high levels of acceptability of group work interventions amongst those using them.

#### *Behavioural counselling/ social support/mentoring/coaching/telephone hotlines*

Eight responses: Three intensive on-going or one-off interventions using CBT or other psychological approaches; two one-to-one interventions in community settings; one peer mentoring intervention, one self- assessment/reflection tool for use by MSM attending a GUM clinic, and one telephone information and advice service.

- Responses describing therapeutic one-to-one interventions cite evidence-based practice.
- Internal evaluations of interventions using before/after approaches describe evidence of self-reported change along key behavioural and attitudinal indicators.

- Similar evaluations describe high levels of acceptability of the intervention amongst those using them.
- Responses describing informational one-to-one interventions using before/after/follow-up approach report self-reported change in knowledge, testing intentions, attitudes and risky behaviours and high levels of acceptability amongst those taking part in the intervention.

### *'Integrated' Support Programmes*

Two responses targeting MSM: both based on periodic assessment (initiated by health trainers/volunteers) using an outcomes focused common assessment tool (BASK). Men are referred into different services depending on assessed need. The first is London-wide and the second is borough-wide.

One response targeting African communities: The Safer Partnership targets African Communities in South London. Interventions are inter-linked through three work-streams: one-to-one outreach, community mobilisation and condom distribution.

- Before/After/Follow-up monitoring of integrated programmes show self-reported (subjective) and observed (objective) change along attitudinal and behavioural variables.
- However it is not clear whether or not the programmatic element adds to effectiveness of the individual interventions administered as part of the programme.

### ***Intervention type 3: Media***

#### *Social networking*

Two responses: One social media component of a national HIV prevention campaign; one digital platform to support sexual health education and marketing campaigns.

#### *Website*

Three responses: one online risk assessment tool for MSM, one long-running health promotion website used by MSM, one 'synthesis' website currently in development.

#### *Mass media and Newspaper/magazines*

2 responses: One is a sexual health magazine aimed at MSM; the second describes a mass media campaign to raise awareness of PEP amongst MSM.

- The two interventions using social networking approaches describe far higher than expected coverage with specific target groups.
- Monitoring data and independent evaluation of a website aimed at MSM reports substantial coverage, high levels of user satisfaction and self-reported attribution of change in sexual risk behaviour and intention to use sexual health service to visiting the site.
- Monitoring data and independent evaluation of a magazine aimed at MSM report high levels of user satisfaction and self-reported attribution of change in sexual risk behaviour, and intention to use sexual health service after encountering the magazine.

- One intervention demonstrates strong potential for mass media advertising, when properly targeted, to bring about substantial changes in knowledge, behaviours and intentions where the knowledge base is low to begin with.

#### ***Intervention type 5 Educational and Support Interventions on a Community Level***

In this category are interventions that are educational or support interventions in approach but work on a community level to change community norms or practices.

Two responses describe interventions to work *with Community leaders*. The first carries out work with Church leaders and congregations; the second works with community leaders and proprietors in a range of settings.

Two responses describe interventions working around *Football tournaments*. The first is a combination of community workshops, outreach and point of care testing (POCT) at community football events; the second is a one-off Football Tournament.

Two responses describe *Multiple-methods*, or the simultaneous use of a wide range of approaches to carry out community-based work with African communities, the first with adults and older people and the second with younger people.

- The community-based interventions describe evidence of feasibility and acceptability of interventions as well as satisfaction amongst those using them.
- Some cite evaluations reporting self-reported changes in behaviours and attitudes as a result of contact with the intervention.

#### ***Other Interventions***

Two responses: The first is a capacity building intervention for African community organisations and the second describe the activities of a medium-sized agency.

- The agency response reports self-reported change on a range of key dimensions as a result of service use from internal evaluative activities.



## 1. Background and Process

### 1.1 Context

In February 2013 the Leaders Committee at London Councils recognised the shortcomings of the Pan London HIV Prevention Programme (PLHPP) approach to HIV prevention. In response, Association of Directors of Public Health (ADPH) London, working with London Councils, designed the Future Commissioning of London HIV Prevention Services (FCLHPS) Project to oversee a London-wide needs assessment over the summer of 2013.

The FCLHPS project included six work streams:

- Epidemiological review
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The overall findings of the needs assessment are published in the report, "HIV Prevention Needs Assessment for London" (November 2013). This report is the output of one of the six underpinning work streams and focused on the call for evidence. ADPH London and London Councils will develop an options paper for a meeting of the leaders of the 33 councils in London, due to take place in November 2013.

### 1.2 The Process

In July 2013, Directors of Public Health issued a call for evidence of 'what works' in the primary and secondary prevention of HIV. The call sought unpublished 'grey literature' on successful HIV prevention interventions and programmes, to include conference papers, presentations and reports, project and programme evaluations and service audits (see appendix A). The call asked for submissions of evidence for HIV prevention and behavioural interventions that met the following criteria:

- The intervention can be clearly described
- That clear objectives and outcomes were defined for the intervention/programme
- The intervention/programme has been / is being evaluated providing evidence relating to the effectiveness and /or cost effectiveness of the intervention
- The intervention has been delivered in urban settings in a high income country.

Particular emphasis was placed on projects or interventions working with high HIV prevalence population groups in London, in particular MSM (including gay men) and black African communities. Effective interventions were defined in the call as those that have reduced HIV incidence over time, those that have reduced late diagnosis of HIV, and/or those that have shown sustained behaviour change amongst target population groups in relation to HIV transmission. Responses were subjected to a word limit of 500 words and a pro-forma was supplied for responses asking the responder to specify: where the intervention took place; the target population/s; the project/ intervention activity; intended outcomes; whether outcomes were achieved; the cost and how it was evaluated.

The call for evidence was supported by a call for evidence briefing that was promoted in the following ways:

- Emailed through the London Directors of Public Health Network to be cascaded to borough sexual health leads and commissioners
- A presentation to the London Sexual Health Commissioners Network meeting and subsequently emailed to all known sexual health and HIV commissioners
- Presentation at the Safer Partnership Project Evaluation Report launch and members of SWAGNET at a workshop focused on the needs assessment
- On London Councils website [www.londoncouncils.gov.uk/hivprevention](http://www.londoncouncils.gov.uk/hivprevention) , promoted via tweets and direct email out by London Councils to over 7,000 individuals and organisations which received their e-newsletter
- To named stakeholders identified by the FCLHPS Steering Group, HIV Commissioners, the Project Delivery Team from their extensive contacts in the HIV sector, by London Councils and by posting details on the UKCAB website

The closing date for submissions was 5pm 9th August 2013.

The brief for this report is (a) to describe the process of sorting and analysing submissions, (b) to present the submissions sorted into useable categories, (c) to describe interventions and abstract the evidence provided on their effectiveness and (d) report on the strength and types of evidence cited. The process described here and this report cannot be considered to constitute a review of the grey literature as this would involve an active search for evidence of effectiveness within unpublished or non-peer reviewed publications rather than the call and response approach used here.

### 1.3 Responses

84 responses were received. Responses varied enormously in the extent to which they complied with the pro-forma supplied. Many did not use the pro-forma and were instead, narrative submissions which may or may not describe an intervention. Others were 'grey literature' submissions: that is a report of an evaluation or a conference presentation that has not been published in a peer-reviewed journal. Those that described interventions varied between those describing a single intervention, those describing programmes or groups of interventions and those simply describing the activities of an agency.

As there was such variation in responses, an initial analysis was necessary to sort responses into categories for more detailed analysis. This yielded four categories.

1. Responses describing a pilot, an intervention, a set of interventions or a set of health promotion activities (N=53).
2. Responses that presented 'grey' literature outputs (reports, conference presentations) of pilots or evaluations (N=8).
3. Narrative responses attending to over-arching or strategic aspects of planning, commissioning or evaluating HIV prevention services in London (N=18).
4. Responses that presented behavioural data or data relevant to HIV prevention needs in a range of formats (N=5).

As many responses incorporated detailed descriptions of organisational activities, anonymisation of responses for analysis was not possible. All responses were read through twice and a framework was developed which allowed sections of responses to be chunked in order to enable comparison and

analysis. This framework allowed responses to be categorised according to type of intervention, the target group, the aims and objectives of the intervention, any outputs and outcomes of the intervention and finally, any citations of evidence in connection with the intervention. Given the limited number of dimensions and the fact that a thematic content analysis was required, it was not necessary to use qualitative analysis software (such as NVivo).

After consideration of the findings of this analysis, it was concluded that it would be better to report on the responses in categories three and four (responses on strategy, planning and needs) in the companion report on stakeholder engagement (see *The Future Commissioning of HIV Prevention in London Stakeholder Engagement Report*) as these responses both strengthened and refined the findings already contained in that report. This report therefore focuses solely on the 53 responses describing interventions alongside the eight responses describing grey literature outputs.

#### 1.4 Who responded?

Of the 61 responses (53 describing interventions and 8 containing grey literature), just under two-thirds (39/61) came from voluntary sector organisations and just under one-fifth (13/61) came from NHS clinical service providers. The remaining responses were divided between Local Authority Public Health departments (4/61) and Public Health England (formerly Health Protection Agency) (5/61). Broadly speaking, the voluntary sector responses tended to describe interventions that were classified as Support, Media-based or Educational whilst clinical providers tended to describe interventions classified into the Prevention category with a particular emphasis on HIV testing and other clinical interventions. Local authority responses described a range of interventions whilst PHE responses were all categorised as grey literature.

#### 1.5 Assessing the evidence provided

The brief for this work stream included some kind of description or analysis of the evidence provided for particular interventions. Given the nature of this call for evidence and the types of responses received, the process of assessing evidence was not straightforward.

For the vast majority of responses describing interventions, the type of comprehensive evidence of effectiveness requirements described in classificatory tools such as the Cochrane Evidence Level Classification would not be met. That is, there was little or no evidence of ‘high-quality’ experimental, case control or case-matched studies used to support interventions. Although several responses did cite evaluations using before/after approaches, there was no evidence to confirm that the relationship between intervention and outcome was necessarily causal. Therefore, the majority of evidence cited might be defined as belonging in the category of non-analytic studies or case reports.

This should not be surprising given the fact that the majority of responders to the call for evidence were voluntary and statutory sector service providers or commissioners and this conclusion should in no way be seen as a criticism of the evaluative evidence cited. Rather, the evaluations carried out on interventions and included in responses tended to be (a) those that are most useful to service providers and (b) those that are within the means of providers to carry out. In short, it is beyond the resources and capacities of providers and those asked to monitor and evaluate them to conduct prospective experimental trials to demonstrate effectiveness. This is especially the case for non-clinical health promotion interventions which are particularly challenging when it comes to designing and carrying out experimental evaluations. Such trials are rare in the field of health promotion

generally and in the field of HIV prevention in particular. Moreover a lack of evidence of effectiveness does not equate to a lack of actual effectiveness. Rather interventions may not have been evaluated in ways that would demonstrate effectiveness or the lack thereof.

Despite this, in response to the call for evidence of ‘what works’ a range of evidence-based responses were elicited with nearly all responses citing evidence of one sort or another. We therefore conducted an analysis of the types of evidence that were provided to support interventions. From this, it is possible to classify the evidence submitted into the following types:

- Evidence of **effectiveness** cited from previous intervention studies or applications elsewhere.
- Evidence of **need** – that the need for this or a similar intervention has been demonstrated.
- Evidence of **feasibility** - that the intervention is feasible in terms of practicality or cost
- Evidence of **acceptability** - that the intervention is acceptable to the target group, beneficiaries or others
- Evidence of **outcomes** - that the intervention brought about some observed and/or measured change. These could be either intended or unintended outcomes.

The level of detail provided in each response varies greatly as does what the responder chose to emphasise in each individual response. This makes any assessment of the ‘strength’ of evidence submitted for each intervention hazardous and does not allow us to compare interventions or types of interventions in terms of their evidential strength. Rather, this process allows us to:

- To describe the interventions submitted by a range of voluntary and statutory providers to a general call for evidence of ‘what works’. Given the nature of submissions, this includes what interventions providers judge to ‘work’ based on the evidence available to them or known by them but may also be based on their professional and community experience.
- To describe the types of evidence providers use when assessing ‘what works’.

Thus, we will get a sense of the relative importance placed on interventions and the types of evidence used to support these judgements.

## 1.6 Classifications of responses into ‘types’ of interventions

In order to maintain continuity across the various evidence reviews making up the overall needs assessment, a typology of interventions was established listing five primary categories and 38 secondary sub-categories of HIV prevention. The responses describing interventions and those describing grey literature outputs were assigned to one of the five primary categories. As many interventions are multi-faceted and complex, it was not always possible to assign them definitively to secondary categories. In addition, interventions traversed primary categories and it was necessary to assign them based on the main approaches described in the response. The primary and secondary categories are presented in the table below.

Primary	Secondary
Education	Information/knowledge

	Skill building (general)
	Perception/Attitude
	Interpersonal skills training
	condom use skills training
	Self-efficacy
	Role play
	Condom promotion
	Service promotion
	Motivational
Prevention	Needle/syringe sharing
	Condom distribution scheme
	Circumcision
	Contact tracing / partner notification
	Screening/testing
Support	Counselling
	Peer group support
	Social support
	Support network
	Mentoring/coaching
	Behavioural (inc Cognitive/CBT)
	Hotline/helplines
	Case Management
	Community Support Group
	Family/friend
Media	Mass media
	Newspaper/magazines
	Leaflets/posters
	TV
	Website/internet
	Advertising
	Social network website
	Texting
	Multi-media
Bio-medical	Drug treatment (ART)
	Opioid substance therapy
	PEP
	PrEP

The 61 responses (incorporating the 53 that described interventions or collections/programmes of interventions and the eight we describe as ‘grey literature’) were assigned to categories as follows:

1. Prevention (27 responses)
2. Support (19 responses)
3. Media (7 responses)
4. Educational/Support interventions on a community level (6 responses)
5. Other (non-classified) (2 responses)

## 2. Prevention

### 2.1 Screening/testing

The case for expanded HIV testing to detect undiagnosed HIV infection and prevent late HIV diagnoses has been abundantly made. Earlier diagnosis and treatment of HIV lead to lower rates of morbidity and mortality, reduces viral load and may lead to behavioural changes which in turn mediate onward transmission risk.

National HIV testing guidelines recommend the expansion of HIV testing in high prevalence areas (defined as those with a diagnosed prevalence of more than two per thousand among 15-59 year olds) beyond antenatal and sexual health clinic settings (BHIVA, BASHH, BIS. , 2008). They advocate the routine offer of an HIV test to all adults registering in general practice and all general medical admissions in high prevalence areas. Further guidance describes HIV testing for high risk groups (NICE, 2011a) (NICE, 2011b). The Health Protection domain of the Public Health Outcomes Framework has included the proportion of persons presenting with HIV at a late stage of infection as an indicator of essential actions to be taken to protect the public's health.

A report (HPA, 2012) submitted as evidence for this review by Public Health England lays out detailed evidence of acceptability, feasibility, clinical benefit and cost-effectiveness of expanding HIV testing in general medical admissions and new registrants in general practice. It recommends that where blood tests are taken routinely for hospital medical admissions, HIV testing should be introduced and that this should imply minimal associated extra staff time or cost. It also recommends that HIV testing by general practitioners should be widely promoted. However, it also recommends some caution with respect to BHIVA guidance that HIV test should be considered for all new patients registered in high prevalence areas since not all primary care facilities conduct new patient health checks. It thus recommends investigation of a range of models in this respect. Finally, the same report estimates that the annual cost of expanding testing into general medical services nationally in areas of high prevalence with coverage of 75% would be £1.3 million: the cost for an average high prevalence PCT would be £19,000 per 100,000 population.

A second (then) HPA report (Health Protection Agency, 2011) submitted in response to the call for evidence gives the results of eight pilot HIV testing projects in different clinical settings. Within the eight projects, 12 different models of testing were piloted. In hospitals HIV testing was piloted in an emergency department, three acute admissions units and a dermatology outpatients department. Testing in primary care was assessed by three pilots (one of which was primarily a hospital project with an additional primary care arm). Two of the primary care projects aimed to offer testing to newly registering patients within surgeries, while one aimed to offer testing to all patients attending the practice. Four models of testing were piloted in community /outreach settings. Each of the pilot projects was implemented between 2009 and 2010. All except one were in high prevalence areas (where diagnosed HIV prevalence is greater than two per thousand among 15-59 year olds). Projects ran for periods of 3-12 months between 2009 and 2010.

Across the eight projects the overall positivity rate was four per thousand tests with the majority of settings finding positivity rates of at least one per thousand tests, which is the threshold for cost-effectiveness. The cost per test conducted within different settings varied dramatically with the highest costs observed in community settings. Estimates of costs per newly diagnosed individual

within pilots also varied with community settings and primary care settings coming out as most expensive. However, as already said, work in all settings was seen to be cost effective. The highest positivity rates were reported in community based projects (most likely due to effective targeting).

The report concluded that the routine offer of an HIV test in primary care and hospital settings is feasible and acceptable to both staff and patients and that it was also feasible and acceptable to establish HIV testing services in community-based settings. Moreover pilot projects also concluded that the costs and preparation associated with setting up interventions in all settings should not be underestimated. Logistical considerations within pre-existing clinical settings were extensive and complex whilst community testing needed the full involvement of the communities targeted in order to be appropriate.

A further submission describes the UK and Ireland Fellowship Programme on HIV testing projects supported by Gilead. Between 2009 and 2011 the programme funded 39 projects on HIV testing outside traditional settings to improve individual and public health benefits of HIV early diagnosis. Project findings of an external PHAST reported that feasibility of projects varied with test offered to test accepted rates varying between 10% and 100%. However, overall feasibility was similar to that reported by the HPA in pilot projects (see above). Overall acceptability was lower than that found by the HPA pilots; however the authors conclude that eligible populations generally find the offer of HIV testing acceptable in non-traditional settings although test acceptance may be low due to risk perception of individuals. The interventions collectively achieved an overall screen-positive rate of 0.7% (range: 0% to 9.1%). Screen positivity was high in hospital settings, in community settings and in primary care. Finally, like the HPA pilots, the UKIFP screen positive rates are substantially above acceptable cost-effectiveness thresholds.

The 18 responses describing individual HIV testing interventions or pilots of interventions are divided into the following sub-categories.

#### *HIV testing using POCT in community settings*

Six responses describe HIV testing in community settings using POCT.

Three were programmes of community testing at sites where MSM and African communities were targeted (commercial venues, community centres and attached to other clinical and non-clinical services). Two describe testing in saunas frequented by MSM and one describes HIV testing in a Brook young person's sexual health clinic (aimed at young men).

All were in high prevalence areas. However, targeting of particular venues and settings was carried out so that sub-groups of African people or MSM likely to be at greater risk for HIV infection or less likely to test (for example, MSM using recreational drugs, MSM who do not identify as gay, younger MSM, those unlikely to use GUM services etc.) were specifically targeted.

In addition to reducing undiagnosed infection, all responses stress other aims, benefits and outcomes including diagnosing and treating STIs which may in turn facilitate HIV transmission, raising awareness of risk practices in relation to HIV, raising awareness of the need to test and venues for testing, overcoming psycho-social obstacles to testing amongst individuals and normalising HIV testing within communities and populations.

Administrative data is cited for numbers of tests carried out as well as HIV positivity/reactive rates which range between 0% and 6% and clearly depend on prevalence in the population targeted, setting and the percentages of those approached who take up the offer of an HIV test. Some also collect data on numbers tested who had either never tested before or who had not tested recently. All cite internal user surveys demonstrating high levels of acceptability/satisfaction of service to those using it.

A slightly different response describes a pilot which aimed to assess whether POCT is acceptable as part of community-based cardiovascular risk assessments (NHS Health Checks), targeting communities at increased risk of HIV and individuals not accessing other testing sites. Health checks including POCT were being delivered in a range of wellbeing centres and two sites were added for the pilot: a church hall and a community centre. POCT was offered alongside cardiovascular risk assessment. 90% of those offered testing accepted it amongst which 52% had never had a previous HIV test and one third were not registered with a GP. Eight new HIV diagnoses were made (1% prevalence). The authors conclude that it is feasible to deliver HIV testing in a community setting alongside cardiovascular risk assessment, that the offer of an HIV test in these settings is acceptable to the community and that this approach may target individuals at risk of HIV who might not access traditional HIV testing sites.

#### *Interventions to enable/promote testing in other clinical settings*

Seven responses describe interventions to promote the offer of an HIV test or opt-out testing in non HIV/GUM clinical settings. All are in high prevalence areas where testing is recommended.

The aim of all of these interventions was to identify undiagnosed HIV and open up care pathways. For one intervention, the aim was to identify primary HIV infection in order to prevent onward transmission. Secondary aims were also identified, mainly concerned with de-stigmatising and normalising HIV testing in a range of clinical settings, that is, with both patients and staff.

A suite of responses describe interventions or pilots of interventions in various clinical settings. Each intervention was aimed at a patient group thought or known to be at elevated risk of HIV exposure and/or unlikely to use GUM services. The aim of each of the interventions was to decrease undiagnosed infection by removing the barriers to testing in a range of clinical settings.

The first intervention, based on a pilot study, was opt-out testing in a Medical Admissions Unit. The authors report identifying substantial undiagnosed infection. Moreover, they show that opt-out testing is feasible and acceptable to medical staff in this setting, though less is known about patient acceptability of opt-out testing.

The second intervention, under the same response was an offer of an HIV test in a termination of pregnancy (TOP) clinic. At the time of submission, take up was rising (at over 60%) and so far the intervention had identified a slightly lower prevalence of new HIV diagnosis to the GU clinic at the same hospital. The authors conclude that it is feasible and sustainable to perform HIV testing in TOP clinics and that this is a method of diagnosing HIV in individuals at risk of HIV, but who might not otherwise receive an HIV test.

For both of these interventions, cost-effectiveness was not evaluated, but they predict, given the nature of the innovation that the cost is likely to be relatively low.



The third was aimed at women using colposcopy services offering point of care testing to previous and new attendees. During the pilot phase, the authors report a testing uptake rate of 75% which falls to 41% after the pilot period with one previously undiagnosed infection identified. The authors conclude that although the running costs of this innovation are likely to be minimal after initial set up and that it is possible to perform HIV testing in colposcopy services, the intervention also met with resistance from the British Society for Colposcopy and Cervical Pathology who felt it desirable for HIV testing to be performed outwith colposcopy services.

The fourth aimed to increase the uptake of HIV testing and treatment by embedding an HIV nurse within in-patient and community mental health teams. The number of HIV tests performed in this setting rose five-fold resulting in 2 new diagnoses of HIV. However, other benefits were identified with enhanced treatment support/ care for those already diagnosed and the identification of 3 individuals who had previously disengaged with HIV care (and brought back into care). In addition, improved screening for Hepatitis B & C and syphilis resulted in diagnosis of 3 cases of chronic hepatitis B infection, and 3 cases of late syphilis which were subsequently engaged in care and treatment. The cost of this initiative was largely the staffing cost. The authors claim that it is possible to improve the HIV diagnosis and treatment for HIV infected individuals within this patient group as well as reducing the perceived stigma of HIV testing among staff and patients within mental health services.

The final intervention pilot was aimed at the male partners of pregnant women attending for routine ultrasound examination. Men were offered on-site serology for HIV. The reported acceptance rate was 35%, however no HIV diagnoses were made. The authors claim that it is acceptable and feasible to engage heterosexual men for testing in this setting, however low uptake did not justify the costs of the intervention.

A further two separate responses are included here. The first describes opt-out HIV testing in an acute medical unit. The authors describe the uptake of testing as lower than expected. However, conclude that this is not because the intervention was unacceptable to patients. Rather, difficulties with feasibility (for example staff turnover and management considerations) were impeding the intervention's proper implementation.

The second response describes a Health Advisor service aimed at supporting testing in a range of clinical settings as well as increasing the numbers of partners of those testing positive who test themselves. This is in accordance with new CQUINS with regard to partner-testing .

### *HIV testing in Primary Care Settings*

Three responses describe pilots to increase HIV testing in Primary Care settings. The interventions were very different as were the methods used in the pilot and the outcomes specified so any comparison between them is hazardous.

The first targeted those considered 'high risk' patients or patients presenting with one or more clinical indicator condition/s and used Point of Care testing (POCT) in two General Practices. GPs received training to identify indicator conditions and offer a test. Clinical support pathways were enhanced and were provided by local GUM services. A total of 40 tests were carried out, identifying previously unknown HIV.

The second supported GPs to offer opt out HIV testing as part of new registration process, conducting HIV testing (POCT and serology) on asymptomatic patients and delivering the results. Management support included a supply of POCT tests and practices were initially paid a fee for each test carried out, which was later discontinued

The third provided SHIP training, (training in sexual health clinical skills to general practitioners and practice nurses in a Local Authority). SHIP training aims to break down stigma in sexual health and provide sexual history and communication tools and resources to practices.

The strongest evidence to support an intervention to increase numbers of tests overall is provided by the SHIP intervention, which compared overall numbers of tests carried out by trained practices to those who had not received training. A year after SHIP training, the number of HIV tests per 1000 patients had increased by 220% in trained practices, and by 29% in untrained practices. The increase was most pronounced (430%) in an area of the borough where diagnosed prevalence was highest, i.e. where the population was most at risk and testing was most needed. Positivity rates were reported as much higher than that seen in other pilots leading authors to conclude that this intervention made use of pre-existing clinical skills in diagnostic testing. Moreover, these increased rates of testing were sustained for up to a year after the original training.

The other two studies showed acceptable positivity rates and widespread clinician acceptability in (a) carrying out HIV tests with patients identified to be at higher risk of HIV acquisition or with clinical symptoms or (b) in offering opt-out testing to all new admissions. In the first instance, the intervention was small scale with two GP practices and emphasised the quality of training and support. In the latter case, the intervention was at a Borough level, with much more diffuse support. In the latter case, the authors emphasise implementation issues. That is, they point out that considerable variation in the new patient registration process across clinics brought into question the potential for a truly opt out methodology with a universal test offer. These conclusions echo those of PHE cited above. Uptake was also crucially dependent on practice capacity and staff awareness leading the authors to recommend a whole practice team approach. Finally, they recommend improved systems for data recording and follow-up of attendance at acute clinical services and for more research into cost-effectiveness of screening alongside or compared to opportunistic and diagnostic testing.

There is clear evidence of the acceptability of HIV testing, either diagnostic or in terms of screening in primary care from clinicians and indeed evidence that interventions can bring about substantial and sustained increases in HIV testing carried out in these settings. However, the nature of the intervention is in question. There is strong evidence to support the kind of sexual health training offered as part of the SHIP intervention. However, both of the other pilots emphasise the need for practical and infrastructural support for individual practices, especially if screening of all new registered patients is the aim as opposed to diagnostic or opportunistic testing.

### *Other HIV testing interventions*

Finally three further interventions do not fit into the above categories.

The first concerns an on-going pilot of a Home Sampling HIV test Service aimed at MSM and African Communities the aim of which was (a) to increase testing amongst these groups and (b) to test

whether the method of testing was acceptable to users. So far the authors report a 45% return rate on the kits ordered and a 2.19% positivity rate on those taking the test.

The second is a pilot of Active Recall to clinic intervention for HIV and STI testing for MSM using a GUM clinic and who report sexual HIV risk behaviours in the previous 3 months. The authors report that their previous work has shown that active recall is feasible inasmuch as 68% of those recalled re-attended. The primary outcome will be re-attendance rate at 3-4 months after initial visit. Secondary outcomes include STI and HIV rates in the re-attending population and proportion of MSM reporting unprotected anal intercourse (UAI). Aggregate comparisons will be made between pre-intervention and intervention periods, re-attending and non-re-attending groups and initial and re-attendance visits. The cost of the intervention will also be calculated. In addition, the authors are also exploring the facilitators and barriers to active recall using mixed quantitative and qualitative methods.

The third describes a pilot of a HIV home testing intervention targeted at MSM through Gaydar social network website. The objectives of the pilot were to determine (1) uptake of an online HIV risk self-assessment (2) uptake of offer for home testing (3) the proportion of those completing the assessment that is high risk. Over a two-month period, the risk assessment was offered to 4500 London-based Gaydar users. 8% clicked through to the project website of whom 88% completed the HIV risk assessment. Of these, 45% were defined as “high risk”. Of those who clicked through for information on home sampling, 39% had never HIV tested. 132 test kits were requested of which 55% were returned, 4 of which were new HIV diagnoses (3% of kits sent and 5.5% of samples returned). The authors conclude that the intervention appears to reach a population of men that are “less tested”, though similarly risky to those who would use GUM clinics and a scale up is in train, the aim being to provide evidence to inform the potential roll out of online strategies to enhance community based HIV testing in the UK.

#### *Summary of evidence provided*

- Submissions describing HIV testing interventions cite evidence of acceptability, feasibility, clinical benefit and cost-effectiveness of conducting HIV testing in a range of clinical settings and community settings.
- They raise questions regarding the best ways of implementing HIV testing in primary care settings and signal caution with the recommendation that all new registrations at primary care practices should be offered testing.
- There are good models of interventions targeting primary care practitioners with strong evidence of one intervention increasing number of HIV tests carried out at GP practices overall.

## **2.2 Condom distribution scheme**

Two responses describe condom distribution schemes.

The first targeted at MSM in commercial gay venues and aimed to enable men to use condoms and lubricant who would otherwise (based on the cost of condoms, their physical location or other

factors) engage in UAI. Condoms and lubricants were distributed to venues and available in dispensers in each venue. The authors have conducted online and venue-based surveys reporting high usage of the scheme and acceptability of the intervention amongst those taking part. They also refer to independent community surveys that report easy accessibility of condoms for MSM resident in London.

The second describes more personalised condom and information resource dissemination through one-to-one and group information (targeted workshops) and advice targeted at African communities. Condoms and lubricants were distributed across 100 local African business and social outlets. In addition, femidoms were distributed to empower vulnerable women to negotiate safer sex through increased access to female condoms and flavoured condoms were distributed to promote and normalise the use of condoms among young people. The authors report that a community user survey reports on prevalence of condom use, difficulties with condom use and familiarity with femidoms.

#### *Summary of evidence provided*

- Condom distribution schemes show high levels of satisfaction amongst users of the scheme

### **2.3 Needle/syringe sharing**

One response describes a proposal for new needle exchange service targeting MSM injecting drugs in the context of sex in group situations. This is in response to reports of growing IV drug use among MSM and calls to integrate sexual health and substance misuse service provision for MSM, with integrated care pathways into specialised support. The intervention proposes to set up a needle exchange service for men using key clinical GUM and drug support services in London. The service would provide safe injecting packs and educate, initiate risk reduction, screen and refer men into services and would be provided at a pre-existing community drug treatment and support service.

## **3. Support**

In this section, interventions that use interpersonal approaches to meet their aims are described: that is one-to-one or group encounters that may be therapeutic, supportive and/or educational in nature.

### **3.1 Behavioural/therapeutic and peer /community group interventions**

Reports submitted to this review (Foskett & Brophy, 2006) base the rationale for group interventions in evidence that experiential and reflexive learning is necessary for behaviour and attitude change and that time-limited facilitated group interactions have been shown to be an effective and efficient way of delivering this learning. In addition, groups serve a therapeutic purpose, allowing those experiencing difficulties with behaviours, feelings and moods to reach a resolution and work towards more beneficial or less risky behaviours. Many group programmes also draw on a cognitive behavioural therapy technique which is one of the evidence-based psychological therapies supported by the National Institute for Health and Clinical Excellence. Group work should not be seen as a whole population intervention but is rather suitable for those experiencing difficulties

around their current behaviours or feelings in relation to HIV and/or those who would benefit from this experiential/reflexive learning experience.

The first response describes a range of time-limited group work interventions aimed at sub-groups of MSM: Black African, Caribbean and Asian men, men newly out or questioning their sexuality, HIV-positive and negative men and those engaged in high-risk sexual behaviours. Groups aimed to improve self-understanding and emotional wellbeing, confidence, negotiation skills, communication and relationship and intimacy skills as well as increasing motivation and ability to have safer sex. Hard outcomes specified for this work included increased knowledge of HIV, sexual health services and PEP. 'Softer' outcomes included: changes to knowledge, personal goals and skills.

As part of the consecutive London programmes and as a continuing commissioned service, this work has been subject to independent monitoring and evaluation activities. The authors submit that the most recent internal monitoring data shows high rates of service user satisfaction and a self-reported high rating for having achieved their personal goals and having increased knowledge around PEP.

The second response describes a similar programme of time-limited gay men's group work including a course for those newly diagnosed and one for HIV negative partners of positive men, an addictions course, courses on sex and relationships and Hepatitis C and HIV Co-infection. The therapeutic courses such as the addictions courses are facilitated by a trained counsellor or psychotherapist using a range of cognitive behavioural techniques. Non-therapeutic courses are facilitated by trained facilitators. By focusing on both HIV positive and HIV negative men, the programme of group work has a complementary primary and secondary prevention focus.

Measureable outcomes are set according to the groups, but in general the groups aim to increase knowledge about HIV transmission, sexual health services and PEP as well as confidence in negotiating sex and the ability to manage HIV as a long term condition. Before/after questionnaires seek to measure self-reported change amongst users and last quarter data is quoted to illustrate substantial increases along the various knowledge indicators and increases in ability to self-manage HIV.

The third response describes a 1-day one-off group interaction targeted at African MSM who have tested negative or presume to be HIV negative and those who have never tested. The purpose of the group appears to be mainly educational aimed at identifying cultural myths, increasing understandings of risk factors that influence HIV transmission, educating about condom use and sexual negotiation, discussing issues affecting MSM in African communities and increasing knowledge on accessing PEP. Men were also encouraged to test at the end of the course and invited to become peer educators or outreach volunteers.

The final two responses describe Living Well Positive self-management interventions

The first was targeted at people with HIV generally and consists of seven weekly peer-facilitated workshops that provided coping skills to people living with HIV in a supportive group environment. Participants took part in an evaluation process that incorporated the Medication Adherence Scale (MARS) and items based on the WHOQOL-HIV BREF (WHO, 2002). The authors report a 60% completion rate of the course and that participants reported significant increases in their ability to

make informed decisions in a range of key areas that promote self-care and wellbeing and significant increases in their self-confidence, ability to manage HIV and their ability to improve their life.

The second was targeted at African people living with HIV. The intervention aimed to provide support and advice on living positively with HIV and improve participants' sense of social inclusion and self-confidence in managing disclosure and access to treatment and support. The intervention included peer-led advisory groups, positive self-management training and training in IT and job access skills. Participants worked on personalised short term health goals including healthy eating, treatment adherence and effective condom use. Monitoring data described numbers of beneficiaries directly supported, numbers accessing the positive self-management programme, numbers supported into volunteering, training and employment and numbers of peer mentors and facilitators trained to support others. The authors stress that using volunteer peers is cost-efficient and improves the acceptability and reach of the intervention. This intervention has also been evaluated as part a larger programme evaluation.

#### *Summary of evidence provided*

- Responses describing therapeutic group work cite evidence-based practice.
- Internal evaluations of interventions using before/after approaches describe evidence of self-reported (subjective) and observed (objective) change along key behavioural and attitudinal indicators.
- Similar evaluations describe high levels of acceptability of group work interventions amongst those using them.

### **3.2 Behavioural counselling/ one-to –one Interventions**

The following four responses describe intensive on-going or one-off interventions using CBT or other psychological approaches following clear identification of elevated need in the client.

The first response describes the introduction of a stepped care service model and intensive psychological intervention to address different levels of risk behaviour amongst patients attending a GUM clinic. This comprised: identifying sexual risk behaviour within the GUM clinic (Level 1); delivery of brief interventions by a Health Advisor, for example, motivational interviewing ( Level 2), and provision of interventions for the most complex risk takers, for example high intensity multi-modal psychological intervention, including CBT (Level 3).

Outcome measures included reductions in high risk sexual behaviour, reductions in substance use and linking patients with appropriate mental health and/or drug and alcohol services. Improvement in mental health functioning was measured using standardised tools for depression and anxiety. A case notes review for 155 patients referred for Level 3 showed that nearly half were MSM. Authors report high level of engagement, substantial reductions in risk taking behaviour and statistically significant reductions in anxiety and depression. The intervention also identified patients with severe and enduring mental health difficulties who were referred to specialist mental health services.

The second response describes time-limited one-to-one counselling using a Cognitive Behavioural approaches integrating Sexual Health Counselling for MSM demonstrating high need and entrenched risk behaviours. The counselling was in line with NICE sexual health and talking therapies guidelines and used predominantly volunteer and training counsellors. Clients were referred following a short intervention with GMI health trainers (see below) in a community setting, and could also be self-referred or referred by other therapeutic settings.

The aim of the intervention was to bring about behaviour change – reducing risky sexual behaviour, including unprotected sex. Outcomes were measured using a before/during/after and 3 month follow-up survey covering behaviour, attitude, skills and knowledge in relation to sex (BASK - Behaviour, Attitudes, Skills and Knowledge instrument) as well as well-being, Symptoms, Functioning and Risk (CORE instruments). Authors report that CORE results show improvement in all areas concerning general health and emotional well-being while BASK results show concrete behavioural changes. The authors attribute these outcomes to appropriate targeting/triage of the intervention as a result of being integrated into a broader programme where clients are assessed for a range of different interventions (the GMI programme).

The third response describes a one-off, one to one advice, motivational interviewing and psychosocial intervention alongside medical support, HIV testing and other sexual health screening for MSM engaging in sexual risk within the context of recreational drug use. Interventions were delivered in a community STI clinic and GUM settings where MSM present with urgent PEP or STI need. Interventions aimed to support behavioural change including increased control over drug use; reduction in injecting; increased condom use; reduced partner numbers; increased testing and improved adherence to HIV medication whilst using party drugs. Data was collected on need at outset (for example injecting drug use and control over drug use, drug use and risk) and on client's self-reported outcomes (but not clear from response how data is collected or the times of follow-up). The authors report substantial self-reported improvements in health & well-being, knowledge of drugs, engagement in social and physical activity as alternatives to drug use and sex, cessation of injecting and cessation or reduction in drug use.

The fourth describes a pilot for the use of a self-assessment tool for use by MSM attending a GUM clinic to address 'upstream factors' associated with poor sexual health (depression, drugs, violence and sexual health issues). Patients waiting for a consultation are offered a pen and paper self-assessment tool for depression, violence, drugs and alcohol problems which is scanned and attached to the patient notes. The tool is reviewed at the consultation and the patient signposted towards appropriate self-help, NGOs, primary care or secondary care NHS services. The authors report the results of an audit of attendees that concludes that self-assessment is acceptable to the client group and is easily completed in the waiting room, the results being easily incorporated into a clinical

#### *Summary of evidence provided*

- Responses describing therapeutic one-to-one interventions cite evidence-based practice.
- Internal evaluations of interventions using before/after approaches describe evidence of self-reported (subjective) and observed (objective) change along key behavioural and attitudinal indicators.
- Similar evaluations describe high levels of acceptability of the intervention amongst those using them.
- The use of a self-assessment tool amongst GUM clinic attenders to identify and signpost 'upstream factors' leading to poor sexual health is acceptable to users and feasible within clinics.



consultation and do not significantly increase consultation durations, thus facilitating a change of focus of the intervention from sexual health promotion towards interventions to address upstream risks. They also conclude that it is not clear that screening or intervention reduces upstream risk behaviour or STI or HIV risk taking.

### 3.3 Social support/mentoring/coaching

The next three responses both describe one-to-one interventions in community settings, the purpose of which is to educate, raise-awareness and bring about behaviour change (such as testing for HIV), but also to refer clients into other services.

The first is the GMI Health Trainers initiative targeted at MSM which provides information, support, signposting and referrals around sexual health issues. Health Trainers used a 'sexual health life check', (BASK) questionnaire to identify gaps in knowledge and service needs among MSM, and as an assessment tool to make referrals into GMI peer mentoring and counselling. They could also offer a number of personalised one-to-one sessions for clients who are not ready for longer term services or want a more in-depth discussion about sexual health issues. Finally, they offered POCT at weekly clinics at commercial venues and special events. They also distributed sexual health information and resources for information racks at venues.

Monitoring data collected numbers of men approached, BASK assessments completed, numbers of men provided with sexual health information, signposted /referred and this can be broken down by demographics and risk behaviours. Outcome data was collected (though no detailed information in the response regarding methods or sampling etc) and the authors report self-reported improvements in knowledge, intent to test, uptake of test and motivation to change sexual health behaviour after the Health Trainer intervention. They also report high client satisfaction.

The second describes a one-to-one intervention aimed at African and Caribbean people disclosing multiple (two or more) sexual partners and considered at risk of contracting HIV and other STIs (identified using a screening tool). The intervention was piloted to assess acceptability to African people of various ages, nationalities, and of different levels of formal educational attainment and feasibility in terms of recruiting and training outreach workers. The intervention used motivational interviewing techniques delivered by outreach workers of African origin and offered in a range of African languages. A structured questionnaire taking 45-60 minutes to complete assessed the individual's knowledge and beliefs about HIV; perceptions of the risk of the sexual transmission of HIV and their testing history. It also provided the opportunity to discuss and explore the client's sexual behaviour within a safe environment. The interview recorded the impact of the intervention on the client's intention to test, and to change their sexual behaviour. Individuals requesting testing were fast tracked to services. The learning gathered from this intervention informed local HIV prevention commissioning decisions and formed the basis for design of follow-up interventions.

A further response describes a one-to-one peer mentoring intervention for MSM who are HIV negative and at significant risk of becoming HIV positive. A trained volunteer peer supported mentees to remain HIV negative by working through structured modules focused on HIV testing, self-esteem, identity, relationships, condom-use, goal-setting and social responsibility allowing men to reflect on their sexual risk. Mentees were referred following a short intervention with GMI health trainers in a community setting. The aim of the programme was to reduce the risk of seroconversion amongst mentees by reducing unprotected sex. Additional aims included improving safer sex



knowledge and negotiation skill and a shift in attitude to risk and safer sex. Outcomes were measured using a before/during/after and 3 month follow-up surveys covering behaviour, attitude, skills and knowledge in relation to sex (BASK instrument). The authors report behavioural changes indicating a drop in risky sexual activities and improvements in knowledge and attitude scores that are sustained in the 3 months post-intervention.

### 3.4 Hotline/helplines

One response describes an intervention to give assurance, practical information and referrals to MSM as part of a broader telephone service offered by volunteers (London Lesbian & Gay Switchboard (LLGS)). The telephone line is open 13 hours per day and was accompanied by a website, promoting sexual health, instant messaging on the internet and email support. The authors report being able to speak to demographic groups not amenable to other interventions, such as MSM who are not identified as gay or not accessing LGBT media or venues. They also report covering topics related to sexual risk and STIs (such as alcohol and drug use). Finally, the authors report being able to give information entirely tailored to the circumstances of the caller.

#### *Summary of evidence provided*

- One-to-one Health trainers and peer mentoring interventions using before/after/follow-up approach report self-reported (subjective) and observed (objective) change in knowledge, testing intentions, attitudes and risky behaviours.
- All responses describe high levels of acceptability amongst those taking part in the intervention.

### 3.5 'Integrated' Support Programmes

Three responses describe a programme of integrated interventions targeting at MSM.

The first programme aims to reduce the risk of HIV infection / transmission by working with MSM, one-on-one, to reduce risk behaviours, change attitudes around HIV, develop skills and increase knowledge. The programme rationale is based on research that suggests a need for combined medical and behavioural approaches to HIV prevention identifying dimensions of successful programmes that are of sufficient intensity, tailored to individual need, holistic and multi-dimensional. Men recruited into the programme were assessed periodically (outcome, completion and follow-up) using an outcomes focused common assessment tool (BASK). Initial assessment was carried out by Health Trainers working in venues. Men were referred into different services (such as long term counselling or peer support mentoring services) depending on assessed need. MSM enrolled in the programme self-report knowledge increase, increased likelihood to test and screen for STIs and increased motivation to change behaviours after intervention. The authors report that such improvements are statistically significant and indicate sustained behaviour change.

Whilst the first response is London wide, the second very similar programme was provided on a local (borough) level to a local 'micro-community' of MSM. It describes the same assessment process alongside the creation of referral pathways within and between local services (outreach, peer mentoring, counselling, condom acquisition, group work and clinics). Assessed and willing men were

referred to holistic clinical services that referred those considered in need to ongoing intensive services (peer-mentoring or 1-1 counselling). Monitoring activities recorded change at different assessment periods and progress through the programme interventions. The authors report an average infection rate of those screening for all STIs of 7.8%. They also report improvements on BASK scores at different assessment points.

A third response describes the Safer Partnership which targeted African Communities in South London. This was a programme of HIV prevention interventions inter-linked through three work-streams: one-to-one outreach, community mobilisation and condom distribution. The intervention trained and accredited community advisors, ran community awareness events, made referrals for HIV testing in clinical and community settings. Evaluative data was collected through focus groups, questionnaires and community surveys. An evaluative report summarises elements of the programme that were judged to work well highlighting social and business community engagement, support groups, advocacy, workshops, training, resource distribution, signposting and referrals.

#### *Summary of evidence provided*

- Before/After/Follow-up monitoring of integrated programmes show self-reported (subjective) and observed (objective) change along attitudinal and behavioural variables.
- However it is not clear whether or not the programmatic element adds to effectiveness of the individual interventions administered as part of the programme.

## **4. Media**

Responses in this section describe interventions that use mass or social media approaches, that is, they are interventions aimed at reaching a mass audience either through static paper promotion, online advertising, and interactive online approaches or through online social networking sites. No interventions in this section describe the production of small media.

### **4.1 Social networking websites**

Three responses fall under this category.

The first describes the Social Media component of a national HIV prevention campaign (*It Starts With Me*), aimed at MSM aged 18 to 35 and black Africans aged 25 to 45 in England. Two separate Facebook pages were created. Facebook pay-per-click advertising recruited MSM and Africans to join the pages and receive messages from the campaign. Pay-per-click advertising allowed for targeting by age, gender, sexuality and geographical location, and “key words” allow targeting by ethnic origin. The rationale behind this method of engagements is that social media may provide an efficient channel to engage Africans who may not access local services, and MSM whose areas of residence and social networks may differ. Campaigns contained core HIV prevention messages and information on wider determinants for sexual health (drugs and alcohol, mental health, and gender equality issues). People connected via social media to others who had joined the page are exposed to messages and can engage, thus amplifying the campaign and adding peer validation to content. The aim of the intervention was to increase the reach of HIV prevention and sexual health

promotion campaigns with target populations and increase engagement of target populations with HIV prevention and sexual health promotion elements of the national campaign.

The social media component of the campaign was monitored by a weekly internal audit to ascertain reach of campaign content and engagement with campaign content. The authors report that the project exceeded expectations in its ability to reach Africans and MSM citing data on numbers of page 'likes' broken down by basic demographic information. Further engagement was measured by numbers watching a video or sharing a post and total reach of campaign was measured by numbers who have seen campaign content, such as a post or advert. Internal and external evaluation is planned and costs are included in the response.

The second response describes a flexible digital platform to support sexual health education and marketing campaigns from a range of providers using Google Adwords in London to signpost clients to services. The response describes a current proof of principle trial examining the potential for expanding public health marketing strategy across various digital platforms such as Facebook, Twitter, Gaydar, Grindr, Manhunt etc. In addition, further partnership work would involve the use of NFC tags and QR codes in venues to support access to information on sexual health and services. Monitoring data is available on numbers of times adverts have been displayed, numbers clicking on adverts and deriving the average cost per click. Data is also available on site users' choice of clinic following information accessed on provider's sites.

The third describes an online risk assessment tool aimed at MSM delivered as part of a wider condom promotion campaign. The tool gathered data on sexual risk behaviours and knowledge providing each user with an instant risk rating plus the option to be emailed a detailed breakdown of risk factors. High risk men could be identified and contacted for further interventions and men could be segmented according to behaviours for appropriate interventions such as testing. The aim of the tool was to increase men's awareness of their HIV exposure/transmission risk and how to reduce their risk. Focus group pre-testing prior to creation helped determine content, structure and promotion. Monitoring data (numbers of visits to campaign website, number completing the risk assessment and numbers requesting a breakdown of risk behaviour by email) was collected for the first 10 weeks of operation and analysed. Based on this analysis the authors report that the tool was effective at identifying men engaging in higher risk behaviour and engaging men who had not been in contact with GU services in the previous year.

#### *Summary of evidence provided*

- The two interventions using social networking approaches describe higher than expected coverage, reach or impact with specific target groups.

## **4.2 Website/Internet**

Two responses describe websites aimed at MSM

The first is a long-running website providing sexual health and HIV prevention information and advice, details of sexual health and HIV preventions services, facilities for online booking of

groupwork courses and links to all other local services. Visitors to the site could ask sexual health questions and receive personalised responses. The rationale behind the website was that it provided population level interventions which addressed basic knowledge needs in far greater numbers and lower costs than individualistic interventions in addition to signposting those who need more intensive prevention interventions. The authors cite independent community surveys which show that the largest proportion of gay men prefer to access HIV prevention information online. Monitoring information is available on site visits from London IP addresses and the authors report substantial use from London MSM. Outcomes were assessed in an online evaluation developed by independent evaluators which demonstrated use by men from every London Borough and indicating high levels of satisfaction by users as well as self-reported impacts on sexual risk behaviours, intention to attend a GUM service or other sexual health service as a result of visiting the site. Cost per London contact is also provided.

The second response describes a 'synthesis' website (in development - not yet online) presenting health/lifestyle information to MSM. Content will include information and discussion reflecting life/real life scenarios and topics will be correlated/connected with related issues to assist users better understand the holistic context of their behaviour. Short films will illustrate subject matter and content is being written by MSM, knowledgeable of MSM life challenges collaborating with organisations/health professionals to ensure information is accurate/up to date.

#### *Summary of evidence provided*

- Monitoring data and independent evaluation of a website aimed at MSM reports substantial coverage, reach or impact, high levels of user satisfaction and self-reported (subjective) attribution of change in sexual risk behaviour, intention to use sexual health service to visiting the site.

### **4.3 Mass media and Newspaper/magazines**

Two further responses can be classified under this category.

The first is a bi-monthly sexual health magazine (FS) aimed at Gay men / MSM and distributed free to London gay venues, GU services and available online and as a downloadable app for mobile devices. The magazine provided accessible information and advice on HIV prevention, as well as sexual and emotional health and was packaged in a style comparable to commercial gay publications. The aim of the intervention was to inform and educate gay men about issues and information regarding sexual health, HIV and general health and well-being. Various external evaluations have been conducted all reporting high levels of acceptability. Reader surveys also report high levels of self-reported impacts on knowledge and sexual risk behaviours and testing intentions.

The second describes a mass media campaign the aim of which was to raise awareness of PEP amongst MSM in high prevalence metropolitan areas, especially men with higher partner numbers, aged 20-35 and gay scene-attached. The campaign included a web site with PEP self-assessment, press and online advertising. The authors report that an evaluation using a periodic community survey (annual Gay Men's Sex Survey - GMSS) showed that men were 2.4 times more likely to be

aware of PEP after the pilot campaign and that this multiple increased substantially amongst men with higher numbers of partners. Further increases were observed following roll-out of the campaign with greatest increases in knowledge amongst those in metropolitan areas and with higher numbers of partners. A further study of PEP seeking and prescriptions at two GU clinics (London and Brighton) showed an 84% increase in individuals requesting PEP and a 111% increase in MSM starting PEP. Nearly 1/3 of MSM cited the campaign as the source of their awareness of PEP.

Although this response shows strong evidence for the effectiveness of a mass media campaign to raise knowledge and uptake of an intervention, it should be noted that PEP was an entirely new innovation at this time, so the start out knowledge base was low to zero. We should expect much smaller increases in uptake of a pre-existing intervention where knowledge/awareness is high (for example, HIV testing).

#### *Summary of evidence provided*

- Monitoring data and independent evaluation of a magazine aimed at MSM report high levels of user satisfaction and self-reported (subjective) attribution of change in sexual risk behaviour, and intention to use sexual health service after encountering the magazine.
- A mass media intervention demonstrates strong potential for mass media advertising, when properly targeted, to bring about substantial changes in knowledge, behaviours and intentions where the knowledge base is low to begin with.

## **5. Educational and Support Interventions on a Community level**

The six responses in this category do not easily fit into the typology provided inasmuch as they incorporate both educational and support elements but also seek to change community norms or practices around HIV prevention. In this sense, they function at a community as well as a group and individual level. For this reason they are described under a separate heading here.

Two interventions specify working with community leaders or role-models.

The first targets African communities in Lambeth, Southwark & Lewisham and describes extensive work with Church leaders and congregations to counter stigma associated with HIV, normalise HIV testing and safer sex practices and facilitate church communities in offering support to people affected by HIV within their congregations. The rationale behind this intervention is that church congregations are a major part of African community life and that faith leaders have significant influence on congregations and communities. By working with leaders, perceptions of African faith groups with regard to issues of sexual health and HIV can be changed. The authors describe the benefits of the intervention as increasing congregational members' confidence and a commitment to sexual health promotion, clarifying their role in relation to HIV prevention, normalising HIV testing amongst congregants and linking early diagnosis to primary care registration. Other outcomes include congregations being more able to support other congregants living with HIV, the inclusion of HIV testing in the church's pre-marital counselling policies and faith leaders discussing HIV prevention and encouraging HIV testing.

The second appears to be primarily an educational intervention and seeks to benefit Black African/African Caribbean (BAC) living with or affected by HIV. It describes work with community leaders and proprietors in a range of settings e.g. business venues, community centres, social clubs, night clubs, youth clubs and faith settings across 10 boroughs in South London. Information and training was provided to the proprietor or community leader to raise their confidence in supporting the programme. This work enabled a programme of condom distribution, sexual health outreach, group workshops and information dissemination in such venues.

The aims of the intervention were to increase access to sexual health information, increase understanding and awareness of condom use, HIV prevention, transmission and treatment and bring about reductions in onwards transmission of HIV within BAC, increase awareness of benefits of HIV testing, reduce HIV related stigma and increase access to primary care. The authors report that independent qualitative evaluation activities show that the intervention is acceptable to proprietors and leaders and feasible. Interviews with group participants show self-reported change in attitudes towards sexual health and increases in knowledge and intentions to use condoms and attend sexual health services. Monitoring data show numbers of people engaged in various interventions and resources distributed.

A further two submissions describe working around football tournaments.

The first targeted Black African Men from communities with higher prevalence rates such as Zimbabwe, Nigeria, Uganda and Zambia and aimed to increase HIV testing among this group and improve access to information on HIV prevention, treatment and support. The project utilised a combination of interactive community workshops, outreach and the use of POCT at community football events organised either by the provider (Terrence Higgins Trust) in partnership with community groups or entirely organised by community groups.

Internal monitoring data was collected and internal evaluation included pre-intervention surveys and feedback forms and observation of events to ascertain how beneficiaries engaged with the intervention. The authors describe an average of 25 HIV tests conducted per event (positivity rate of 1.3%) with at least 30% of those having tested over a year beforehand as well as numbers of individuals attending and accessing information and condoms. The authors report that some men now play a leading role in identifying further health promotion opportunities in their communities such as community websites, gatherings and events.

The second describes a one-off Football Tournament organised for Somali communities in south London during refugee week consisting of six Somali teams aged between 14 and 26. The event attracted over 200 African Muslim young people from several boroughs. An information stall was provided alongside outreach and targeted mini workshops on sexual health and HIV testing for the teams. The aim of the intervention was to educate young men about sexual health and HIV, to encourage them to go for a sexual health check-up and to consider having an HIV test. Feedback from attendees and team members indicate acceptability and feasibility of the intervention.

Two further responses (part of the SAFER partnership) report the simultaneous use of a wide range of approaches to carry out community-based work with African communities, the first with adults and older people and the second with younger people.

For the first, the main aim appears to be to raise awareness of HIV transmission and testing amongst various groups at risk of late diagnosis (including over 50s, African Francophone communities and newly arrived refugees and asylum seekers). The intervention linked a range of centre-based and community-based activities, such as one-to-one advice sessions, group work and the static/interactive distribution of resources to HIV testing services. Outreach carried out by community volunteers took place in faith based settings, pubs, clubs, barber shops and cab offices. More intensive work was carried out with faith and community leaders. Like the GMP partnership, BASK assessments are carried out but there is little detail on this in the submission.

The second targeted African people aged 30 or under using multiple approaches. This intervention had a greater emphasis on the use of young role models to spearhead campaigns and utilised social media approaches, music, art, drama and comedy-based campaigns. It also incorporated the training and deployment of young 'community champions'. Trained outreach teams offered 1-2-1 advice and information at African churches/mosques and other venues frequented by the target group as well as community based rapid HIV testing delivered by trained peer HIV testers. Again BASK surveys are used (but little detail is given)

For both interventions, monitoring data records numbers of individual engaged including demographic details, numbers of events held and resources distributed as well as ongoing engagement with social media campaigns (where applicable). The authors report that using community volunteers makes the intervention cost-effective, increases the reach and penetration of the intervention into communities and increases the acceptability of the intervention to communities. Both interventions have been evaluated under the SAFER HIV Partnership in Lambeth Southwark and Lewisham.

#### *Summary of evidence provided*

- The community-based interventions describe evidence of feasibility and acceptability of interventions as well as satisfaction amongst those using them.
- Some cite evaluations reporting self-reported changes in behaviours and attitudes as a result of contact with the intervention.

## **6. Other Interventions**

This final section describes interventions described that do not fit into any of the above categories.

The first describes a capacity building and co-ordination intervention for African community organisations delivered in Lambeth, Southwark and Lewisham. The intervention aims at facilitating effective partnerships, networking, advocacy, campaigning, and information sharing and learning among its members. The intervention facilitates collective and coordinated bidding for funds, activities to support the development of organisational capacity, support to develop skills in health promotion, community health development and public health, co-ordinating and facilitating contributions to local and national health and social care policy development. The authors report that the intervention has not been evaluated in recent years, however they stress that the

intervention is useful for engaging hard to reach communities and offers a platform through which African communities can give collective voice to health issues concerning people from the communities they serve.

The second describes the activities of a single large agency. The organisation lists approximately 4000 service users (members) all of whom are HIV positive or affected by HIV. 68% identify as Black African. Members undergo comprehensive, regular needs assessments on individual and population level which guides the agency's approach. Interventions provide support in physical health, mental health, psychosocial well-being, practical support, and maximising productivity. The submission describes a range of interventions (including condom distribution, one-to-one, small group, large group, expert and peer-led interventions, media campaigns, condom distribution) and services (including mental health services, pregnancy workshops). The authors cite their most recent quarterly data to show self-reported improvements in understanding and knowledge of HIV and sexual health, feeling more supported and better able to disclose HIV status and improved medication adherence amongst service users. The same data is used to cite improved CORE counselling scores amongst those receiving counselling. The authors also cite evidence of reach of and responses to mass media interventions. Finally authors refer to an external evaluation of their Teen Spirit and Young Adults programmes which 'showed a significant social return on investment': evaluation forthcoming.

#### *Summary of evidence provided*

- An agency reports self-reported change on a range of key dimensions as a result of service use from internal evaluative activities.

## **7. Discussion**

Although this is a stand-alone report, it is also part of a broader review which gives a much more complete picture of the state of play with regard to HIV prevention activities and evidence for effectiveness of interventions. This report should therefore be read in conjunction with those reporting on other work streams; in particular the evidence review update, the stakeholder engagement report and the activity mapping exercise. Moreover, the destination of this work stream and report is to be incorporated into the final synthesis report for the project as a whole.

The call for evidence that preceded this report was designed to elicit the type of information that would not be available to other work streams. Moreover, it serves the dual function of eliciting evidence that will not necessarily fit the criteria used in other parts of this review (for example the evidence review update) whilst also increasing the engagement of those currently involved in HIV prevention in London. Therefore the results of this exercise will not be systematic and may throw up some unexpected findings.

It is also important to emphasise what this call for evidence is *not*. First, it is not a review of the grey literature. The call did elicit a small amount of what we might call grey literature; that is reports or presentations of evaluations that have not been presented in peer-reviewed outputs. However, a



review of the grey literature would constitute a systematic search of a range of sources alongside a systematic process of logging and assessing such evidence. Furthermore, it is not a map of HIV prevention activities in London. As this was a call for responses, it is limited to those who had the capacity to respond within the time allocated. Moreover, we did not seek to elicit a comprehensive description of interventions, but rather a description of what responders considered to work. Such a map has been carried out elsewhere as part of the overall review.

When considering what this call for evidence *is* and what it can tell us, it is important to be clear about who contributed to this call. As the majority of responders were service providers, we should expect responses to reflect providers' activities, concerns and resources. The ways in which evaluations are carried out and evidence produced within the context of on-going service development delivery will be very different to evaluations aimed at providing rigorous evidence of the effectiveness of a single health promotion or public health approach.

The types of 'high quality' evidence for effectiveness provided by randomised controlled trials or other experimental designs requires the type of investment, both in terms of time and money, that is not at the disposal of providers or, for the most part, those commissioning them in the UK. Moreover, such trials require very high levels of expertise from a range of different disciplines. As stated before, such trials are especially difficult to design and execute within the context of complex social interventions operating in the 'messy' social world. Finally, such trials tell us about efficacy as opposed to effectiveness. That is, they generally demonstrate effectiveness within often very circumscribed and controlled conditions where the intervention is closely monitored and very well-resourced. Further studies are often needed to show how the intervention fares when applied more generally in less well-resourced circumstances. In view of all of these considerations, it is not surprising that such trials are relatively rare.

What is clear from the responses we received, is that the concerns of providers, and often those commissioning them, focus instead on other evaluative dimensions that are arguably of more immediate use and relevance: what is acceptable to the target group?; what is feasible given the resources available?; what changes or outcomes can be observed using what techniques in the absence of an experimental design? These are the types of evaluative questions and activities which (a) are suited to the immediate questions of implementation, (b) achievable given available resources and the complexity of the social field within which providers operate.

Within this context, what the call has shown us is that there is plentiful evidence regarding the acceptability of a range of interventions to the target group alongside the feasibility of such interventions. There is also substantial evidence of both self-reported and observed change along key indicators for many interventions.

It should not be surprising also to find that the strongest evidence for effectiveness is shown where interventions take place in bounded or relatively controlled circumstances (for example HIV testing in clinical settings or therapeutic work done on a one-to-one or group basis) or where interventions are seeking to work in an entirely new area (for example, introducing HIV testing to novel clinical settings, mass media about an entirely new HIV prevention technology such as PEP). This is because, compared to interventions working for example, at the level of communities, it is far easier to demonstrate change in these relatively bounded settings. Conversely therefore, the more diffuse the intervention and the more 'messy' or complex the field in which the intervention operates, the

harder it is to demonstrate evidence of effectiveness or change. Hence the interventions that work on a community level tend to focus on evaluating acceptability or feasibility. This finding underscores a major insight afforded by this review: that is, a lack of evidence of effectiveness does not equate to a lack of actual effectiveness. It is important therefore not to restrict health promotion interventions to those for which effectiveness can easily be demonstrated. The task of evaluators rather is to devise novel ways of testing the effectiveness of complex, diffuse interventions that work in complex or messy social environments.

This call for evidence has been useful in eliciting and articulating the types of evidence that are used and valued 'on the ground' in the design, development and delivery of services. In addition, the call has illustrated the various ways in which providers of services go about evaluating their interventions within the context of limited resources and the need to continue service delivery whilst carrying out evaluative activity. What is notable is the extent to which providers are engaged with and knowledgeable about evaluative techniques and are producing a body of evidence that is substantial and growing.

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London DsPH

## CALL FOR EVIDENCE HIV Prevention

The number of new HIV infections in the UK continues to rise and by the end of 2011, an estimated 96,000 people were living with HIV in the UK. Approximately one quarter (22,600, 24%) of people with HIV are undiagnosed and unaware of their infection. Over 50% of people with HIV in the UK now live in London.

From 1<sup>st</sup> April 2013 a range of public health responsibilities, including the commissioning of HIV prevention services, transferred from the NHS to local authorities. The London boroughs are keen to ensure that the HIV prevention activities they commission are effective and meet the needs of their local populations. HIV prevention encompasses a range of activities and interventions which aim to reduce or eliminate the risk of HIV transmission between people.

There are several factors that may contribute to HIV risk taking behaviour by individuals and within some population groups.

These may include:

- Lack of knowledge about routes of HIV transmission and levels of risk
- Health beliefs and health literacy (particularly for some black and minority ethnic groups)
- People with multiple needs (e.g. mental health, language needs, alcohol and drug issues)
- Individuals not accessing or being aware of where to access sexual health/ HIV prevention services or information
- Multiple factors related to risk-taking, including the impact of peer/cultural/behavioural norms within groups and communities

Against the backdrop of a changing epidemic and increasing HIV prevalence in London, the Directors of Public Health (DsPH) for London have commissioned a London-wide needs assessment to inform the future commissioning of HIV prevention services.

A key part of this needs assessment is to gather evidence of “what works” in the primary and secondary prevention of HIV, and interventions focused on reducing or modifying risk-taking behaviours. In addition to reviewing relevant published studies and information on HIV prevention, we are issuing a call for evidence to identify unpublished ‘grey literature’ on successful HIV prevention interventions and programmes. This ‘grey literature’ may include:

- Conference papers, presentations and reports
- Project and programme evaluations
- Service audits

We are calling for submissions of evidence for HIV prevention and risk taking behaviour interventions that meet the following criteria:

- The intervention can be clearly described
- That clear objectives and outcomes were defined for the intervention/programme
- The intervention/programme has been / is being evaluated providing evidence relating to the effectiveness and /or cost effectiveness of the intervention
- They been delivered in urban settings in a high income country

We are particularly interested in projects or interventions that have or are currently working with highHIV prevalence population groups in London, in particular:

- MSM (gay men)
- Black African communities

Effective interventions can be defined as those that have reduced HIV incidence over time, that have reduced late diagnosis of HIV, and/or that have shown sustained behaviour change amongst target population groups in relation to HIV transmission

Submissions should be no longer than **500 words**. The deadline for submissions is **9<sup>th</sup> August 2013** .

Please return submissions electronically to : [evidence.fclhps@gmail.com](mailto:evidence.fclhps@gmail.com)

Or complete the online form at [www.londoncouncils.gov.uk/hivprevention](http://www.londoncouncils.gov.uk/hivprevention)

We attach a submission outline document to help you formulate your response.



London DsPH

# CALL FOR EVIDENCE

## HIV Prevention

Your response to the DSPH for London

<b>Name</b>	
<b>Email address</b>	
<b>Name of Organisation (if applicable)</b>	
<b>Position (if applicable)</b>	
<b>Address</b>	
<b>Contact Number</b>	

If you do not wish for your response, or the fact that you have made a response, to be made public please indicate this by ticking the relevant box below.

I do not wish for my response to be made public

☐

I do not wish for the fact that I have made a response to be made public

☐

### Submission outline

Please describe the intervention by answering the following questions.

- Where did it take place?
- Who was the target population group(s)?
- What was the project/ intervention activity?
- What were the intended outcomes?
- Were these outcomes achieved?
- What was the cost?
- How was it evaluated?
- Who undertook the evaluation?

#### **REMINDER**

**Submissions should not exceed 500 words. Please keep within this limit.**

Please send an electronic copy of the relevant document with your submission or indicate where a copy can easily be obtained.

**Please note, your response should reach the DsPH for London by 5 PM, 9th August 2013**

Please return submissions electronically to : [evidence.fclhps@gmail.com](mailto:evidence.fclhps@gmail.com)

Or complete the online form at  
[www.londoncouncils.gov.uk/hivprevention](http://www.londoncouncils.gov.uk/hivprevention)