IMPACT

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This issue of Impact throws the spotlight on prevention issues.

The Department of Health has highlighted in its National Strategy for Sexual Health and HIV for England that preventing one HIV infection saves ‘between half a million to a million pound in terms of individual health benefits and treatment costs.’ (1.21) In high prevalence countries the social costs of failure to tackle prevention early are proving calamitous with impacts across all sectors of society and for these countries HIV is increasingly categorised as a national security issue.

Within the UK we have benefited from the speed with which Government responded to the epidemic in the 1980s through public education, the introduction of needle exchange schemes, ensuring protection of the blood supply and supporting the growth of an HIV voluntary sector. However, changes to the way HIV prevention work is funded and commissioned across the UK coupled with public and political complacency now threatens past investments.

In England and Wales, HIV prevention has, for the first time, been positioned squarely within a sexual health policy agenda. The ring fence on HIV prevention funds has been abolished and from April newly established Primary Care Trusts (PCTs) inherited the commissioning role. In Wales, new Local Health Groups will take on HIV commissioning from 2003. There are fears in the sector that these changes could lead to widespread disinvestment in local prevention services, as HIV is likely to fall well down the list of priority health issues for most PCTs.

This summer NAT and THT are leading a joint campaign on the impact of NHS changes on HIV services and as part of this we will be highlighting the need for commissioners to give HIV prevention a clear priority when they make their commissioning decisions for 2003/04 in October.

On all these fronts, we cannot afford to let our guard down. As the recent growth in the epidemic amongst our African migrant communities demonstrates, the UK is not isolated from global trends. Over the coming years the epidemic is likely to impact UK communities with close links to the Caribbean, South Asia and Eastern Europe.

We are facing an increasingly complex prevention challenge, and will need to diversify our prevention strategies to respond accordingly. This will require leadership from Governments, more champions for the cause at every level, and a willingness to support innovative approaches including investment in vaccines and microbicides. Moreover, we need to come to grips with the implications of the rapid growth in the number of people living with HIV in the UK. With over 33,500 people living with HIV across the UK, there is an imperative to work more closely with communities living with HIV in devising prevention campaigns and to recognise that stigma has to be combated if prevention efforts are to make headway.

It is time for us to remember the community of people with HIV as representing our greatest asset in planning future prevention strategies.

Derek Bodell
Chief Executive
HIV prevention, migration and African communities living in England – a partnership approach to national policy

Susie McLean, Senior Policy Officer, National AIDS Trust

Last year NAT worked in partnership with the African HIV Policy Network (AHPN) and a range of other stakeholders to develop national policy on HIV prevention for African communities living in England. What came out of that work is best reflected in three policy documents that are all currently in draft form and have been submitted to the Department of Health for final sign off and publishing. They are:

1. HIV Prevention and African Communities Living in England – A Framework for Action

plus two supporting documents:

2. HIV Prevention and African Communities Living in England: A Review of the Literature by Martha Chinouya and Rhon Reynolds


The work came out of a growing sense among African HIV community organisations that a national approach to HIV prevention was critically important. Until now, there has been very little that defines and describes the national issues in relation to HIV prevention for African communities. There is a growing body of excellent local work, or work focusing on specific sub-populations, but the ability for us all to look at the pertinent needs and issues across England was hampered by an absence of strategy. The national Framework is the first attempt to remedy this, and we hope it will lead to a future strengthened by greater national co-ordination of our HIV prevention efforts.

The Department of Health and the London HIV Commissioners have always supported this work, and indeed were supportive of a policy development process that was able to draw on a wide range of expertise from many people working in the field. The Framework forms just one part of a much larger jigsaw that sees an increasingly strategic approach to HIV in England. It sits alongside the National Sexual Health and HIV Strategy, the London HIV Strategy and the Framework for Social Care for Africans affected by HIV in England, that is being led by the AHPN.
This article is an opportunity to summarise the Framework. At the same time, however, it is an opportunity to discuss the challenges in the work as well as some of the specific needs of African communities in England that had to be factored into the successful development of the Framework. The process has provided us with learning for future work. The learnings are discussed as a precursor to the findings from the Framework.

A range of factors needed to be considered when developing the Framework. They are:

1. **Bringing together experts**

NAT drew on the expertise of an excellent advisory group to help identify knowledge in many places in order to define priorities, make difficult decisions and define the scope of the work. As the first substantial process of national policy development on HIV prevention for African communities, it was critically important to bring together expertise from a wide range of sources.

The group was made up of a range of stakeholders - HIV prevention providers, people with HIV, researchers, members of the AHPN, HIV commissioners and the Department of Health. The majority of the members of the advisory group worked directly in or with African communities, although we also involved a couple of advisors who specialised in HIV prevention for gay men, to try and link our learning from gay mens’ HIV prevention to this process. In addition, later in the development process, the AHPN’s health promotion sub-group quite profoundly shaped the work. Members of that sub-group have direct and important expertise in some of the more challenging issues, as well as having been involved in some of the best successes in community based HIV prevention targeting African communities.

So the greater part of the policy development work was spent identifying expertise in many places and drawing it together to define priorities, make decisions and define the scope of the work.

2. **Collecting the evidence**

The other major shapers of the work were the findings of our literature review and our study into the challenges of providing HIV prevention services in community settings. From these two studies we were able to identify what we know about HIV prevention needs in African communities, and then how HIV prevention services and programmes are working to meet these needs. By using this 'needs led' approach, informed by 'Making it Count' (a planning framework for HIV prevention for gay men), we were able to focus in on where transmission of HIV is occurring, and what are the needs African communities and community members have that require addressing in order to reduce HIV transmission.

3. **Setting values and principles**

A range of values and principles shaped the Framework, and the work leading up to it. The primary set of principles were borrowed from the National Sexual Health and HIV Strategy and the Ottawa Charter, both of which underline the importance of...
building healthy public policy which addresses inequities, promotes knowledge and positive attitudes through education, and which strengthens community action to achieve better sexual health. A second set of values were defined by the advisory group. These are published as part of the Framework, but it is worth noting two critical values that strongly influenced our approach:

A II people have a right to self-determination and therefore African communities should be empowered to make their own choices, and

Responses should be sensitive to peoples’ cultures and differences.

4. Understanding the social context
Understanding HIV prevention issues for African communities living in England requires understanding the social context that shapes the lives of those with HIV and those vulnerable to HIV. These social issues are wide ranging, complex and fundamental to how we understand HIV. Central to this social context is an understanding of the diversity of African communities. Many ethnic and national identities, languages and religions are shaping the lives of individuals and communities, and this throws up a whole set of challenges to how we promote sexual health, how we provide information, how we support communities and how we promote safer sex.

Understanding the nature of this diversity is an important priority for research and for interventions.

The very nature of this diversity is often an outcome of specific social processes:

Patterns of migration and settlement between many African nations and the UK. Trends in migration change over time, and the size and social capital of different ethnic or national groups varies considerably. Some of the more recent trends in migration are influenced by the numbers of students from African countries studying at universities across the UK, and by asylum seekers arriving in London who are often rapidly ‘dispersed’ outside of London to places where very little community infrastructure exists.

The demographic(such as age and education) of Africans living in England. The Framework discusses the relatively young age of Africans living in England, and the high levels of educational qualifications. High levels of unemployment confound this picture, as does a much broader range of inequalities that create significant social exclusion for many African communities - poor housing, low incomes, poor health.

The Framework also discusses what we know from the literature about sexual attitudes and lifestyles in this social context.

5. Understanding the distinct epidemiology
The epidemiology of HIV amongst Africans living in England sheds light on the priorities for our work.

The numbers of new infections continue to rise, and there is evidence that many infections remain undiagnosed. The heterosexual nature of the epidemic is an important trend for the UK's HIV epidemic, as are the numbers of mother to child infections.

In 2000, ‘black Africans' accounted for over a third of newly diagnosed HIV infections in the UK, while making up less than one per cent of the population.

6. Considering learning from previous studies regarding the HIV prevention needs specific to the African communities
From the literature, we know that there are a range of HIV prevention needs in African communities. We group these into four areas:

a) The need for knowledge
A number of studies point to the widespread unmet need for basic information about HIV transmission, testing and treatment. This need for information exists in the context of culture - perceptions of condoms, different meanings attached to sexual behaviours, reproduction, breastfeeding and secrecy - and it is important to remember that there may be as much variation within communities on these kinds of matters as there is between. It is important also to note that there are a range of issues that challenge our traditional emphasis in HIV on information in print - leaflets, posters etc. It is unrealistic to believe that information needs can always be met simply through the distribution of leaflets and posters.

For those of us who are more familiar with issues of context and culture when working with gay men, the landscape looks almost entirely different.

b) The need for skills
From the literature, and from working in African and other communities, we know that information alone cannot change behaviour and reduce risk. Negotiating safer sex between partners can challenge deeply rooted ideas about identity, commitment, gender, sexuality and pleasure. It also brings to the forefront issues of power - personal, social and within relationships; and of control - over sexual decision making, over life choices, over reproduction.

Acquiring the skills necessary to
African people seeking asylum or with uncertain immigration status understandably avoid contact with official organisations wherever possible. However for the sake of their health and the greater public health, their unrestricted access to sexual health and HIV services is vital. Access to condoms and femidoms is also identified in the literature as a significant need.

e) The need not to suffer HIV related discrimination
The Framework stresses that HIV is heavily stigmatised in African communities and that people with HIV in these communities require particular support. HIV discrimination is not only unacceptable in and of itself, but it also acts as a significant barrier to sexual autonomy and satisfaction by inhibiting disclosure, undermining self esteem and creating fear and uncertainty. It severely hampers HIV prevention efforts. The discrimination that many people with HIV experience often exists in a context of financial insecurity and uncertain immigration status.

The process of distilling the many needs identified in the literature into these five categories was not unproblematic. We felt however, that as the first process of national policy development in this area, that this was an accessible way for a variety of audiences to approach and understand HIV prevention need.

Framework findings
The national Framework, after setting context and identifying need, goes on to describe some of the types of interventions that are currently being used, and the settings in which they are occurring. It is not a critical account of settings and methods, that was beyond the scope of the work, but it does go some way towards defining how HIV prevention interventions targeting African communities have developed so far.

The final section of the Framework recommends a series of important areas for development that should strengthen our approach to HIV prevention for African communities.

The need to develop partnerships
The Framework identifies and articulates the role that a range of stakeholders must play in order to maximise our HIV prevention efforts. The stakeholders that are identified include: African communities themselves and African community organisations that seek to represent and support their communities, the African HIV Policy Network (AHPN) as the national organisation that represents African communities nationally in relation to HIV, NHS commissioners, strategic health authorities, local authorities and NHS health services, HIV prevention providers, researchers and the Department of Health.

All of these groups, organisations and institutions have a responsibility to work in a co-ordinated way that ensures we bring the best expertise, best practice and best learning to the task of preventing HIV in African communities.

The value of research
A number of pressing social and epidemiological research priorities are identified in the Framework. The priorities include more work on the epidemiological and demographic features of the HIV epidemic amongst Africans living in England, gender specific research, work on specific sub-populations and a critically important set of research questions in the area of how well our health services meet the needs of Africans living in England, and how
effective our HIV prevention interventions are.

Most importantly, the Framework identifies a critical need for better understanding of the sexual behaviours and attitudes of Africans with or at risk of HIV, in the context of cultural practices and beliefs, relationships, gender disparity and economic status. The Framework calls for research funding agencies to invest strategically and according to agreed priorities in work that targets and involves African communities.

**Actions, investments and responsibilities**

The Framework identifies the key national task as the development of a supportive infrastructure to promote collaboration, capacity building and best practice for African HIV prevention. At a national level, this should promote national collaboration and co-ordination, identification and sharing of best practice, the development of quality standards, the development of a national African HIV research agenda, a central focus for HIV prevention training and capacity building and for training in cultural competence, and technical support for new developments in HIV prevention targeting African communities.

The Framework goes on to underline the importance of work that is based on a clear understanding of HIV prevention need, and for a wide range of interventions that respond creatively to local need and community tradition. There is also an emphasis on the importance of evaluating interventions.

There is a call for greater resourcing of HIV prevention for African communities outside London, and for greater pan-London planning. Existing African organisations are encouraged to embrace HIV prevention work in addition to their other roles and functions, and the capacity building needs of African HIV prevention organisations are prioritised.

Institutional racism is highlighted as a barrier to this work, and the Department of Health’s commitment to tackling these problems is noted. The role of NHS commissioners in this task is also noted.

Matching investment to the scale of the epidemic amongst African communities is a critical feature of the Framework, as is an approach to investment that matches need not population size. As we try to understand the investment needs in this area, the Framework underlines our fundamental approach to HIV prevention amongst African communities in England – that social factors like racism and social exclusion increase HIV prevention need, and so our efforts must be as much about building social capital as about providing information.

**Where to from here?**

The Framework and its supporting documents are currently with the Department of Health. They are planning to finalise and publish the work as part of their National Sexual Health and HIV Strategy programme of work in June. The Department will be working closely with the African HIV Policy Network to plan a work programme informed by the Framework. We eagerly await the final versions of the documents, so that the work to promote national best practice and collaboration can really begin.
Mark Ward, Healthy Gay Scotland

Review by Sobia Chaudhry, Policy Officer, National AIDS Trust

In this new report ‘Count Us In’ Mark Ward explores the inclusion and involvement of gay men living with HIV in the planning and delivery of health services in Scotland. The report also features a new intervention initiative which took place in Scotland.

Current practice
Mark Ward recounts in ‘Count Us In’ how the introduction of HAART (Highly Active Anti-Retroviral Therapy) or combination therapy has reduced mortality from HIV but not the number of new HIV cases; and how HAART has allowed many gay men with HIV to lead a healthier life, which includes the right to lead a sexually fulfilling life.

The report also explores why the focus of HIV prevention has traditionally been on gay men without HIV or untested gay men and not gay men with HIV.

The argument for the inclusion of gay men with HIV into planning and delivery of health services is also presented. For example, by asking more open questions regarding sexual well being and sexuality of gay men with HIV, more open responses can be obtained, thus allowing service providers to plan appropriate prevention interventions.

Current involvement of gay men with HIV in preventative work:
To understand what the current opinions on involving gay men with HIV into service provision and prevention are, the report examines interviews held with gay men with HIV, voluntary sector agencies and self help groups.

Below are the main points that arose from each discussion group:

Gay men with HIV
The report looks at the views and experiences of eleven gay men with HIV who are active in voluntary or statutory sector HIV work.

From the interviews many felt consultation in HIV prevention too tokenistic and that prevention work had little to do with gay men with HIV and more with negative gay men. Though the report found support for the notion of gay men...
Consultative Intervention for gay men with HIV: ‘The Glen House Weekend’

A three day residential consultative intervention took place in 2001 for gay men with HIV in Scotland to explore issues around sexuality and service provision. This three day event composed of workshops and discussion groups on topics such as sex and relationships and service provision. As well as providing support for gay men with HIV, the event served as a learning point for similar future events.

Some of the main points from this intervention include:

1. How peer support is highly valued.
2. How stigma and discrimination are still true barriers and the effect this has on the sexual health and well being of gay men with HIV.
3. How the voluntary sector is highly regarded by gay men and the need to continue funding these services.
4. Support for gay men with HIV e.g. training, financial and material support.
5. Monitoring & evaluation of all of the above.

‘Count Us In’ is produced by Health Gay Scotland, please log on to www.healthygayscotland.com for further details or to obtain this report.

The role of self-help groups

When self help groups were asked about their involvement in HIV prevention work, all responded by saying that though HIV prevention was not part of their remit, some supportive work around HIV prevention was being carried out.

Though the self help groups may have played a limited role in specific HIV prevention work, they did bring people with HIV together, and discussed sexual health as part of group sessions. In addition, all the self help groups thought it was important for gay men with HIV to become involved in HIV prevention work.

From the interviews and discussions reported it is clear that there is strong agreement on what the perceived benefits of inclusion and involvement of HIV positive men are. However, there is less clarity on how this would actually take place. It also shows that service providers need to prioritise work to include gay men with HIV into their HIV prevention work.

Voluntary agencies

Twelve workers from voluntary sector agencies around Scotland were asked for their views on HIV prevention work for gay men with HIV.

The report describes how there is a strong belief amongst HIV agencies that prevention work needs to include gay men with HIV, though most agencies were unsure how this could take place. Also, further questions revealed that no agency had a systematic model or policy for ensuring inclusion of gay men with HIV into prevention work. An important point to note from the report is the concern managers expressed at commissioners being unable to see the link between care and support agencies and sexual health.

with HIV being involved in developing HIV service provision, many men also expressed fears about talking openly about their sex lives with other workers, especially in formal meetings.
Gay Men with Low Educational Qualifications: The Challenge for Health Promotion

Peter Keogh, Senior Research Fellow, Sigma Research, Faculty of Humanities and Social Sciences, University of Portsmouth, UK.

**Introduction**

In the last two years, our quantitative research has shown that compared to men who are educated to A-level or degree, men with lower educational qualifications (LEQ): have a higher prevalence of diagnosed HIV infection (Hickson et al, 2000, Weatherburn et al, 1999), are more likely to engage in anal intercourse (AI) and less likely to always use a condom and are more likely to be involved in HIV sero-discordant unprotected anal intercourse (sdUAI). Men with LEQ also score higher on a range of HIV prevention and health need indicators than their higher educated counterparts. In spite of this, they are less likely to encounter community HIV health promotion. That is, they are less likely to attend a gay social group, read the gay press, or go to a gay bar or club than men with a higher educational qualifications (Hickson et al, 2000).

These findings have attracted a lot of interest. In the last year, men with LEQ (like men with HIV and young gay men before them) have emerged as the target group of choice. It seems that all interventions must be appropriate to this group. However, no-one seems to know how to target men with LEQ. Some attend to reading age and complexity of concepts. Others take a social inclusion approach and seek to increase social capital through training and skills acquisition. Whereas both of these approaches are valid, it remains unclear what they have to do with men with LEQ. Vitally, we tend to assume that there is a factor common to all men with LEQ which can be intervened with.

**Defining Men with LEQ**

A similar assumption informed our design of what seemed like a relatively straightforward qualitative study of men with LEQ. We sought to interview twenty or so men who had left school aged 16 or under to investigate contexts of risk, infection and attitudes to community health promotion. The study attracted much interest, not to say further funding and quickly grew to a two year study interviewing seventy-five men.

The history of this study is interesting. We assumed that leaving school at sixteen and being unemployed or in a blue collar job was a reasonable marker of class. We assumed we were studying ‘working class’ men. We were wrong. Our sample included a fair proportion of what we have called ‘dissenters’. These are men who have rejected formal education and employment. They were not, working class, but they were still men with LEQ.

We therefore moved on to thinking about employment, education and health more generally. However, as
we changed our recruitment method of recruiting from a pre-existing panel to recruiting through service providers, (thanks to Healthy Gay Living Centre and PACE for this) we started to recruit men with mental health problems (e.g., agoraphobia), men with learning difficulties, men from custodial settings, dysphrasic or dyslexic men etc.

When we started to recruit through postcards on the gay scene (thanks to Healthy Gay Living Centre and CLASH), we started to attract migrants. Men born to mostly, but not exclusively, poorer families in countries in North and South America, Europe, and Asia. Their stories were mediated by their experiences of migrating to the UK, for a whole host of reasons concerning economics, sexuality, culture etc.

We therefore rethought our project in terms of social exclusion. However, we felt that this was capitulation to New Labour ideology which uses this term to classify people who are not easily classed. With this phrase, we were collectivising a group of men who share little except their gay sexual identity. In short, we have found ourselves conducting a study which is infinitely larger and more complex than we thought.

Some Results
In this article, I have provided some of our interim findings of men in one group: men who were born in Britain to parents who both left school at 16 or under - what might be called British men from blue collar backgrounds (N=22). We investigated the factors which they felt were important in shaping their lives. Our analysis generated a list of categories. We assigned men to a category according to how important this category was to their personal development. The relative ‘popularity’ is presented below.

No category contained more than 12 men. That is, none of these categories were particularly strong. What this indicates is that men’s experiences are diverse with no one common experience or ‘x’ factor which unites them. We will however, cover the four most popular categories: gay identity, job and money, therapeutic discourses and family.

Gay Identity
We asked men how coming out and being gay affected their lives. For the most part, coming out brought few advantages and little change. Many saw it as a mildly unfortunate incident in their lives - something which they had learnt to manage. Others had a fluid picture of their sexuality. That is, they identify as gay, yet their behaviour and social role would indicate a heterosexual orientation. Men talked of wanting to be husbands and fathers. A minority said that being gay interfered with family relations and friendships. Moreover, adopting a gay identity sometimes meant relinquishing personal fulfilment. That is, gay social structures don’t offer as great a potential for personal and emotional fulfilment as heterosexual structures.

Family
Those who felt that their family backgrounds had contributed to their development tended to concentrate on negative aspects. Some retrospectively labelled their upbringing as ‘abusive’, often referring to a lack of appreciation or encouragement from parents or in some cases bullying behaviour. Some men are involved in ongoing social support as a result. Some felt their family had had a constraining effect on their ability to express their sexuality openly. Despite this, many
placed a very high value on the family and maintained close ties with family members.

**Therapeutics**

Related to childhood abuse, some men reported symptoms of self-destructive behaviour including excessive alcohol or drug use and sexual problems. The majority had used counselling or group support, emphasising life changes brought about by these interventions. Men did not enter counselling to effect long term personal change, but rather to get to the bottom of what was bothering them and take remedial action. Actions centred around personal control and discipline: controlling drinking, recreational drug use, diet, debts etc. The desire was to restore relative normality rather than self discovery or personal change.

**Jobs**

The majority were unemployed, either through lack of education or training, mental health difficulties or a conviction that work was oppressive, mind-numbing and best avoided. For some, the goal of living quietly on a giro was enough. When men talked about jobs, roughly half saw employment as something that should be fulfilling. Ideal jobs were often of an ‘eclectic’ nature: merchant navy, caring, writing, dancing, sports or DJ-ing. Here employment represents an escape from drudgery. Others saw employment as a means of gaining a basic income rather than constituting part of their social world or identity. Men with mental health problems spoke of the potential of employment to restore their self-confidence. Some saw employment as a possible ‘rescue’ from a family cycle of deprivation and income support. Therefore, employment held a range of symbolic meanings and potentials for men, representing both the structures of oppression as well as the means of fulfilment.

**Conclusions**

It is hard to draw conclusions from this research so far. We might warn against interventions based around gay identity, community structures or familial or ethnic structures. We might recommend that psychotherapeutic interventions be instrumental (skills based) rather than attempting to foster self actualisation.

There are broader lessons to be learned. Gay community health promotion relies on what unites gay men: their similarities. Client centred work is based on common narratives: ‘the coming out story’, ‘the incident of risky sex’. Community health promotion appeals to social experience: ‘the gay scene’, ‘fucking in backrooms’, ‘dealing with homophobia’.

Targeting men with LEQ forces us to grapple with difference. They are a heterogeneous and complex group. Health promotion for gay men tends to break down when we talk about the factors which fragment or dissipate our target groups. Our impulse is to incorporate differences in ethnicity, education, social status, ability, class etc. into the overall totality rather than working with such differences. Therefore, we talk of Black gay men, Asian gay men and gay men with low educational qualifications rather than thinking critically about the experiences and needs of men who are both gay and Black, both gay and Asian, both gay and migrants, both gay and working class. The problem is such experiences do not lend themselves to the way that we practice HIV health promotion for gay men. What this tells us is that health promotion for gay men can only ever hope to speak to part of our lives. Is this good enough? Is it enough to promote a man’s health solely in terms of his sexuality at the expense of his gender, masculinity, ethnicity, class, education and age? Perhaps we must think less of groups and more of problematics. Gay men with LEQ are not a target group, but are emblematic of a set of social factors which fragment and give lie to the myth of a straightforward gay identity. As HIV organisations deal increasingly with generic gay health, the question becomes: is gay identity a sufficiently rich enough social category upon which to hang a health agenda?

**References**


Current HIV prevention efforts have failed to avert over five million new infections around the world over the past year. Few dispute the need to radically scale up HIV prevention efforts on a range of fronts. There is widespread consensus that we need to invest more in education efforts, to tackle stigma and address the social causes of HIV vulnerability. However there is far less consensus about the role that new technologies, particularly vaccines and microbicides, should play in future prevention strategies.

NAT’s position is that we need to expand access to educational programmes, strengthen condom distribution and scale-up behaviour change initiatives while at the same time developing new prevention technologies. We reject an “either/or” approach and argue that it must be a multi-pronged strategy.

Escalation of interest in new prevention technologies is occurring as evidenced by the increasing number of Governments that are investing in vaccines and microbicide initiatives. This raises important issues about the priority we are according to biomedical research and technological solutions as against social and behavioural prevention interventions. Consequently, we must ask how best to position technological options within our prevention thinking.

NAT firmly believes that it is imperative to promote vaccine and microbicide developments because of their potentially major contribution to reduce, or even halt the spread of the global epidemic. However we recognise that this view is not universally held and we should not shy away from acknowledging the downsides of an over-emphasis on technological solutions to social problems.

No longer just an idea
Preventive HIV vaccines and microbicides are no longer just ideas on paper. Studies are underway to look at candidate vaccines in humans. There will be considerable benefit to human health and, possibly even more importantly, poverty reduction when vaccines and microbicides become a permanent fixture on the HIV prevention landscape. The future of developing countries rests on this.

Trials of preventive vaccines are currently taking place in London and Oxford (see below). Thousands of people across the globe are already involved in clinical trials with many more to be enrolled in large scale Phase II and III vaccine and microbicide trials over the next few years.
Phase III trials began in 1992 and ahead of vaccines trials. The first microbicide research is considerably the Nonoxynol 9 trials, on the whole. Despite the disappointing findings of vaccines for wider use. Developing the next generation of important stage on the road to AIDSVAX results will mark an prove to offer only partial protection, although, at best, AIDSVAX will due to be announced later this year. HIV vaccine trial (AIDSVAX) are years. Results of the first Phase III HIV vaccine trial (AIDSVAX) are due to be announced later this year. Although, at best, AIDSVAX will prove to offer only partial protection, AIDSVAX results will mark an important stage on the road to developing the next generation of vaccines for wider use.

Despite the disappointing findings of the Nonoxynol 9 trials, on the whole microbicide research is considerably ahead of vaccines trials. The First Phase III trials began in 1992 and there are around 60 microbicide candidates in the pipeline. The science indicates that in the short-term, the prospects for an effective microbicide against HIV might offer more than an effective HIV vaccine. Microbicides have a broad global base of support amongst sexual and reproductive health NGOs and increasingly microbicides are seen as a tool for gender empowerment given their role in giving women vulnerable to HIV more control over sexual safety (see box).

Certainly, even before these technologies are widely available, the fact that vaccines and microbicides are known to be on the horizon may generate effects on sexual attitudes and behaviours, particularly amongst the members of communities at risk of HIV within which trials are occurring. There are also likely to be impacts on the general public’s perceptions about the likely future course of the epidemic. Given these concerns, we urgently need to consider the impact on HIV prevention of large-scale trials for microbicides and vaccines, and to review our medium to long-term plans on the basis that at least partially effective vaccines and microbicides are likely to be available before the end of the decade.

The downsides
Whilst the increase in investment for microbicides and vaccine research and development has been welcomed by scientists, a range of concerns are being voiced about the potential damage of an over-emphasis on technological solutions.

Firstly, there is concern that it encourages the false belief that science will provide the magic bullets to end the epidemic. Sceptics of the technological approach argue that the focus on new prevention technologies may turn into a dangerous distraction from the need to promote safer sex and encourage widespread and consistent condom use. Can we afford a focus on new technologies when we already know that tried and tested condoms work (or at least most of the time, with appropriate behavioural interventions)? Why not invest scarce resources on ensuring that affordable condoms are more widely available immediately, rather than on the long haul of clinical trials?

Secondly, there is anxiety that HIV risk behaviours will actually be encouraged by the promised future availability of effective prevention technologies. Thirdly, some are worried that access to technologies will be limited to an elite who can afford it, and only compound power imbalances. Finally, there are concerns that the development of new technologies may act as a political distraction when treatment access issues are so pressing for the majority of people living with HIV. Furious criticism has been levelled against supporters of new technologies by some treatment advocates who see the expansion of access to treatments for the millions of infected people as the priority.

Technologies - an essential part of the jigsaw
NAT believes that vaccine and microbicide developments should only happen alongside growth in investment in behavioural interventions, condom promotion, access to HIV and STI testing and treatment, greater access to antiretrovirals including, in particular, to prevent mother-to-child transmission and measures to reduce social vulnerability.

We cannot afford to take an “either/or” approach to prevention options.
Instead we need to take the steps necessary to prepare for the emergence of a complex and nuanced prevention environment characterised by the application of a combination of complementary, although only partially effective, technologies. This new environment will force us to move away from relaying simplified health promotion messages to delivering messages that promote a more complex harm reduction or risk minimisation approach to HIV prevention based on a wider prevention mix.

With a number of the most promising vaccine and microbicide candidates moving into large-scale human clinical trials, we need to work through the implications of these developments systematically to ensure that risks of adverse impacts are minimised and the benefits optimised. For now, we believe the priority should be to ensure that well informed debates take place on the implications of developments, and that a social research evidence base is developed to inform choices and strategies to minimise harm.

Five actions for the UK: NAT recommendations

1 Link domestic and international strategies
The UK government needs to address prevention technologies within domestic HIV strategies as well as our international development strategies. As communities understand that new technologies may soon be available and as clinical trials are promoted locally, impacts are likely to be felt on the behaviour of domestic populations. Significantly, there are strong links between communities resident in the UK and communities where Phase II and III trials are planned over the next 5 years, particularly sub-Saharan Africa and the Caribbean. The Sexual Health and HIV Strategy for England needs to address the health promotion impacts of vaccines and microbicides.

2 Support community involvement
Greater attention needs to be paid to community preparedness issues by all those involved in advocacy, research and development. Community involvement in vaccine and microbicide trials is essential to ensure the success of the trials as well as to guard against ethical and human rights violations. This goes as much for UK communities as for those in the South. Issues which need to be addressed include transparency of trial programmes, community participation in trial management, strategies to ensure that communities have equitable access to technologies once they are available, and the rights of communities to benefit directly from successful trials.

3 Biomedical research must be complemented by social research
The UK government has demonstrated leadership in this area as the first funder to IAVI, its

London vaccinations commence

A new phase of the world’s first clinical trial to test a vaccine candidate for one of the most prevalent HIV strains affecting Africa started in April in London and Oxford. This phase expands the ongoing trials in Oxford and Nairobi which aim to harness the ability of the body’s own immune system to fight disease.

St Mary’s Hospital, Paddington is working with the Medical Research Council Human Immunology Unit in Oxford (MRC HIU). 120 volunteers at low risk of HIV are being recruited to the London and Oxford trials which will take place over the next 12 months. The International Aids Vaccine Initiative is funding the trials. This research is part of the larger initiative to develop a simple, effective and affordable HIV vaccine, which is the basis of the unparalleled partnership between IAVI, the MRC HIU and the University of Nairobi, Kenya. Imperial College will play an important role in this phase of the UK trials.

The vaccine has two parts, one to prime the immune system and one to boost it.

The DNA (prime) component contains genetic information about the virus to prime the immune system and provoke an immune response. The body is tricked into defending itself against the virus before it is there. The aim is to give the body a head start in fending the virus off to stop it overpowering the immune system and taking hold. An MVA booster which contains the same genetic information and has a powerful ability to stimulate the killer T cells, is used to keep the immune system responding.

Genetic information about the Clade A HIV virus, common in Eastern Africa, is contained within the vaccine. There is no live HIV material so participants are not at risk of infection.

The vaccines are among more than six being developed with IAVI support. By 2007, IAVI hopes to move 8 to 12 vaccine candidates through early human trials, with the most promising two or three in final-stage studies.

London vaccinations commence
investment in microbicide testing and development and through its strong support for increased European funding and involvement in clinical trials for these new technologies. However, to date, its support for corresponding social research lags far behind its support for scientific research. There is now an urgent need for social research to be funded to examine the impact of vaccine and microbicide trials on attitudes and behaviours not only of trial volunteers but also of populations within which trials are occurring. Furthermore research should be re-designed so that social research is integrated into the trial protocol. Social researchers in developing countries should be partners in the research process. Social research agendas should be extended to identify and address questions that will arise once technologies become available.

4 Engage professionals, researchers and activists in a joint agenda
Greater awareness about preventive technologies should be fostered amongst HIV professionals. Health promotion workers need to have a better understanding of the likely implications of trials on sexual behaviour. Research that further illuminates how new technologies will widen the prevention hierarchy and complement behavioural approaches is needed. Those who implement behaviour interventions must engage in joint planning with scientists to prepare for the complex prevention environment that we must all come to terms with in the near future. Similar links also need to be developed between treatment activists and prevention activists on human rights issues, as there are many parallels, particularly as regards the rights of trial participants.

5 Develop ethical and human rights standards
Many of the ethical issues faced in running vaccine and microbicide trials are unique, for example the need to consider the impact of HIV stigma when seeking volunteers for trials. Greater attention should be accorded to ethical and human rights issues facing trial participants such as access to health promotion expertise, measures to mitigate social harms such as stigma and discrimination, rights to treatment access to trial volunteers who are exposed to HIV and compensation issues. These issues are particularly complex in resource poor settings such as trial sites in sub-Saharan Africa. The UK is well positioned to develop international best practice in ethical and human rights standards in these areas.

NAT’s contribution
NAT is the UK partner of the International AIDS Vaccine Initiative (IAVI). We provide independent advice to volunteers enrolled in the London and Oxford trials. We are also investigating the ethical and human rights aspects of the east African trials. We work in partnership with national Dutch and Danish organisations on Vaccines advocacy. For more information about NAT’s vaccines programme contact Wanjiku Kamau 020 78146758.

NAT is a member of the Global Campaign for Microbicides. The European Commission recently agreed to fund a European microbicides advocacy project, to be led by IFH (International Family Health). NAT is working with IFH to promote the campaign in the UK. For more information about NAT’s microbicides programme contact Rebekah Webb 020 78146731.
Since joining the London Providers Consortium I have made it my business to look at how generic health and social policy impacts on HIV. Five years out of the HIV sector in a public health department taught me that health issues do not exist in isolation and that action is needed on many levels, including the social determinants of health, if we want to make a difference. At the same time, health policy has changed out of all recognition. It was not so long ago that the Government saw ‘health’ as a matter for the individual and wouldn’t acknowledge that social factors such as poverty had an impact. In those days the HIV sector was doing real cutting-edge work and setting standards for others to follow. Now I fear that we have come full circle with many mainstream policies and initiatives on health leaving much of the HIV sector lagging behind. How different our National Strategy for Sexual Health and HIV, with its emphasis on health services and health information, is from a lot of new public health thinking! This, coupled with massive NHS reorganisation and the mainstreaming of HIV prevention funding, is causing considerable panic in the sector, but it needn’t be so! Here are some perspectives on what voluntary organisations particularly should be doing to exploit some of the new opportunities. They are written from an unashamedly London perspective but will have relevance elsewhere.

A social model of health?
How much is HIV the defining issue? Many organisations acknowledge the fact that HIV is just one of many issues, all interconnected, that people are dealing with. With HIV funding we have often played a game of implying that everything is HIV-related when our work actually covers many other underlying issues. There is a real challenge defining which interventions need a specialist HIV input. For example, should we not be thinking in terms of gay men’s health with HIV as a part of it rather than the other way around? New public health thinking increasingly acknowledges this approach and the importance of working in partnership so we must make better links with public health networks and the public health functions of PCTs to make sure our issues are included.

Ring-fencing - blessing or curse?
The expectation is always that ring-fenced allocations will be mainstreamed. It is a way of kick-starting something while you work with mainstream funders to get support for what you are doing. It’s been quite convenient for us to remain separate but can do so no longer. There are opportunities to mainstream our work, particularly as a lot of funding is going into public services, albeit into schemes which will themselves need to be mainstreamed. The trick is to jump onto this merry-go-round.
In London, black and minority ethnic health is on the agenda like never before so we must make sure HIV issues for Africans are included. This will be more difficult with gay men's work given that institutionalised homophobia is alive and well, but we must make the work we do fit with the health inequality and social exclusion agendas. Nobody else will do it for us.

A 'local' approach
Whether we like it or not, power has been devolved to local level. In London, this represents a missed opportunity to develop new models of planning for highly mobile populations and we need to press for Primary Care Trusts (PCTs) to work together as well as with local partners. Although they will take time to establish themselves, there is a lot of new energy in PCTs. They have a job of modernisation to do and they realise they cannot do it alone. HIV organisations have to build relationships with their PCTs, particularly public health and health strategy staff in order to ensure our issues get on the agenda. Local Strategic Partnerships will bring together local players to decide on priorities for most aspects of public services including health so we must ensure that the interests of our communities are represented.

Scrutiny and involvement
There is a major emphasis on public bodies to involve communities. Voluntary and community organisations have a vital role to play in enabling this to happen and we must ensure that the voices of vulnerable people are heard. Local authorities will have a new role in scrutinising health services and health improvement - we have to become more adept at playing the political game at local level and developing new alliances with councillors. The GLA can scrutinise public services in London and has just started a scrutiny of access to primary care - this gives an opportunity to highlight issues for our communities who experience major problems here.

Public Health Observatories exist in each region to monitor health trends and make recommendations for action. As a significant public health issue, HIV must be included. Many Observatories are leading the development of Health Impact Assessments which are a good way to work out the effects of policies and decisions on people's health - shouldn't we conduct some on the effects of the end of ring-fencing on HIV health promotion?

Networks
The message is very much that HIV has to come out of isolation and live a bit in the wider world. HIV organisations and workers must become more integrated and networks can help this. Public health and voluntary sector networks are particularly useful for communicating about policy information and are being used increasingly as vehicles for consultation. Don't forget that there is more strength in unity than in going it alone!

Despite our current insecurities there are opportunities to put our work on a more secure footing in future, but this will involve thinking outside the familiar, being prepared to take chances and being absolutely up to date with policy changes. It is vital that organisations prioritise some time to do this. The rhetoric is full of possibilities - let's see if we can make it a reality.
Established in 1997 CHAPS – Community HIV and AIDS Prevention Strategy – is a Department of Health-funded partnership of 12 agencies in England and Wales working around gay men’s sexual health. Its work and annual conferences are co-ordinated by the Terrence Higgins Trust. This year’s conference, held in London in February was the largest ever, both in terms of programmed sessions and workshops (almost 30) and delegates attending (over 300). Judging from delegates’ written evaluations, C5 was the best received CHAPS conference to date, in no small part a result of incorporating feedback from previous years’ gatherings.

The conference is the main opportunity for those who work with gay men around their sexual health to learn of research, share good practice and network. It attracts delegates from within and beyond the CHAPS partnership, as well as from overseas. In addition to planners and commissioners of health services, those attending include workers and volunteers from gay men’s health projects, researchers, gay community groups and workers from the GU service.

With an overwhelming focus on HIV, the conference has, however, increasingly incorporated wider issues relating to HIV risk. This year such topics included ‘sexual addiction’, syphilis, social exclusion and health campaigning. The ‘hottest topics’ were an indication of current preoccupations of the HIV health promotion field. Cathy Hamlyn from the Department of Health spoke on the Government’s Sexual Health Strategy and HIV’s position within it. The abolition of ring-fenced funding for HIV prevention was another issue of great concern to delegates. Oral sex risk and the rise of the Internet as a way of making sex contacts were other issues generating much discussion, as was the debate around whether agencies should diversify into general sexual health education.

A key issue was highlighted by Peter Keogh in the opening plenary and picked up in the later session on social exclusion. The research and epidemiology increasingly show that men with less education and/or from lower socio-economic groups are more likely to become HIV positive and they respond least to health promotion as it currently is carried out. So, much of what is done by us, they do not connect with. Quite why this is, is currently being looked at by Sigma Research. As HIV has been to some degree ‘normalised’, especially among gay men (after 20 years only to be expected), it now increasingly takes its place among a host of other concerns gay men have in their lives. It is not seen as the most important thing they must attend to as it probably was for many in the past. For men from lower socio-economic groups I suppose this process is magnified by their overall apparent disinterest in attending to their health per se. Perhaps we are running up against the limits of what health promotion can achieve in its current form. This may create frustration and a sense of failure in some when faced with a rate of infection among gay men that, for the moment, appears not to be going up but isn’t coming down either.

The mood of the conference was excellent and it seemed to be that the conference embraced the fact that they tried to cater for as many different interests as possible and attendees appreciated the one chance to gather on a national level. As the big international AIDS conferences become increasingly disinterested in the gay epidemic and are less and less useful for those working with gay men and their health, the CHAPS conference grows in importance (several overseas agencies no longer bother with the World AIDS Conference but come to CHAPS instead).

For conference summaries visit: www.tht.org.uk/chapsconference5.htm
Development of the HDA

Simon Ellis, Health Development Agency

The Health Development Agency (HDA) was set-up in April 2000 as a result of the White Paper, Saving Lives, Our Healthier Nation. It is a special health authority, working to improve the health of people and communities in England, in particular, to reduce health inequalities. In partnership with others, it gathers evidence of what works, advises on standards and develops the skills of all those working to improve people's health.

When the Department of Health published its National Strategy for Sexual Health and HIV last July, it identified a crucial role for the HDA: "Effective commissioning of HIV/STI prevention needs up to date evidence of what and how different interventions work. The Department has commissioned the Health Development Agency to draw together the available evidence, assess what works and make clear recommendations on future approaches by the end of 2002. The Department will use that work to set the direction for local prevention activity." (3.19)

The task over the last six months has focused on effective interventions to impact on the sexual risks for the priority groups at risk of HIV infection in the UK. And, although the HDA values the full range of evidence to inform thinking about intervention effectiveness, for practical reasons this has been limited to a 'review of reviews'.

Reviews are a useful starting point in that they condense large amounts of information from individual studies, often focusing on particular types of interventions or work with different target audiences. However, it is acknowledged that there are limitations in drawing conclusions on this type of evidence alone; not least because the traditional processes to identify, select and appraise reviews tend to favour a relatively narrow spectrum of potential evidence - that which is mostly drawn from randomized controlled trials and/or sits easily within traditional evidence hierarchies. Other types of methodological approaches - especially, but not exclusively, qualitative work - tend to be under-represented in reviews.

Over the next year, the HDA will be looking at what we can learn from other kinds of evidence, including primary research, non-published literature and expert opinion.

The results of the work undertaken during 2001/2 will be published in May in a document which provides key research, policy and practice recommendations. This paper will join many other topic based papers on the HDA’s Evidence Base website at http://www.hda-online.org.uk/evidence.

For further information, contact Simon Ellis at the HDA’s National HIV Prevention Information Service (NHPIS) on 020 7061 3155 or email simon.ellis@hda-online.org.uk.
Healthy Gay Scotland published ‘Testing Barriers’ last year, a two year research report which examined the issues surrounding HIV testing for gay men in Scotland. ‘Testing Barriers’ has now been condensed into a smaller booklet entitled ‘Breaking Down Barriers’.

The information contained in this booklet is not only timely (Scotland has some of the lowest HIV testing rates in Europe and the UK) but is also ideal for policy makers, health and voluntary services.

‘Breaking Down Barriers’ highlights the psychological, social, sexual and medical factors which influence attitudes towards HIV testing; the outlook of testers and non-testers to HIV testing; the effects of treatment; sexual behaviour, and the attitudes of gay men to HIV testing who are perceived to be at an increased risk of acquiring HIV.

Recommendations from this report include:

■ Campaigns for HIV testing for gay men require a wider approach to tackle the social, medical and psychological issues which hinder HIV testing.
■ Gay men’s sexual health organisations need to highlight benefits of HIV antibody testing in GUM (genitourinary medicine) clinics rather than through GP’s.

■ Gay men need to receive adequate counselling pre and post HIV testing.
■ Different HIV testing sites need to be evaluated to assess how gay friendly they are. This information then needs to be relayed to the gay men.

‘Testing Barriers’ and ‘Breaking Down Barriers’ are both produced by Health Gay Scotland, please log on to www.healthygayscotland.com for further details on obtaining these reports.
New UK HIV diagnoses for 2001 were at record levels, with over 4160 new diagnoses reported, up from 3700 in 2000.

In the UK gay men continue to experience the most serious impact of the epidemic, and sex between men is the main route of HIV transmission in the UK. Sex between men accounts for 55% of the total 48,226 diagnoses of HIV reported in the UK. Recent sharp rises in STIs amongst gay men have given rise to concern that high risk sexual behaviour amongst gay men is increasing.

There is a slow but significant increase in the number of heterosexuals becoming infected by HIV in the UK. Since 1999 the number of new HIV diagnoses acquired heterosexually has been higher than the number of people diagnosed through sex between men (see chart). However, of the heterosexually acquired infections, about 80% of cases are thought to have been acquired abroad, particularly in sub-Saharan Africa.

Source: PHLS

NAT and fpa are joining with the Health and Social Care Quality Centre to mount the UK sexual health conference of the year this October. Further, to broaden access to the event the conference will be held in both London (11th October) and Leeds (1st November), with similar speakers covering the same subjects.

The focus of the conference will be the implementation of the New National Strategy for Sexual Health and HIV. Keynote presentations from leaders in primary care and public health will be followed by workshops testing practical approaches to the three level service and the health promotion issues envisaged in the strategy. ‘Primary Care organisations as commissioners’ as well as ‘providers of care services and partnerships with social care and the voluntary sector’ are also themes being explored.

Building on last year’s hugely successful October conference, the events in London and Leeds continue the debate on service improvement and strategic planning at the core of providing good quality and clinically governed services for people affected by HIV.

For more information about the conference contact NAT at 0207 814 6730
NAT (National AIDS Trust)

NAT is the UK’s leading AIDS advocacy organisation. We work to improve the UK’s response to HIV both domestically and globally. In addition to co-ordinating the annual World AIDS Day campaign we: engage decision-makers with HIV/AIDS issues; develop innovative policies to tackle the epidemic; advocate for the protection of the human rights of people living with HIV/AIDS; and campaign for greater global investment to find an AIDS vaccine.

Derek Bodell
Chief Executive

Dame Ruth Runciman
Chair

IMPACT

IMPACT is produced by NAT’s policy team and seeks to stimulate debate within the HIV sector and beyond on the quality of the UK’s response to HIV.

IMPACT also aims to provide a platform to other voices in the HIV sector to express their views on important HIV issues.

IMPACT is published by NAT (National AIDS Trust).
ISSN 1463-1903

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NAT policy team

John Godwin
Head of Policy & Advocacy
T 020 7814 6727
john.godwin@nat.org.uk

Susie McLean
Senior Policy Development Officer
T 020 7814 6754
susie.mclean@nat.org.uk

Wanjiku Kamau
Senior Policy Development Officer
T 020 7814 6738
wanjiku.kamau@nat.org.uk

Rebekah Webb
Policy Officer (International)
T 020 7814 6731
rebekah.webb@nat.org.uk

Sobia Chaudhry
Policy Officer (UK)
T 020 7814 6735
sobia.chaudhry@nat.org.uk

Address details

NAT (National AIDS Trust)
New City Cloisters
196 Old Street
London
United Kingdom
T +44 (0)20 7814 6767
F +44 (0)20 7216 0111
info@nat.org.uk
www.nat.org.uk

Charity registration details

National AIDS Trust is a Registered Charity No. 297977 and a Company Limited by Guarantee No. 2175938. Registered Office: Howard, James & Co., 14 Yardley Street, Wilmington Square, London WC1X 0EZ

Please send all correspondence regarding IMPACT to the NAT office address given above.

Design: Ideology
Printing: Good News Press