Pan London HIV Prevention Programme Needs Assessment

Work stream summaries and recommendations for further work

Prepared by Inner North West London Primary Care Trusts on behalf of the Pan London HIV Commissioning Group

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Lead Author

Dr. Jeffrey Lake – Consultant in Public Health

Hammersmith and Fulham

Kensington and Chelsea

Westminster

Table of Contents

1. Introduction 2
2. Epidemiology 2
3. Evidence 3
3.1. Interventions that specifically target MSM 4
3.2. Interventions that specifically target African communities 9
4. Interventions for people living with HIV 14
5. Relevant findings associated with successful HIV interventions. 15
6. Limitations of the evidence review 15
7. Review of cost effectiveness 16
7.1. Results of literature learch 16
7.2. Findings 16
7.3. Conclusion 17
8. Local evaluation 18
9. Engagement 19
9.1. Key messages 19
10. Recommendations for further work 22
10.1. Evidence review 22
10.2. Service mapping 23
10.3. Epidemiological analysis 23
11. Appendix 1: Reviews identified by the evidence literature search 25
12. Appendix 2: The current programme 32

1. Introduction

A rapid needs assessment has been conducted to inform commissioning of the Pan London HIV Prevention Programme. The work has been overseen by a steering group with representation from public health, commissioning, clinicians and academia. It has incorporated 3 separate work streams: epidemiology, evidence, and engagement. Each work stream has produced a report. This document provides a brief overall summary of each of the work streams and what they tell us about the current programme (on overview of which is included in the appendix), together with recommendations for future research and needs assessment.

2. Epidemiology

- In 2009, 28,285 people were living with a diagnosed HIV infection in London.
- South East London Cluster had the largest proportion of residents accessing HIV-related care (28%). North West London – 22%; North Central London – 18%; Inner North East London – 13%; South West London – 12%; Outer North East London 7%.
- An estimated 26% of Londoners infected with HIV remain undiagnosed.
- The population of HIV diagnosed patients is increasing but the annual rate of increase is slowing. In 2009, there was a 5% increase (1,436) from 2008. This is the lowest proportional increase in the past nine years.
- 26/31 PCTs are above the prevalence threshold of universal testing of adults when entering into primary or secondary care.
- In 2010, there were 2,841 new diagnoses of HIV in London clinics. This is similar to the 2009 total of 2,851.
- Although numbers of new HIV diagnoses have been in decline since the peak reached in 2003 (3,251), the number for 2010 was 21% higher than the number reported for 2000 (2,352).
- Black Africans make up 5.5% of the London population, but account for 32% of those newly diagnosed with HIV and 35% of the population currently diagnosed and accessing care in London.
- Black African females outnumber black African males in terms of those diagnosed with HIV and accessing care, and new HIV diagnoses; contrary to all other ethnic groups.
- Since peaking in 2003, the number of black Africans newly diagnosed with HIV has been falling. Also, the rate of increase in those diagnosed and accessing care has been slowing for eight out of the past nine years to 2009.
- Areas where there are high numbers of black Africans diagnosed with HIV and accessing care include Hackney, Lambeth, Newham, and Southwark; as well as some areas in Greenwich, Enfield and Croydon.

- MSM also make up the largest risk group of those diagnosed and accessing care in London (13,009; 46%). The annual increase has been fluctuating at around 600 to 800 patients per year.
- There is still little information regarding a denominator population of MSM in London.
- There is a concentration of those MSM diagnosed with HIV around the centre of London spreading outwards almost symmetrically into the boroughs of Westminster, Camden, Islington, Hackney, Tower Hamlets, Southwark and Lambeth.
- MSM make up the largest risk group within those newly diagnosed with HIV (49% in 2010). Unlike other the overall trend, the 2010 figure is the highest proportion in the last 11 years.
- Very late diagnosis levels for MSM have fluctuated between the high teens and low twenties of percent between 2004 and 2009.
- At the beginning of the PLHPP, suggested levels of PCT financial contributions were set out according to the respective diagnosed populations at the time.

3. Evidence

The evidence has been summarised by risk groups currently targeted: 1. MSM; 2. Black Africans and 3. PLWHIV. The summary evidence statements are mainly derived from the review of systematic reviews evidence; where there is a paucity of evidence the grey literature has also been discussed. Each section has been summarised in the following way.

3.1. Interventions that specifically target MSM

Group Interventions that specifically target MSM	
Evidence Statement	➢ **There is evidence to support Group Interventions targeted at MSM** ➢ **Behavioural interventions administered at group level appear to reduce risky sexual behaviour associated with HIV/ STI transmission.** ➢ **Multiple intervention features impact efficacy of group interventions.**
Evidence supports	- Group-level work - Multi-component group-level work - Multiple sessions of group-level work - Cost effectiveness of group-level interventions - Greater effectiveness of group interventions that include Risk Reduction Education - Greater effectiveness of group interventions that include Negotiation/ Communication Skills - Greater effectiveness of group interventions that include Personal Skills (eg keeping condoms available, behavioural self-management) - Greater effectiveness of group interventions that include Peer Support - Greater effectiveness of group interventions that encourage Self Efficacy - Greater effectiveness of small group interventions that focus on loses rather than gains - Greater effectiveness of group interventions that include MSM minority populations - Group behavioural interventions reduce risky sexual behaviour associated with HIV/ STI transmission. - Increased condom use (2 MSM studies: OR=1.64 range 1.27-1.13 and OR=1.61 range 1.16-2.22) - Decreased unprotected sex (4 meta-analysis, OR range= .65–.78)
Comment	Group Interventions currently being Commissioned are supported by the evidence

Education via Media targeted at MSM	
Evidence Statement	➢ **Only tentative review level evidence to support education via Media among MSM. The evidence that does exist on campaigns using media targeted at MSM is mixed and not of high quality.**
Evidence supports:	– Evidence on campaigns using specialist media targeted at MSM is mixed and not of high quality. – Tentative review level evidence to support the effectiveness of mass media interventions in influencing the uptake of HIV VCT in MSM (Downing et al) – There is some evidence that web-based campaigns may be a promising way of increasing HIV testing in high-risk MSM. (NICE) – Internet is a potentially effective tool as it is cost effective and can be used to reach wider and less accessible populations (Dufour et al 2000, Mustanski 2001). – Evidence to support community-level interventions involving popular opinion leaders. (Downing et al) Popular people who endorse innovations (eg, HIV risk reduction) can help to refine behavioral norms and standards. (Herbst et al)
Comment	Education via media targeted at MSM has low evidence ***There is paucity of evidence to support MSM specific small media and magazines currently being commissioned. There is tentative review level evidence to support the effectiveness of mass media interventions.*** ***Only limited evidence to support website/internet based media however with newer technologies there is inevitably a lag time for quality evidence studies to be included in systematic reviews.*** ***Education via the Media Interventions currently commissioned are not supported by the evidence.***

Counselling (including CBT & Mentoring) targeted at MSM	
Evidence Statement	➢ **There is evidence to support Counselling & CBT Interventions targeted at MSM**
Evidence supports:	– Small-group & individual-level interventions that address perception of risk & losses ('unsafe sex puts you at risk') rather than gains ('safer sex protects you') (Johnson et al.) – Review-level evidence to suggest HIV prevention interventions can be cost-effective and cost-saving when aimed at MSM (Downing et al). – Effectiveness of cognitive behavioural individual-level interventions; cognitive-behavioural group work focusing upon risk education (Downing et al)
Comment	Counselling & CBT Interventions currently being Commissioned are supported by the evidence ❖ There is a paucity of evidence to support mentoring for MSM ❖ No evidence was identified in the systematic reviews to support MSM targeted telephone support
	Interventions addressing risk education/ losses rather than gains.

Condom Distribution targeted at MSM	
Evidence Statement	➢ **There is Insufficient review-level evidence to support or reject condom promotion and distribution approaches targeted at MSM**
Evidence supports:	– There is a paucity of systematic review evidence to support Condom Distribution targeted at MSM.
Comment	There is a paucity of systematic review evidence to support Condom Distribution specifically among MSM in a UK setting ❖ The Condom Distribution Interventions targeted at MSM currently being Commissioned are supported by the grey literature evidence
	Grey evidence indicates that condom distribution plays an important role in sexual health improvement but further evaluations of existing schemes targeting MSM are required in UK. Consider factors associated with more successful condom distribution programmes aimed at general population: link to promotional activities, offer condoms free, link to broader skills training/education programmes, connected with community mobilisation and parents when targeting young people.

What basis is there to prioritise particular interventions targeted at MSM within the programme?

MSM Summary:
MSM Review-level Evidence Supports Interventions that include:
-Individual, Group & Community level setting
-Counselling
-CBT
-Risk reduction education
-Interpersonal skills training (Negotiation/communication skills)
-Personal skills
-Peer support
-Self efficacy
-Interventions targeting minority MSM groups
-Interventions focusing on younger populations
-Group and Community level interventions found to be cost effective
-Importance of adapting behavioural interventions to needs & resources of community
-Theory based interventions
-Multiple delivery methods
-Multiple sessions

There is a Lack of MSM Review-level Evidence to Support:
-Education via Media
-Telephone Support
-Mentoring
-Condom Distribution

Two areas currently not being commissioned for MSM where there is a good evidence base of effectiveness:
-Individual & Community level interventions
-Interventions targeting MSM minority groups: HIV positive MSM, Young MSM, (YMSM), MSM who do not openly identify as gay and black MSM

Evidence Based Recommendations:
-**Continue to commission group-level interventions for MSM that include evidence based intervention features (listed above).**
-Continue to commission counselling and CBT interventions.
-Potential for diversification of intervention delivery methods to include individual and community level interventions as well as the group level intervention delivery.
-Expansion of services currently commissioned to include focus on MSM minority groups such as HIV positive MSM, Young MSM (YMSM), MSM who do not openly identify as gay and black MSM.
-Consider whether interventions currently commissioned that are not supported by review level evidence impact positively on local MSM populations and should be re-commissioned.

NICE Guidance – recommendations to increase the uptake of HIV testing among men who have sex with men	
Evidence Statement	➢ ***NICE Guidance -Increasing the uptake of HIV testing among men who have sex with men*** ***http://www.nice.org.uk/guidance/PH34***
NICE Evidence supports the following recommendations	- Planning services – assessing local need and developing a strategy - Promoting HIV testing among men who have sex with men - Specialist sexual health services: offering and recommending an HIV test - Primary and secondary care: offering and recommending an HIV test - Outreach: providing rapid point-of-care tests - Repeat testing - HIV referral pathways
Level of evidence	*"The absence of recommendations on any particular activities in this NICE guidance is a result of a lack of evidence that could be included in the evidence reviews. It does not reflect a judgement on the effectiveness or cost effectiveness of such interventions."NICE*
Comment	***The Guidance is designed for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, increasing the uptake of HIV testing among men who have sex with men. This includes those working in local authorities and the wider public, private, voluntary and community sectors. It will also be of interest to members of the public, in particular men who have sex with men.***

3.2. Interventions that specifically target African communities

Black African and black Caribbean communities are amongst those who are at ‘highest risk’ of STIs.

In England, of all other ethnic groups, black Africans are at greatest risk of HIV, the majority of whom will have acquired their infection heterosexually, in Africa.

Mass Media	
Evidence Statement	➢ **There is a paucity of evidence to support Mass Media Interventions targeted at African Communities**
Evidence supports:	- Paucity of review level evidence to support mass media targeted at African communities.
Comment	Mass Media Interventions currently being Commissioned are not supported by the evidence With newer technologies and there is inevitable a lag time for quality evidence studies to be include in systematic reviews.
	Consider carefully whether mass media interventions are the most effective way of increasing knowledge about HIV and the uptake of HIV testing.

Condom Distribution	
Evidence Statement	➢ **There is limited evidence to support Condom Distribution Interventions targeted at African Communities**
Evidence supports:	- Paucity of review level evidence to support condom distribution targeted at African communities.
Comment	The Condom Distribution Interventions currently being Commissioned are supported by evidence relating to general populations
	Consider carefully how Condom Distribution interventions are implemented in BME groups.

Small Media Interventions	
Evidence Statement	➢ **No systematic reviews described website interventions, Banner or Radio advertisements targeted at African groups** ➢ **There is no evidence in the systematic reviews identified to support Small Media Interventions targeted at African Communities**
Evidence supports:	- Paucity of review level evidence to support small media targeted at African communities.
Comment	The Small Media Interventions currently being Commissioned are not supported by the evidence ❖ With newer technologies there is inevitable a lag time for quality evidence studies to included in systematic reviews. ***Consider carefully whether small media interventions are appropriately designed and targeted at BME in London. Some Websites are designed to promote effective HIV Interventions and programs see the Website described below.***

Knowledge – Health Promotion Interventions	
Evidence Statement	➢ **Evidence supports Health Promotion HIV risk reduction interventions targeted at African Communities.** ➢ **Interventions that specifically target African females using gender- or culture-specific materials and female deliverers are recommended** ➢ **Specific features were identified which frequently occurred within successful interventions**
Evidence supports:	- There is evidence to support Health Promotion HIV risk reduction interventions targeted at African Communities**.** - Interventions that are designed specifically targeted at African females using gender- or culture-specific materials and female deliverers are recommended - Across all reviews, intervention features most frequently occurring within successful interventions targeting people of black ethnic origin were: information/ knowledge, skills building (general) and interpersonal skills training, testing and use of magazines to inform.
Comment	The Knowledge / Health Promotion Interventions currently being Commissioned are supported by the limited evidence that exists ❖ Culture specific materials to support the health promotion interventions are recommended ***Consider carefully whether given the cultural differences to the UK's African populations (compared to US) some findings may not be transferable to the UK's African population.***

What basis there is to prioritise particular interventions within the programme?	
Evidence Statement	➢ **NICE has recently published detailed guidance to increase the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England.**
Evidence supports:	- See NICE summary
Comment	*Commissioners should consider prioritising interventions to increase the uptake of HIV testing among black African communities living in England*

Review of the effectiveness of behavioural interventions with Africans living in the UK and Europe	
Evidence Statement	➢ **There is limited local literature to support Health Promotion HIV risk reduction interventions targeted at African Communities**
Evidence supports:	A review commissioned by Local authorities in UK was published in 2008 by Prost et al., which focused on evidence from the UK and Europe. This included a review of the effectiveness of behavioural interventions with Africans living in the UK and Europe. The authors were unable to draw any evidence points from the available literature due to methodological limitations. Although intervention outcomes were not addressed the following recommendations were made. - Comprehensive preparatory research, community involvement, and the use of findings from sexual health 'needs and attitudes' surveys can help guide the development, piloting, and evaluation of interventions to ensure their sustainability. - Involving community-based organisations and informal African networks remains the key to designing effective interventions with Africans living with HIV.
Comment	***The learning that did emerge from the broader review of the grey literature could be useful in directing future work: voluntary counselling and testing (VCT) remains the most effective method of reducing high levels of undiagnosed HIV infection and promotion should continue; interventions must be culturally acceptable; HIV prevention initiatives should focus on young people, heterosexual African men and African MSM; secondary prevention programmes must work towards understanding and meeting the psychosocial needs of African parents and children; primary care practitioners must be involved in distribution of HIV prevention materials and carrying out HIV testing; given that poverty remains the overriding issue of Africans living with HIV in Europe, interventions that encourage entry into the workforce are a priority.***

If there is a clear and sound rationale for the prevention activity commissioned at a Pan London rather than at a more local level?	
Evidence Statement	➢ **Targeting interventions at different black communities that include culture specific materials to support the health promotion interventions are recommended by the review.**
Evidence supports:	- Targeting interventions at different black communities that include culture specific materials to support the health promotion interventions
Comment	Targeting interventions at different black communities that include culture specific materials to support the health promotion interventions are recommended by the review. ❖ The debate for commissioners will be whether these materials will be commissioned to be developed locally or developed for black groups from different ethnic origins on a Pan London basis

African Communities Summary

Review-level Evidence Supports Interventions for African Communities that:
-Specifically targeted African American females, MSM, HIV positives
-Used gender- or culture-specific materials
-Used female deliverers for female groups
-Include Knowledge / Health Promotion for female groups
-Addressed empowerment issues for female groups
-Provided skills training in condom use and negotiation of safer sex for female groups
-Used role-playing to teach negotiation skills for female groups
-Provided intensive content across multiple sessions
-Provided intensive interpersonal skills training
-HIV Testing

Grey Literature Supports:
-Voluntary counselling and testing (VCT)
-Focus on young people, heterosexual African men and African MSM
-Secondary prevention programmes meet psychosocial needs of African parents & children
-Primary care practitioners distributing HIV prevention materials & carrying out HIV Testing
-Interventions that encourage entry into the workforce (to combat poverty)

There is a Lack of Review-level Evidence to Support Interventions for African Communities:
-Mass Media
-Small Media
-Condom Distribution

Evidence Based Recommendations:
-**Continue to commission Knowledge- Health Promotion Interventions, include features supported by evidence as listed above**
-Continue to commission HIV Testing (NICE guidance)
-Expansion of services currently commissioned to include focus on BME minority groups
-Consider whether interventions currently commissioned that are not supported by review level evidence impact positively on local BME populations and should be re-commissioned

4. Interventions for people living with HIV

Interventions currently commissioned for people living with HIV include:

- Information/ knowledge
- Small media
- Fact sheets
- Patient information booklets, newsletter
- Information events
- HIV treatments directory
- Website
- Health trainers

Evidence Statement	➢ **There is tentative review-level evidence to support the effectiveness of behavioural interventions in increasing condom use and decreasing unprotected sex and STI acquisition** ➢ **There is tentative review-level evidence to support partner notification in influencing the sexual risk behaviours of people living with HIV**
Evidence supports:	- Behavioural intervention increase condom use and decreasing unprotected sex and STI acquisition - Partner notification influences the sexual risk behaviours of people living with HIV
Comment	***Commissioners should consider prioritising interventions that include behavioural interventions and partner notification.*** ***Involving community-based organisations and informal African networks remains the key to designing effective interventions for Africans living with HIV.***

Interventions are needed to address high rates of HIV among injecting drug users and to deal with the links between injection and sale of sex. More information is available in the full report.

5. Relevant findings associated with successful HIV interventions.

Finally it is important to recognise that there are some overarching messages that are relevant to all population groups in terms of characteristics associated with successful interventions. These are well summarised by Fullerton and Burtney in a review of reviews which include:

- A clear and articulated theoretical approach underpinning interventions (although there is some evidence that different theory bases are required for different population groups)
- Targeted and tailored interventions in terms of age, gender, ethnicity, culture and social
- Surroundings needs assessment and formative research to inform programme development interventions with clear messages and emphasis on risk reduction
- Integration of skills training involvement of peers and community leaders where appropriate
- Sufficient opportunities to practise skills or absorb information on offer
- Interventions that are multi-component (e.g. Skills training, role play, information sessions etc)
- Training and support for those delivering programmes.
- Further evaluation and replication research is required to assess the transferability and translation of evidence-based programmes from the USA to the UK context.

6. Limitations of the evidence review

As with any piece of rapid research, there are limitations to this draft review. It aims to present an overview of the key messages emerging from national and international review-level evidence on the effectiveness of sexual health improvement interventions. Given the scope of this task and the short timescales, the most appropriate research approach was decided with the lead of the work stream to undertake a review of systematic reviews.

While this approach permits a rapid assessment of the current available evidence on a broad range of topics, its reliance on secondary analysis of material has limitations.
Some of the evidence has been summarised, which means that it is not always possible to present details on the effectiveness of the interventions or to draw out clear practice messages without going back to the primary studies.

7. Review of Cost Effectiveness

7.1. Results of literature search

In total ten reports identified in the search of publications and grey literature met the criteria for consideration. Of these, four studies met the inclusion criteria for review and reporting.

These concerned the following types of interventions:

- Peer HIV test recruitment
- Extended health settings for HIV testing
- School education programmes
- Community-based behaviour change & risk reduction

Two of the studies are UK based and two are from the USA. The applicability of the latter to the UK setting is uncertain.

The findings are reported below.

7.2. Findings

A NICE review of interventions to increase HIV testing in men who have sex with men1 identified just one relevant study. The publication (Golden et al. 2006) reported a costing study of an observational evaluation of a peer HIV test recruitment campaign in Washington state, USA, 2002 – 2004, for men who have sex with men. Both recruiters and recruitees were of low socio-economic status, and included a high proportion of minority ethnic individuals and people with a history of injecting drug use.

Overall, 438 peers were recruited, and 22 (5%) were HIV positive, 18 of whom received their test results. The total cost of the programme was US$103,752. However, excluding the costs associated with other STIs, the HIV-associated costs alone were US$59,142. The total cost per new case of HIV infection identified was US$4929, and per person receiving a positive test result, US$5377. The authors considered these costs to compare favourably with those observed for bathhouse testing programmes and for programmes working with community-based organisations to promote testing, in the USA.

A UK HTA systematic review and economic evaluation reported on the effectiveness and cost effectiveness of school-based skills building behavioural interventions to adopt and maintain safer sexual behaviour to prevent STIs. The evidence demonstrated that the intervention can bring about improvements in knowledge and increased self-efficacy, but no significant influence on sexual risk-taking behaviour or infection rates was found. Due to the extent of uncertainty over the effect of the intervention on behaviour, the economic evaluation was only able to deliver 'illustrative' results. The costs of teacher-led and peer-led interventions, were £4.30 and £15 per pupil, respectively. Teacher-led interventions were more cost effective due to the less frequent need for training. The incremental cost effectiveness

of the teacher-led and peer-led interventions was £20,223 and £80,782 per quality adjusted life year again, respectively.

A review of studies examined the cost effectiveness of community-based behaviour change and risk reduction interventions (i.e. sexual & injecting drug use). The interventions considered included peer advocacy programs to change risk taking norms in the community, outreach to high risk individuals (e.g. condom, bleach, & syringe distribution programs), and media programs. The review included peer reviewed publications before 1999. Twelve studies from the USA were reviewed, five concerned sexual risks and seven injecting drug use. None concerned community-based media interventions. The authors summarised their findings as follows (P17):

A conference poster presentation by UK HPA staff presents the interim results of an evaluation of a collection of pilot projects in UK cities examining the expansion of HIV testing non-specialist (i.e. non GUM) health care settings. Despite not including any formal health economic analysis the authors make the following relevant comment:

The majority of pilot projects exceeded the American cost effectiveness threshold of one new diagnosis per 1000 tests. However, further economic analysis is required to establish a UK threshold.

7.3. Conclusion

A very limited evidence base exists regarding the cost effectiveness of interventions to prevent HIV. The fact that two recent high quality systematic reviews on key relevant topics found such little work eligible for review confirms this finding. Also, the uncertainty surrounding the economic findings of the school based education review was clearly stated by the authors. It is also important to acknowledge the uncertainties regarding the UK applicability of studies undertaken in the USA.

Bearing these comments in mind, the following conclusions can be drawn:

1. One US study (Golden et al. 2006) provides limited quality evidence that peer HIV testing recruitment in men who have sex with men is relatively cost effective compared to other methods of encouraging HIV testing.

2. A UK systematic review and economic model provides tentative evidence that teacher-led school-based sexual behaviour interventions are cost effective compared to conventional cost per QALY thresholds.

3. A review of US studies presents moderate quality evidence that a range of community-based initiatives (i.e. both sexual behaviour change & injecting drug use risk reduction) are cost saving.

4. The interim findings of a UK evaluation suggested that extending HIV testing to non-specialist health care settings was cost effective according to US thresholds.

8. Local evaluation

Local evaluation of the PLHPP has been conducted. It concluded that the programme failed and summarised the reasons for this under the following headings:

- Lack of a strategic change management process
- Governance and accountability
- Service Level Agreements
- Performance monitoring
- Recovery planning
- Programme communications and stakeholder engagement
- Inter-provider synergies and care pathways
- Marketing and distribution

It is for the Pan London Commissioners to determine the extent to which commissioning and programme management have compromised the PLHPP. Whilst concerns in these areas clearly merit attention they do not relate to the effectiveness of the interventions that make up the PLHPP per se.

An earlier evaluation progress report included an assessment of the theories of action offered by providers to explain the mechanisms by which they expected to achieve desired outcomes.

Clarification of causative mechanisms is a useful step in informing evaluation and an assessment of a provider's ability to offer a convincing theory of action provides an indication about their familiarity with, and use of, theory in informing their practice. Nevertheless, the absence of a clear theory of action amongst providers does not amount to evidence that their interventions are ineffective.

Specific concerns were raised about what informed media resources design, distribution of resources and the targeting of interventions all of which are legitimate questions for providers that would be useful to clarify in commissioning contracts.

The eighteen month summative evaluation also provided summaries of activity conducted against targets (see appendix 1) although it noted that the targets were contested. Nevertheless, it is clear though that there was significant under performance across a number of the interventions within the programme. Some Q1 monitoring returns for the 2011/12 FY have been submitted and present a mixed picture of delivery. Other providers are yet to submit their Q1 returns.
Attempts have been made to determine on what basis the targets were set and the extent to which they can be regarded as appropriate with reference to published evidence, comparison with similar services, cost calculation or

historical spend. No rationale has been identified however and the evaluators have indicated that they understand them to have been derived from negotiations between providers and commissioners. The current targets for providers in the 2011/12 FY are reflected in the 'current programme' section of this document above. Again the basis for these targets is unknown. One programme has no agreed activity target as yet.

Further work to extract any further learning from the evaluation that might contribute to the evidence base of effective HIV prevention proved challenging because it has not been possible to differentiate any judgements about the interventions themselves from those concerned with programme management.

9. Engagement

The engagement process invited stakeholders to contribute their thinking about what interventions should be commissioned, whether on a pan London or local level, and how we should think about their effectiveness. Stakeholders were also invited to send in reports to be considered as part of the evidence review work stream.

9.1. Key messages

Integrated Interventions

- Commission a range of interventions linked together through clear care pathways, and are closely linked in with clinical interventions.
- Ensure a whole systems approach to commissioning and a partnership delivery approach.
- Link HIV support services with prevention services.
- Local and pan London services and clinical services need to be linked to support access.
- Critical to commission distribution schemes for condoms; media resources; and for them to be coordinated with outreach services.
- Information to the public should be made available about all services however they are commissioned; currently information is promoted separately about local services; pan London services; clinical services. More useful for the public to know about all services they can access, not the funding streams.

Frameworks and Evidence base

- Base interventions on existing frameworks: Making it Count 4 Framework and the Knowledge, Will and Power Framework; NICE guidance.
- Only commission evidence based interventions.

Evaluation

- Create a collectively owned approach to monitoring and evaluation, and allow for planning and budgeting of data tracking systems in the tendering process.

Peer led interventions

- Peer led interventions are better able to give culturally competent and grounded messages both to African communities and to MSM.

Scale of intervention

- Maintain local and pan London prevention services; both are needed. Everything can be commissioned at a pan London level with local delivery partners.

Targeted interventions

- There is a need for culturally specific African interventions.
- Commissioning intentions for gay men's interventions and for African interventions should be different to reflect the different needs.
- Young people need specific prevention messages; SRE education should be improved; groups for young gay men; different messages for young 2nd generation African communities who have different cultural perspectives to their parents.

Testing

- Stigma still an issue which creates barriers to testing and treatment.
- Maintain structural/biomedical interventions including testing in community and primary care settings, active recall for regular testing' prompt diagnosis at clinics; home testing kits for partners; open access to GUMs; needle exchange programmes; testing everyone at GUM clinics and antenatal clinics; PEP; clinical trials for PReP; treatment; condom distribution; incentives to increase testing in primary care.
- Focus community interventions on implementation failures ie getting the right people (people who take risks) to test; reducing late diagnosis through interventions focused on the barriers to testing; use non clinical workers to increase trust.

Population Interventions

- Commission population interventions, including media (print, electronic and social), outreach and peer led brief interventions which are culturally specific, use positive speakers to communicate messages.

Interpersonal Interventions

- Commission interpersonal interventions, including behaviour change interventions e.g. group work, counselling, mentoring, health trainers, workshops; work with faith leaders/community leaders; both brief and longer term or intensive; peer support or use peers to deliver the interventions.
- Brief interventions to highlight and assess risk taking behaviour.
- Intensive interventions to assess motivation for and support behaviour change of risk taking behaviour.
- Workshops/group work to build skills and reinforce norm development by peers.

Working with faith leaders

- Faith leaders to challenge attitudes and communicate messages about testing and treatment and reduce stigma.

Omissions from the needs assessment

The following areas were not covered by this needs assessment:

- HIV prevention needs in prisons.
- The role sex on premises venues can play in HIV prevention, including the need for more condoms to be made available at venues where sex is known to take place.
- Female sex workers who are HIV+, crack users and IVDUs.
- Treatment information needs of PLHIV.

Divergent views

There were a number of areas with less consensus, mentioned only by one stakeholder, or with divergent views:

- Whether interpersonal services should be commissioned pan London or locally.
- That we should not commission everything on a pan London basis as the national, pan London and local services all reach different people because of the ways they are commissioned and the broadest access would be maintained by not integrating.
- People should be able to access services outside their borough to protect confidentiality.
- Value of local organisations and local knowledge was stressed in particular for interpersonal African organisations; evidence was also provided of pan London access by a gay men’s and a family organisation where services are provided centrally and used by people from all boroughs.

- Capacity development of smaller organisations does need support and needs the involvement of local commissioners.

10. Recommendations for further work

10.1. Evidence review

A number of areas have been highlighted in the needs assessment and evidence review that would benefit from further research in order to best inform the evidence base for HIV prevention intervention in London. It is acknowledged that some of this research would need to take place at a national or international level, while some research could be undertaken in local communities or across London.

Treatment as Prevention - it is recognised that there have been a number of significant publications recently concerned with treatment as prevention and increasing advocacy of a fundamental reorientation of HIV prevention towards this model. As yet however, there is little review level evidence of treatment as prevention and significant uncertainty remains as to the costs and benefits of such a fundamental reorientation. The evidence review conducted to inform the needs assessment has been restricted to reviews and grey literature from local evaluation and the engagement exercise so it has not considered treatment as prevention in detail.

Africans groups living in UK - there is a paucity of evidence for HIV prevention interventions specifically targeting African women, young Africans, African IDU, African MSM, African PLWHIV and stigmatisation. Further research in local communities could clarify whether materials and interventions designed and developed for some communities are generalisable across London, e.g. if interventions for one Somali community in London are effective for other Somali communities.

In addition, research to compare cultural differences between US African communities with UK counterparts would be useful to identify more precisely where the evidence is transferable.

MSM - MSM subgroups where there is less evidence for interventions include YMSM and MSM IDU. Further research targeting these groups would be beneficial.

New technologies for communication and prevention interventions - as these technologies are relatively new very little review level evidence exists. There is some limited evidence that the internet is a useful tool due to its' low cost and ability to reach a wider and less accessible population. Further research at a London and UK level is required to assess the effectiveness of these new technological interventions, in particular websites, text messaging/PDA communications, social marketing /networking, and general mass media interventions.

Behaviour change indicators - identifying indicators for monitoring behaviour change that are relevant to the stakeholder group (local communities or Pan London), which are easy to collect and audit.

Health economics analysis - identify where a health economics analysis could compare costs and activity of local intervention programmes with other similar London-based or UK prevention intervention programmes.

10.2. Service mapping

A service mapping was not completed as part of the needs assessment. Future work should include service mapping of all HIV prevention services commissioned on a local, regional and pan London basis, and also indicate what is commissioned on a national basis. This is needed to inform the appropriate level of commissioning for effectiveness, access and value for money.

In addition mapping needs to be done of HIV testing, including testing in hospital settings, community settings and primary care; POCT; and testing eg in termination of pregnancies, hepatitis clinics, oncology clinics, A&E, prisons. This is needed to assess what prevention interventions are needed to signpost into testing, reduce late diagnosis and link together prevention and testing services.

10.3. Epidemiological analysis

Further analysis of MSM denominator – Examine different methodologies for estimating MSM population in London.

A more suitable denominator will allow for more accurate prevalence and incidence to be calculated. More accurate rates can help with service as budgetary decision making for both treatment and prevention. Also, this can allow for better comparison with other risk groups.

Age profile – Analysis of incidence and prevalence by age group to inform targeting of intervention.

This can show proper progression through age groups, and look at new cases along with age progression. This can help to understand/highlight some reasons behind the differences. This could tie with the population segmentation work also recommended.

Acquisition of infection (place) – Look at the proportions in the different risk groups of those acquiring HIV in the UK or abroad, especially in Africa.

The balance between acquiring HIV in the UK or abroad is important in helping to focus HIV prevention programmes more effectively.

Co-infection – Examine the wider context with regard to co-infection with other STIs and certain diseases such as hepatitis and TB.

HIV does not stand alone, but is often part of a wider problem connected to other diseases. Hence, the epidemiology should reflect this connectedness and look at co-infection prevalence and incidence.

Population segmentation – Examine the potential to use behavioural population segmentation for more sensitive targeting of intervention.

One of the issues with the current analysis has been that the current risk groups do not adequately reflect the picture of HIV in London, and in turn, services cannot be sufficiently targeted. To be in a position where commissioners are able to better target services, we need a more detailed picture about what works with whom and where they are. This will also allow for analysis of overlap (if any) between the MSM and black African risk groups.

11. Appendix 1: Reviews identified by the evidence literature search

No	Review Title	Citation	Author(s)
1.	HIV in young men who have sex with men: A review of epidemiology, risk and protective factors, and interventions	Journal of Sex Research, March 2011, vol./is. 48/2-3(218-253), 0022-4499;1559-8519 (Mar 2011)	Mustanski, Brian S, Newcomb, Michael E, Du Bois, Steve N, Garcia, Steve C, Grov, Christian
2.	Interventions to reduce sexual risk for human immunodeficiency virus in adolescents: a meta-analysis of trials, 1985-2008.	Archives of Pediatrics & Adolescent Medicine, January 2011, vol./is. 165/1(77-84), 1072-4710;1538-3628 (2011 Jan)	Johnson BT, Scott-Sheldon LA, Huedo-Medina TB, Carey MP
3.	Behavioural interventions to reduce HIV risk: what works?	AIDS, October 2010, vol./is. 24 Suppl 4/(S4-14), 0269-9370;1473-5571 (2010 Oct)	Ross DA
4.	Sexual risk reduction interventions for patients attending sexually transmitted disease clinics in the United States: a meta-analytic review, 1986 to early 2009.	Annals of Behavioral Medicine, October 2010, vol./is. 40/2(191-204), 0883-6612;1532-4796 (2010 Oct)	Scott-Sheldon LA, Fielder RL, Carey MP
5.	Cognitive behavioral theories used to explain injection risk behavior among injection drug users: a review and suggestions for the integration of cognitive and environmental models.	Education & Behavior, August 2010, vol./is. 37/4(504-32), 1090-1981;1552-6127 (2010 Aug)	Wagner KD, Unger JB, Bluthenthal RN, Andreeva VA, Pentz MA
6.	Amphetamine-group substances and HIV.	Lancet, August 2010, vol./is. 376/9739(458-74), 0140-6736;1474-547X (2010 Aug 7)	Colfax G, Santos GM, Chu P, Vittinghoff E, Pluddemann A, Kumar S, Hart C
7.	Interventions for young people in Australia to reduce HIV and sexually transmissible infections: a systematic review.	Sexual Health, June 2010, vol./is. 7/2(107-28), 1448-5028;1448-5028 (2010 Jun)	Kang M, Skinner R, Usherwood T
8.	Economic modelling of HIV treatments.	Current Opinion in HIV & AIDS, May 2010, vol./is. 5/3(242-8), 1746-630X;1746-6318 (2010 May)	Simpson KN
9.	Weighing the gold in the gold standard: challenges in HIV prevention research.	AIDS, March 2010, vol./is. 24/5(621-35), 0269-9370;1473-5571 (2010 Mar 13)	Padian NS, McCoy SI, Balkus JE, Wasserheit JN
10.	HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage.	Lancet, March 2010, vol./is. 375/9719(1014-28), 0140-6736;1474-547X (2010 Mar 20)	Mathers BM, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A, Strathdee SA, 2009 Reference Group to the UN on HIV and Injecting Drug Use
11.	The effectiveness and cost-effectiveness of behavioural interventions for the prevention of sexually transmitted infections in young people aged 13-19: a systematic review and economic evaluation.	Health Technology Assessment (Winchester, England), February 2010, vol./is. 14/7(1-206, iii-iv), 1366-5278;1366-5278 (2010 Feb)	Shepherd J, Kavanagh J, Picot J, Cooper K, Harden A, Barnett-Page E, Jones J, Clegg A, Hartwell D, Frampton GK, Price A
12.	Systematic review of interventions to prevent the spread of sexually transmitted infections, including HIV, among young people in Europe.	Croatian Medical Journal, February 2010, vol./is. 51/1(74-84), 0353-9504;1332-8166 (2010 Feb)	Lazarus JV, Sihvonen-Riemenschneider H, Laukamm-Josten U, Wong F, Liljestrand J
13.	Couples-focused behavioral interventions for prevention of HIV: systematic review of the state of evidence.	AIDS & Behavior, February 2010, vol./is. 14/1(1-10), 1090-7165;1573-3254 (2010 Feb)	Burton J, Darbes LA, Operario D
14.	Does opioid substitution treatment in prisons reduce injecting-related HIV risk behaviours? A systematic review.	Addiction, February 2010, vol./is. 105/2(216-223), 0965-2140;1360-0443 (Feb 2010)	Larney, Sarah
15.	Linking sexual and reproductive health and HIV interventions: a systematic review.	Journal of the International AIDS Society, 2010, vol./is. 13/(26), 1758-2652;1758-2652 (2010)	Kennedy CE, Spaulding AB, Brickley DB, Almers

No	Review Title	Citation	Author(s)
			L, Mirjahangir J, Packel L, Kennedy GE, Mbizvo M, Collins L, Osborne K
16.	A systematic review of the quality of trials evaluating biomedical HIV prevention interventions shows that many lack power.	HIV Clinical Trials, November 2009, vol./is. 10/6(413-31), 1528-4336;1528-4336 (2009 Nov-Dec)	Graham SM, Shah PS, Aesch ZC, Beyene J, Bayoumi AM
17.	The efficacy of HIV/STI behavioral interventions for African American females in the United States: a meta-analysis.	American Journal of Public Health, November 2009, vol./is. 99/11(2069-78), 0090-0036;1541-0048 (2009 Nov)	Crepaz N, Marshall KJ, Aupont LW, Jacobs ED, Mizuno Y, Kay LS, Jones P, McCree DH, O'Leary A
18.	Behavioral interventions for African Americans to reduce sexual risk of HIV: a meta-analysis of randomized controlled trials.	Journal of Acquired Immune Deficiency Syndromes: JAIDS, August 2009, vol./is. 51/4(492-501), 1525-4135;1525-4135 (2009 Aug 1)	Johnson BT, Scott-Sheldon LA, Smoak ND, Lacroix JM, Anderson JR, Carey MP
19.	Secondary prevention of HIV infection: the current state of prevention for positives.	Current Opinion in HIV & AIDS, July 2009, vol./is. 4/4(279-87), 1746-630X;1746-6318 (2009 Jul)	Fisher JD, Smith L
20.	A 10-year systematic review of HIV/AIDS mass communication campaigns: Have we made progress?.	Journal of Health Communication, January 2009, vol./is. 14/1(15-42), 1081-0730;1081-0730 (2009 Jan-Feb)	Noar SM, Palmgreen P, Chabot M, Dobransky N, Zimmerman RS
21.	Efficacy of computer technology-based HIV prevention interventions: a meta-analysis.	AIDS, January 2009, vol./is. 23/1(107-15), 0269-9370;1473-5571 (2009 Jan 2)	Noar SM, Black HG, Pierce LB
22.	The effectiveness of behavioural and psychosocial HIV/STI prevention interventions for MSM in Europe: A systematic review.	Euro Surveillance: Bulletin Europeen sur les Maladies Transmissibles = European Communicable Disease Bulletin, 2009, vol./is. 14/48, 1025-496X;1560-7917 (2009)	Berg R
23.	Behavioral counseling to prevent sexually transmitted infections: a systematic review for the U.S. Preventive Services Task Force.	Annals of Internal Medicine, October 2008, vol./is. 149/7(497-508, W96-9), 0003-4819;1539-3704 (2008 Oct 7)	Lin JS, Whitlock E, O'Connor E, Bauer V
24.	Behavioral interventions to reduce HIV-related sexual risk behavior: review and synthesis of meta-analytic evidence.	AIDS & Behavior, May 2008, vol./is. 12/3(335-53), 1090-7165;1090-7165 (2008 May)	Noar SM
25.	Social, behavioural, and intervention research among people of Sub-Saharan African origin living with HIV in the UK and Europe: literature review and recommendations for intervention.	AIDS & Behavior, March 2008, vol./is. 12/2(170-94), 1090-7165;1090-7165 (2008 Mar)	Prost A, Elford J, Imrie J, Petticrew M, Hart GJ
26.	Behavioral interventions to reduce risk for sexual transmission of HIV among men who have sex with men.	Cochrane Database of Systematic Reviews, 2008, vol./is. /3(CD001230), 1361-6137;1469-493X (2008)	Johnson WD, Diaz RM, Flanders WD, Goodman M, Hill AN, Holtgrave D, Malow R, McClellan WM
27.	Strategies for primary HIV prevention that target behavioral change	Clinical Infectious Diseases, December 2007, vol./is. 45/SUPPL. 4(S300-S307), 1058-4838 (15 Dec 2007)	Safren S.A., Wingood G., Altice F.L.
28.	HIV preventive interventions for adolescents: a look back and ahead.	Current HIV/AIDS Reports, December 2007, vol./is. 4/4(173-80), 1548-3568;1548-3568 (2007 Dec)	Malow RM, Kershaw T, Sipsma H, Rosenberg R, Devieux JG
29.	Systematic review of abstinence-plus HIV prevention programs in high-income countries.	PLoS Medicine / Public Library of Science, September 2007, vol./is. 4/9(e275), 1549-1277;1549-1676 (2007 Sep)	Underhill K, Operario D, Montgomery P
30.	HIV and sexually transmitted infection prevention online: Current state and future prospects.	Sexuality Research & Social Policy: A Journal of the NSRC, June 2007, vol./is. 4/2(65-73), 1868-9884;1553-6610 (Jun 2007)	Rietmeijer, Cornelis A, Shamos, Sara J
31.	The effectiveness of individual-, group-, and	American Journal of Preventive	Herbst, Jeffrey H,

No	Review Title	Citation	Author(s)
	community-level HIV behavioral risk-reduction interventions for adult men who have sex with men: A systematic review.	Medicine, April 2007, vol./is. 32/4, Suppl 1(S38-S67), 0749-3797 (Apr 2007)	Beeker, Carolyn, Mathew, Anita, McNally, Tarra, Passin, Warren F, Kay, Linda S, Crepaz, Nicole, Lyles, Cynthia M, Briss, Peter, Chattopadhyay, Sajal, Johnson, Robert L, Task Force on Community Preventive Services
32.	Recommendations for use of behavioral interventions to reduce the risk of sexual transmission of HIV among men who have sex with men.	American Journal of Preventive Medicine, April 2007, vol./is. 32/4, Suppl 1(S36-S37), 0749-3797 (Apr 2007)	Task Force on Community Preventive Services
33.	Improved effectiveness of partner notification for patients with sexually transmitted infections: Systematic review.	BMJ: British Medical Journal, February 2007, vol./is. 334/7589(354), 0959-8138 (Feb 2007)	Trelle, Sven, Shang, Aijing, Nartey, Linda, Cassell, Jackie A, Low, Nicola
34.	Best-evidence interventions: findings from a systematic review of HIV behavioral interventions for US populations at high risk, 2000-2004.	American Journal of Public Health, January 2007, vol./is. 97/1(133-43), 0090-0036;1541-0048 (2007 Jan)	Lyles CM, Kay LS, Crepaz N, Herbst JH, Passin WF, Kim AS, Rama SM, Thadiparthi S, DeLuca JB, Mullins MM, HIV/AIDS Prevention Research Synthesis Team
35.	A review of female-condom effectiveness: Patterns of use and impact on protected sex acts and STI incidence.	International Journal of STD & AIDS, October 2006, vol./is. 17/10(652-659), 0956-4624 (Oct 2006)	Vijayakumar, Gowri, Mabude, Zonke, Smit, Jenni, Beksinska, Mags, Lurie, Mark
36.	Behavioral HIV risk reduction among people who inject drugs: meta-analytic evidence of efficacy.	Journal of Substance Abuse Treatment, September 2006, vol./is. 31/2(163-71), 0740-5472;0740-5472 (2006 Sep)	Copenhaver MM, Johnson BT, Lee IC, Harman JJ, Carey MP, SHARP Research Team
37.	Behavioral Interventions for HIV-Positive and HCV-Positive Drug users.	AIDS and Behavior, March 2006, vol./is. 10/2(115-130), 1090-7165;1573-3254 (Mar 2006)	Strathdee, Steffanie A, Patterson, Thomas L
38.	Sexual Risk Reduction Interventions Do Not Inadvertently Increase the Overall Frequency of Sexual Behavior: A Meta-analysis of 174 Studies With 116,735 Participants.	JAIDS Journal of Acquired Immune Deficiency Syndromes, March 2006, vol./is. 41/3(374-384), 1525-4135;1077-9450 (Mar 2006)	Smoak, Natalie D, Scott-Sheldon, Lori A.J, Johnson, Blair T, Carey, Michael P, SHARP Research Team
39.	Media messaging: A synthesis of lessons from the literature to inform HIV prevention amongst young people.	Journal of Child and Adolescent Mental Health, 2006, vol./is. 18/2(61-72), 1728-0583;1728-0591 (2006)	Selikow, Terry-Ann, Flisher, Alan J, Mathews, Catherine, Ketye, Thabile
40.	Sexually transmitted infection and blood-borne virus screening in juvenile correctional facilities: a review of the literature and recommendations for Australian centres.	Journal of Clinical Forensic Medicine, January 2006, vol./is. 13/1(30-6), 1353-1131;1353-1131 (2006 Jan)	Templeton DJ
41.	HIV intervention research for men who have sex with men: a 7-year update.	AIDS Education & Prevention, December 2005, vol./is. 17/6(568-89), 0899-9546;0899-9546 (2005 Dec)	Johnson WD, Holtgrave DR, McClellan WM, Flanders WD, Hill AN, Goodman M
42.	A test of major assumptions about behavior change: a comprehensive look at the effects of passive and active HIV-prevention interventions since the beginning of the epidemic.	Psychological Bulletin, November 2005, vol./is. 131/6(856-97), 0033-2909;0033-2909 (2005 Nov)	Albarracin D, Gillette JC, Earl AN, Glasman LR, Durantini MR, Ho MH
43.	Reducing the risk of sexually transmitted infections in genitourinary medicine clinic patients: a systematic review and meta-analysis of behavioural interventions.	Sexually Transmitted Infections, October 2005, vol./is. 81/5(386-93), 1368-4973;1368-4973 (2005 Oct)	Ward DJ, Rowe B, Pattison H, Taylor RS, Radcliffe KW

No	Review Title	Citation	Author(s)
44.	A programmatic and methodologic review and synthesis of clinic-based risk-reduction interventions for sexually transmitted infections: Research and practice implications	Seminars in Pediatric Infectious Diseases, July 2005, vol./is. 16/3(199-218), 1045-1870 (Jul 2005)	DiClemente R.J., Milhausen R., McDermott Sales J., Salazar L.F., Crosby R.A.
45.	A meta-analytic review of HIV behavioral interventions for reducing sexual risk behavior of men who have sex with men.	Journal of Acquired Immune Deficiency Syndromes: JAIDS, June 2005, vol./is. 39/2(228-41), 1525-4135;1525-4135 (2005 Jun 1)	Herbst JH, Sherba RT, Crepaz N, Deluca JB, Zohrabyan L, Stall RD, Lyles CM, HIV/AIDS Prevention Research Synthesis Team
46.	Prevention interventions with persons living with HIV/AIDS: State of the science and future directions	AIDS Education and Prevention, 2005, vol./is. 17/SUPPL. A(6-20), 0899-9546 (2005)	Gordon C.M., Forsyth A.D., Stall R., Cheever L.W.
47.	Highly Active Antiretroviral Therapy and Sexual Risk Behavior A Meta-analytic Review.	JAMA: Journal of the American Medical Association, July 2004, vol./is. 292/2(224-236), 0098-7484 (Jul 2004)	Crepaz, Nicole, Hart, Trevor A, Marks, Gary
48.	HIV prevention interventions in adolescent girls: what is the state of the science	Worldviews on Evidence-Based Nursing, 2004, vol./is. 1/3(165-75), 1545-102X;1545-102X (2004)	Morrison-Beedy D, Nelson LE
49.	Male circumcision for prevention of heterosexual acquisition of HIV in men.	Cochrane Database of Systematic Reviews, 2003, vol./is. /3(CD003362), 1361-6137;1469-493X (2003)	Siegfried N, Muller M, Volmink J, Deeks J, Egger M, Low N, Weiss H, Walker S, Williamson P
50.	Interventions to modify sexual risk behaviors for preventing HIV infection in men who have sex with men.	Cochrane Database of Systematic Reviews, 2003, vol./is. /1(CD001230), 1361-6137;1469-493X (2003)	Johnson WD, Hedges LV, Diaz RM
51.	Cost-effectiveness of community-level approaches to HIV prevention: A review	Journal of Primary Prevention, December 2002, vol./is. 23/2(175-198), 0278-095X (Dec 2002)	Pinkerton S.D., Kahn J.G., Holtgrave D.R.
52.	Women, sex, and HIV: Social and contextual factors, meta-analysis of published interventions, and implications for practice and research.	Psychological Bulletin, November 2002, vol./is. 128/6(851-885), 0033-2909;1939-1455 (Nov 2002)	Logan, TK, Cole, Jennifer, Leukefeld, Carl
53.	Effectiveness of interventions to prevent sexually transmitted infections and human immunodeficiency virus in heterosexual men: a systematic review.	Archives of Internal Medicine, September 2002, vol./is. 162/16(1818-30), 0003-9926;0003-9926 (2002 Sep 9)	Elwy AR, Hart GJ, Hawkes S, Petticrew M
54.	Review and meta-analysis of HIV prevention intervention research for heterosexual adult populations in the United States.	Journal of Acquired Immune Deficiency Syndromes: JAIDS, July 2002, vol./is. 30 Suppl 1/(S106-17), 1525-4135;1525-4135 (2002 Jul 1)	Neumann MS, Johnson WD, Semaan S, Flores SA, Peersman G, Hedges LV, Sogolow E
55.	Meta-analysis of the effects of behavioral HIV prevention interventions on the sexual risk behavior of sexually experienced adolescents in controlled studies in the United States.	Journal of Acquired Immune Deficiency Syndromes: JAIDS, July 2002, vol./is. 30 Suppl 1/(S94-S105), 1525-4135;1525-4135 (2002 Jul 1)	Mullen PD, Ramirez G, Strouse D, Hedges LV, Sogolow E
56.	A meta-analysis of the effect of HIV prevention interventions on the sex behaviors of drug users in the United States.	Journal of Acquired Immune Deficiency Syndromes: JAIDS, July 2002, vol./is. 30 Suppl 1/(S73-93), 1525-4135;1525-4135 (2002 Jul 1)	Semaan S, Des Jarlais DC, Sogolow E, Johnson WD, Hedges LV, Ramirez G, Flores SA, Norman L, Sweat MD, Needle R
57.	HIV prevention research for men who have sex with men: A systematic review and meta-analysis	Journal of Acquired Immune Deficiency Syndromes, July 2002, vol./is. 30/SUPPL. 1(S118-S129), 1525-4135 (01 Jul 2002)	Johnson W.D., Hedges L.V., Ramirez G., Semaan S., Norman L.R., Sogolow E., Sweat M.D., Diaz R.M.
58.	Meta-analysis of the effectiveness of HIV prevention interventions for women.	AIDS Care, April 2002, vol./is. 14/2(163-80), 0954-0121;0954-0121 (2002 Apr)	Mize SJ, Robinson BE, Bockting WO, Scheltema KE
59.	HIV health promotion and men who have sex	Rees R, Kavanagh J, Burchett H,	Rees R, Kavanagh J,

No	Review Title	Citation	Author(s)
	with men: a systematic review of research relevant to the development and implementation of effective and appropriate interventions	Shepherd J, Brunton G, Harden A, Thomas J, Oliver S, Oakley A (2004) HIV Health promotion and men who have sex with men (MSM): a systematic review of research relevant to the development and implementation of effective and appropriate interventions. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.	Burchett H, Shepherd J, Brunton G, Harden A, Thomas J, Oliver S, Oakley A
60.	NICE: Preventing and reducing HIV transmission among men who have sex with men (MSM): interventions to increase the uptake of HIV testing Systematic reviews of effectiveness, cost-effectiveness and qualitative evidence.		Theo Lorenc, Isaac Marrero, Alexis Llewellyn, Chris Cooper, Angela Lehmann, Catriona Lindsay, Peter Aggleton
61.	Highly Active Antiretroviral Therapy and Sexual Risk Behavior: A Meta-analytic Review		Nicole Crepaz, Trevor A. Hart, Gary Marks
62.	Circumcision Status and Risk of HIV and Sexually Transmitted Infections Among Men Who Have Sex With Men: A Meta-analysis		Gregorio A. Millett, Stephen A. Flores, Gary Marks, J. Bailey Reed, Jeffrey H. Herbst
63.	Do prevention interventions reduce HIV risk behaviours among people living with HIV? A meta-analytic review of controlled trials.		Nicole Crepaz, Cynthia M. Lyles, Richard J. Wolitski, Warren F. Passin, Sima M. Rama, Jeffrey H. Herbst, David W. Purcell, Robert M. Malow, Ron Stall
64.	HIV prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission: Evidence Briefing Update		Jennifer Downing, Lisa Jones, Penny A. Cook, and Mark A. Bellis
65.	HIV prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission	Ellis, S., Barnett-Page, E., Morgan, A. Et al (2003). HIV prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission. London: HDA	Ellis, S., Barnett-Page, E., Morgan, A. Et al
66.	A Systematic Review of HIV Partner Counseling and Referral Services: Client and Provider Attitudes, Preferences, Practices, and Experiences		Warren F. Passin, Mph, Msw, Angela S. Kim, Mph, Angela B. Hutchinson, Phd, Mph, Nicole Crepaz, Phd, Jeffrey H. Herbst, Phd, Cynthia M. Lyles, Phd, And The Hiv/Aids Prevention Research Synthesis Project Team
67.	The Lancet Volume 378 Number 9787 Pages 199-288 (July 2011)	The Lancet Volume 378 Number 9787 Pages 199-288 (July 2011)	
68.	Antiretrovirals for reducing the risk of mother-to-child transmission of HIV infection (Review)	Antiretrovirals for reducing the risk of mother-to-child transmission of HIV infection (Review) Copyright © 2011 The Cochrane Collaboration. Published by JohnWiley & Sons, Ltd.	Siegfried N, van der Merwe L, Brocklehurst P, Sint TT
69.	Antiretroviral pre-exposure prophylaxis (PrEP) for preventing HIV in high-risk individuals (Review)	Okwundu CI,Okoromah CAN. Antiretroviral pre-exposure prophylaxis (PrEP) for preventing HIV in high-risk individuals. Cochrane Database of Systematic Reviews 2009, Issue 1. Art. No.:	Okwundu CI, Okoromah CAN

No	Review Title	Citation	Author(s)
		CD007189. DOI: 10.1002/14651858.CD007189.pub2.	
70.	Antiretroviral therapy for prevention of HIV transmission in HIV-discordant couples (Review)		Anglemyer A, Rutherford GW, Egger M, Siegfried N
71.	BRIEF REPORT: Methadone Treatment of Injecting Opioid Users for Prevention of HIV Infection		Linda R. Gowing, Michael Farrell, Reinhard Bornemann, Lynn E. Sullivan, Robert L. Ali
72.	BHIVA-BASHH : Gathering evidence for expanding HIV testing in England: an overview of eight pilot projects		Alicia Thornton, Valerie Delpech, Anthony Nardone
73.	BHIVA-BASHH : REPORT ON THE ENGAGEMENT PROCESS OF THE PAN LONDON HIV PREVENTION NEEDS ASSESSMENT		
74.	BHIVA-BASHH : HIV Needs Assessment Evidence Template (BLANK)		
75.	BHIVA-BASHH Position Statement on PrEP in the UK		Sarah Fidler, Martin Fisher, Sheena McCormack
76.	Body & Soul completed HIV Needs Assessment Evidence Template		
77.	Community Services Ealing: Harrow HIV Testing Pilot Report Apr. 2009		
78.	GMFA: Evidence of Interventions, Response to Question 2		
79.	GMFA response to HIV Needs Assessment Evidence Template: Insight from service users and providers		
80.	House of Lords: HIV and AIDS in the United Kingdom, Written Evidence from witnesses A-M		
81.	House of Lords: HIV and AIDS in the United Kingdom Written Evidence from witnesses N-Z		
82.	Individual Responses: HIV Needs Assessment Evidence Insight from service users and providers		Peter Loght
83.	Individual Response Q: HIV Needs Assessment Evidence Insight from service users and providers		
84.	Metro Centre MSM: HIV Needs Assessment Evidence Template Insight from service users and providers		Dr Greg Ussher
85.	Metro Centre African: HIV Needs Assessment Evidence Template Insight from service users and providers		Dr Greg Ussher
86.	NAM: HIV Needs Assessment Evidence Template Insight from service users and providers		
87.	PACE: HIV Needs Assessment Evidence Template Insight from service users and providers		
88.	PACE Talking Spaces		Tim Foskett, Alfred Hurst
89.	Shout Loud 2010 Survey Results		
90.	PACE: Talking Spaces II: Evidence-Based Therapeutic Groupwork with Gay and Bisexual Men		Tim Foskett, Marcia Brophy and Alfred Hurst
91.	T Cell Survey Comments		
92.	T Cell Survey LA		
93.	PACE: First Time Experiences: Young LGBT People's Needs Assessment		
94.	Positive Catholics: CAPS Newsletter:		

No	Review Title	Citation	Author(s)
	CATHOLICS FOR AIDS PREVENTION & SUPPORT		
95.	‘Positive Catholics’ Annual Retreat 2008, synopsis.		Ninon van der Kroft
96.	Brief Report from Positive Catholics Summer Retreat 2009		
97.	Brief Report from Positive Catholics Summer Retreat 2010		
98.	Julian of Norwich Pastoral Review 2011		
99.	A GIFT WEAVED FROM THORNS: HIV as Gift and Challenge in the Church, A Pastoral Reflection		Vincent Manning
100	Positive Catholics – Annual Review and Planning Meeting 2010		
101	Positive Catholics Review and Planning Meeting Jan 22nd 2011		
102	Rain Trust completed HIV Needs Assessment Evidence Template		
103	SIGMA completed HIV Needs Assessment Evidence Template		
104	SIGMA: FRAMEWORK FOR BETTER LIVING WITH HIV IN ENGLAND		Peter Keogh, Yusef Azad, Michael Carter, Elisabeth Crafer, Sinead Cregan, Chris Morley, Priscilla Nkwenti, Will Nutland, Roger Pebody, Rhon Reynolds, Jack Summerside, Peter Weatherburn
105	SIGMA: MAKING IT COUNT. A collaborative planning framework to minimise the incidence of HIV infection during sex between men		
106	THT African Communities Organisational Development Programme Evaluation Report by the Advisory Board		
107	AODP Feedback Event - Quotes from OD clients		
108	The London Health Forum, Public Health and HIV in London		Terrence Higgins Trust
109	THT: RS completed HIV Needs Assessment Evidence Template		RS
110	THT: SC completed HIV Needs Assessment Evidence Template		SC
111	THT: MAMBO ISSUE 6 READER SURVEY REPORT		
112	THT: JO completed HIV Needs Assessment Evidence Template		JO
113	PRO-FORMA QUESTIONNAIRE, THT African OD Programme Evaluation - Mentoring		
114	Widows & Orphans completed HIV Needs Assessment Evidence Template		
115	Sex Workers, references for evidence review		
116	CDC: BEHAVIOURAL INTERVENTIONS, Key evidence from systematic reviews and meta-analyses		
117	Evidence Template		
118	SUMMARY OF DISCUSSIONS FROM WORKSHOPS		
119	HIV Prevention Evidence Briefing – Lambeth, Southwark and Lewisham (September 2010)		
120	NHS Health Scotland: An overview of the effectiveness of sexual health improvement interventions FINAL REPORT		Deirdre Fullerton, Elizabeth Burtney

12. Appendix 2: The current programme

All components of the programme the same aim unless otherwise stated: to improve knowledge or understanding of HIV prevention and improve access to HIV/STI testing and treatment and access to safer sex promoting interactive services.

There are 3 target groups: MSM, African communities and people living with HIV. The service components are summarised below for each target group noting the scale or reach of intervention noted where specified in the contracts.

MSM
650 hours of psychotherapeutic group work (152.8k)
500 hours of group work (96.9K)
2 mass media campaigns (77.9K)
1 small media booklet with email notification and alerts to no less than 4,000 (87.9K)
6 x 25,000 copies of magazine (98.5K).
1 web site (30.9K)
Telephone switchboard service and website (59.2K)

    Responding to between 1,500 and 2,800 calls of 10 minutes or less and 1,500 and 2,800 calls of 10 minutes or more.

Sexual health counselling (163.7K)

    28 completing CBT
    20 completing sexual health counselling
    14 completing a course of mentoring
    32 completing a course of long-term counselling
    80 completing a course of counselling

Sexual health trainers (290.1K)

    3950 short Contacts and 1580 in-depth Contacts all completing BASKS inventory
    11160 resources distributed

Condom distribution service to enable men to use condoms and lubricant.

    Distributing 1,099,192 condoms and 1,024,400 sachets of lubricant

African communities
1 mass media campaign (105.8K)

    Including distribution of 10,000 Condoms and condoms packs

Small media (39.1K) including:

    1 web site.
    Banner ads
    3 booklets
    3 radio ads

1 to 1 Information and advice -500 Sessions, 2000 people
Group information and advice -8 sessions, 80 people
Distribution of resources

    -300 sessions , 24,340 resources distributed + 1500 via membership

Organisational development to assist communities in providing HIV health promotion (90K) including:

10 days of needs assessment for between 10 and 20 organisations
40 days of training
20 days of consulting
2 days of sector development workshops

Health promotion skills and practice service with the aim of providing group and individual skills training/mentoring (21.4K).

Health promotion training (34.5K)
36 sessions, 120 participants
1 half day session, 60 participants

PLWHIV

Small media to improve knowledge and understanding of HIV(and STIs), treatment, adherence and the maintenance of good health. (169.4K)

Summary Resource	4000
Fact Sheets	12000
Patient Information Booklets	6000
Newsletter	24000
Information Events	50
HIV Treatments Directory	120
Website	269222

Health trainers (170.6K)

No activity targets yet