Pan London HIV Prevention Programme Needs Assessment

Engagement Process Report

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

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1. Introduction & background

The engagement process is one of 3 workstreams feeding in to the Pan London HIV Prevention Programme Needs Assessment. The needs assessment is being conducted by Public Health INWL in order to gather the evidence about the level of need for HIV prevention across London and the evidence of the most effective and efficient HIV prevention interventions.

The aim of the needs assessment is to make clear evidence based recommendations for the commissioning of a Pan London HIV Prevention Programme with a view to maximising effectiveness and efficiency of HIV prevention activity.

The methods used in the needs assessment include an epidemiological review; an evidence review and an engagement process.

The needs assessment is being led by a steering group comprising public health practitioners, clinicians, academics and commissioners from across London.

The written submissions and this report will be available on the website http://www.northwestlondon.nhs.uk/westminster/

This report summarises insight gathered from the engagement process, including opinions from stakeholders, references to evidence about effective interventions and reflections about prioritising interventions.

The evidence submitted as references and as unpublished reports will be included in the report of the evidence review.

1.1. Aims and purpose of events & written contributions

The aim of the engagement process was to invite contribution from stakeholders, including clinicians, service users, and statutory and voluntary sector providers of HIV prevention services in order to:

- Gather the insight and experience of stakeholders to contribute to the shaping of the needs assessment.
- Gather 'grey literature' – unpublished reports which will contribute to the evidence review.
- Involve service users as well as other stakeholders in the process.

Contribution was invited through written responses to a questionnaire, and/or attendance at workshops run on July 12th and 13th. 63 people attended the workshops and we received 18 written responses. Both the workshops and the written responses were asked to focus on the following questions:

- Given your or your organisations experience, what HIV prevention interventions work?
- Based on your experience as a service user or provider of HIV prevention interventions, how do you know they work?

- Which interventions work best at what level (Pan-London, Sector, Borough or Neighbourhood) and why?
- What key outcomes do we need to incorporate in evaluating whether an intervention works?
- Given the responses from the above questions, which key interventions you would prioritise for pan London HIV prevention interventions?

1.2. Next Steps in the Needs Assessment

The Engagement report will be reviewed together with the Epidemiology report, the Evidence review, and any completed comparative financial modelling. These three reports together will be used to form the basis for a summary of recommendations for commissioning intentions based on the conclusions of the needs assessment.

This will go to cluster Directors of Public Health for sign off in early September, followed by Chief Executives sign off. Draft commissioning intentions will be produced at the end of September. If there are changes to the current Pan London Programme there will be a twelve week consultation period, and an Equalities Impact Assessment will be undertaken.

The tender for the Pan London HIV prevention services will then be drawn up, based on the intentions and the consultation feedback, and published in early January. A paper on the commissioning timeline and process will be available on the website http://northwestlondon.nhs.uk/westminster/

2. Themes from the workshops and written submissions

2.1. General programmatic responses

Responses highlighted the need for a **range of interventions** which were linked together through clear care pathways, and that there should be partnership working to increase the effectiveness and reach of all interventions. Interventions which support access into and good use of clinical interventions are critical.

Many references were made to the importance of basing interventions on the **Making It Count 4 Framework, and the Knowledge, Will and Power Framework**, as having identified the key criteria, components and standards for effective interventions. In addition it was recommended that NICE guidance is used. Reference was made to the key roles that organisations like the African Health Forum and the African HIV Research Forum can make in contributing to this process and the later consultation process.

There was consensus that all interventions should be **evidence based**, based on the appropriate **theoretica**l approach, and use a good system for measuring, communicating and reporting on outcomes. In addition comments were made that when interventions are evidence based attention should be paid to the best validated evidence which highlights the most effective interventions in preventing HIV as well as the most cost effective interventions.

The importance of having a **collectively owned approach to monitoring and evaluation** was stressed. Reference was made to the Time2Know partnership as an example where the proposed monitoring and data tracking systems were laid out in the commissioning

intentions, allowing for the planning and budgeting of data tracking systems in the tendering process.

Although the prevention needs assessment specifically did not set out to review HIV support services, a clear case was made for **linking support with prevention services**, and for the role support services have to play in communicating messages, developing skills and confidence development in HIV+ people, as well as reducing fear and stigma. The SLHP (South London HIV Partnership) was mentioned as a model for a programme which effectively links support and prevention services.

Peer led interventions were emphasised as being better able to give culturally competent and grounded messages which could be trusted and accessed by the people who needed them, both for gay men and for African communities.

Ensuring a **whole systems approach to commissioning services** - Importance of integrated and clear pathways. Comments were raised about the need for pan London and local commissioners working together. Examples were given of current distribution problems with interventions in the pan London programme and the need to make sure local organisations with access to population groups were adequately resourced to get the materials and condoms distributed.

Integrated delivery and partnership working of different prevention services, and linking in with local clinical services were stressed as vital to deliver the level of impact which a prevention programme can deliver, and work to prevent failure of implementation of any one aspect of it. Organisational development; joint skills training for organisations; working together to design campaigns, were all mentioned as ways to promote working together.

2.2. Key groups

Omissions
Comments have been raised about key groups omitted from inclusion in the workshops and in this report. In particular it has been noted that no mention has been made of the HIV prevention needs in **prisons.**

Additional comments were made about the need to include work with **female sex workers** who are HIV+, using crack and IDU. Recommendations were made about programmes which help women to exit from sex worker and manage their drug use, as well as work with men who use sex workers.

Treatment information, although currently commissioned in conjunction with the Pan London Prevention Programme, has been omitted from this needs assessment. That should not mean that treatment information is omitted from the next stage of commissioning and the process of identifying the needs for treatment information needs to be specified.

African Communities
Concerns have been raised that as this report is structured as an integrated report, rather than as separate recommendations for gay men and for African communities, it will not help commissioners think about the different needs of these two groups, or how to commission programmes which will be most effective.

This is felt to be a particular weakness as although a wide range of interventions are already commissioned at pan London level for gay men, most one to one and interactive interventions with African communities are commissioned at local or sector level. More comments on this will be found later in the section on pan London and sector commissioning.

In addition, as there has been less research published based on the needs of African communities, there is a greater risk of underestimating those needs and the validity of interventions which are targeted at UK based African communities.

NICE guidance 33 notes that collaborative working with local African communities is essential to any strategy to reduce late and undiagnosed infection.

There was a general concern raised that pan London commissioning must not be seen as a valid reason to cut or reduce local HIV prevention interventions.

There was complete consensus around the need for targeted culturally appropriate interventions for African communities, and complete consensus that African communities should remain a key target group for the HIV prevention programmes.

MSM
There was complete consensus that MSM should remain a key priority group for HIV prevention interventions.

Young People
Concerns were raised about the need to focus messages and interventions on young people, and that better **SRE education** should take place in schools.

Young gay men were noted as having particular prevention needs which were unlikely to be met through SRE in schools, and support should be provided through **young LGBT** groups.

In addition comments were made about the different needs of young African communities who have a different culture to that of their parents, and the need to think about messages specifically for them as a group living across cultures, who may not identify with purely 'African' messages or ways of communicating.

2.3. Interventions

The following three areas of intervention were prioritised in both the workshops and in the written submissions.

2.3.1. Structural/biomedical Interventions

Aimed at improving service provision and access (availability, usability, relevance and equity) to health services for affected communities:

These interventions largely refer to the clinical structures, services and methods of prevention we need in place to reduce HIV transmission. They include:

- Prompt diagnosis
- Improve service provision and access
- Deliver rapid testing at GP surgeries

- Implement active recall for regular testing
- Provide home sampling kits for partners
- Maintain open access to GUMs
- Maintain needle exchange programmes
- Maintain testing everyone at GUM clinics and antenatal clinics
- Provide PEP
- Clinical trials for PreP
- Use CQINs, LES as incentives to increase testing
- Provide treatment for everyone
- Condom distribution

Discussion around these points raised the following points:

Access

- How do you get the right people – those who are taking risks – to come for testing? 25% of people who are HIV+ are undiagnosed. Need for links to testing campaigns. Take into account HPA reports and national data on the national DH testing pilots which fundamentally addressed late diagnosis.
- The negative impact on getting people to test The lack of experience of confidentiality in GP waiting rooms creating lack of trust in GP based testing services
- The importance of testing in community settings and the clear evidence which supports the efficacy of this approach.
- The importance of having 'non NHS/non clinical' workers providing testing, in order to increase trust and access to testing

Fear/Stigma

- when fear based campaigns are used – i.e. if people are afraid, they are less likely to test, and balancing this with campaigns which stress the importance of personal responsibility

Adherence/barriers

- The difficulty some people have of adhering to treatment, even for the period of PEP
- 'For every £1 spent on treatment, £0.005 is spent on treatment information. Is this the right balance?'

Distribution

- The importance of distribution schemes for condoms and small media information resources

Condoms

- The question whether free condoms is what we need when they are widely available at low cost
- The need to 'eroticise' condom use – i.e. do people not use condoms because they do not understand or underestimate the risk of transmission, or do they not use condoms because they don't like using condoms, or because they lack negotiation skills – links to skill based workshops and groups to develop confidence and negotiation skills
- For every £1 spent on treatment, £0.05 is spent on prevention. Is this the right balance?

Implementation failure

- Many times when people test negative they are not offered education/counselling which might effect future risk taking behaviour, pointing to the need for clear, prompt pathways into structured interpersonal interventions for both negative and positive results given in a GU or community clinic.
- Need for local projects to promote good practice in GP testing

2.3.2. Population interventions

Population intervention discussions focused on what **knowledge** needs to be communicated, to whom and how. The key delivery of these interventions is increasing knowledge in the targeted populations about HIV testing and treatment, understanding of risk, how and where to access services, and changing attitudes and perceptions at a community level. Taking into account as well the need to develop tools to measure changes on knowledge outcomes as a result of population interventions.

Population level interventions can also **address implementation barriers** in structural biomedical interventions, i.e. why people don't go for testing, why people don't go for PEP.

Population interventions contribute the following to prevention programmes:

- Knowledge dissemination about HIV, prevention and services
- Consistent information
- Economies of scale
- Consistent quality
- Reaches greatest number of people
- Culturally competent and grounded

Interventions are delivered through **print media** – advertising campaigns, magazines targeted at MSM and African Communities, small media resources; **electronic media** – radio, TV and websites; and **social media**, including face book, twitter, and social networks such as faith leaders.

Interventions should focus on **changing perceptions and attitudes** in the at risk populations of MSM and African communities, as well as **targeting** messages more specifically, i.e. to young people, sero-discordant couples.

The advantage of the population interventions commissioned at a pan London level include consistent messaging; the ability to link/promote other services and campaigns; reaching a higher percentage of the population at a lower cost; the consistent quality of the messaging.

The risk with these interventions at a pan London level is that they do not signpost to local services and are not integrated in local pathways.

There is a need for these interventions to be calibrated with national population interventions, including CHAPS and NAHIP.

Discussion around this raised the following points:

Distribution
- Need to commission distribution of resources or they just sit on shelves
- Need to involve local outreach organisations in campaigns' design and delivery so they can distribute effectively

Stigma
- Need to address stigma in African communities

Linking outreach, media campaigns
- Importance of working more effectively with faith leaders to communicate messages about testing and treatment
- The value of involving outreach organisations in design of campaigns and resources so that the conversations they have around their distribution are more likely to be effective

Peer led interventions
- Importance of Positive Speakers to deliver powerful messages

Cost reduction
- Can commercial advertising be used in magazines to subsidise the costs
- Questions were raised about the value of help lines as opposed to internet based access

Interventions prioritised in both the written evidence and the workshops included:
- Targeted segmented media campaigns through press, magazines, radio, websites
- Information resources linked with web information and local information
- Campaigns to encourage testing
- Websites to promote information and access to services, online risk assessment

2.3.3. Interpersonal interventions

These are interventions **focused** on those who are known to be taking risks, have motivation to look at changes in behaviour, are based on **behaviour change theory**.

Responses focused on the value of behaviour change theory in indicating a **range of interventions** likely to be successful in changing risk taking behaviour. The interventions focus on motivation, risk awareness, active negotiation skills practice, and practising disclosure, addressing fears and self efficacy, frank discussion amongst peers

There is evidence that interventions which **practise skills** are more effective in changing behaviour than interventions which focus on knowledge alone.

There is evidence that **more intensive interventions**, i.e. scheduled over 10 or more sessions, are more likely to be effective than brief interventions in changing behaviour, although there is also evidence that short structured interventions (including CBT) are effective in creating change over time. Providing choice of both brief and more intensive interventions increases access and focuses more intensive approaches on those with greatest need. It enables participants to choose options best suited to their personal circumstances and approaches.

Brief interventions can be used effectively to highlight and assess risk taking behaviour and signpost to services and to more intensive interventions. Brief interventions are particularly useful in assessing knowledge of and attitudes to risk taking.

Therapeutic group work interventions work both in terms of behaviour change theory and in terms of peer reinforcement and support and norm development.

The **BASK inventory tool** works to assess risk and to assess improvements/outcomes, and to ensure that changes in risk practices are measured in a balanced way across the four key domains of behaviour, attitudes, skills and knowledge.

Interventions which **encourage positive behaviours and self efficacy** are more likely to be effective than ones which emphasise social responsibility

There is evidence that **HIV+ people** respond as well or better to behaviour change interventions as HIV- people

SRE in schools and LGBT groups have a key role to play in teaching knowledge and skills and self confidence

There is a need to **target African priority groups**, including HIV+, people with multiple partners, sero-discordant couples

The following interventions were prioritised in both the events and in the written submissions:

- Peer led interventions
- Mentoring
- Counselling
- Therapeutic group work
- Workshops: skills building, disclosure,
- Health trainers
- Work with faith leaders
- 1-2-1 information and advice
- Peer support interventions where user involvement, leadership and personal development are central

Discussion around behavioural interventions raised the following points:

Peer led interventions

- Peer led interventions are critical to building trust and self esteem and self confidence
- The need to have non clinical staff delivering interventions
- Central role of user involvement, leadership and personal development
- Peer to peer skill sharing around disclosure, negotiation of sex and condom use
- Central role of volunteers, including volunteer counsellors, mentors and health trainers

Targeted interventions

- Targeted interventions – i.e. groups for young people, gay men, African communities.
- The ideal of specific education following a negative test in a clinic rarely happens, but could happen if there were not standardised implementation problems – i.e. having new staff as health advisors who were not trained appropriately.
- There is a need for a clear pathway of structured interpersonal interventions which support a client in remaining HIV- at critical junctures.
- Importance of focusing interventions on those taking risks.

Access

- Groups and workshops should be available across London on a borough basis

Evidence Base

- There is no hard evidence about peer educators, African counselling, and behaviour change interventions; there is a need for more research to be commissioned specifically about African interventions in the UK.
- evidence for all interventions was given; see appendix of references and reports submitted.

Linked interventions and pathways

- Behaviour change and interpersonal interventions need to be linked to local clinics and integrated with care pathways.
- Challenges of getting community interventions working in clinics/linking closely with clinics.
- Community outreach services commissioned locally work when there is a good fit, including good personal relationships between the individuals involved, with local HIV testing services and support services.
- Services need to be linked together to maximise the 'learning moment' of either a positive or negative diagnosis.

Work with Faith Leaders and Faith Communities

- Work with faith leaders to challenge attitudes and pass on messages about testing and treatment.
- Supported faith interventions to reduce stigma, isolation, judgement, increase informed religious leader approaches and practical support, increase disclosure, opportunities for prevention work, peer support.
- The value of positive belonging within a faith community; the role faith communities play for many people where support is informed, open and possible; the negative impact where faith communities spread messages which increase fear and stigma and isolation.

Skill Development

- Need for support and skill re partner notification.
- Practical, emotional, psychological and spiritual outcomes for service users
- Negotiation skills for young gay men and African women in sex and condo use.
- Value of self confidence, self esteem, self efficacy.
- Need to specify the outreach skill set expected as part of a programme's quality assurance.

3. Outcomes measurement

Defining outcomes should start at the **design** of the intervention and relate to the **Making it Count Framework** and **the Knowledge Will and Power Framework.**

Outcomes should focus on **pre, post and longer term** follow up of changes in behaviour, attitude, skills and knowledge – see **BASK** (Behaviour, Attitudes, Skill and Knowledge) tool

For some media interventions, **changes in population attitudes** recorded over time are a key impact measure – see GMSS and BASS Line survey

For some media interventions, **awareness/recognition of campaigns** is a key impact measure

All current pan London services provided detailed examples of how they include output and outcome assessment. Concerns were raised in discussion about providers reliance on 'outputs' – numbers of people accessing a service, number of events held – as indication of outcomes. Concerns were also raised that outcomes indicating increased awareness of risk does not indicate that less risk is being taken i.e. may not be an indication of an HIV prevention outcome.

Prevention programme outcome measures:

- Change in HIV diagnosis rates
- Increase in HIV testing
- Behavioural and attitude changes – pre, post, long-term
- Changes in community attitudes
- Increased use of clinical services, like GPs, community reproductive health and GUM.
- Reduction in late diagnosis
- Adherence to, and increase use of PEP

3.1. Discussion around outcomes

Interpretation of Increase/decrease in diagnosis rates

- Discussion around interpretation of increase in diagnosis rate as positive outcome, i.e. indicating reduction in undiagnosed, or negative outcome, i.e. more people taking risks.

Theory/Evidence

- If commissioning is evidence based, don't measure outcomes through restating the theoretical evidence; focus on assessing whether/how outcomes are achieved.
- No evidence is not evidence of failure.

Role of external evaluation

- May be valuable to commission external evaluation outside of the programme of specific services.

Access reporting

- Is reporting access and use an indicator of outcome? Relevant if aim of service is e.g. to increase uptake of testing in a specific community, or % of a community who recognise a campaign about PEP.

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Linking faith and outcomes

- Importance of including faith in demographic data so that this aspect can be evaluated in terms of access and outcomes.

Service user outcomes

- Self reported measures
- Service user experience
- Self reported behaviour/knowledge change Practical, emotional, psychological and spiritual outcomes for service users

4. Pan-London or Local Commissioning Views

4.1. Areas of broad consensus:

- Everything can be commissioned at a pan London level with local delivery partners, such as the C Card distribution scheme.
- Mass media, small media, magazines, websites, condom distribution – all the population level interventions, lend themselves to pan London commissioning to avoid duplication and create consistent messaging of a high quality.
- Clinical services should be available at borough level to support local access, both in clinics and community settings.
- The need for local organisations and services to be linked with pan London and national programmes in an integrated pathway was stressed.
- Looking at interventions for MSM and interventions for African communities as though they are the same programme will conflate the different needs of the two communities and lead to difficulties in commissioning – commissioning intentions need to be separated so that the most effective interventions and delivery systems can be different according to needs.
- Look at a model of central coordination and locally accessible delivery.
- Distribution schemes for media resources are critical for the resources to be used effectively; need to coordinate media with local outreach services.

4.2. Areas with divergent views:

- Mixed views about the best level for commissioning interpersonal interventions. The value of local organisations with local knowledge was stressed in terms of access to particular communities, particularly African communities.
- Some comments were raised that national, local and pan London interventions both need to be commissioned as they reach different groups and together reach more people because they are designed differently – that a both pan and local approach is needed, not one single pathway.
- Evidence was submitted by a number of organisations who provide support and groups in one central location which is widely accessed by service users from across London, suggesting the interpersonal work can be commissioned at a pan London level and still reach people from every borough of London.

- Capacity development of smaller organisations does need active support and engagement of local commissioners to be effective.
- All interpersonal, 121 and group work should be available across London, and information should be available to the population whether it is commissioned locally or at sector or pan London level – currently information tends to be available or distributed according to commissioning structure rather than a total picture of what is available to all residents of London.
- People should be able to access services outside their own borough or locality to protect their confidentiality.

5. Messages for commissioners

- Commission a range of interventions
- Base interventions on evidence and theory
- Use existing frameworks e.g. Making It Count, Knowledge Will and Power, etc
- Commission peer led interventions
- Focus interventions on dealing with implementation failures (see point 3.1.2 above)
- Commission structural, population and interpersonal interventions
- Commission targeted interventions
- Link local, regional and pan London services and pathways
- Encourage partnership working in design and delivery of services

6. Appendices

6.1. Appendix 1: List of Cited references

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NICE public health guidance 33: Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England www.nice.org.uk/PH33

NICE public health guidance 34: Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among men who have sex with men www.nice.org.uk/PH34

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6.2. Appendix 2: Unpublished Reports

African Communities Organisation Development Programme: quotes from OD clients

African OD Programme 2008-2011 Outcomes Report THT

Behaviour Attitude Skills Knowledge toolkit

BHIVA HIV Testing Overview, HPA, Thornton, Delpech, Nadone

BHIVA-BASHH Position Statement on PrEP in the UK

Brief Report from Positive Catholics Summer Retreat Douai Abbey, July 31st – August 2nd 2009

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GMI Cat IPOC Questionnaire draft 2 GMI final cover letter to Ergo document

GMI Client Pathway

GMI Health Trainer BASK revised

GMI mentoring Presentation

GMI New Mentoring BASK

GMI paper BASK

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GMI PLHPP Care Pathway

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Harrow Community HIV Clinical Nurse Specialists. “a report on Harrow HIV Testing Pilot”. Harrow Primary Care Trust

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HIV Needs Assessment NAM submission table

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Sarah Fidler, Martin Fisher, Sheena McCormack

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T-cell survey comments. PACE

The London Health Forum – HIV in London

THT African Communities Organisational Development Programme

6.3. Appendix 3: Websites/Links

A paper to inform national strategic planning for sexual health and HIV in 2011

African HIV Prevention Handbook

Antiretroviral prophylaxis: a defining moment in HIV control, Lancet paper published online July 15 2011 DCI:10.1016/S0140-6736(11)61136-7

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http://tampep.eu/documents/European%20Overview%20of%20HIV%20and%20Sex%20Work.pdf

http://www.aidsmap.com/resources/Preventing-HIV/page/1412415/

http://www.bashh.org/documents/1118/1118.pdf

http://www.eurosurveillance.org/ViewArticle.aspc?ArticleId=19914

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http://www.parliament.uk/business/committees/committees-a-z/lords-select/hiv-select-committee/publications/

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http://www.sigmaresearch.org.uk/files/report2009e.pdf

http://www.surreycc.gov.uk/sccwebsite/sccwspublications.nsf/f2d920e015d1183d80256c670041a50b/ae416f8239f800bc802572f3005561c5/$FILE/SSCB%20Prostitution%20Strategy.pdf

http://www.ukcab.net/forum/index.php?topic=1250.0

London Sexual Health Programme and HIV Prevention
Nam conference e-bulletins can be found here:

http://aidsmap.com/ias2011/Bulletins/page/1827114/

NICE Guidelines (Reports and Publications)

The House of Lords Committee on HIV/AIDS in the UK

Treatment IS Prevention

www.aidsmap.com/Measuring-effectiveness/page/1768149/

www.effectiveinterventions.org.

6.4. Appendix 4: Participants in Engagement Process

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Carmelo Di Maria
Caspar Thomson
Catheriner Pearson
Charles Bell
Chikwaba Oduka
Chris Payne
Clement Musonda
Colin Bently
Daniel West
David Burlinson
David Naylor
Dee Wang
Deirdre Love
Denis Onyango
Dr Catherine Dodds
Dr Daniel West
Dr Greg Ussher
Dr Karen Rogstad
Dr Margetts Alexander
Dr Mirjana Jovanovic
Dr Su Yin
Dr Wondwossen Eshetu
Eddy Aroda
Eleanor levy
Elizabeth Takaedza
Emma Passera
Ewan Jenkins
Francis Kaukumba
Franco Saiglia
Funwi Akinpelu
Gaetan Fryer
Gerthrude Otieno
Gill Tyson
Gus Cairns
Heather Wilson
Ian Lechie
Jacqueline English
Jamie Perkins
Jim Jewers
Jo Robinson
Joseph Ochteng
Karen Randall
Katy Harrad
Keith Spendlove
Kevin Kelleher
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King Keith
Louise Gibbs
Malin Stenstrom
Martha Bisivikiva
Martha Stafford
Maureen
Maxine Sesay
Mezfin Ali
Michael Mancinelli
Michael Parra
Nana
Nathaniel Adam Tobias Coleman
Oola Balam
Paul Steinberg
Perez Ochieng
Peter Onwu
Phillip Wragg
Richard Scholey
Rob Wardle
Robbie Currie
Robert Goodwin
Sam Cunningham
Samuel Serunjogi
Sanna Savolainen
Simon Bellham
Simon Edwards
Simon Jones
Sona Barbosa
Sonna Savolainen
Steve Worrall
T Risatti
Tim Franks
Tom Ojwang
Vincent Manning

6.5. Appendix 5: Participating Organisations

1. African Cultural Promotions	2. African Advocacy Foundation
3. African Health Forum	4. Africans Getting Involved
5. AHPN	6. Barnet Hospital
7. BHASHH	8. BHIVA
9. Body and Soul	10. Bromley PCT
11. CNWL	12. Community Services Harrow
13. CPS	14. EHF African HIV Service Users Forum
15. Embrace UK	16. FFENA
17. Freedoms Shop	18. GMFA
19. GMI (Positive East, the Metro Centre, West London Gay Men's Project)	20. Goodwin Consultancy
21. GSTT Community	22. HART (Hillingdon Aids Response Trust)
23. Imperial College	24. INWL PCTs
25. LB Haringey	26. LB Hillingdon
27. LB Hounslow	28. Living Well
29. NAM	30. NAZ Project London
31. Opportunities for All	32. PACE
33. Pamodzi	34. Positive Catholics
35. Positive East	36. Rain Trust
37. Sigma Research, London School of Hygiene & Tropical Medicine	38. SMZ (Hounslow)
39. The Metro Centre	40. The Rain Trust
41. THT	42. West London Gay Men's Project
43. Youth Project International	