A good practice guide for choosing and implementing community-based HIV prevention interventions with African communities in England

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The publication of this guide marks a further important stage in the implementation of the Sexual Health and HIV Strategy. This first ever National strategy highlighted the need to tailor health promotion interventions specifically for groups at greatest need, including African communities living in England.

This comprehensive guide builds effectively on the advice contained within the Department of Health “Effective Sexual Health Promotion” toolkit, which explores issues around different settings for health promotion work with different groups and developing an evidence base for what works well. These and many other issues are tackled in the current guide, and the collaborative approach used in compiling the material and the clarity of the advice given should ensure that the guide enjoys national coverage. Together with the forthcoming “HIV & AIDS in African Communities: A Framework for Better Prevention and Care Services”, this guide provides a comprehensive resource for commissioners and service providers which I am confident will deliver better quality services for people from African communities affected by HIV in England.

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The development of this practice guide has involved contributions from a number of organisations and individuals with expertise in health promotion and HIV prevention work with African communities.

In particular, we would like to acknowledge the following —

Members of the steering group: Fred Semugera (Croydon Primary Care Trust), Jennifer Nsubuga (West London Health Promotion Agency), Walter Gillgower (Terrence Higgins Trust), Joshua Odongo (Newham Primary Care Trust), Chinelo Nwajiobi (Enfield and Haringey Primary care Trust), Feli Okoko (Islington Zairian Refugee Group), Mark Bitel (Partners in Evaluation), and Lillian Ndawula (African HIV Policy Network).

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All colleagues from the African organisations (see Appendix 11) who contributed to the audit of interventions, participated in the focus groups and consultation meetings held in London and Manchester. We particularly want to thank Syson Namaganda and her colleagues at Black Health Agency for organising meetings in Manchester.

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Special thank you to Lillian Ndawula, Project Manager, National African HIV Prevention programme for her contribution and assistance throughout this project.

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Glossary

References
IV prevention work with African communities in the UK remains of paramount importance given the continuous rise in HIV infections within this population over the last few years. In 2002 a total of 9,712 Black Africans were diagnosed with HIV and they remain the second largest social group affected by HIV epidemic after Gay men. Against this background, the English National Strategy for Sexual Health and HIV, published by the Department of Heath in 2001, prioritises HIV prevention within African communities as a target population.

In the absence of a standard practice guide for implementing HIV prevention interventions among African communities, health promotion specialists, community workers and volunteers have used various innovative methods to reach African communities, in order to provide information and skills necessary to address their HIV prevention needs. Key among these are information needs, need to understand safer sex practices, access to services and the need to address HIV-related stigma.

The first of its kind in the United Kingdom, this practice guide gives practical key approaches and methods used to date in HIV prevention work with African communities in the United Kingdom. Through identification of best practice in intervention methods, the practice guide provides a coherent framework that will guide and direct the provision of community based HIV primary prevention interventions to African communities. In this way, it functions as a good practice guide that will ensure a standard approach to the delivery of a chosen intervention or method.

This practice guide is primarily aimed at community-based HIV prevention providers, but it is also useful to those with responsibility for commissioning HIV prevention work with African communities.

Drawing on Hartley’s (1999) model of interventions, this practice guide has defined the identified HIV prevention interventions in accordance with the ASTOR model (Aims, Settings, Targets Objectives, Resources). Based on the ASTOR model the practice guide further identifies the levels at which different interventions can be delivered. These have been summarised in the table opposite.
In the practice guide, directions are given on assessing need, choosing the right intervention to meet the right need, monitoring and evaluating each intervention including the monitoring and evaluation tools.

Therefore, the practice guide will enable community-based HIV prevention workers to assess HIV prevention needs, as well as structure, plan, deliver, monitor and evaluate the delivery of community-based HIV prevention interventions for African communities in the UK.
The African HIV epidemic in the UK is one of the big challenges for those involved in efforts to reduce the prevalence of HIV. In the last ten years, health promotion specialists, community workers and volunteers have used various innovative methods to reach the African community, in an effort to provide individuals with the information and skills necessary to reduce the spread of HIV. In the absence of a standard practice guide for implementing HIV prevention interventions among African communities, much of this work has been based on their experience of mobilising these communities and using acquired skills to influence people’s attitudes, beliefs and behaviour.

This practice guide is based on the learning and experience derived from the audit of current interventions and literature review. It gives a set of guidelines for each community-based intervention that has been and can be used to reduce the prevalence of HIV among African communities in England.

Using this guide will enable health promotion workers to —

- Understand the HIV prevention interventions that can be used with African communities.
- Find the structure and consistency they need in order to plan and deliver community-based HIV prevention interventions.
- Choose appropriate tools that will enable them to plan, deliver, monitor and evaluate HIV prevention activity.
- Monitor the delivery of HIV prevention activities and begin the process of evaluating their impact on reducing the spread of HIV among African communities.

The need for this practice guide was identified in HIV and AIDS in African Communities: A framework for better prevention and care, (African HIV Policy Network and National AIDS Trust, 2003) which called for —

- The building of a national infrastructure for African HIV prevention work to facilitate national collaboration and coordination;
- The identification and sharing of best practice models;
- The development of quality standards and the creation of a focus for prevention training and capacity-building.

The National Strategy for Sexual Health and HIV: Implementation Action Plan (Department of Health, 2002) also recommends developing a health promotion toolkit that includes best practice guidance on working with targeted groups and communities. This practice guide for community-based HIV prevention will form part of this toolkit.

Primarily African community-based HIV prevention providers, but other professionals providing community-based HIV health promotion services to African communities will also find it useful.
It may also have a role in the commissioning of community-based HIV prevention work with African communities.

1.4 How is it Organised?

The practice guide begins with an Executive Summary.

Chapter 1 – Introduction
This chapter gives an overview of the African HIV epidemic in England. It explains the reasons for producing this guide and identifies who can use it.

Chapter 2 – The Context
This chapter sets the practice guide in context. It briefly outlines the epidemiological need for HIV prevention interventions among African communities. It also looks at the needs of Black African communities in relation to information, understanding safer sex practices, access to services and addressing HIV related stigma.

Chapter 3 – Framework for behaviour change
This chapter provides a framework for behaviour change that includes personal and structural modifying factors that influence sexual risk behaviour. It also provides details of how HIV interventions are grouped and delivered.

Chapter 4 – ASTOR Model
This chapter defines the ASTOR model and how interventions can be planned or described using this model.

Chapter 5 – Needs Assessments
This chapter explains why you need to conduct a need assessment and provides guidelines on how to do it.

Chapters 6 – Individual level interventions
This chapter provide details on individual level interventions (i.e. drop-in-space, telephone advice and help lines, internet-based work, and outreach).

Chapter 7 – Group level interventions
This chapter describes group level interventions (seminars, and workshops).

Chapter 8 – Community-level interventions
This chapter provides details on community-level interventions (condom and lubricant distribution, mass media interventions, campaigns, peer interventions, community events, creation of spaces, community empowerment, and organisational intervention).

Chapter 9 – Socio-political level interventions
Details on socio-political interventions are outlined including advantages and disadvantages of using these interventions.

In Chapters 6, 7, 8 and 9 guidance is given on how to implement, monitor, and evaluate each chosen intervention successfully.

Chapter 10
Key issues relating to choosing, monitoring, and evaluating interventions including learning points described in this practice guide, are summarised in this chapter.

Appendices
At the end of the practice guide there are useful monitoring and evaluation tools, a glossary of keywords and terms used, as well as a list of references and useful contacts for information on African communities work.
Epidemiology of HIV among African communities in the UK.
National Strategy on sexual health and HIV
What is HIV prevention?
HIV prevention needs of black African communities.


b) As far back as 1997, Black Africans have been the most rapidly increasing population in terms of HIV infection in the UK (DeCock and Low, 1997).

c) In 2002, Africans featured in all the main transmission routes for HIV, but most cases of HIV diagnosed among Africans in the UK were reported as heterosexually acquired. The 2002 surveillance data also reported the following —

- 9,712 Black Africans were reported to be living with HIV compared to 16,492 white counterparts.
- Eighty eight per cent of the African population with HIV had acquired their infection through heterosexual intercourse, of which 66% were women.
- Of the women, 92% had acquired their infection through heterosexual intercourse.
- Of all HIV positive women giving birth in 2002 for whom the country of origin was known, 77% were from sub-Saharan Africa.
- Eighty nine per cent of the Black African men were infected through heterosexual intercourse, while 6% had acquired their infection through sex with other men.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>White</th>
<th>Black African</th>
<th>Black Caribbean</th>
<th>Other / mixed</th>
<th>Indian, Pakistani or Bangladeshi</th>
<th>Black other</th>
<th>Not known</th>
<th>Total</th>
</tr>
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<td>Male</td>
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<td>950</td>
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<td>153</td>
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<td>50</td>
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</tr>
</tbody>
</table>

For the latest UK figures of HIV prevalence visit the Health Protection Agency (HIV/STI department: Communicable disease surveillance centre) website at http://www.hpa.org.uk
The National Strategy for Sexual Health and HIV identifies Black Africans as a priority target population for HIV prevention work. The broad aims of such work are —

- To reduce the transmission of HIV and sexually transmitted infections (STIs).
- To reduce the prevalence of undiagnosed HIV and STIs.
- To reduce the stigma associated with HIV and STIs.

HIV prevention work with African communities in the UK is of paramount importance if we are to reduce the prevalence of HIV within this population.

HIV prevention is part of the process of health promotion that offers education, awareness and empowerment to individuals to enable them to have access to clear, accurate and credible information about HIV and AIDS, quality services and to increase their control over HIV in their everyday lives.

Therefore all activities whose purpose is to remove the individual, community and societal barriers that prevent individuals from having control over making informed decisions about their risk of acquiring or transmitting HIV are called HIV prevention interventions.

Traditionally, HIV prevention work is undertaken at three levels — primary, secondary and tertiary.

1. Primary HIV prevention activities focus on preventing uninfected people from becoming infected (e.g. through sex education, condom distribution, information campaigns).

2. Secondary HIV prevention activities are aimed at enabling people with HIV to stay well (e.g. through the prevention of sexually transmitted infections and protection from infection with further strains of HIV) and to prevent onward transmission to others.

3. Tertiary HIV prevention activities aim to minimise the effects of ill health experienced by someone who has symptomatic HIV disease (e.g. the effective use of HIV treatments).

This practice guide focuses on primary HIV prevention interventions.

This practice guide focuses primarily on interventions that address sexual exposure such as sex between men and women and sex between men and men. Interventions that reduce the risk of mother-to-child transmission are medical, and are normally carried out by trained medical personnel. However, community-based interventions to promote the named antenatal HIV antibody test (which is the starting point for reducing mother-to-child transmission) are vital and the interventions covered in this practice guide can be applied to promote named antenatal HIV antibody tests in community-based settings.
Having accepted that there is a need to carry out HIV prevention interventions, it is important to note that these interventions should meet identified HIV prevention needs.

‘The collective task of those whose aim is to meet the needs of black African communities should be to organise HIV prevention activities, so that they have the maximum impact on reducing need and hence HIV occurrence.’

(Hickson, 2001)

It is therefore important that we understand what these identified needs are. They have been identified for us through research and through the experience and expert opinion of those who have been providing HIV prevention interventions for many years. The needs are categorised as set out in HIV and AIDS in African Communities: A framework for better prevention and care (African HIV Policy Network and National AIDS Trust, 2003).

2.4 HIV PREVENTION NEEDS OF BLACK AFRICAN COMMUNITIES

Information

Black Africans need to acquire knowledge and information about the following —

- HIV transmission (including mother-to-child transmission, sexual transmission, needle sharing), testing and treatment (First National Black African Communities HIV Primary Prevention Report, Ndofor-Tah et al, 2000).
- The medical aspects of HIV and AIDS (Ndofor-Tah et al, 2000).
- The key cultural perceptions and practices that put them at risk of HIV infection, including those regarding perceptions of condoms, polygamy, sexual behaviours, reproduction and breastfeeding, secrecy and taboos. African communities need culturally appropriate information about the relationship between HIV and sexual practices, relationships, sexual negotiation, reproduction and sexuality and about the implications of sero-concordant/discordant sex (Ndofor-Tah et al, 2000, Chinouya et al, 2000, Maharaj, 1998), in order to make decisions about the levels of risk they are prepared to take.
- Sexuality, homophobia and the sexual health needs of Black African men who have sex with men (Black African Men’s Seminar, 2000).

The need to understand safer sex

Black African communities need —

- To develop skills in order to deal with the cultural barriers to adopting and maintaining safer sex practices (such as gender issues, relationships) (University of Reading, 1998, Amamoo, 1996).
- Information about the effectiveness of condoms in reducing the risk of transmitting and/or acquiring HIV and other sexually transmitted infections (Ndofor-Tah et al, 2000).
- Easy access to free condoms and lubricants (Holtgrave, 1995; Camden and Islington Health Authority, 1998).
Access to services

Black African communities need —

• To be informed of the availability and accessibility of sexual health services and HIV treatment services (Ndofor-Tah et al, 2000, The First National Black African Communities HIV Primary Prevention Conference, 2000).


• Access to a range of services, including HIV treatment services, sexual health services, welfare and immigration rights services, social support services and health promotion services for Black Africans living in England who have applied for asylum or other leave to remain (McMunn, 1997).

• Better access to services for Black Africans living outside London (The First National Black African Communities HIV Primary Prevention Conference, 2000).

HIV-related stigma

• HIV is heavily stigmatised in Black African communities in the UK (Erwin 1999).

• Black African people living with HIV need support to deal with the stigma they confront within their respective communities (Goldin 1994; Bhatt, 1996).

• Stigma in Black African communities exists in the context of secrecy, financial insecurity and uncertainty about immigration status (McMunn et al, 1997).

• Some Black African women experience additional gender-related problems as a result of HIV-related stigma – such as domestic violence and rejection from their homes (Erwin, 1999).

• Some Black African men who have sex with men face homophobia and stigma within their respective communities (Big Up, 1999).

• HIV-related stigma and fear of disclosure of HIV status act as barriers to accessing services (Erwin, 1999).

How might stigma impact upon sexual behaviour and HIV transmission?

Fear of stigma prevents people from —

• Discussing HIV risks and HIV prevention strategies.

• Accessing HIV and sexual health services.

• Testing for HIV/knowing their status.

• Notifying their partners about their HIV status.

• Disclosing their HIV status to friends, family members, employers and service providers.

• Accepting and adjusting to their HIV diagnosis.

• Adhering to antiretroviral treatment.

• Planning for the future.
Sexual behaviour may be influenced by personal and structural modifying factors. All HIV prevention interventions aim to change sexual behaviour of individuals and groups by addressing these modifying factors.


3.1 Framework for Behaviour Change & HIV Prevention Interventions

Personal modifying factors —

• Knowledge and awareness e.g. of HIV risk, of condom effectiveness, of resources and of the availability of condoms and the HIV test.

• Attitudes, motivations and intentions e.g. attitudes towards condoms and safer sex, intentions to use condoms, motivation to use condoms.

• Beliefs and perceptions e.g. how you see yourself with regard to the risk of acquiring HIV, perceived social norms (peer norms) regarding safer sex, beliefs about the seriousness of HIV, cultural and religious beliefs about sexual practices.

• Skills – sexual negotiation skills, condom skills, sexual assertiveness.

Structural modifying factors include —

• Economic factors e.g. funding.

• Policy factors e.g. laws and regulations (age of consent to sex).

• Societal factors e.g. community/peer norms regarding safer sex, cultural and religious beliefs and practices.

• Organisational factors e.g. the structures and functions of service organisations and their capacity to sustain prevention programmes.
3.3 How are HIV Prevention Interventions Delivered?

Some interventions are effective when used with one person, while others are effective when applied to a group of people. Most interventions can be grouped according to delivery as defined by Exner et al. (1997) in the following categories —

### Individual level interventions

Individual level interventions cover any one-to-one or face-to-face interactive interventions. They operate mainly on personal modifying factors, such as knowledge, attitudes, intentions, skills and self-esteem.

Individual level interventions include —

- Voluntary counselling and testing.
- One-to-one counselling.
- Face-to-face detached or outreach work.
- Telephone help and advice lines.
- Some internet-based work.

### Group-level interventions

Group-level interventions are facilitated sessions or activities delivered to small groups of individuals. Sessions can be one-off or regular, of varying length and intensity, and either didactic or interactive (or a mixture of both). Such interventions include —

- School-based sex education.
- Community-based seminars.
- Community-based workshops.
- Small group work, including therapy aimed at enhancing coping strategies and bringing about change in behaviour or thinking patterns.

Small group interventions can be used to provide a range of skills and information. The interventions may involve role-play and problem solving strategies. (e.g. getting members to think about risky situations and practice how they would respond to them).

Group-level interventions therefore mainly operate on personal modifying factors such as knowledge, attitudes, perceptions and skills. They can also take advantage of the make-up of the group to address structural (societal) modifying factors, e.g. peer and group norms about how African men regard condom use.)
Community-level interventions

Community-level interventions target defined ‘communities’, such as newly sexually active young people, the Congolese community, religious leaders, or Africans with HIV living in Manchester. Interventions at this level can also target organisations and professionals working with specific populations.

Examples of community-level interventions include —

• Small media (leaflets and booklets).
• Mass media (posters and advertisements in newspapers).
• Condom and lubrication provision.
• Peer education and social diffusion.
• Some Internet interventions e.g. website, chat rooms.
• Community empowerment and development, including building community infrastructure.
• Influencing practice of organisations, including training and technical advice.

The Community-level interventions attempt to change behaviour by —

• Influencing social norms.
• Providing information or skills through community-based work.

Socio-political level interventions

• Legislation, including anti-discrimination laws and laws about the age of consent to sex.
• Equality work – activities to reduce discrimination and social exclusion by influencing national and local policies.
• Facilitation interventions – research and development, programme planning, communication and collaboration between agencies.
• Resource allocation.
• Regulation (e.g. labelling of condoms with lower age limit).

Socio-political interventions mostly affect structural modifying factors.

It is important to note that the modifying factor, rather than the risk behaviour or intervention method, is the starting point for interventions – that is where HIV prevention activity has to be focused.
What is the ASTOR model?

Intervention description.

Aim — reflecting the modifying factors that the intervention is trying to change.

What is the intended outcome?

An aim provides general information about the purpose of a piece of work. If we compare an intervention to a journey, the aim provides information about the general direction of travel. It may, for example, be a desire to increase something (such as awareness about HIV testing), to decrease something (such as isolation), or to maintain something (such as access to condoms). Related to an aim can be a statement about intended outcomes. This provides a sense of how far the aim is to be achieved (for example, to what degree awareness about HIV testing is to be raised).

Setting (context) — Where does the intervention take place?

How do individuals come into contact with it?

Information about a setting identifies how the target group will come into contact with the intervention, and where the activity will take place.

Target population — the specific focus of the intervention.

Among whom is the proposed change intended to occur?

Who is prioritised for the intervention?

Who do you not want to encounter the intervention?

This will usually be information about the people whom the intervention chiefly seeks to influence e.g. young people 15–25 years.

Objectives — the content and method of delivery.

What does the intervention consist of?

What do you actually do?

Objectives provide information about specific events that take place during the life of an intervention.

Again in comparison to a journey, the objectives might include: get a car, find a driver, drive, stop at services, drive again, etc. In terms of HIV prevention intervention, the objectives of an aim to raise awareness of HIV testing options could include: carry out a poster campaign, publicise in a local newspaper. Implicit within objectives are the tools or methods to be used e.g. develop a poster for the campaign, write a newspaper article.

Resources — staff, budgets, other material assistance, volunteers.

What human and financial resources are needed?

How much time is needed?

Information about resources should identify what needs to be put into a project so that intended outcomes are achieved. This might, for example, cover such things as staff costs, volunteer time, numbers of information resources needed, as well as travel and subsistence costs.
5.1 Why do you need to do needs assessments?

HIV prevention interventions are undertaken to address an identified need. In order to choose the best intervention to use, it is important that you are clear about the needs of your target population.

Your target population may have various needs, however it would be useful to assess the following —

- People’s awareness of what HIV is and how it can be transmitted.
- Their awareness of HIV risk behaviour.
- What they think can be done to reduce their risk.
- What their perceptions are of their own risk of being infected by HIV.
- How well they think they can maintain their safe behaviour or change their behaviour towards safer sex practices.
- What their intentions/plans are.
- Who they would most likely find credible in the provision of prevention information.
- What the barriers are to them accessing information and treatment services.

This information can be obtained through a needs assessment and it will assist you to —

- Establish appropriate aims, objectives and activities.
- Define the scope of the interventions.
- Identify the social/behavioural attitudes, beliefs and perceptions of the target population.
- Establish community-based support for the proposed activities.
- Provide the basis for evaluation of the interventions.

5.2 Informal and Formal Needs Assessment

An informal needs assessment may occur through frequent conversations and personal interactions with colleagues and members of the target population during staff meetings or service delivery respectively.

A formal needs assessment requires you to —

- Identify questions that need to be answered.
- Determine what information will be collected, how and from whom.
- Identify existing sources of data, e.g. previous research done by other people, reports on seminars or conferences.
- Collect the data.
- Analyse the data.

Before conducting a needs assessment, it is useful to consult with key people. This may be a leader from the target population, for example, to get their views on their community’s needs, discuss the plans to conduct the assessment and to build a working relationship with them in order to obtain community support for the proposed activities.
### 5.3 How to Conduct a Needs Assessment

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Identify sources of information and data.</td>
<td>e.g. epidemiological data, census data, data collected through activities in your own or other organisations.</td>
</tr>
<tr>
<td>2.</td>
<td>Review existing information on the specific problem.</td>
<td>e.g. books, research reports, conference reports.</td>
</tr>
<tr>
<td>3.</td>
<td>Contact other organisations in the community, Primary Care Trusts and Sexual health leads to avoid unnecessary overlap in activities and to identify new issues.</td>
<td>e.g. other community-based organisations working with your target population or doing similar activities.</td>
</tr>
<tr>
<td>4.</td>
<td>Interview key people in the target community and other communities who have knowledge or experience with the problem.</td>
<td>e.g. elders/church leaders, community-based healthcare workers, leaders of similar projects and statutory workers who can make a useful contribution.</td>
</tr>
<tr>
<td>5.</td>
<td>Analyse your findings and make recommendations for taking work forward e.g. identifying the needs that will be addressed by different HIV prevention interventions.</td>
<td>You can analyse the findings yourself or seek the services of an expert individual or organisation to assist you in making sense of the information you have collected.</td>
</tr>
</tbody>
</table>
What is a drop-in space?

A drop-in space is a service to provide a designated area in a community-based agency’s premises, which allows individuals to visit without appointment. The drop-in could take place on a specific day or at a specific time set aside to allow staff or volunteers to provide services to those who come without an appointment. The service does not necessarily have to be HIV-related, but can provide opportunities for face-to-face discussions on HIV-related issues and services, or the distribution of condoms. Individuals can also be referred to other HIV service providers.

How does it contribute to reducing the incidence of HIV among African communities?

A drop-in service can address information needs and promote access to sexual health services, by signposting clients to the relevant agencies.
Advantages & disadvantages of using a drop-in space

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
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<tbody>
<tr>
<td>• Direct contact with the target population.</td>
<td>• Short-term contact.</td>
</tr>
<tr>
<td>• It is a good method of reaching a range of people in need, in one setting.</td>
<td>• Usually one-off contact.</td>
</tr>
<tr>
<td>• Can be used to address needs not met by interventions such as small media (leaflets, posters, booklets).</td>
<td>• Requires consistent human resources that are not available for many African organisations, and this limitation may restrict the numbers that can benefit from this type of intervention.</td>
</tr>
<tr>
<td>• Facilitates distribution of health promotion resources such as small media and condoms.</td>
<td></td>
</tr>
<tr>
<td>• Staff can pick up issues direct from the population.</td>
<td></td>
</tr>
<tr>
<td>• The intervention offers opportunities to promote other services or health promotion initiatives.</td>
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Monitoring the drop-in space *(See Appendix 1 – Monitoring form)*

In monitoring a drop-in space you should record the following —

<p>| |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>• The profile of individuals reached – age, ethnicity, area of residence.</td>
</tr>
<tr>
<td>• The number and nature of referrals made to other organisations.</td>
</tr>
<tr>
<td>• Key issues discussed, including any problem areas.</td>
</tr>
<tr>
<td>• Nature of advice given and recommendations to the individual.</td>
</tr>
<tr>
<td>• Printed and safer sex materials made available to the individual.</td>
</tr>
<tr>
<td>• Number of sessions provided to each individual.</td>
</tr>
<tr>
<td>• Length of contact or session.</td>
</tr>
<tr>
<td>• Number of staff and volunteers providing services in the drop-in.</td>
</tr>
<tr>
<td>• Record of financial resources spent on the intervention.</td>
</tr>
<tr>
<td>• The methods used to promote sessions and recruit participants.</td>
</tr>
</tbody>
</table>
Evaluation

In the short term, you can compile all the information on the monitoring forms e.g. all individuals that have received this intervention for a period of six months.

This will give you —

- The number of people you have reached.
- How many are men or women.
- Where they are from, e.g. borough of residence.
- An idea of the common issues individuals are concerned about.
- An idea of gaps in the knowledge of individuals, their perceptions, beliefs, attitudes and practices.
- An idea of gaps in knowledge about HIV and about sexual health services.
- The main focus of advice given to individuals who are reached through the drop-in space.

To assess whether your drop-in space intervention has achieved its aim, in the long term, you will have to do a follow-up investigations with certain individual clients. At the time of the intervention, select a percentage of the clients and inform them that you would like to contact them at a later stage. When a time has been arranged, you can conduct a follow-up interview.

You can assess whether their knowledge, attitudes, beliefs and practices have changed since they attended the drop-in space. (For example, whether they adopted safer sex practices as a result of that contact and how they benefited from the advice you gave them and the referrals you made for them). Your questions will have to be based on the information they gave you initially, which you will have recorded on the monitoring form.

Practice guidelines

- There should be a confidential space in the organisation where one-to-one discussions can take place, e.g. a room that can be used by the two people at the time of the intervention.
- There should be clear guidelines on what the individual should expect from the service, and it should be made clear to them at the start of the discussion.
- It is useful to have resources on display where clients can access them easily.
- Health promotion staff working in the drop-in space should be given regular training to keep up with developments in the HIV sector. They should be given regular supervision.
- Staff members should be given motivational interviewing skills training.
- It is useful to develop quality standards for this intervention to achieve consistency in the way the intervention is delivered.
- There should be proper procedures governing access to confidential files and sharing information.
- Staff members should work within agreed professional boundaries in the course of their duty and in any future relationships with those who use or have used the space.
- The service should be widely promoted to encourage active referrals and uptake.
What is telephone advice?

Telephone advice is a service where experienced advisers use their skills and knowledge to give advice and provide information and support to callers over the telephone. Callers are able to contact advisers using the telephone to explain their needs and receive appropriate advice or referral to other services. A dedicated telephone line can be used for this service at organisational level. (Currently there is a national help line for African communities, the National African AIDS Help line 0800 0967 500. It covers a range of African languages).

What type of intervention is telephone advice?

A telephone advice service is an individual level intervention. It can be used alongside other interventions.

How does it contribute to reducing the incidence of HIV among African communities?

A telephone advice service can be used to meet information needs of many individuals within the target population. Advisers are able to make contact with and provide up-to-date information and referrals to Africans who may not be reached by other means and those preferring to seek information anonymously.

<table>
<thead>
<tr>
<th>ASTOR Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim</strong></td>
</tr>
<tr>
<td>1. Reduce the acquisition and transmission of HIV and sexually transmitted infections among Africans in the UK.</td>
</tr>
<tr>
<td>2. To increase knowledge &amp; access to HIV information, services and related issues.</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
</tr>
<tr>
<td>• Community-based organisation offices.</td>
</tr>
<tr>
<td>• Call centre (for the national help line).</td>
</tr>
<tr>
<td><strong>Target</strong></td>
</tr>
<tr>
<td>• Young people (and sub-groups such as young people between the age of 13–15, young offenders, young people in local authority care, young people who have left school, unaccompanied minors).</td>
</tr>
<tr>
<td>• Students.</td>
</tr>
<tr>
<td>• Specific vulnerable groups, such as commercial sex workers, African men who have sex with men, drug users, homeless people, refugees and asylum seekers, people living with HIV.</td>
</tr>
<tr>
<td>• Men and women between 16–55 (single, partners, parents, carers, friends, or other family members).</td>
</tr>
<tr>
<td>• Religious and community leaders.</td>
</tr>
<tr>
<td><strong>Target numbers</strong></td>
</tr>
<tr>
<td>400 and above.</td>
</tr>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>Information giving, increase access to information, HIV and counselling services.</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
</tr>
<tr>
<td>Telephone, out-of-hours answering service, staff, volunteers, information resources, quiet and private location &amp; sufficient funds.</td>
</tr>
</tbody>
</table>
Advantages & disadvantages of using a telephone advice service as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anonymity — telephone advice services can reach people afraid of face-to-face contact.</td>
<td>• Lack of face-to-face interaction.</td>
</tr>
<tr>
<td>• Provides access to populations who may not be reached by other means and can be used as a needs assessment tool to establish community and individual needs.</td>
<td>• May be subject to abuse that may distort monitoring of data.</td>
</tr>
<tr>
<td>• It is an effective method of providing up-to-date information and discussing issues of concern to the caller.</td>
<td>• Can be time-consuming.</td>
</tr>
<tr>
<td>• Information received can help individuals make informed choices and sustain behaviour change.</td>
<td>• Labour intensive and can be expensive to run.</td>
</tr>
<tr>
<td>• It is interactive, motivational, influential, and supportive.</td>
<td></td>
</tr>
<tr>
<td>• Provides referrals to other services such as testing, counselling and support services.</td>
<td></td>
</tr>
<tr>
<td>• It is widely accessible with a potential to reach many people</td>
<td></td>
</tr>
<tr>
<td>• They are helpful for people in crisis.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring telephone advice (See Appendix 2 – Monitoring form) [4]

- Record number of calls received and the length of the call or contact.
- Monitor the nature of enquiries and information about the callers (who is calling the advice line and where they are calling from).
- Monitor referrals made, and to assess the uptake of services, obtain feedback from agencies where users are referred.
- Monitor regular callers & those willing to participate in follow up interviews.
- Monitor the advice, printed and safer sex materials made available to the callers.
- Record the number of staff and volunteers who are providing advice services, and keep records of any training provided.
- Record the methods used to promote the advice line.
- Record the financial resources spent on the intervention.

Evaluation

It is very hard for community-based organisations to evaluate the effectiveness of telephone advice lines in meeting their aims and objectives. Such an evaluation process requires contacting a large number of people to get information from a representative sample. This requires a lot of resources that may not be available to community groups.

However, the monitoring information compiled can be used to evaluate the process of providing telephone advice.

Where a caller’s contact details are known, callers (with their permission) can be sent survey forms asking for their views about the quality of services received.

Practice guidelines

- Opening times should meet the needs of the target population.
- Consideration should be given to people who are deaf or hard of hearing when setting up the telephone system.
- Operators should be trained on HIV/AIDS, advice, communication and motivational skills. They should be courteous, non-judgemental and patient and should have a sound knowledge of the range of services to which callers can be referred.
- Operators should be given regular supervision, and counselling should be available for all operators, as they may have to deal with stressful situations from time to time.
- There should be guidelines on how to deal with abuse and threats.
- Staff should be familiar with the confidentiality policy and guidelines relating to sharing information within or outside the organisation.
- The service should be provided in different languages, where there is a demand for it.
- The telephone advice line number should be widely promoted among the target population and among service providers to encourage service uptake.

6.3 Internet-Based Work

What is internet-based work?

This is a quick and anonymous method of conveying messages and raising awareness of HIV/AIDS, treatments, care and support, resources, news updates, jobs and volunteering opportunities, information on campaigns, conferences and fundraising events (The Field Guide, 2003). It can be interactive and provides opportunities to ask questions on HIV, and other related matters. Advice can be e-mailed to clients where appropriate.

What type of intervention is internet-based work?

Internet-based work can be used as an individual-level intervention to provide information on HIV and related issues via a website or chat room to a large number of people through an anonymous and confidential medium.

How does it contribute to reducing the incidence of HIV among African communities?

Internet-based work provides opportunities to increase individual knowledge and awareness of risks, as well as awareness of available services. Activities can be structured to address specific issues, such as attitudes towards safer sex, motivation to use condoms, individual beliefs and perception of risk, communication and sexual negotiation skills.
### ASTOR Model

| **Aim**                          | 1. Increase levels of knowledge about HIV.  
|                                | 2. Develop sexual negotiation skills.  
|                                | 3. Reduce stigma and discrimination against people living with HIV.  |
| **Setting**                     | Internet can be accessed in —  
|                                | • Cafes.  
|                                | • Social clubs.  
|                                | • Schools, colleges, universities.  
|                                | • Homes.  
|                                | • Workplaces.  |
| **Target**                      | • Young people and the sub-groups, such as young people between the age of 13 to 15, young offenders, young people in local authority care, young people who have left school, unaccompanied minors).  
|                                | • Adult men and women aged 16 and above.  
|                                | • Students.  
|                                | • African men who have sex with men.  
|                                | • Refugees and asylum seekers.  
|                                | • People living with HIV.  
|                                | • Faith communities.  |
| **Target numbers**              | Over 500.  |
| **Objective**                   | • Information giving using Internet-based activities.  |
| **Resources**                   | • Computer or link to the Internet.  
|                                | • Budget to cover project costs, including subscription to access the Internet, web design, management and administration.  
|                                | • Web designer.  
|                                | • Web host to manage the website.  
|                                | • Information officer to update the website.  |
Advantages and disadvantages of using internet-based work as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Interactive, anonymous and effective method of transmitting information.</td>
<td>- No face-to-face contact.</td>
</tr>
<tr>
<td>- Easy access to information outside office hours.</td>
<td>- May not be accessible to individuals who are not literate or who have no computer skills.</td>
</tr>
<tr>
<td>- Links to useful sites or further information can be provided.</td>
<td>- Requires access charges or investment in IT skills and computer equipment.</td>
</tr>
<tr>
<td>- Cheap method of advertising.</td>
<td>- Requires access charges or investment in IT skills and computer equipment.</td>
</tr>
<tr>
<td>- Ability to reach diverse communities.</td>
<td>- Individuals may be overwhelmed by the amount of information available to them.</td>
</tr>
<tr>
<td>- Accessible by millions of people.</td>
<td>- Some of the information available on the Internet may be inaccurate or outdated.</td>
</tr>
<tr>
<td>- Information can be updated quickly.</td>
<td>- Delays encountered in downloading information may discourage some users.</td>
</tr>
<tr>
<td>- Quick reference point for answers to frequently asked questions</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring internet-based activities (Website) [See Appendix 3 – Monitoring form] ^5^  

You can monitor the use of your internet-based activities such as website, or news updates through the following —

- Number of page requests to determine information screened by users.
- PDF file downloads to see what information interests users.
- Number of subscriptions to e-mail lists.
- Referrals – this includes the number of sessions referred to your site. Users in search engines to access your site enter key words and search enquiries. The key words will help to identify what leads users to your site and how successful search engines are at finding your website.
- Time taken by users to access or download information on your site.
- Time taken by your organisation to respond to users’ queries.
- Feedback received from users and issues raised.
- Number of staff and volunteers trained or working on the website.
- The methods used to promote internet-based interventions.
- Record of financial resources spent on the intervention.

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^5^ For more information on monitoring and evaluating websites see: Sustainable Development Communications Network: Monitoring and Evaluating Web Communications, http://www.sdcn.org/webworks/monitoring/
Evaluation

- Obtaining feedback from users about your website can be achieved through the use of user feedback forms. This form can include users’ views about the health promotion information and messages to determine whether they are useful, easy to understand and appropriate to their needs. Feedback forms can also contain comments, complaints and requests for further information. They can be filled in online (See Appendix 3).

- Evaluation of a user’s experience with your site can also be done via user tests that involve asking staff or representatives of the target population to look through the site for a specified period of time. You then ask them to perform specific tasks and identify what they like or do not like about your site, after which they complete a questionnaire on their impressions about the site in terms of navigation, graphic consistency, structure and attraction.

Practice guidelines

- Information displayed on a website should be reviewed and updated regularly for accuracy.

- Messages and information posted on the website should be pre-tested with representatives of the target audience to establish if the information is easy to understand, interesting, clear and appropriate.

- The website should be easy to navigate.

- Include a feedback form that users can complete online.

- Include a frequently asked questions page where users can be referred for answers.

6.4 Outreach

What is outreach?

Outreach has been defined as ‘a community-based activity with the overall aim of facilitating improvement in health and reduction in the risk of HIV transmission for individuals and groups who are not effectively reached by existing services or through traditional health education channels’ (Rhodes, Hartnoll and Johnson, 1991).

It involves staff going out to meet people where they are, rather than expecting people to come to them (Ewles, L. and Simnett, E., 1999).

What type of intervention is outreach?

It is an individual-level direct-contact intervention and involves health promotion staff making one-to-one contact with the target population (or sub-population of it) in a variety of settings to meet health promotion need, e.g. if the main target population is the African community, a sub-population could be African women using a hair salon, or African mini-cab drivers.

How does it contribute to reducing the incidence of HIV among African communities?

Outreach can be used as a tool to meet information needs or used alongside other interventions to increase African individuals’ access to sexual health services.
## ASTOR Model

<table>
<thead>
<tr>
<th><strong>Aim</strong></th>
<th>Reduce HIV transmission, address information needs and increase access to sexual health services.</th>
</tr>
</thead>
</table>
| **Setting** | Places where identifiable individuals or groups of African people are found —  
- African social clubs.  
- African restaurants.  
- Shops and businesses.  
- Hair-dressing and barber shops.  
- Money exchange services.  
- Washing bays.  
- African markets.  
- Cab offices.  
Situations can also be settings for outreach in the African community and may include —  
- Country Independence Day celebrations.  
- House parties.  
- Weddings.  
- Stag parties.  
- Funeral gatherings or vigils. (Some African communities will gather in large numbers in the event of a death to keep company with the bereaved family sometimes for up to a week. You may need to seek permission from the bereaved family to do outreach in this setting.)  
- Cultural ceremonies or meetings, e.g. naming ceremonies, bridal showers (hen parties at which the bride-to-be is given presents for her kitchen) etc.  
- Community events and health fairs.  
**Note:** Most African nationalities have their own meeting places or events. Knowledge of the settlement patterns of each sub-population is essential in identifying places or situations where outreach can be applied. |
| **Target** | • Sexually active African individuals.  
• Or a sub-population (men at a barber shop, young people at a party, Zambian women at a bridal shower, Ethiopians at an Ethiopian restaurant). |
| **Target numbers** | 1 or more people. |
| **Objective** | HIV prevention service delivery usually involving one or more of —  
- Distributing printed materials (leaflets, booklets, cards, posters).  
- Face-to-face discussion between two people, either as a single encounter or as an on-going activity.  
- Condom and lubricant distribution.  
- Referral to other sexual health/HIV prevention services. |
| **Resources** | Resources for outreach may include —  
- Information resources: e.g. HIV/AIDS booklets, leaflets and flyers.  
- Materials: condoms, lubricants, condom demonstrator.  
- Notebook or monitoring form, pen or pencil.  
- Identification: e.g. identity card, documentation with your employer’s address.  
- Your contact cards.  
- Travel expenses.  
- Mobile phone. |
Advantages and disadvantages of using outreach as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Direct contact with the target population.</td>
<td>• Short-term contact.</td>
</tr>
<tr>
<td>• Facilitates distribution of small media resources.</td>
<td>• Usually one-off contact.</td>
</tr>
<tr>
<td>• Facilitates condom distribution.</td>
<td>• Lack of structured follow-up.</td>
</tr>
<tr>
<td>• Information resources and condoms reach the target population.</td>
<td></td>
</tr>
<tr>
<td>• Staff can pick up issues direct from the population.</td>
<td></td>
</tr>
<tr>
<td>• The intervention offers opportunities to promote other services or health promotion initiatives.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring outreach interventions

There are two main ways in which outreach interventions can be monitored —

1. You could write down a narrative account of what happened during and after the intervention on a de-briefing sheet (See Appendix 4).

2. You could also fill in an activity form (See Appendix 5). You should complete a form for each outreach session, not each individual contacted during outreach.

In addition to the above-mentioned methods, you could also monitor the following —

• The number of outreach contacts made.
• The timing of outreach activities.
• Length of the sessions.
• The methods used to promote the sessions and recruit participants.
• Number of referrals made.
• The number of staff and volunteers trained and involved in organising and running outreach activities.
• Record of financial resources spent on the outreach intervention.
Evaluation

In order to evaluate whether your outreach activity has achieved its aim, you will need to inform clients at the time of the intervention that you might wish to contact them at a later stage (possibly by mobile phone or email) about follow-up. When the time comes to conduct the evaluation, you can send a text message or email indicating that you would like to speak to them and if they agree, you can then arrange a convenient time for the follow-up interview.

You will need to establish how their knowledge, beliefs and practices have changed as a result of the intervention. Your questions will have to be based on the information you compiled about the population in that setting on the de-briefing sheets and on the monitoring form.

Practice guidelines

- Good background planning —
  1. What is happening? (The nature of event taking place).
  2. Where is it taking place? (Setting/venue).
  3. Distance and means of transport required (how will you get to/leave the setting? How far is it from where you are?).
  4. Time e.g. opening/closing hours.
  5. Admission i.e. restricted, open, paid.
  6. Do you need permission prior to your session?
  7. Knowledge of the target population (age, gender, social inclination e.g. religious group, activists, students, general community).

- Outreach should be done in pairs.
- Clear guidelines on how to deal with safety issues should be developed by organisations, and workers involved in outreach should follow them.
- Staff should work within agreed professional boundaries.
- Identification is essential: Always carry an identity card or documentation with a named contact or your employer’s contact number and address. You may need to identify yourself to those you come in contact with or to authorities in the area.
- Business cards are also useful to carry.
- Some money for use in an emergency.
- A mobile phone is essential in case you need to be contacted or you need to contact someone in an emergency.
What is a seminar?

A seminar is a structured session whereby individuals are recruited and brought together in a setting and receive HIV information from a health professional or community worker.

What type of intervention is a seminar?

It is a group-level intervention and involves health promotion staff facilitating a group of individuals from the target population or sub-population. Seminars are mainly information giving using educational methods. Although seminars mainly operate on personal modifying factors such as knowledge, attitudes and perceptions, they can also take advantage of the make-up of the group and address structural (societal) modifying factors – i.e. peer norms regarding safer sex, cultural beliefs and practices.

How does a seminar contribute to meeting the needs of African communities?

Seminars contribute to meeting the information needs of African individuals.

<table>
<thead>
<tr>
<th>ASTOR Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim</strong></td>
</tr>
<tr>
<td><strong>Setting</strong></td>
</tr>
</tbody>
</table>
| **Target** | • Sexually active African individuals.  
• Or a sub-population (young people). |
| **Target numbers** | 10–25 people. |
| **Objective** | HIV prevention service delivery, usually involving —  
• Giving information about a specified aspect of HIV prevention to participants.  
• Questions from participants about aspects of the information received or related areas.  
• Distributing supporting information relevant to the topic.  
• Referral to other services/places where more information on the topic can be obtained.  
• Facilitating community involvement. |
| **Resources** | Resources for a seminar may include —  
• The information source (health professional/trainer).  
• Information (handouts, booklets, reports).  
• Training equipment (overhead projector, power point projector – these could be hired).  
• Pre- and post-seminar assessment tools (questionnaire).  
• Refreshments (tea, coffee, food). |
Advantages and disadvantages of using a seminar as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Direct contact with the target population.</td>
<td>• Short-term contact.</td>
</tr>
<tr>
<td>• Information is given directly to those who need it.</td>
<td>• Usually one-off contact.</td>
</tr>
<tr>
<td>• Facilitates obtaining information from other sources.</td>
<td>• Lack of structured follow-up of those attending.</td>
</tr>
<tr>
<td>• Staff can pick up barriers and knowledge gaps direct from the target</td>
<td>• Attracts only those who are interested in the information, not necessarily</td>
</tr>
<tr>
<td>population.</td>
<td>those who are at risk of HIV infection.</td>
</tr>
</tbody>
</table>

**Monitoring seminars** (for a monitoring form see Appendix 6 (1))

- How many people attended and their profile (age, gender, nationality).
- If your publicity was effective in attracting the target population.
- Publicity tips (how did they know about the seminar?).
- Whether the participants easily found the place where the seminar was held.
- Whether the place where the seminar was held was suitable.
- Length of the seminar.
- Information, educational or safer sex materials made available.
- Number of staff and volunteers involved in organising and hosting the event.
- Methods used to promote the seminar and recruit participants.
- Record of financial resources spent on hosting the seminar.
Evaluation

The best way to evaluate whether a seminar has achieved its aims is usually to give each participant an assessment tool. This might usually be a questionnaire assessing participants’ knowledge/views regarding the subject areas to be covered in the seminar. The questionnaire can be filled in by participants before the seminar. Then the same questionnaire can be given again at the end of the seminar, to see whether the information given during the seminar has changed their understanding of the seminar topics. An example is given in Appendix 6 (2).

You may evaluate whether participants demonstrate —

- A change in knowledge of issues.
- A change in attitude.
- New concepts acquired after the seminar.
- New knowledge e.g. knowledge about HIV transmission.

In order to assess the impact of the seminar in the short term, you need to compile all the information given by all participants on the pre-seminar questionnaires and compare it to compiled information from the post-seminar questionnaires. You also need to compile the information from the process evaluation questionnaires.

Long-term evaluation of the seminar will involve obtaining participants’ consent for follow-up. You can interview those who consent to the follow-up; to assess what impact the seminar has had on their knowledge, attitudes and beliefs and whether they have changed their practices as a result.

Practice guidelines

- Choose seminar topic e.g. basic information about HIV.
- Write down your intended outcomes (what participants will achieve from the seminar).
- Identify a suitable speaker/trainer who will be able to achieve the seminar outcomes.
- Identify a suitable date, time and venue (this depends on your target population and whether they are able to attend when you want to run it).
- Any incentives will increase attendance at a community-based seminar, e.g. providing a crèche, a meal, reimbursing travel.
- Put out your publicity in good time, at least six weeks before the seminar, in places where African people are likely to see it, e.g. African organisations, clubs, community centres. You can also mail directly to organisations and individuals. Reminders should be sent out two weeks before the event to ensure a good turnout at the event.
- Publicity should be explicit, with information included about the intended outcomes and about the incentives.
- Take advantage of publicising the event using the Internet or email.
- If you are able to, follow up with telephone calls to those you think might want to come, at least a week before the seminar.
- On the day, make sure the venue is well sign-posted. You may need volunteers to guide the participants.
What is a workshop?

A workshop is a structured session for which individuals are recruited and brought together in a setting to receive HIV information from a health professional or community worker. It may be a one-off session or a series of workshops.

What type of intervention is a workshop?

It is a group-level intervention and involves health promotion staff facilitating the workshop for a group of individuals from the target population or sub-population. It attempts to re-frame participants’ thinking about their sexual behaviour. It is a combination of a behavioural intervention (attempting to offer techniques for avoiding situations, negotiating safer sex etc) and an informational intervention.

A workshop combines educational and interactive approaches (e.g. lectures and role plays, scenarios) and approaches that develop the skills of the participants (e.g. sexual assertiveness, for example regarding condom use).

Although workshops mainly operate on personal modifying factors such as knowledge, attitudes, perceptions and skills, they can also take advantage of the make-up of the group in addressing structural (societal) modifying factors – i.e. peer norms regarding safer sex, cultural beliefs and practices.

How does a workshop contribute to reducing the incidence of HIV among African Communities?

Workshops contribute to meeting the information needs and the need to understand safer sex for African individuals.
### ASTOR Model

| **Aim** | To reduce the primary HIV need to understand factual information about HIV and safer sex. |
| **Setting** | Formal settings e.g. halls, training rooms. |
| **Target** |  
- Sexually active African individuals (a general mixed-gender, mixed-nationality, mixed-age group of African people).  
- Or a sub population (women). |
| **Target numbers** | 5–15 people. |
| **Objective** | HIV prevention service delivery, usually involving one or more of the following —  
- Giving information about a specified HIV prevention area to participants.  
- Interactive session e.g. role-play.  
- Problem-solving aspect e.g. scenario.  
- Group work (sharing experiences in a sub-group).  
- Facilitated discussion e.g. brainstorming session.  
- Distributing supporting information relevant to the topic area.  
- Referral to other services/places where more information on the topic area can be obtained.  
- Facilitating community involvement. |
| **Resources** | Resources may include —  
- The information source/facilitator (health professional/trainer).  
- Information (handouts, booklets, reports).  
- Equipment to facilitate interaction (flip charts, boards).  
- Equipment (overhead projector, power point projector).  
- Pre- and post-workshop assessment tools (questionnaire).  
- Refreshments (tea, coffee). |
Advantages and disadvantages of using a seminar as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Direct contact with the target population.</td>
<td>• Short-term or one off contact.</td>
</tr>
<tr>
<td>• Information is given directly to those who need it.</td>
<td>• Lack of structured follow-up of those attending.</td>
</tr>
<tr>
<td>• Facilitates obtaining information from other sources.</td>
<td>• Attracts only those who are interested in the information, not necessarily those who are at risk of HIV infection.</td>
</tr>
<tr>
<td>• Gives a chance for participants to reflect on their sexual behaviour and to assess sexual risks.</td>
<td></td>
</tr>
<tr>
<td>• Staff can pick up barriers and knowledge gaps direct from the population.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring workshops

To monitor the process of organising the workshop, the following should be recorded —

• How many people attended and their profile (age, gender, nationality).
• If your publicity was effective in attracting the target population.
• Publicity tips (how did they know about the workshop?).
• Whether the participants easily found the place where the workshop was held.
• Whether the place where the workshop was held was suitable
• Length of the workshop.
• The type of information and number of educational or safer sex materials made available.
• Number of staff and volunteers involved in organising and hosting the event.
• Methods used to promote the workshop and recruit participants.
• Record of financial resources spent on hosting the seminar.
Evaluation

The best way to evaluate whether a workshop has achieved its aims is usually to give each participant an assessment tool. This might usually be a questionnaire assessing participants’ knowledge/views regarding the subject areas to be covered in the workshop. The questionnaire should be completed by participants before and after the workshop. This will help to determine whether the information given during the workshop has changed the participants’ understanding of the workshop topics. You can follow the example given in Appendix 6 (3); this example will usually be given at the end of the workshop.

You may assess whether participants demonstrate —

- A change in knowledge of issues.
- A change in attitude.
- New concepts acquired after the seminar.
- New knowledge e.g. knowledge about accessing sexual health services.
- Any new skills gained (e.g. ability to use condoms).

In order to assess the impact of the workshop in the short term, you need to compile all the information given by all participants on the pre-workshop questionnaires and compare it to compiled information from the post-workshop questionnaires, for each workshop. You also need to compile the information from the process evaluation questionnaires. If you are running a series of workshops on a topic area, you will need to run a questionnaire reflecting the entire series at the beginning and at the end to assess the overall impact of the series. All of this information together will give you an overall short-term evaluation of the intervention.

Long-term evaluation of the workshop you will need to inform participants at the time of the intervention that you would like to contact them at a later stage (perhaps by mobile phone or email) about follow up. You can send a text message or email indicating that you would like to speak to them and if they agree, you can then arrange a convenient time for the follow-up interview.

You can interview those who consent to the follow-up to assess what impact the workshop has had on their knowledge, attitudes and beliefs. You can also ask whether they have changed their practices as a result of attending that particular workshop.
Practice guidelines

- Choose a workshop topic, e.g. social and cultural issues that put people at an increased risk of HIV infection.

- Write down your intended outcomes (what participants will achieve from the workshop).

- Identify a suitable speaker/trainer who will be able to achieve the workshop outcomes.

- Identify a suitable date, time and venue (this depends on your target population and whether they are able to attend when you want to run it).

- Any incentives will increase attendance at a community-based workshop, e.g. providing a crèche, a meal, reimbursing travel (remember most African people have children and are quite likely to be unemployed).

- Put out your publicity in good time, at least three weeks before the workshop, in places where African people are likely to see it e.g. African organisations, clubs, community centres. You can also mail directly to organisations and individuals.

- Publicity should be explicit, intended outcomes and incentives should be included.

- If you are able to, follow up with telephone calls to those you think might want to come, at least a week before the workshop.

- On the day, make sure the venue is well sign-posted. You may need volunteers to guide the participants.
Condom and lubricant distribution.
- Media interventions.
- Campaigns.
- Peer intervention.
- Community events.
- Creation of spaces to deliver interventions.
- Community empowerment and development.
- Organisational interventions.

8.1 Condom & Lubricant Distribution

What is condom distribution?

Condom and lubricant distribution is the process of giving out condoms and lubricant to a target population in defined settings. It may or may not involve physical contact with the target population.

What type of intervention is condom and lubricant distribution?

It is a community-level intervention and involves health promotion staff or volunteers delivering condoms and lubricants to a defined target population, or sub-population, in defined settings.

Condoms and lubricant can be strategically placed at different access points for the target population. e.g. distributing condoms and lubricant through outreach at a community function or leaving condoms and lubricant in accessible places (e.g. in the toilet area at a social or night club) or it may involve distributing condoms by mail order to a defined target group.

How does condom and lubricant distribution contribute to reducing the incidence of HIV among African communities?

The distribution of condoms and lubricant facilitates the acceptability of condom use and contributes to meeting the need for African individuals to understand safer sex practices. The availability of free condoms can also facilitate condom accessibility and use among the target population.
## ASTOR Model

<table>
<thead>
<tr>
<th>Aim</th>
<th>Reduce primary HIV need to understand safer sex practices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>Accessible pick-up points in places and situations where identified Africans can be found including —</td>
</tr>
<tr>
<td></td>
<td>• African social or night clubs.</td>
</tr>
<tr>
<td></td>
<td>• African restaurants.</td>
</tr>
<tr>
<td></td>
<td>• Shops and businesses.</td>
</tr>
<tr>
<td></td>
<td>• Hairdressing and barber shops.</td>
</tr>
<tr>
<td></td>
<td>• Money exchange services.</td>
</tr>
<tr>
<td></td>
<td>• Washing bays.</td>
</tr>
<tr>
<td></td>
<td>• African markets.</td>
</tr>
<tr>
<td>Situations/events —</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Country Independence Day celebrations.</td>
</tr>
<tr>
<td></td>
<td>• House parties.</td>
</tr>
<tr>
<td></td>
<td>• Weddings.</td>
</tr>
<tr>
<td></td>
<td>• Stag parties.</td>
</tr>
<tr>
<td></td>
<td>• Funeral gatherings or vigils.</td>
</tr>
<tr>
<td></td>
<td>• Cultural ceremonies or meetings e.g. naming ceremonies.</td>
</tr>
<tr>
<td></td>
<td>• Community events.</td>
</tr>
<tr>
<td></td>
<td>• Community health fairs.</td>
</tr>
<tr>
<td>Examples of pick up points —</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Toilets (clubs, restaurants and community events).</td>
</tr>
<tr>
<td></td>
<td>• African community organisations’ offices.</td>
</tr>
<tr>
<td></td>
<td>• Drop-in services.</td>
</tr>
<tr>
<td></td>
<td>• Mail order</td>
</tr>
<tr>
<td>Target</td>
<td>Sexually active African individuals or a sub-population of them (e.g. African men at a car washing bay).</td>
</tr>
<tr>
<td>Target numbers</td>
<td>1 or more people.</td>
</tr>
<tr>
<td>Objective</td>
<td>HIV prevention service delivery usually involving one or more of the following —</td>
</tr>
<tr>
<td></td>
<td>• Distributing condoms and lubricant.</td>
</tr>
<tr>
<td></td>
<td>• Distributing information relevant to condom usage.</td>
</tr>
<tr>
<td></td>
<td>• Promoting access to other services.</td>
</tr>
<tr>
<td>Resources</td>
<td>Resources for condom distribution may include —</td>
</tr>
<tr>
<td></td>
<td>• Condoms.</td>
</tr>
<tr>
<td></td>
<td>• Lubricants.</td>
</tr>
<tr>
<td></td>
<td>• Condom demonstrator.</td>
</tr>
<tr>
<td></td>
<td>• Information resources (leaflets, booklets relevant to condom usage).</td>
</tr>
<tr>
<td></td>
<td>• Notebook or monitoring form, pen or pencil.</td>
</tr>
<tr>
<td></td>
<td>• Identification: e.g. identity card, documentation with your employer’s address.</td>
</tr>
<tr>
<td></td>
<td>• Your business/contact cards.</td>
</tr>
<tr>
<td></td>
<td>• Mobile phone.</td>
</tr>
<tr>
<td></td>
<td>• Postage costs.</td>
</tr>
</tbody>
</table>
Advantages and disadvantages of using condom and lubricant distribution as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Direct contact with the target population.</td>
<td>• Short-term contact.</td>
</tr>
<tr>
<td>• Condoms and lubricant reach the target population.</td>
<td>• Usually one-off contact.</td>
</tr>
<tr>
<td>• Staff can pick up information about barriers to condom usage direct from the population.</td>
<td>• Lack of structured follow-up.</td>
</tr>
<tr>
<td></td>
<td>• Cannot tell whether condoms and lubricant will be used.</td>
</tr>
</tbody>
</table>

Monitoring condom and lubricant distribution

The best way to monitor condom and lubricant distribution is to use a monitoring form. An example has been done for you (see Appendix 7). You should use a form for distribution in each setting.

In addition to completing the monitoring forms, you need to monitor the following —

• Client characteristics.
• Distribution sites or settings.
• Number of distribution events held.
• The frequency and timing of the distribution events.
• Details of condoms, sites and distribution methods preferred by target population.
• Information or educational materials distributed.
• Referrals made.
• The number of staff and volunteers involved in condom distribution.
• Record of financial resources spent on the intervention.

The main tip for monitoring this intervention is to count the condoms and the lubricant sachets before you start the distribution and count what is left after the distribution. The difference between the two numbers is what you have distributed.
Evaluation

In the short term, you can compile all the information on the monitoring forms, e.g. condom and lubricant distribution in all the settings in the last six months. This will give you an evaluation of the following —

- The number of condoms you have distributed.
- The number of lubricant sachets you have distributed.
- Where (settings) the target population is found e.g. postcode area, barber shops, clubs.
- The common issues around condom use that individuals are concerned about.
- Gaps in the knowledge of individuals, their perceptions, beliefs, attitudes towards condom and lubricant use and safer sex in general.
- Gaps in knowledge of availability and access to condoms.
- Whether the intervention increased their use of condoms and consistency of use.
- Barriers to the practicalities of using condoms.
- The most popular condom brand for the target population.
- The main problem areas in distributing condoms and lubricant in different settings.
- How this intervention can be developed in the future.

In cases where you were able to distribute condoms using a one-to-one approach, to evaluate whether condom and lubricant distribution has achieved its aim, you will need to inform the individuals at the time of the intervention that you will contact them at a later stage about follow-up.

- You can interview those who consent to the follow-up, to assess how their knowledge, attitudes and beliefs around using and condoms and lubricants have changed since then. Are they now using condoms and lubricants consistently and correctly? What are their concerns/challenges to adopting and maintaining safer sex?

Practice guidelines

Where condom distributed directly to individuals —

- It is important that you consult the venue owners (or event organisers) before distribution and agree on how this will be done successfully.
- In some situations, it might be difficult to make prior arrangements. Knowledge of the target population (e.g. their attitudes to condoms, whether condom distribution will be acceptable and feasible at, say, a funeral) is essential. You may need to do some work to ascertain the target population’s attitudes to condom usage before distribution begins. Consult with the target population first.
- Staff/volunteers may follow the outreach practice guidelines in Chapter 6 to guide their fieldwork.
- Staff/volunteers need to have sufficient knowledge of all the condoms that they are distributing (what they’re made of, and any special attributes they may have, e.g. polyurethane condoms for those allergic to latex).
- You need to ensure that you have adequate storage facilities and sufficient quantities of resources to meet demand.
Media is one of the communication channels through which messages are conveyed to the general public or target population.

In selecting which type of media to use to reach your target population, you need to take into consideration —

- The amount and type of information you want to present.
- Where the target group will be reached.
- Their preferences.
- The financial and human resources available.

For the purpose of this practice guide, we have divided the media interventions into mass media, small media, and other media projects. Each component is described in more detail in the following sections.

**What is mass media?**

Mass media refers to channels of communication which are used to broadcast information to the general public. Using mass media may include local or national campaigns organised through TV, radio, billboards, posters, newspapers, magazines and films.

**What type of intervention is mass media?**

Mass media can be used as a community-level intervention to convey messages to individuals, groups or communities.

**How does this contribute to reducing the incidence of HIV?**

Mass media campaigns help to promote access to and increase awareness of specific issues on HIV and services. It can also be used to influence group or community norms and attitudes.
### ASTOR Model

| **Aim** | 1. Increase HIV/AIDS awareness among specific target populations.  
2. Raise awareness of HIV-related stigma. |
| --- | --- |
| **Setting** | Social networks where Africans are likely to congregate such as —  
- Social venues and clubs.  
- Schools, colleges, universities.  
- Workplaces, Public places.  
- Streets and commercial outlets.  
- Homes.  
- Galleries, museums, cinemas, theatres. |
| **Target** |  
- Large groups of people.  
- Specific vulnerable groups – young people, men and women aged between 16 to 55 years of age, sex workers, African men who have sex with men people living with HIV.  
- Professionals such as musicians, actors, disc jockeys.  
- Faith and community leaders.  
- Policy-makers. |
| **Target numbers** | More than 50 people. |
| **Objective** | Information-giving using —  
- TV advertisements and programmes highlighting HIV/AIDS issues.  
- Radio discussion and drama programmes.  
- Billboards and posters.  
- Newspapers. |
| **Resources** |  
- Staff/volunteers.  
- Designs.  
- Training.  
- Advertising spaces.  
- TV and radio spots.  
- Audio and videotapes, recording equipment.  
- Technical experts (health promotion specialists media specialists, marketing officers, designers researchers).  
- Budget.  
- Transport. |
Advantages and disadvantages of using mass media as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mass media interventions can reach a very wide audience including hard to reach groups.</td>
<td>• Messages will not reach people without access to television, radio or newspapers.</td>
</tr>
<tr>
<td>• Films and videos can provide a consistent message, which can be reinforced through repeated viewing.</td>
<td>• Mass media offers restricted opportunities for interaction.</td>
</tr>
<tr>
<td>• Audiences can engage with the message without the personal commitment required with a health promotion worker.</td>
<td>• Mass media interventions can be expensive to run.</td>
</tr>
<tr>
<td>• Radio and television can reach people with limited reading skills.</td>
<td></td>
</tr>
<tr>
<td>• Message may be remembered long after the individual has heard or seen the production/product.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring mass media interventions

To establish whether your mass media intervention is achieving its objectives you need to monitor the following —

- The audience figures from the companies delivering the mass media interventions.
- Ways in which the programmes were distributed to media outlets.
- The times and number of hours the television and radio programmes are broadcast.
- The number of articles written and newspapers or magazines printed.
- Monitor responses to your advertisement campaign in form of telephone calls, letters or newsletter subscriptions.
- Number of adverts and posters produced and sites where displayed.
- The numbers of people and percentage of the target population who were exposed to the intervention.
- Their understanding and interpretation of images or messages.
- What the target audience thinks about the intervention in terms of its acceptability and effectiveness in meeting their HIV prevention information needs.
- Number of staff and volunteers involved in organising the intervention.
- Record of financial resources spent on the intervention.
Evaluation

- A reference group may be used to develop the ideas for the campaign and may be used to pre-test the materials prior to the campaign.

- A research study may be conducted in social settings within three months of carrying out the intervention to determine its impact on the target population. Questions may include whether they have seen the campaign materials, their understanding of what the campaign was trying to get across, the appropriateness of the message for the target community, whether they thought that it might have an impact on changing the behaviour of other people like them, and whether it would have an impact on their own behaviour.

- To evaluate mass media interventions successfully you require a large sample of people to interview and a considerable amount of resources at your disposal. This will not be available to most African community based organisations.

- It is recommended that evaluation of mass media interventions should be done through a network (such as a Forum) where resources can be pooled together to evaluate mass media interventions.

Practice guidelines

- Involve members of the target audience and media specialists in the planning and design of campaigns.

- Text messages should be short and easy to read and understand.

- Images should be culturally appropriate.

- Pre-test campaign messages among target audience before transmission.

- Messages should be placed where the target audience is likely to encounter them.

- Allow plenty of time for planning the intervention.

- Record the television broadcast on videotape and an audiocassette tape for radio programmes or obtain transcripts for review.

- Have clear guidelines on feedback and decision-making within the project team.

- Consider how members of the general public will receive and interpret the messages transmitted.

- Consider use of dialogue e.g. questions on posters to encourage further consideration of the issues by the target group.

- Mass media campaigns should be supported by other interventions such as leaflets, or workshops to increase exposure among the target population.

- Promote the campaign widely among the target audience, service providers and policy makers.
**Aim**

Improve the level of knowledge and raise awareness of specific HIV-related issues among African communities.

**Setting**

- Schools, Colleges, Universities.
- Social venues (pubs, cafes, clubs, toilets, waiting rooms, cab offices, hair salons).
- Advice centres, libraries, sports centres.
- Community-based organisations.
- Streets, commercial outlets.
- Community events.

**Target**

- Specific vulnerable groups – young people, sex workers, African men who have sex with men, people living with HIV.
- Adult men and women aged 16 and above.
- Refuges and asylum seekers.
- Students.
- Parents, carers, older people, people with disabilities.
- Facilitators/trainers.
- Community and religious leaders.
- General public.

**Objective**

Information-giving using display and distribution of printed materials such as —

- Leaflets.
- Newsletters.
- Service cards.
- Books.

**Resources**

- Staff/volunteers.
- In-house training.
- Budget to meet project costs.

---

What are small media?

Small media refers to leaflets, newsletters, comic strips, information sheets, information cards/flyers, and booklets that are commonly used to transmit information to individuals and groups.

Support media relates to products that are used to support and transmit key campaign messages to target populations, with contacts for further information. These include postcards, stickers, badges, mugs, plates, place mats, t-shirts, badges, pens, pencils, rubbers, key rings, crafts.

What type of intervention are small media?

Small media are a community-level intervention that can be used to target specific at-risk groups, communities, organisations and professionals.

How do small media contribute to reducing the incidence of HIV among African Communities?

Small media can be used alongside other interventions such as mass media to meet HIV prevention information needs and increase awareness of available services among the target population.

**ASTOR Model**

<table>
<thead>
<tr>
<th>Aim</th>
<th>Improve the level of knowledge and raise awareness of specific HIV-related issues among African communities.</th>
</tr>
</thead>
</table>
| Setting | • Schools, Colleges, Universities.  
| | • Social venues (pubs, cafes, clubs, toilets, waiting rooms, cab offices, hair salons).  
| | • Advice centres, libraries, sports centres.  
| | • Community-based organisations.  
| | • Streets, commercial outlets.  
| | • Community events. |
| Target | • Specific vulnerable groups – young people, sex workers, African men who have sex with men, people living with HIV.  
| | • Adult men and women aged 16 and above.  
| | • Refuges and asylum seekers.  
| | • Students.  
| | • Parents, carers, older people, people with disabilities.  
| | • Facilitators/trainers.  
| | • Community and religious leaders.  
| | • General public. |
| Objective | Information-giving using display and distribution of printed materials such as —  
| | • Leaflets.  
| | • Newsletters.  
| | • Service cards.  
| | • Books. |
| Resources | • Staff/volunteers.  
| | • In-house training.  
| | • Budget to meet project costs. |
Advantages and disadvantages of using small media as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• They are portable, easy to produce and distribute.</td>
<td>• Illiteracy and lack of reading culture may affect distribution.</td>
</tr>
<tr>
<td>• They can be used to supplement workshops, seminars and other interventions.</td>
<td>• Translations may be difficult where there are no appropriate words in the chosen language or dialect.</td>
</tr>
<tr>
<td>• They can be distributed in locations frequented by the target population.</td>
<td>• Information dates quickly and needs to be updated regularly.</td>
</tr>
<tr>
<td>• Messages can be effectively targeted at specific subgroups.</td>
<td>• Competition from other small media (e.g. leaflets produced by other providers) may affect circulation.</td>
</tr>
<tr>
<td>• Target group can request and use them when they are ready.</td>
<td></td>
</tr>
<tr>
<td>• Small media can be used to introduce new messages, reinforce existing ones and serve as a reference source.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring small media interventions (7)

(See Appendix 8 (1) & (2) – Feedback & Distribution monitoring form)

When monitoring small media you can collect information on the following —

• Monitor the process of developing the resource.
• Number of staff and volunteers trained and involved in developing and distributing resources.
• Number of resources produced and distributed.
• Sites or settings where resources are distributed.
• Methods and frequency of distribution.
• Requests for information, education and safer sex materials.
• Record of financial resources spent on the intervention.
• Number of people who have seen or read the leaflet or booklet.

(7) For further information see: CDC, National Centre for Prevention Services, 1995, Paul Kinder et al., 1999, Weatherburn P et al., 2001
Evaluation

- Small media resources can be evaluated by using focus groups, self-administered questionnaires or interviews conducted with representatives of the target population to determine its effectiveness in meeting their information needs.

- To establish whether the resource is suitable and of good value, you need to consider the process of developing the product and whether it is of interest to the target group. Is it easy to understand? Is it culturally appropriate? Is it relevant to the reader and is it credible? Is it reaching your target population? Is the timing of distribution appropriate to your target group? Are you distributing enough resources to make a difference among your target group? To what extent are the resources and activities consistent with your project’s aims and objectives?

Practice guidelines

- Identify the need for the resource among target population.

- Involve members of the African community in the planning and developing process.

- Ensure that the content, images and messages are culturally appropriate to the target population.

- Ensure that the message is engaging and easily understood by your target population.

- Accessibility – messages should be translated into languages commonly used by the target population.

- It is important to pre-test the resource among the target population before publication. You can use focus groups or peer reviews to obtain feedback.

- Seek professional advice on designing and printing of resources.

- Provide contacts for further information.

- Promote and distribute the resource widely among the target population.
Visual arts — paintings, sculpture, photography, design exhibitions, crafts.

Visual arts programmes can be used to raise awareness of HIV/AIDS through exhibitions, events, publications and joint projects with artists, photographers, galleries, museums and community-based groups. They can also be used to raise funds for prevention and education projects.

Performing arts — drama, dance, poetry, music.

African community-based organisations can work in partnership with leading performers, musicians, disc jockeys, dance groups and recording companies, using entertainment approaches such as concerts, plays and music events to raise awareness and promote HIV prevention among African communities. Entertainment and humour are effective in promoting open discussion of sensitive issues among peers, couples and friends.

### ASTOR Model

| Aim | 1. Increase HIV/AIDS awareness among specific target populations.  
2. Behaviour change. |
|---|---|
| Setting | • Schools, colleges, universities.  
• Streets, commercial outlets.  
• Social venues.  
• Community-based organisations.  
• Galleries, museums, cinemas, theatres.  
• Community events. |
| Target | • Peer educators.  
• Trainers/facilitators.  
• Community leaders.  
• Artists, musicians, actors, disc jockeys.  
• Specific vulnerable groups – young people, men, women, sex workers, African men who have sex with men, people living with HIV.  
• General public.  
• Community and religious leaders.  
• Policy makers. |
| Target number | 20 to 200 people. |
| Objective | Information giving and media intervention using —  
• Visual arts such as painting, sculpture, photography, design exhibitions (fashion shows) and films.  
• Performing arts such as drama, poetry, and music. |
| Resources | • Staff/volunteers.  
• In-house training.  
• Equipment.  
• Posters.  
• Budget to meet project costs. |
Advantages and disadvantages of using other interventions

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Innovative and effective education method of addressing issues within the target population.</td>
<td>• Entry fees may prevent some people from visiting the exhibition.</td>
</tr>
<tr>
<td>• Engaging, interactive and effective in transmitting messages, promoting discussion of difficult issues and sharing experiences with a large number of people.</td>
<td>• Messages may not always be interpreted by the target audience as intended by the organisers.</td>
</tr>
<tr>
<td>• Drama and other entertainment forms of behaviour modelling can be effective in helping target audiences to move beyond awareness to behaviour change.</td>
<td>• Can be expensive to organise.</td>
</tr>
<tr>
<td>• Provides opportunities for promoting access to services, fundraising and collaborative ventures.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring other media initiatives

- Record numbers attending the shows (this may include details about the audiences, such as age, occupation and area of residence).
- Length of the sessions or events.
- Key issues covered.
- Record the event on videotape that can be reviewed when evaluating the event.
- Identify which agencies or persons from the community are involved in carrying out the intervention.
- Record the participants’ main sources of information or training and whether they have access to services.
- Record the informational, educational or safer sex materials made available.
- Number and types of referrals made.
- Methods used to promote the events and recruit participants.
- Number of staff and volunteers involved in organising and hosting events.
- Record of financial resources spent on the intervention.

---

**Evaluation**

- To determine whether you have achieved your activity’s aims and objectives, you can conduct interviews, focus group discussions or self-completion questionnaires with a sample of people who attended the events.

- You will need to inform participants at the time of the intervention that you will contact them at a later stage (preferably using their mobile phone) about follow up. You can send a text message indicating that you would like to speak to them and if they agree, you can then arrange a convenient time for the follow up interview.

- Participants may be asked to comment on how the intervention affected or influenced their HIV knowledge, beliefs, and practices. Whether they are likely to change their behaviour as a result of the information and messages received at the event and if they will recommend it to other people.

**Practice guidelines**

- To promote learning, messages should be provided in different formats (e.g. painting, photography, poetry, music).

- Event organisers should aim to work with leading or popular performers to attract large audiences.

- Identify which method is most suitable for your target audience e.g. popular music and disco for young people, concerts or cultural performances for adults.

- These events require a lot of time and human resources to organise. Involve as many agencies and community members as possible to ensure a good turnout.

- Select a suitable and easily accessible venue to stage the event.

- Advertise the event widely.

- Provide information on HIV and related issues for participants to read or take away to reinforce the messages given during the event.
What are campaigns?

A campaign is usually a time specific, planned, co-ordinated and organised course of action designed to shift opinion, stimulate actions and/or change behaviour and attitudes.

What type of intervention are campaigns?

A campaign can be described as a community level intervention if it is initiated to influence the public and can also be described as a socio-political intervention if it initiated to influence policy.

How does it contribute to reducing the incidence of HIV among African Communities?

Campaigns can give information about HIV, they can be used to stimulate debate on issues that put individuals at an increased risk of HIV infection and can be used to facilitate access to other HIV prevention interventions and HIV and Sexual Health Services.

### ASTOR Model

| Aim | 1. Increase HIV/AIDS information and awareness among the population or sub-population.  
2. Influence behaviour change. |
| --- | --- |
| Setting | • Schools, colleges, universities.  
• Streets, commercial outlets.  
• Social venues.  
• Community-based organisations.  
• Galleries, museums, cinemas, theatres.  
• Community events.  
• Radio/ television.  
• Community magazines, newspapers.  
• Internet. |
| Target | • General public.  
• Specific vulnerable groups – young people, men, women, sex workers, people living with HIV.  
• Policy makers. |
| Target number | More than 1 person. |
| Objective | Information giving and media interventions —  
• Information materials such as posters, cards, calendars.  
• Mass media (radio, television, newspapers).  
• Other media (t-shirts, badges, cups, balloons).  
• The Internet.  
• Visual arts.  
• Performing arts. |
| Resources | • Slogan/key message.  
• Campaign materials (posters, cards etc).  
• Campaign media (radio, television, websites etc).  
• Budget. |
Advantages and disadvantages of using campaigns

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provokes debate among the population.</td>
<td>• The target audience as intended by the organisers may not always interpret messages.</td>
</tr>
<tr>
<td>• Can reach a large number of people.</td>
<td>• Can be expensive to organise and implement.</td>
</tr>
<tr>
<td>• Provides opportunities for promoting access to services.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring campaigns

Campaigns can be monitored by collecting information on the following —

• Activities carried out.
• Number of focus groups commenting on the materials.
• Number of adverts produced and sites where displayed.
• Numbers of all campaign materials distributed.
• Numbers of people to whom the campaign materials are given.
• Total numbers of visitors to a campaign website.
• Record of financial resources spent on the campaign.
• Costs incurred.
Evaluation

To establish whether your campaign was effective you can —

• A reference group may be used to develop the ideas for the campaign and may be used to pre-test the materials prior to the campaign.

• A research study may be conducted (using interviews and questionnaires) in social settings within three months of carrying out the intervention to determine its impact on the target population. Questions may include whether they have seen the campaign materials, their understanding of what the campaign was trying to get across, the appropriateness of the message for the target community, whether they thought that it might have an impact on changing the behaviour of other people like them, and whether it would have an impact on their own behaviour.

Practice guidelines

• Allow plenty of time for planning the intervention.

• Involve members of the target audience and media specialists in the planning and design of campaigns. Develop a comprehensive plan including a starting point, achievable goals, defined target population and settings, key messages, key actions, monitoring, evaluation and end point.

• The Campaign title should give a clear message about the nature of the campaign and of its objectives in a form that is acceptable to all participants.

• A high profile campaign requires a good slogan and clear identity, and needs to be supported by good quality publicity materials.

• Text messages should be short and easy to read and understand.

• Images should be culturally appropriate.

• Pre-test campaign messages among target audience before transmission.

• Messages should be placed where the target audience is likely to encounter them.

• Distribute the campaign materials well in advance of the campaign start date to promote their use within the target population. This will also help to increase participation and support for the campaign.

• Record the television broadcast on videotape and an audiocassette tape for radio programmes or obtain transcripts for review.

• Have clear guidelines on feedback and decision-making within the project team.

• Consider how members of the general public will receive and interpret the messages transmitted.

• Consider use of dialogue e.g. questions on posters to encourage further consideration of the issues by the target group.

• Mass media campaigns should be supported by other interventions such as leaflets, or workshops to increase exposure among the target population.

• Promote the campaign widely among the target audience, service providers and policy makers.
What is peer intervention?

Peer intervention is an HIV prevention method in which some members are used to bring about change amongst other members in the same group.

The English term peer means "one who is the equal of another in rank, merit, quality". Peer group refers to a group of people who are connected and of the same status. The same status may relate to age, standing or grade.

Individuals who have influence within the group such as group or community leaders are recruited, trained and supported to increase their ability to influence attitudes, beliefs and behaviour change among their peers. On completion of the training, these individuals (who may be referred to as peer educators in some interventions) are used to provide information on HIV/AIDS, referrals, emotional support and skills to their peers.

Peer intervention can be informal, such as discussions on HIV-related issues among friends or family members, or they may be formal, taking the form of —

- Established peer support groups.
- Skills-based information programmes delivered by peers.
- Health promotion programmes that are delivered in community settings.
- Outreach work.

What type of intervention is peer intervention?

Peer intervention can be used as individual-level interventions by influencing a person’s knowledge belief and attitudes, but it can also be used at community and socio-political level to effect change in group norms or encourage collective action by the group leading to change in programmes and policies.

Peer intervention may also be used to support other interventions such as outreach work. Peer educators may reach out to friends, family members, and small groups to address information needs on safer sex, negotiation skills and condom use. They may also be used to support larger programmes on condom distribution, management of sexually transmitted infections, media interventions, counselling and advocacy.

How does it contribute to reducing the incidence of HIV among African Communities?

Peer intervention is considered to be the most effective form of education and credible source of group behaviour change by way of group or peer influence. Peer educators or leaders can help their peers by answering questions and influencing community practices, to reduce the risk of HIV transmission within their social groups. Messages may be personalised or interactive, and can target specific groups or communities.
### ASTOR Model

| **Aim** | 1. Reduce the transmission and acquisition of HIV and sexually transmitted infections among specified target groups.  
2. Increase the ability of peers to train or influence other people within their groups or communities.  
3. Reduce stigma associated with HIV. |
| **Setting** | Places where effective interventions can be carried out include —  
- African social clubs.  
- African restaurants.  
- Schools.  
- Universities and colleges of further education.  
- Telephone helplines.  
- Homes.  
- Hair saloons and barbershops.  
- Washing bays.  
- Cab offices.  
- Shops and commercial outlets.  
- Churches.  
- Young offenders’ institution, bail hostels, prisons.  
- Community-based organisations.  
Other settings include —  
- Community events.  
- Day trips.  
- Cultural ceremonies.  
- House parties. |
| **Target** | Peers within these subgroups —  
- Young people (and sub-groups, such as young people between the ages 13 –15, young offenders, young people in local authority care, young people who have left school, unaccompanied minors).  
- Students.  
- Men and women between 16 and 55.  
- Specific vulnerable groups such as commercial sex workers, drug users, homeless, refugees and asylum seekers, people living with HIV.  
- Religious leaders.  
- Community elders.  
- Sports personalities.  
- Musicians and other artists. |
| **Target numbers** | More than 20 people. |
### Objective

To increase knowledge of HIV and related issues among the target population.

To train and support peers within these sub-groups to carry out interventions at individual, group or community-level.

Interventions may include —
- Face-to-face discussion or counselling (formal or informal).
- Group work aimed at improving knowledge and skills.
- Outreach initiatives.
- Community mobilisation (Using opinion-formers or community leaders).
- Distribution of materials.
- Making referrals to services.
- Providing support to individuals, groups or communities.

### Resources

Resources for peer interventions may include —
- Individuals selected to be trained as peer educators.
- Trainers or facilitators.
- Budget for the project.
- Printed and recorded information materials (leaflets, posters, books, cards, videos, audio tapes).
- Condoms, femidoms, and lubricants.
- Flip chart, overhead projector, pencils, pens, and notebooks.
- Venue or location.
Advantages and disadvantages of using peer intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Interventions can be effective in increasing awareness of HIV and shaping people’s attitudes and behaviour change.</td>
<td>• The target audience as intended by the organisers may not always interpret messages.</td>
</tr>
<tr>
<td>• Messages can be passed on to more people as the intervention has a snowballing effect.</td>
<td>• Can be expensive to organise and implement.</td>
</tr>
<tr>
<td>• Peers can act as supporters and contacts between service providers and the target population.</td>
<td></td>
</tr>
<tr>
<td>• Personal development for peers.</td>
<td></td>
</tr>
<tr>
<td>• Peer intervention is interactive and applicable to a variety of groups and situations.</td>
<td></td>
</tr>
<tr>
<td>• Peers can help to sustain the prevention programme after the health professionals have gone.</td>
<td></td>
</tr>
<tr>
<td>• Encourages individuals and communities to get involved and take responsibility for their well being.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring a peer intervention

A peer intervention can be monitored by collecting information on the following —

• Date of the intervention or event.
• A description of the intervention/event.
• Who was involved in the intervention/event (monitor age, area of residence, marital status, education level, occupation)?
• Number and percentage of the target population actively involved in peer interventions.
• Record of attitudes, knowledge and risk behaviour among the target population.
• Record of printed information materials, condoms and femidoms distributed.
• Number of referrals made to other services as a result of this intervention.
• Organisations contributing resources or participating in the intervention.
• Number of events held or contacts made by peer educators.
• Number of peer educators, staff or volunteers trained during the intervention.
• Record of financial resources spent on the intervention.
Evaluation

To establish whether your peer intervention was effective you can —

- Obtain feedback from the target population through interviews or questionnaires to assess how the intervention met the participants’ HIV prevention or health promotion needs. Information captured on the feedback forms may include age, area of residence, exposure to the intervention, knowledge about HIV, what they learnt from the intervention, whether it was useful, interesting, acceptable, credible, and whether they would participate in similar events in the future or recommend them to other people. Space should be provided for comments, complaints and suggestions on how the intervention could be improved.

- Obtain feedback from peer educators, staff and volunteers about the skills and experience gained through participating in the programme.

Practice guidelines

- Assess knowledge of the target group prior to starting the intervention.

- Peer educators should have good communication skills and access to Skills-building education programmes.

- Peer educators should respect the confidentiality of members of the target population.

- Roles and responsibilities of peer educators should be set out clearly.

- There should be guidance on peer educators’ professional conduct and personal safety.

- There should be a good project plan that clarifies the aims, objectives and project outcomes.

- The planning process should include representatives from the target group, funders and key service providers or partners to promote ownership of the project.
Community events are gatherings organised for a specific purpose. Such events often provide opportunities for HIV prevention work and are used as settings to target large numbers of people.

This may include such events as listed below —

- **World AIDS Day**
  Community groups and agencies organise a variety of public events to mark World AIDS Day (1st December). The type of events organised will depend on the ideas and resources available to the group. Events may include exhibitions, advertisements, television and radio programmes, memorial services, music, dance, sports, street fairs, health fairs, leaflet and condom distribution and fundraising events. The purpose of these events is to raise awareness of HIV/AIDS within each community.

- **Health fairs**
  These events may be organised by organisations or health professionals to educate the public on general health matters and can offer free screening, literature, information on services and opportunities for answering questions.

- **Community /cultural festivals**
  Many communities organise a variety of events to mark important dates in their history, religion or culture. Such events provide opportunities for disseminating information and resources on HIV and discuss strategies for dealing with issues of concern to the community.

- **Sports**
  Community-based organisations can work in partnership with sports associations to promote HIV awareness through organised sports and competition events. Mass media, interpersonal communication and community mobilisation are some of the different interventions, which can be attempted. Sportsmen such as footballers can be used to deliver or promote HIV prevention messages among the target population.

**What type of intervention are community events?**

Community events are community-level interventions used to raise awareness and get the community involved in addressing issues. They provide good opportunities to mobilise communities to discuss the impact of HIV and strategies for HIV prevention work.

**How do they contribute to reducing the incidence of HIV?**

Community events can be used to raise awareness and give information to individuals, groups and communities about HIV/AIDS and provide a constant reminder of HIV prevention messages to the target population.

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(9) For more information on sports events see: HIV InSite, Cultural responses, http://www.hivinsite.com/InSite/?page=li-05-23
## ASTOR Model

### Aim
1. Raise awareness of HIV/AIDS.
2. Reduce HIV-related stigma and discrimination.

### Setting
- Community networks.
- Community-based organisations.
- Religious groups or churches.
- Embassies.
- Clubs and restaurants.
- Schools, colleges, universities.
- Sports venues and clubs.
- Businesses.

### Target
- Young people less than 16 years of age.
- Adult African men and women.
- Specific African communities such as Zambians, Ugandans, Kenyans, South Africans, Congolese.
- Sportsmen and women, coaches, sports associations.
- Community-based and voluntary organisations.
- Community leaders and policy-makers.

Community education, information and resource distribution using participatory and entertaining initiatives to increase community involvement and awareness of HIV/AIDS.

Activities can include —
- World AIDS Day celebrations.
- Health fairs.
- Community festivals.
- Sports events.

### Objective
Community education, information and resource distribution using participatory and entertaining initiatives to increase community involvement and awareness of HIV/AIDS.

Activities can include —
- World AIDS Day celebrations.
- Health fairs.
- Community festivals.
- Sports events.

### Resources
- Staff.
- Role models.
- Condoms.
- Leaflets.
- Venue.
- Refreshments.
- Entertainment.
- Budget.
Advantages and disadvantages of using community events as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Offers good opportunities to provide health promotion messages to large numbers of people.</td>
<td>• Limited time for personal contact.</td>
</tr>
<tr>
<td>• Innovative ideas can be used to reach the target audience.</td>
<td>• Time-consuming.</td>
</tr>
<tr>
<td>• More activities can be organised with pooled resources.</td>
<td>• Expensive to run.</td>
</tr>
<tr>
<td>• Media exposure.</td>
<td></td>
</tr>
<tr>
<td>• Improves networking among agencies and helps to promote the event and awareness of the issues among the target population.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring community events

In order to establish whether you are achieving your intervention’s objectives it will be useful to collect information on the following —

• The number of people participating in the event.

• Percentage of the target population participating in or exposed to the event.

• Places (newspapers, newsletters, websites, radio and TV channels) where the event is publicised.

• Organisations or groups contributing to or participating in the event.

• Uptake of information materials and condoms.

• Requests for information, advice and services received during and after the event.

• Uptake of your services or increased knowledge about your organisation as a result of people’s exposure to the event.

• How participants knew/heard about the event.

• Number of referrals made.

• Community networks established as a result of the intervention.

• Number of staff and volunteers involved in organising and hosting the event.

• Record of financial resources spent on the intervention.
Evaluation

Feedback about how effective the intervention has been can be obtained through —

• A survey of participants (attendees and exhibitors) at the end of the event to establish their views on how well the event was organised? Did it run smoothly and on time? Did it provide good opportunities for members of the target population to participate? Did the event increase awareness or educate participants on HIV prevention and related issues? Was it interesting? Would they participate in future events or recommend them to other people? Questionnaires and interviews can be used for the survey.

• A post-event meeting for staff and volunteers to review the event, the planning process, the publicity, implementation and outcomes and share their information on the positive and negative aspects of the event, skills and knowledge gained by staff and volunteers participating in the event.

• You need to compare the number of participants expected with actual attendance; establish how many of the target population participated and their perception of the event; and review the media coverage. Results should be distributed to the whole team and used to inform planning and hosting of future events.

Practice guidelines

• Involve members of the target audience in the planning of the event.

• Have an action plan with timescales that can be used to monitor progress in achieving project tasks.

• Work in collaboration with other organisations that may have an interest in the event such as other community groups, health promotion departments, sports, art and cultural associations.

• Involve sponsors and the media in the planning process.

• Delegate duties and responsibilities according to skills, and review progress regularly.

• Select activities that are likely to attract the target audience and ensure that they can afford the entry fees.

• Timing of the event is very important.

• Advertise the event in places and in suitable media where the target audience will see or hear of it, to ensure good attendance at the event.
This is when settings/sessions are created for a particular target group, e.g. a support group or regular nightclub for African men who have sex with men. The target population is mobilised to attend/visit. This provides a conducive environment to carry out health promotion work at the specified setting/session on a regular basis, as well as discussing particular issues that may affect the target population.

What type of intervention is the creation of spaces?

It is a community-level intervention; it works on the social environment and community factors of the target population. It is not an end in itself but facilitates the delivery of HIV prevention interventions.

How does creation of spaces contribute to reducing the incidence of HIV among African communities?

The creation of social spaces facilitates interventions that attempt to alter behaviour by influencing social norms, as well as interventions that provide information (affect personal modifying factors), and resources such as condoms.
ASTOR Model

<table>
<thead>
<tr>
<th>Aim</th>
<th>To reduce HIV transmission, and address information needs.</th>
</tr>
</thead>
</table>
| Setting | • Formal settings e.g. halls, conference centres, existing community settings.  
• Social settings e.g. clubs, pubs, cultural festivals/events, and national independence celebrations.  
• A day or time set aside within an organisation’s schedule. |
| Target | • Sexually active African individuals (a general mixed-gender, mixed-nationality, mixed-age group of African people).  
• Or a sub population (women, community leaders, African men who have sex with men).  
• Groups of people identified as needing a service but for some reason are not accessing the generic services offered by the organisation. |
| Target number | 10 people to – as many as the setting can allow. |
| Objective | HIV prevention service delivery usually involving one or more —  
• Distributing printed materials (leaflets, booklets, cards, posters).  
• Face-to-face discussion between two people either as a single encounter or as an on-going activity if possible.  
• Condom and lubricant distribution.  
• Referral to other sexual health/HIV prevention services. |
| Resources | Resources for a space may include —  
• Venue e.g. a nightclub.  
• Condoms and lubricant.  
• Information resources including written resources, merchandise T-shirts, cups, etc).  
• Outreach workers/Coordinator. |

Advantages and disadvantages of using community events as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| • Direct contact with the target population.  
• Facilitates distribution of small media resources.  
• Facilitates condom distribution.  
• Information resources and condoms reach the target population.  
• Staff can pick up issues direct from the population.  
• The intervention offers opportunities to promote other services or health promotion initiatives.  
• Can reach large numbers of the target population (Formal settings). | • Short-term contact.  
• Usually one-off contact with individuals.  
• Lack of structured follow-up.  
• May reinforce prejudice.  
• Takes time to get established. |
Monitoring the creation of spaces

You can monitor the creation of social spaces using the de-briefing sheets (Appendix 4) and Outreach monitoring form (Appendix 5).

The following should be monitored —

- Number of people attending.
- Number of contacts made.
- Issues discussed.
- Number of condoms and lubricant distributed.
- Number and type of information resources distributed.
- How many people attended and their profile (age, gender, nationality) in a very rough way.
- Whether your publicity was effective in attracting the target population.
- The methods used to promote the spaces and recruit participants.
- Accessibility and suitability of the location for the space/session.
- Timing and length of the sessions.
- The number of staff and volunteers trained and involved in organising and running the space activities.
- Record of financial resources spent on the outreach intervention.

Evaluation

In the short term you can compile all the information on the de-briefing sheets and monitoring forms e.g. all sessions done in a period of six months.

This will give you —

- An indication of the approximate number of people you have reached and their gender.
- Approximately how many are men or women.
- Number of condom distributed.
- Level of information resources distribution.
- The common issues individuals are concerned about.
- Gaps in the knowledge of individuals, their perceptions, beliefs, attitudes and practices.
- Gaps in knowledge of HIV and sexual health services.
- The main challenges and successes of creating spaces in different settings.
- How this intervention can be developed in the future.

In order to evaluate whether the space created has achieved its aim, you will need to go back to the settings where the activity was carried out. You may interview a sample of those individuals in attendance at the space, to establish whether they came into contact with the interventions that were carried out, and how their knowledge, beliefs and practices changed as a result of these interventions. Your questions will have to be based on the information you complied about the population in that setting on the de-briefing sheets and on the monitoring form in the short-term evaluation.
Practice guidelines

- A needs assessment should be carried out before implementing the intervention.
- Identify a suitable setting/venue.
- Negotiate with the owners on creating the space.
- Agree boundaries and have a written agreement outlining the agreed outcomes.
- Identify and involve a motivating factor for the target population e.g. a familiar DJ in case of a nightclub.
- Identify the type of publicity that the target population responds to (flyers, magazines, posters, post cards).
- You need to publicise at least two weeks before the day.
- On the day you may involve volunteers to assist in the intervention. Follow the outreach practice guidelines in Chapter 6, if an outside venue is used.

What type of intervention is community empowerment and development?

It is a community-level intervention that works on the social and political environment to encourage or create a supportive atmosphere that facilitates the delivery of HIV prevention interventions.

Intervention might include supporting African-led businesses such as pubs, clubs, hair salons, minicab offices to carry out HIV prevention work, sponsoring social events, anti-discrimination and homophobia campaigns, and increasing participation of African people in local decision-making processes and training. It involves developing strong infrastructure that can be used to carry out effective HIV prevention interventions.

How does community empowerment and development contribute to reducing the incidence of HIV among African communities?

Community empowerment and development supports the creation and functioning of community infrastructure and increases settings in which HIV prevention interventions can occur.

“The lack of community infrastructure limits the range of settings in which interventions can occur”

(Making It Count 2000)

Interventions can work with community members to increase their ability to organise and form community-based organisations, address the needs of Africans in the community, challenge discrimination, lobby policy makers and funders and participate in the decision-making process.
ASTOR Model

<table>
<thead>
<tr>
<th>Aim</th>
<th>Improve organisations’ ability to organise, deliver HIV prevention interventions and influence HIV policy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>Staff meetings, management committee meetings and organisational networks, workshops.</td>
</tr>
<tr>
<td>Target</td>
<td>Organisations and institutions involved in HIV prevention work.</td>
</tr>
</tbody>
</table>
| Objective | • Training to improve knowledge and skills among staff.  
• Supporting organisational capacity development.  
• Lobbying.  
• Liaison with policy makers and other service providers.  
• Policy formulation and implementation. |
| Resources | • Resource centre  
• Staff/volunteers  
• Educational materials  
• Trainers  
• Budget. |

Advantages and disadvantages of organisational interventions

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| • It facilitates the development of community infrastructure and community response to HIV.  
• Improved capacity of organisations to deliver quality services.  
• Increases client accessibility to health services. | • Rely on the organisation to improve direct service provision to the people. |

For more information on capacity building intervention see: The Field Guide (2003), Page 77 to 80
Monitoring organisational interventions

You can assess whether you are achieving your organisational interventions’ objectives by monitoring the following —

- The number of organisations receiving capacity development i.e. training and support (Paul Kinder et al., 1999).
- The number staff and volunteers recruited, and trained.
- The number of community-based organisations planning to or implementing changes in organisational structures, or with improved capacity and credibility as a result of the intervention.
- The number of community-based organisations utilising acquired skills, implementing HIV health promotion workplace policies and supporting HIV prevention programmes.
- Percentage of the community-based organisations receiving funding to carry out HIV prevention work as a result of the intervention.
- Services developed in response to identified needs.
- Community-based organisations’ involvement in consultation, lobbying, networks, coalitions and policy development processes.
- Increase in efficiency and best practice in service delivery.
Evaluation

Evaluation of each intervention should be based on the context where the project is implemented and should include both quantitative and qualitative measures.

Organisational interventions can be evaluated using the following methods —

- Interviews, focus group discussions and surveys can be used to obtain feedback from community-based organisation.
- Areas of study may include the extent to which project aims and objectives were achieved? Which community-based organisations or groups participated and which ones did not? What activities relating to capacity building were undertaken by the project? Which activities did the target groups participate in? How many people were recruited and trained? To what extent did organisations develop their infrastructure and improve service delivery as a result of the intervention? Were they successful or not? Was the support provided useful and appropriate to their needs? Were the changes in capacity consistent within the objectives of the intervention? What changes in organisational practices, policies, norms, and resources came as a result of the intervention? What lessons were learnt from the project and how were the results disseminated to organisations among the target group that would benefit from such information in the future? (Paul Kinder et al., 1999).

Practice guidelines

- Organisational capacity assessment should be carried out to determine needs.
- Barriers to capacity building need to be acknowledged and attempts made to resolve them where possible.
- Identification of priority areas for action should involve all stakeholders.
- Programme objectives should be clear, specific and realistic.
- All stakeholders should agree performance indicators, targets and action plans.
- Development and training programmes should take into account the diverse needs of African community-based organisations.
- Evaluation of the programmes should be a learning process.
- Findings should be disseminated to all stakeholders and used to inform future capacity building programmes.
What type of interventions are socio-political interventions?

Socio-political interventions are interventions that aim to change structural modifying factors. These include —

- legislation and strategic policy regarding sexual behaviour, and risk reduction behaviour
- national and local laws and policies around sex and sexuality
- strategy concerning prevention and the provision of services
- economic and organisational factors that influence the availability of risk reduction strategies e.g. cost and availability of condoms and health service funding for HIV prevention.

It is good practice for organisations to be aware of the opportunities where they can influence structural modifying factors, such as participating in consultation, conferences and working closely with other organisations.

How do socio-political interventions contribute to reducing the incidence of HIV among African Communities?

Socio-political interventions contribute to reducing the incidence of HIV in the following ways —

- Legislation around sexual activities (age of consent, passing on infection).
- Political policies (ring fencing HIV prevention money).
- Organizational development (the ability of organizations to deliver interventions).
- Facilitation interventions (the development of policy and provision of interventions and research available to provide evidence for the need for HIV prevention).

Restriction on sex education, condom use, distribution and labelling, enjoyment of human rights for people living with HIV, compulsory HIV testing may prevent people from exercising control over their lives, declaring their HIV status or seeking medical help (Family Health International, 1997). It is important to note that legislation is a national and often political intervention. Organisations need to work in partnership with other organisations in order to contribute to legislation or influence local policy. (E.g. Community based organisations need to work with umbrella organisations such as African HIV Policy Network to help influence...
9.2 Resource Allocation Interventions

These interventions aim to ensure that on all levels equitable and suitable resources are provided to meet the aims of HIV prevention initiatives. It includes activities such as requesting the department of health and local commissioners to fund HIV prevention initiatives, and making a claim for funds to local authorities and other funding bodies (The Field Guide).

9.3 Equality Interventions

HIV-related stigma, discrimination, social exclusion need to be addressed to provide a supportive environment for HIV prevention work. Equality interventions seek to influence policy makers at all levels, to enact, modify, and repeal legislation that is unfavourable to meeting HIV prevention objectives (Making It Count, 2000).

Equality interventions include activities that are aimed at reducing discrimination and social exclusion by influencing national and local policies, such as consultation with key stakeholders on policy issues, advocacy, lobbying of policy makers and monitoring of policy implementation.

ASTOR Model

<table>
<thead>
<tr>
<th>Aim</th>
<th>Reduce discrimination and social exclusion by influencing national and local policies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>Social, community and institutional networks.</td>
</tr>
</tbody>
</table>
| Target | - Individuals.  
- Community-based organisations.  
- Statutory, voluntary, private sector organisations.  
- Government departments, policy forums and networks. |
| Objective | - Develop policies and lobby for policies that address HIV-related stigma and discrimination.  
- Train service providers on addressing discrimination and HIV-related stigma.  
- Community involvement and advocacy. |
| Resources | - Staff, volunteers, trainers.  
- Venue.  
- Educational materials.  
- Budget. |

Advantages and disadvantages of equality interventions

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| - Helps to create a more conducive environment for HIV prevention work.  
- Improves access to HIV prevention interventions.  
- Improves communication between health promotion departments and African communities.  
- Helps to involve community-based organisations in strategic policy matters. | - Organisations and individuals may have hidden agendas.  
- Distrust between members may stifle progress.  
- Decision-making process may be complicated and slow.  
- Lack of clear direction.  
- It’s often difficult to attribute policy changes to specific interventions. |
Monitoring equality interventions

You can assess whether you are achieving your equality interventions’ objectives by monitoring the following —

- Responses received from speaking to commissioning managers and local policy makers.
- Community-based organisations’ support for policies i.e. involvement in community mobilisation, consultation, lobbying and policy development processes.
- Number of briefings and training sessions held, and numbers of printed materials distributed.
- Percentage of the target population who understand the messages and rationale for policy review and development.
- The number of networks or coalitions established between community-based organisations and stakeholders as a result of the intervention.
- The number of organisations addressing structural barriers to HIV prevention work e.g. including HIV in their policies that deal with harassment and discrimination in work practices and service delivery.
- The number of organisations providing HIV awareness training to their staff, volunteers and users.
- Evidence of policy implementation, compliance and change in attitudes to HIV/AIDS and people living with HIV/AIDS.
- Level of government and business funding of HIV prevention interventions.
Evaluating equality interventions

Equality interventions can be evaluated using the following methods —

- Process evaluation can be done at the end of each year or decision-making cycle.
- A questionnaire can be used to obtain information on efforts made towards achieving set objectives. You need to know whether the advocacy campaigns run smoothly, obstacles encountered and how they were resolved? How the messages were delivered to the target audience, sites and channels of communication used, and their impact on the target audience? How information and research was used to inform the planning and implementation of the campaign? How the organisations and policy makers were involved in the decision-making process and lessons learnt? Was the information and education provided to the target group, policy makers and power holders sufficient to make them understand the decision making process and sustain their involvement? How useful were the networks or coalitions to achieving your objectives? Whether the financial resources were adequate or used efficiently? What changes were made as a result of the intervention to make the environment conducive to carrying out HIV prevention work? (Paul Kinder et al., 1999, Making it Count 2000).
- Interviewing staff, volunteers and members involved in policy development to obtain their opinions about the consultation and policy development process.
- A review of the current policies should be undertaken to determine whether they are adequate and appropriate to support HIV prevention work.
- Policy makers, power holders, allies, opponents and those affected by the existing problems, need to be engaged as early as possible in the advocacy efforts for change.
- All stakeholders should understand the reasons for developing or modifying policies. This may require briefing sessions, provision of reading materials, or training.
- Forming advocacy networks and building a coalition will be useful in achieving your policy objectives.
- Findings should be disseminated to all stakeholders including the media and used to inform future policy development programmes.
Facilitation interventions include activities that help those engaged in HIV prevention to plan and carry out interventions. This includes education and information activities, such as conferences intended to increase health promotion skills; research and development intended to produce information for use by health promoters; programme planning; and partnerships between agencies.

“Facilitation interventions contribute to raising the effectiveness, efficiency and equality of individual, community and organisational interventions” (Making It Count 2000).

How does a conference contribute to reducing the incidence of HIV among African Communities?

Conferences mainly affect structural modifying factors that may be likely to mediate HIV risk. The outcomes of a conference could include an increase in the range and quality of services offered by African community-based organisations or the development of projects for a particular sub-population (African men who have sex with men) or a campaign to increase HIV testing within the African community.

What is a conference?

A conference is a structured session for which professionals, practitioners and service users working on different aspects of HIV congregate in a setting to share experiences and learn from each other. Conferences can be one-off events or can form part of a series that follow development in a particular area e.g. HIV prevention for African communities, HIV prevention work for African men.

What type of intervention is a conference?

It is a socio-political level (facilitation) intervention and involves work around research and development, programme planning, communication and collaboration between agencies. It mainly affects structural modifying factors.
### ASTOR Model

| **Aim** | Reduce primary HIV prevention needs by allowing attendees chance to better understand factual and structural information about HIV. |
| **Setting** | Formal settings e.g. halls, conference centres. |
| **Target** | HIV health professionals (health promotion staff, sexual health/GUM staff, medical staff), researchers, strategy and policy-makers, commissioners of HIV services, community leaders and service users. |
| **Target numbers** | 50–500 people. |
| **Objective** | HIV prevention service delivery usually involving one or more —  
  - Giving information about a specified HIV prevention area to participants.  
  - Questions from participants about aspects of the information received or related areas.  
  - Facilitated discussion e.g. workshop.  
  - Distributing supporting information relevant to the topic area.  
  - Making recommendations on how to move service provision forward. |
| **Resources** | Resources for a conference may include —  
  - The information sources/facilitators (HIV health professionals).  
  - Information (handouts, booklets, reports).  
  - Equipment for presentations (overhead projector, power point projector).  
  - Extra rooms for the facilitated sessions.  
  - Post-assessment tools (questionnaire).  
  - Refreshments (tea, coffee). |

### Advantages and disadvantages of using a conference as an intervention

<table>
<thead>
<tr>
<th><strong>Advantages</strong></th>
<th><strong>Disadvantages</strong></th>
</tr>
</thead>
</table>
| • Direct contact with those who provide the intervention.  
• Facilitates strategy and policy gains.  
• Gives a chance to participants to reflect on their HIV prevention practice.  
• Facilitates networking and information sharing. | • Lack of structured follow-up of those attending.  
• Attracts only those who provide the interventions not necessarily those who are at risk of HIV infection.  
• Can be very expensive and most people, especially those from small African organisations, may not be able to attend. |
Monitoring a conference  
(See Appendix 10 (1) & (2) – Conference registration & evaluation form)

You can assess whether you are achieving your conference objectives by monitoring the following —

- How many people attended and their profile (age, gender, nationality).
- If your publicity was effective in attracting the target population.
- Publicity tips (how did they know about the conference?).
- Accessibility of the venue.
- Changes participants might like to see in the organisation of future conferences.

Evaluation

The best way to evaluate whether a conference has achieved its aims is usually to give participants an assessment tool (e.g. a questionnaire assessing concepts of the conference) at the end of the conference to see whether the information and interaction during the conference has given participants —

- New knowledge of issues and developments in HIV health promotion.
- Skills in identifying and developing project areas.
- Understanding of new areas of HIV prevention interventions.
- Areas that can be included next time.
- Recommendations.

In order to assess the impact of the conference in the short term, you need to compile all the information given by participants on the evaluation forms. All of this information will give you an overall short-term evaluation of the intervention.

Long-term evaluation of a conference is mainly through its outcomes. For example, as a result of a conference there could be —

- New approaches to HIV prevention.
- An increase in HIV prevention projects e.g. for young people, men.
- A new approach to commissioning HIV prevention work for African communities.
- Research into new areas of risk-taking behaviour.
- An increase in awareness within the community.
Practice guidelines

- Write down your conference proposal. It should include —
  1. Rationale (why you need to hold a conference).
  2. Aims.
  3. Objectives.
  4. Outcomes (what participants will achieve from the conference, and what the conference hopes to achieve overall).
  5. Target population (who you expect to attend the conference?).
  6. How many people do you hope to target?
  7. An idea of what topics or areas to be covered. Who the speakers are going to be (e.g. HIV specialists like epidemiologists, researchers, community-based workers, clinic-based health professionals).
  8. Proposal of a guest speaker (e.g. the Mayor, Minister from Department of Health, Chief Executive of the Primary Care Trust). The guest speaker does not necessarily have to be an HIV specialist; they just need to be in a position to add value to the conference for social, political or legal reasons.
  9. The proposed venue.
  10. A budget, how much the conference is going to cost in detail.
  11. Any sources of funding to meet the cost of the conference.
  12. Publicity strategy.

- Identify a group of people to form a conference steering group, give them the conference proposal and set up a meeting to discuss it.

- The shape, practicalities, timetable, fundraising issues and publicity will be determined from the ongoing meetings of the conference steering group.

- Publicity is key to the success of a conference. The publicity tool, in most cases a flier, should contain the date/s of the conference, the address where it is going to be held, a rationale, the conference theme/title, aims, objectives, target population, the name of the guest speaker, names of all the other speakers, an application form, named contact person and their contact details, details of where more information can be obtained (e.g. a website), an address/fax number to which to send the completed applications and details of payment options if the conference is not free.

- It is important to do your publicity in good time, at least three months before the conference date. Six months before the conference, you might opt for an early conference announcement, which does not yet contain a lot of detail.

- Publicity for a conference could include a website, newspaper and magazine advertisements, radio announcements if possible and appropriate, and direct mailing to organisations/places where you think the target population will be able to see it.

- Venue access details e.g. a map, the timetable, accommodation options can be sent to participants once they have booked a place.

- On the day, make sure the venue is well sign-posted, and the registration/welcoming area is visible. You may need volunteers to guide the participants.
Research and development includes activities such as needs assessments and evaluation of interventions, intended to produce the evidence base for use by health promoters in designing appropriate programmes, and policies to overcome barriers to behaviour change and HIV prevention work. They also support policy makers and resource allocators in drafting policies and allocating resources.

Interventions might include: communicating with and developing partnerships with key stakeholders to facilitate policy development; taking part in consultation processes; lobbying government and research bodies to ensure that research meets the needs of African communities; subscribing to research information sources or joining the African Research Forum or similar networks (Making It Count, 2000, African HIV Policy Network et al., 2003, Health Development Agency, 2003, The Field Guide 2003).

Advantages and disadvantages of using research & development as an intervention

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Help to facilitate strategic planning of HIV prevention work.</td>
<td>• Research process may be intimidating to some people.</td>
</tr>
<tr>
<td>• Provides a better understanding of community needs.</td>
<td>• Distrust between members may stifle progress.</td>
</tr>
<tr>
<td>• Helps to identify problems and develop appropriate programmes.</td>
<td>• Organisations and individuals may have hidden agendas.</td>
</tr>
<tr>
<td>• Improves communication between health promotion departments and African communities.</td>
<td></td>
</tr>
</tbody>
</table>
Monitoring

No single method of monitoring will be appropriate to all research programmes carried out. Monitoring and evaluation methods will need to be adapted to suit the aims and methods of each research project. However you can monitor the progress of your research programme by collecting data on the following —

- The number of people participating in the programme.
- Number of people attending or dropping out of the programme.
- Involvement of the target population in research projects.
- The number of organisations involved in or supporting the programme.
- Type and number of research projects conducted with the target group.
- Methodology used in the research project.
- How the project is managed.
- Number of staff, volunteers recruited, trained and involved in research projects.
- Records of financial resources spent on the project.

Information about the research programme can be collected using surveys, self-completed questionnaires, activity records, observations, keeping a daily journal, report cards, case studies, interviews and conversations with participants, and analysis of relevant documents.

Evaluation

You need to assess all the qualitative and quantitative data collected during the monitoring process in order to determine the success, usefulness and value of the programme. Areas of study may include a measure of the target population that has been reached by the researcher, what efforts have been made to reach the target audience? Whether the dissemination and diffusion activities have been properly targeted? What has been the impact of the research project and how have the findings been used?

Practice guidelines

- Active involvement of the target community in all stages of the research will help to ensure consistency with community norms, cultural competency and responsiveness to community needs.
- Data to be collected and performance indicators should be agreed with the steering group or participants.
- You need to obtain consent from participants to use the information collected.
- Ethics committee approval should be sought where necessary.
- Interviews and conversations with participants may be tape-recorded for review.
- Feedback sessions should be organised to provide an opportunity for target groups to know the results and ask questions about the project.
- Research should be conducted to collect information about best practice.
- Findings should be translated into practice that benefits the target population.
In order to choose the most appropriate intervention for the need you have identified, refer to Chapters 2 and 5, to work out how the different needs can be addressed using different ways of delivering interventions to achieve effective HIV prevention outcomes.

It is advisable to use more than one intervention at all levels, in order to bring about the desired changes in attitude and behaviour.

The tables below and on the following page may act as a guide to your choice —

In addition to the identified need, you may have to consider the following —

- The nature of the target population (their age, gender, how to mobilise or reach out to them, what motivates them to be part of or accept an intervention).
- How acceptable and appropriate the message is to the target population.
- What images, designs or colours are acceptable or appeal to the target population.
- Settings where to find your target population. It is also important to assess how easy or difficult it is to carry out the intervention in any given setting or situation. (For example, you might not be able to do outreach at a club at 8pm because the clubbers have not yet arrived).
- What is the risk involved in any given intervention (e.g. negative press coverage relating HIV to immigration and racism)?
- What costs are involved? Do you have enough money to do an intervention and be effective? Maybe instead of putting on a conference that is very expensive and is a one-off, the money could be better spent on a number of seminars.

### Individual-level Interventions

<table>
<thead>
<tr>
<th>Need</th>
<th>Intervention(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information needs</td>
<td>Outreach, telephone advice and help line, Internet, drop-in space.</td>
</tr>
<tr>
<td>Need to understand safer sex practices</td>
<td>Telephone advice and help line. Drop-in space, peer interventions.</td>
</tr>
<tr>
<td>Access to services</td>
<td>One-to-one detached outreach. Telephone advice and help line.</td>
</tr>
<tr>
<td>The need to address HIV-related stigma</td>
<td>Internet, outreach, telephone advice.</td>
</tr>
</tbody>
</table>
## Group-level Interventions

<table>
<thead>
<tr>
<th>Need</th>
<th>Intervention(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information needs</td>
<td>Seminars, workshops.</td>
</tr>
<tr>
<td>Need to understand safer sex practices</td>
<td>Workshops, seminars, media.</td>
</tr>
<tr>
<td>Access to services</td>
<td>Seminars, workshops, small media.</td>
</tr>
<tr>
<td>The need to address HIV-related stigma</td>
<td>Internet, media, peer interventions.</td>
</tr>
</tbody>
</table>

## Community-level Interventions

<table>
<thead>
<tr>
<th>Need</th>
<th>Intervention(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information needs</td>
<td>Mass media, small media, peer interventions, community events, campaigns</td>
</tr>
<tr>
<td>Need to understand safer sex practices</td>
<td>Condom and lubricant distribution, peer education, campaigns.</td>
</tr>
<tr>
<td>Access to services</td>
<td>Peer interventions, small media, and campaigns.</td>
</tr>
<tr>
<td>The need to address HIV-related stigma</td>
<td>Mass media, small media, community events, community empowerment and development, creation of social spaces, campaigns.</td>
</tr>
</tbody>
</table>

## Socio-political level Interventions

<table>
<thead>
<tr>
<th>Need</th>
<th>Intervention(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information needs</td>
<td>Conferences, training for HIV prevention workers, workshops and seminars.</td>
</tr>
<tr>
<td>Need to understand safer sex practices</td>
<td>Training for HIV prevention workers, workshops, campaigns.</td>
</tr>
<tr>
<td>Access to services</td>
<td>Campaigns, equality interventions.</td>
</tr>
<tr>
<td>The need to address HIV-related stigma</td>
<td>Conference, equality interventions, campaigns.</td>
</tr>
</tbody>
</table>
10.2 Monitoring Interventions

Monitoring is the on-going process of checking a programme to ascertain whether it is delivering its activities according to plan and agreed standards.

Regularly checks will help to determine whether your intervention is successful, useful or of value to the target population. Monitoring helps to recognise problems at an early stage and permits you to make the required adjustments.

The monitoring methods used will depend on the type of intervention carried out and the data you wish to collect.

10.3 Evaluating Interventions

Evaluation is the process of assessing the effectiveness of an intervention (What difference did it make?).

Evaluation of HIV prevention interventions is designed to demonstrate whether the interventions achieved their aims and made a difference. Evaluation can provide evidence that convinces funders that the interventions carried out achieved their policy goals, and also provide the evidence that persuades providers that these interventions are likely to work in their area. Evaluation should be planned at the start of the intervention and not just done as an after thought at the end.

As in all health promotion, robust evaluation of any type of prevention intervention should be carried out.

Such evaluations can include —

- Process evaluation, which focuses on and measures the process of the intervention, including participant feedback and satisfaction, costs, quality, access and practicalities. Process evaluation will be useful in providing an understanding of how the intervention works and guidance for projects in the future.

- Impact evaluation, which focuses on the immediate effects of the intervention, and on intermediate factors such as knowledge, skills, motivation and access. Impact evaluation points to the changes and the extent to which they occurred.

- Outcome evaluation, which focuses on the long-term effects of the interventions in bringing about behaviour change and a reduction HIV infection rates.
1. Activities whose purpose is to remove individual, community and societal barriers that stop individuals from having control over making and implementing informed decisions about their likelihood of getting HIV are called HIV prevention interventions.

2. All interventions are carried out to meet identified HIV prevention needs and are designed to influence modifying factors. Modifying factors rather than risk behaviour is where HIV prevention should be focused.

3. Modifying factors can be individual (e.g. knowledge and attitudes) in that they affect the person, or structural (e.g. policies and community norms) in that they are the context in which the individual lives.

4. The HIV prevention needs of African communities living in England have been identified as: information needs, the need to understand safer sex practices, access to services and the need to address HIV-related stigma.

5. In order to carry out effective interventions you can identify the needs you are trying to address through a needs assessment.

6. In order to achieve effectiveness, interventions can be aimed at an individual, a group, and a community or at the socio-political level. It is important that you work out at what level an intervention will be effective.

7. The ‘ASTOR’ model is used to best describe an intervention. ASTOR breaks down the intervention into Aim, Settings, Targets, Objectives and Resources.

8. The interventions that can be used for HIV prevention work with African communities in England have been identified and grouped as follows —
   a) Individual level interventions —
      • Drop-in spaces.
      • Telephone advice and help lines.
      • Internet-based work.
      • Outreach.
   b) Group-level interventions —
      • Seminars.
      • Workshops.
   c) Community level interventions —
      • Condom and lubricant distribution.
      • Media (small and mass media) interventions.
      • Peer interventions.
      • Community events.
      • Creation of social spaces to deliver other interventions.
      • Community empowerment and development.
   d) Socio-political interventions —
      • Equality interventions (e.g. campaigns and lobbying to influence policies and legislation, such as laws against discrimination).
      • Facilitation interventions (e.g. conferences, and training and developing the skills of HIV prevention workers).
MONITORING FORM FOR A DROP-IN SPACE

This form is confidential and for internal data collection use only. The answers will not be traced back to you.

Date
1. Male □ Female □

2. Age (please tick what applies)
   Under 25 years □ 25 – 35 years □ 36 – 45 years □ 45+ □

3. Area of residence (e.g. London Borough or County Council)

4. Key issues discussed with the health promotion worker, including problem areas

5. Advice and recommendations made

6. Referrals made to other organisations
# Telephone Advice-line Monitoring Form

This form is confidential and for internal data collection use only. The answers will not be traced back to you.

**Date** ____________

1. **Male □**  **Female □**

2. **Age (please tick what applies)**  
   - Under 25 years □  25 – 35 years □  36 – 45 years □  45+ □

3. **Area of residence (e.g. London Borough or County Council)**  
   __________________________________________________

4. **Occupation** ________________________________________

5. **First time caller □**  **Called before □**

6. **Key issues discussed with the health promotion worker, including problem areas**  
   - Basic HIV information □  Counselling □  
   - Sexually transmitted infection □  Social care services □  
   - HIV treatment options □  Support groups □  
   - Health care services □  Immigration matters □  
   - Welfare benefits □  Request for printed resources □  
   - Legal issues □  Housing □  
   - HIV-related stigma & discrimination □  Carers‘ issues □  
   - Advocacy □  Employment advice □  
   - HIV prevention options □  Human rights □  
   - HIV-related diseases □  Other (please specify) □

7. **Summary of advice given**  
   __________________________________________________

8. **Information resources sent**  
   __________________________________________________

9. **Referred to**  
   __________________________________________________

10. **Comments**  
    __________________________________________________
INTERNET-BASED WORK MONITORING FORM

We would like to know your views about our website. This will help us improve the information provided and tell us how we can be of assistance to you.

1. Is this your first time to visit the website?
   Yes ☐ No ☐

2. How easy was it to use the site?
   Very easy ☐ Easy ☐ Difficult ☐ Very Difficult ☐

3. How useful was the information provided on the website?
   Very useful ☐ Useful ☐ Not useful at all ☐

4. Please tell us what you liked about the website?
   ____________________________________________
   ____________________________________________

5. What didn’t you like about the website?
   ____________________________________________
   ____________________________________________

6. Other comments
   ____________________________________________
   ____________________________________________

7. How did you find out about the website?
   Word of mouth ☐ Newsletter/magazine ☐ (Title) ____________________
   Link from another site ☐ Search engine ☐
   Other ☐ (Please specify) ____________________

Optional

Name ____________________________________________
Address ____________________________________________

Male ☐ Female ☐ Age ____________________

Thank you for taking time to complete this form.
Outreach De-briefing Sheet

Outreach De-briefing Sheet

Date __________________________
Venue/Address/Post Code __________________________

Summary of the outreach session __________________________

Number of resources and condoms distributed __________________________

Recommendations __________________________
**Outreach Monitoring Form**

Venue/Address/Post Code

Length of the session  
Estimated number of contacts

Male  
Female  
Aged

Distribution Of Materials

Number of condoms distributed (Single Units)

Number of condom demonstrations made

Lubricant Units

Resources (Single Units)

•
•
•
•

Issues Discussed

Referrals made

Comments

Recommendations
Registration Profile & Process Monitoring Form

Date __________

_________________________________________________________________
_________________________________________________________________
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"SEMİNAR & WوىRKSHOP MONİTOıRING FORM"
Seminar Evaluation Form  

Topic: Basic facts on HIV

Seminars are designed to increase your knowledge in HIV prevention. Please help us assess whether we have been successful by answering the following questions.

Date ____________________________

1. HIV stands for ____________________________

2. AIDS stands for ____________________________

3. List the ways in which HIV is transmitted ____________________________

4. List the ways in which HIV is not transmitted ____________________________

5. You can tell that a person has HIV by looking at them  
   Strongly agree □  Agree □  Not sure □  Disagree □  Strongly disagree □

6. What is the ‘window’ period ____________________________

7. How can you reduce your risks of getting HIV ____________________________

8. My knowledge about HIV transmission has increased as a result of attending the seminar/workshop  
   Strongly agree □  Agree □  Not sure □  Disagree □  Strongly disagree □

9. What particular aspects of the seminar/workshop did you find useful?  
   Why? ____________________________

10. In order to improve the seminar what would you change? ____________________________

11. What would you like to see included in future seminars this nature? ____________________________

12. Any other comments ____________________________
Workshop Evaluation Form

Topic: Cultural & Social Challenges to HIV prevention among African Communities in the UK

Workshops are designed to increase your knowledge and skills in HIV prevention as well as planning future sessions more appropriately. We would be grateful if you complete this evaluation form.

Date __________

1. List the ways in which HIV is transmitted? ________________________________________

2. List the ways in which HIV is not transmitted? ________________________________________

3. List the cultural and social practices likely to increase the risks of contracting HIV in your community ________________________________________

4. The scenario discussed in the workshop addressed the key social and cultural issues likely to put African people in the UK at an increased risk of HIV infection

   Strongly agree ☐  Agree ☐  Not sure ☐  Disagree ☐  Strongly disagree ☐

5. If you had the opportunity to raise awareness of cultural and social issues in your community, who would you target and how would you do it?

6. My knowledge and skills have improved as a result of attending this workshop

   Strongly agree ☐  Agree ☐  Not sure ☐  Disagree ☐  Strongly disagree ☐

7. What particular aspects of the workshop did you find useful? Why?

8. In order to improve the workshop what would you change?

9. What would you like to see included in future workshops of this nature?

10. Any other comments
## Condom & Lubricant Distribution Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Address/PostCode</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of condoms distributed (Single units)</td>
<td></td>
</tr>
<tr>
<td>Number of condoms demonstration made</td>
<td></td>
</tr>
<tr>
<td>Lubricant units distributed (Single Units)</td>
<td></td>
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SMALL MEDIA FEEDBACK FORM

Date __________

1. Male □ Female □

2. Age (please tick what applies)
   Under 25 years □ 25 – 35 years □ 36 – 45 years □ 45+ □

3. Area of residence (e.g. London Borough or County Council) __________

4. Did you receive a copy of this leaflet?
   Yes □ No □

5. Did you take it away or home with you?
   Yes □ No □

6. Did you read it?
   Yes □ No □

7. Was it easy to understand?
   Yes □ No □

8. How would you rate the content? (Text & images)
   Very Good □ Good □ Not Sure □ Poor □ Very Poor □

9. Did you find the information provided interesting?
   Very Interesting □ Interesting □ Not sure □ Not interesting □

10. What did you like most about it?

11. What didn’t you like about it?

12. Would you recommend it to someone else?
   Yes □ No □

13. Any other comments?

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## Small Media Distribution Monitoring Form

<table>
<thead>
<tr>
<th>Name of leaflet</th>
<th>Launch date</th>
<th>Volume developed</th>
<th>Volume distributed</th>
<th>Display / distribution sites</th>
<th>Percentage of the target group who received the leaflet</th>
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### MASS MEDIA DISTRIBUTION MONITORING FORM

<table>
<thead>
<tr>
<th>Name of mass media event or intervention</th>
<th>Number of programmes / events held</th>
<th>Broadcast / Display channels / Sites</th>
<th>Broadcast / Display period</th>
<th>Number of times broadcast or displayed</th>
<th>Percentage of the target group who recognise the intervention</th>
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</table>
# Event and Intervention Summary Report

**Date**

**Event held**

**Lead person**

Details of the event/intervention

1. **Aim(s)**
   
2. **Objective(s)**
   
3. **What activities or services were provided?**
   
4. **Who attended or benefited from the event/intervention?**
   (Target population, numbers in attendance or receipt of services)

5. **Which organisations participated or contributed resources?**

6. **What happened as a result of your intervention?**
Conference Registration Form

Full Name__________________________________________
Job Title__________________________________________
Organisation_______________________________________
Work Address_______________________________________

________________________________________________
________________________________________________

Tel_________________________ Fax_____________________
E-mail address______________________________________

Please tick requirements if applicable
Wheelchair accessibility □ Induction loop □ Vegetarian meal □
Do you have any other specific requirements______________________________________
________________________________________________
Please select

Cost of conference £________ □
2nd Delegate discount £________ □
3rd or more delegate discount £________ □
Total £________

Please tick
Cheque enclosed □ payable to ________________________________
Please invoice me □
Full details of organisation and address to be invoiced are
________________________________________________
________________________________________________
________________________________________________

Please return this form to______________________________________
________________________________________________

________________________________________________
# Conference Evaluation Form

Please answer the following questions to enable us to organise future conferences better.

1. **How would you rate the plenary presentations?**
   - Very good □
   - Good □
   - Poor □
   - Very poor □

2. **How would you rate the workshops/project presentations?**
   - Very good □
   - Good □
   - Poor □
   - Very poor □

3. **How would you rate the organisation of the conference?**
   - Very good □
   - Good □
   - Poor □
   - Very poor □

4. **How would you rate the venue where the conference was held?**
   - Very good □
   - Good □
   - Poor □
   - Very poor □

5. **Was the location of the venue accessible?**
   - Suitable □
   - Unsuitable □
   - No comment □

6. **What did you think about the refreshments and food provided?**
   - Very good □
   - Good □
   - Poor □
   - Very poor □

7. **What would you like to see included in future conferences?**
   
   

8. **Any other comments**

   

   

Thank you for completing the form.
HIV Prevention

The main approaches to HIV epidemic control have historically included —

- **Biomedical interventions**, including STI treatment and control, partner notification, HIV drug treatment to reduce viral load, reduction of vertical mother-to-child transmission, the development of microbicides, and male circumcision.

- **Provision of information**, including sex education and sexual health promotion advice.

- **Behavioural interventions**, including increased use of condoms, a reduction in the number of different sexual partners (including abstinence), a reduction in the number of concurrent sexual partners, and the encouragement of people to have sexual intercourse with partners of the same HIV status.

It is increasingly acknowledged that a multi-factorial approach to HIV prevention, that utilises all of these factors, is the most likely to succeed in the reduction of HIV incidence.

The theoretical basis for this is as follows. The pattern and distribution of a communicable sexual infection within a population are dependent upon three main factors —

1. The sexual behaviour of individuals within that community.
2. The probability or ease with which the infection can be transmitted.
3. The duration with which an infected individual is infectious.

This relationship guides the manner in which disease or epidemic control should be managed; interventions should be aimed at controlling one or more of these factors —

- Individual sexual behaviour is a complex issue that is determined by a range of factors including knowledge, skill, motivation and attitudes, social context and demographic variables (age, gender, ethnicity, socio-economic status, sexual orientation, and so on), as they relate to the individual and to their sexual partners. Behavioural interventions are aimed at manipulating these variables to enhance safer behaviour.

- The probability of transmission when exposed to an infected partner is relatively fixed within any given STI; HIV is only moderately easy to transmit, relative to many other much more infectious diseases such as Hepatitis.

- The duration of infectiousness of any particular STI varies, depending upon its natural course. However, this can be managed through speedy treatment of a curable infection (e.g., the bacterial and fungal STIs) or through management of non-curable STIs to reduce viral load. This is the main driver for setting up accessible STI treatment services.

While concurrent STI treatment programmes are also important, these too are largely dependent upon people’s health service access and treatment adherence behaviour.

---

Modifying factors that determine sexual behaviour include —

- **Psychological variables:** Individual level factors that influence behaviour can be documented under three headings —
  - Knowledge of risk factors and risk reduction strategies (e.g. what is HIV, how is it transmitted, how can transmission be reduced).
  - Behavioural skills or ability to implement risk reduction strategies (e.g. condom access and usage, negotiating safer sex, health-related behaviour).
  - Motivation to implement risk reduction strategies (e.g. attitudes, beliefs, expectations, perception of group norms and willingness to adhere to those norms, self efficacy).

- **Social context variables:** Sexual behaviour occurs within a social context, and there are some key factors within that context that influence and modify an individual’s ability to change their sexual behaviour. These include: national and local legal and strategic policy; power issues prevalent in the community regarding such factors as gender, age, ethnicity, religion, discrimination and the use of violence which are crucial in determining social group norms; and economic and organisational factors that influence the ability of individuals to implement risk reduction strategies (e.g. condoms) and access health service provision.

The application of HIV prevention behavioural interventions

HIV prevention behavioural interventions have been applied across a wide variety of populations and target groups worldwide.

There have been many empirical reports of successful applications of HIV prevention behavioural interventions across a wide variety of populations and target groups, including groups of men who have sex with men, commercial sex workers, inner city populations, and people living with HIV. However, most of this research arises from the USA; very little research arises from the UK.

To date, the vast majority of the world’s HIV prevalence lies within sub-Saharan Africa, and as a consequence there has been extensive development and evaluation of prevention interventions in that context. However, due to resource restraints, there has been very little in the way of robust evaluations of these programmes, although UNAIDS has produced a Best Practice Collection that summarises this cumulative experience.

There have also been a number of studies relevant to black and minority ethnic groups living outside of Africa, including those of African origin. These studies strongly support the use of behavioural interventions with African Americans and Latinos living in the USA.

There is increasing empirical evidence assessing baseline levels of sexual risk related knowledge, attitudes and behaviour in the African communities within the UK and in African people living with HIV within those communities. There has also been a steady increase in the application of behavioural interventions to HIV prevention in African communities residing within the UK over the last 10 years, and while there is much anecdotal evidence to suggest that some of these interventions are appropriate and effective in bringing about significant changes in risk reduction, there has been very little in the way of robust evaluation of these programmes.
What makes behavioural prevention interventions effective?

Behavioural prevention interventions have been utilised across a broad range of key behaviours which are of concern to health promoters, including drug abuse, violence, mental health, and general health (smoking, cancer, sexual behaviour, etc). Research has shown that for all prevention interventions to be most effective, across any context, they must: (1) be comprehensive with multiple components; (2) involve varied teaching methods; (3) have sufficient dosage; (4) be based on evidence-based behavioural theory; (5) promote positive and supportive relationships between key stakeholders (young people, peers, adults, etc); (6) be appropriately timed, and initiated earlier in peoples lives; (7) be socioculturally relevant; (8) have clear goals and objectives and the outcome be evaluated; and (9) have well-trained staff implementing the programme.

A framework for thinking about carrying out behavioural HIV prevention interventions within African communities in the UK

The task of any intervention is to identify the deficit within the individual or group through a needs assessment, and to design and deliver an intervention aimed to address the precise deficit identified. The areas that are most appropriate for identifying need are —

1. Information: levels of knowledge about HIV and its prevention.
2. Behavioural skill: the ability to successfully carry out risk reduction behaviours.
3. Motivation: how motivated people are to become informed about and carry out reduction behaviours.

For example, it may still be the case that certain individuals or groups within the UK are ill-informed regarding the nature of HIV and how it is contracted and how it can be prevented; if this is the case as identified by a needs assessment, then an intervention needs to be developed to provide information and education around those issues. Knowledge is essential in helping people make decisions about their health.
However, people may be well informed about HIV and be aware of what they need to do to protect themselves and others from HIV, but lack the skills necessary to implement these strategies. If a needs assessment identifies this as being a crucial deficit, then interventions need to be developed to help people become skilled in these health behaviours. It is still the case, as so many people working in the area are aware, that individuals and groups may well be aware of the issues and may well be skilled in their ability to adhere to risk reduction behaviour, but they may not be motivated to do so. Examples of this are repeat attendees at STI clinics who continue to become infected with an STI.

**Provision of Information**

Education and information giving can be provided by people who are seen as the most credible sources of information, including —

- NHS and other statutory health professionals.
- Community based health promotion teams.
- Community leaders, including elders, religious leaders, musicians, sports people, and peers.
- Leaflets, posters, handouts, newsletters, magazines (Positive Nation, Vanguard, etc).
- Radio, music, theatre.
- Helplines.

**Behavioural skills**

People can be helped to develop safer sex strategy skills through —

- Formalising safer sex strategies.
- Obtaining and using condoms/femidoms.
- Negotiating condom use (assertiveness, verbal and non-verbal communication, eroticising condom use).
- Accessing sexual health services.
- Relapse prevention techniques (identifying high risk situations, developing functional/alternative options).
- Maintenance of safer sex strategy.
- Coping with ‘heat of the moment’ thinking (“hot cognitions”).

As outlined earlier, while much of the attention of HIV prevention is focussed on individuals and their role in safe and unsafe sexual behaviour, the context within which people make decisions about their sexual behaviour clearly has a profound impact upon those decisions. While considerably more work is required to develop robust interventions aimed at individuals, there also needs to be a focus on socio-political interventions aimed at reducing inequalities in funding, policy, and discrimination on the basis of gender, age, ethnicity, religion, sexual orientation, and so on.
Motivation

People can become more motivated to prevent themselves and others becoming infected with HIV. Information can be provided to help them be more aware of, and/or to shift —

- Perceptions of their own susceptibility/risk for HIV infection.
- Perceptions of the severity of HIV infection (in the context of the new medications).
- Perceptions of their relevant social group expectation/norm.
- Appropriate safer sex intentions/plans.

One of the fundamental phenomenon within both social and behavioural sciences is the power of peer interventions in modifying individual attitudes and hence motivation. There is growing evidence that while many people within the UK’s African communities consider health professionals to be the most credible source of information regarding safer sex and STIs/HIV, a small but significant number find their peers to be the most credible providers of such information. Young people sometimes feel that their peer leaders understand them better and are therefore more likely to be able to provide them with useful information, while elderly people (especially those who have migrated to the UK more recently) may be inclined to rate their community elders as the most credible providers of such information.

Evaluations

As in all health promotion, robust evaluations of any type of prevention intervention should be carried out. Such evaluations can include —

- Process evaluation, focussing on the process of the intervention, including participant feedback and satisfaction, costs, quality and access, and practicalities.
- Impact evaluation, focussing on the immediate effects of the intervention on intermediate factors such as knowledge, skills, motivation and access.
- Outcome evaluation, focussing on the long-term effects of the intervention on key goals such as behaviour and HIV incidence.
<table>
<thead>
<tr>
<th>Organisation</th>
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<tbody>
<tr>
<td>African Families Support</td>
<td>Peace In Millennium Refugee Project</td>
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<tr>
<td>African Community Involvement Association</td>
<td>Reform Corporation</td>
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<td>African Swahiliphone Refugee Group</td>
<td>Sahir House</td>
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<tr>
<td>African Women’s Health Forum</td>
<td>Somali Health Advocacy</td>
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<td>African Youth Liners</td>
<td>The Crescent</td>
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<td>BCAT (Black Sexual Health Organisation)</td>
<td>Ubuntu-Hunhu</td>
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<tr>
<td>Black Health Agency</td>
<td>Uganda AIDS Action Fund</td>
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<td>Blackliners</td>
<td>Uganda Community Relief Association</td>
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<td>Busoga Association</td>
<td>Uganda Youth Support Group</td>
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<td>Camden and Islington Primary Care Trust</td>
<td>United Kingdom East African Women and Children</td>
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<td>Community of Congolese Refugees in Great Britain</td>
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<td>Congolese Youth Association</td>
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<td>Drugs and Alcohol Services for London</td>
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<td>George House Trust</td>
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<td>Heart of Birmingham Teaching Primary Care Trust</td>
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<td>International Gospel and Health Group</td>
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<td>Islington Zairian Refugee Group</td>
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<td>Kenya Community Support Network</td>
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<td>Nest – The Angolan Women’s Project</td>
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<td>Organisation of HIV-Positive African Men</td>
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Advocacy
Advocacy in this context refers to mobilising, and empowering community members and other key stakeholders to influence the policy decision-making and implementation process. This will include activities aimed at increasing their knowledge of political, economic and social environment, determination of priorities for action, participation in decision making processes and allocation of resources, lobbying and activism.

Aim
The overall purpose of a programme or project which is intended to contribute to an identified (health) issue.

Analysis
A structured approach to problem solving.

Antenatal HIV test
Test carried out on the expectant mother during pregnancy to test whether they are infected with HIV.

Attitudes
Feelings, intentions and thoughts about oneself, other people, situations or events.

Beliefs
Opinions or convictions.

Budget
A forecast of income and expenditure required carrying out a project, or running an organisation at a given period of time.

Capacity-building
The mobilisation of individual and organisational assets from the community and combining those assets with others to achieve community development goals.

Census
The official count of an entire population, usually with details being recorded on residence, age, sex, occupation, ethnic group, marital status, birth history, and relationship to head of household.

Collaboration
Is the process by which individuals or groups come together, with a commitment to work together to accomplish common goals and objectives.

Community
An organized group of people, who share a common culture, values and norms, and leadership and who usually, interact within a defined geographical area.

Community-based organisations
Organisations that provide services in the community.

Community development
Group efforts to identify issues, develop responses, and acquire the necessary resources to carry out programmes or activities that tackle the identified issues.

Community empowerment
This process involves mobilising available community resources, structures and functions of community organisations to deliver effective HIV prevention initiative among their target population.

Data
Documented information or evidence.

Database
A collection of information that has been stored in the computer from which specific pieces information can be accessed when required.

Direct impact
An effect of a programme that tackles a stated goal or objective of that programme.

Distribution
The process of providing or allocating resources.

Effectiveness
A measure of the extent to which a programme achieves its planned results.

Efficiency
A measure of how well available resources (human, financial, technical and material resources) have been used to produce outputs.

Epidemic
The occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.
Epidemiology
The scientific study of disease at a population level. It focuses on the spread of disease and monitors the impact on groups within the population or the population as a whole.

Evaluation
Evaluation is the process of assessing the effectiveness of an intervention (What difference did it make?).

Evaluation form
Feedback sheet that is given to participants at the end of the event such as workshop, conference, etc.

Facilitator
A person who supports another person or group by creating opportunities for them to realise and develop their own direction, goals and outcomes.

Focus group
A group of people brought together to talk about a particular matter, give their views, share their experience and make recommendations.

Health
Health is defined in the WHO constitution of 1948 as: a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end that can be expressed in functional terms as a resource that permits people to lead an individually, socially and economically productive life.

HIV incidence
This is the rate at which people in a population are becoming infected with HIV.

HIV health promotion interventions
Activities or strategies for health promotion for the prevention and control of the spread of HIV.

HIV prevalence
The percentage of people in the entire population who currently have HIV.

Homophobia
The fear or dislike of homosexuals and anti-homosexual beliefs and prejudices.

Impact
The effect of the programme on the problem or condition that the programme or activity is addressing.

Impact evaluation
Evaluation of the broad, long-term results of a programme, intervention or activity.

Implementation
The process of putting all programme functions and activities into place.

Incidence
The number of new cases of disease in a defined population over a specific time period.

Interviews
Interviews involve face-to-face situations or telephone contacts in which the researcher orally solicits responses.

Methodology
The way in which information is found or something is done. The methodology includes the methods, procedures and systems used to collect and scrutinise information.

Method
Procedure of doing something.

Monitoring
An on-going process of checking a programme to ascertain whether it is delivering its activities according to plan and agreed standards.

Monitoring form
A document used to record information collected about the activity as part of the monitoring process.

Needs assessment
The process of identifying the needs of a particular group for the purpose of developing an effective programme.
Objective
Specific results that a group or organisation wants to achieve through its programme.

Organisational development
The tools and skills that enable a board and staff to run an organisation effectively and efficiently. Included are resource development, financial management, strategic planning, board recruitment and development, and communications.

Outcome
The impact, effect or difference the programme, intervention or activity has made.

Outcome evaluation
The evaluation of the overall or long-term results of a programme or intervention to determine whether it has achieved its goal.

Output
Outputs describe what an organisation, project, intervention does. For example the number of training courses run and the numbers of trainees.

Partnership
Two or more groups or individuals joining together in a shared and mutually beneficial relationship working toward a common goal.

Participant
Individual or community receiving or participating in services provided by a programme or intervention.

Perception
A process of gathering information through one’s senses, organising and interpreting it.

Planning
The process of anticipating future occurrences and problems, exploring their probable impact, and detailing policies, goals, objectives and strategies to solve the problems. This often includes preparing options documents, considering alternatives, and issuing final plans.

Policy
A governing principle related to goals, objectives and/or activities.

Population
A group or number of people living within a specified area or sharing similar characteristics (such as occupation or age).

Prevalence
The number of existing disease cases in a defined population during a specific time period.

Prevention
Actions that reduce exposure or other risks, keep people from getting sick, or keep disease from getting worse.

Prioritising
A process to decide what population or issues are most important.

Process
The planned series of things done to carry out a programme.

Process evaluation
Evaluation that focuses on how a programme was implemented. It provides an understanding of how the programme operates, and can provide guidance for future projects.

Programme activities
Activities, services or functions carried out within the programme.

Questionnaire
A printed form containing a set of questions for gathering information.

Referral
Information or assistance provided to a client to enable them to access a needed service.

Resources
Assets available and expected for operations. They include people, equipment, facilities and other things used to plan, implement and evaluate public programmes.

Response rate
The number of persons in a sample who respond to a survey, compared to the number of people originally contacted.
Risk
The likelihood that something will cause injury or harm.

Risk reduction
Actions that can decrease the likelihood that individuals, groups or communities will experience disease or other health conditions.

Route of exposure
The way people come into contact with a hazardous substance or infections.

Risk behaviours
Specific forms of behaviour that are known to be associated with increased vulnerability to a specific disease or ill health.

Sample
A subset of the people chosen from a population or environment which your programme or intervention aims to change in some way.

Sample size
The number of units chosen from a population or an environment.

Sero-prevalence
The rate of HIV-infected individuals within a specific population at any time.

Session
A session is any amount of hits or page views that any one person requests from your server. (On the website)

Settings for health promotion
Places or social units that are used as target areas to carry out health promotion.

Service providers
Individuals and organisations that provide services or professional expertise to others as part of their jobs.

Sexually transmitted infections (STIs)
Conditions and diseases that are commonly passed through or during sex. This may include fungal, viral or bacterial infections.

Social diffusion
The influence exerted by one person’s knowledge, attitudes and behaviour on the practices adopted by others.

Social networks
Social relations and links among individuals that may provide access to or mobilisation of social support for health.

Stakeholder
A person, group or community who has an interest in activities or programmes.

Strategies
The specific ways in which objectives are to be met.

Surveillance data
Statistics on the number of people with HIV, AIDS or other disease in a given area based on the reports sent to public health from various sites.

Target
An objective set by programme organisers to communicate programme purpose to operating staff.

Target population
The population, clients, or subjects intended to be identified and served by the programme.

Technical assistance
Specialised help provided by someone with specialised skills.

Tools
Things or instruments used to work on something.

Transmission of infection
Any method or means by which an infectious agent is spread through the surroundings or to another person.

Vertical transmission
Transmission of HIV from mother to child, either before or after birth.
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