Ipsos MORI
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Public Health England
HIV Prevention Innovation Fund

Cohort 1 Evaluation Report

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Executive summary

The HIV Prevention Innovation Fund was set up by Public Health England (PHE) to support voluntary sector organisations reduce the impact of HIV through innovative interventions targeting groups most affected by HIV. Funding was allocated to the first cohort of seven projects in 2015 and it is these projects which form the focus of this report. A second cohort of 13 projects have been awarded funding in late 2016 and are at the early stages of implementation.

PHE commissioned Ipsos MORI to undertake a process and impact evaluation of the Innovation Fund and its projects. This report provides a summary of the activities and achievements of Cohort 1 – assessing the extent to which the projects met their intended outputs and outcomes, looking at what helped or hindered them to do so; concluding with lessons learnt for both projects and PHE.

This evaluation report is based upon the following activities:

- Project evaluation reports: Each project has its own evaluation report, covering project-specific detail. These reports have been reviewed to feed into this overarching evaluation report;
- Interviews with project leads; and
- Interviews with project evaluators.

Project activities and inputs

A brief overview of the seven Cohort 1 projects is presented below:

- HIV Testing in the Workplace (Well for Living partnership): Workplace health events including HIV testing and text message follow-up in distribution centres along the M1.
- Interactive Digital Contact Slip (SXT Health CIC): Development, launch and rollout of an interactive, digital contact slip for partner notification of HIV and STIs.
- Let's Stop HIV (NAZ): HIV awareness raising and testing events with Latin American communities across a number of London boroughs.
- My HIV Prevention Strategy Tool (GMFA/Sigma Research): Development and piloting of an online decision-making tool to assist men who have sex with men (MSM) in choosing HIV prevention strategies.
- Sauna Online Assessment Project (Trade Sexual Health): Development of an online assessment tool and training for 'excellence certification' with saunas. Tool piloted primarily in Leicester.
- Talk and Test (LGBT Foundation/BHA for Equality): Point of Care Testing (POCT) and wellbeing assessments in community settings targeting MSM and Black African communities in the Greater Manchester area.
- Testing Faith (NAZ partnership): Engagement and training of faith leaders for them to create sexual health plans and HIV engagement and testing events for their congregations in London, Luton, Bradford and Wakefield.

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In total, PHE awarded £501,463 across the seven projects, with funds ranging from £55,000 to £100,000, and an average grant of just over £70,000. At the time of writing, four of the projects were able to provide information on the actual direct and staff costs incurred through their work. Two of these projects spent the grant money allocated to them exactly. Two of the projects underspent in the order of 6% and 10%, though the costs associated with some projects do not reflect the true cost, given some projects chose to allocate staff time to the project which was unaccounted for by the grant. The proportion of funding spent on direct costs as opposed to staff costs varied hugely across the projects, reflecting the diversity in project activities.

Project outputs

Overall, the Cohort 1 projects achieved the following outputs:

- They **engaged 5,404 individuals** as a result of their work. This was a core output for all seven projects. Reflecting the diverse nature of the projects' activities and aims, the numbers reached ranged from eight to 3,581 (excluding any media coverage that might have been secured).
- **156 organisations were involved** in some way with the seven projects: this includes delivery partners, Local Authorities, businesses, providers, evaluators and other organisations.
- **76 events** were held by the three projects for whom this was a core output.
- **1,826 HIV tests were conducted** by the five projects who provided testing (ranging from 24-578 tests), with **37% of these being first time tests** (across the three projects able to provide this information, ranging from 32-75%).
- Overall, **33 reactive tests** were identified (18 in 1,000 tests). The number of reactive tests found ranged from none to 19.
- **501 individuals have been referred on** to a health service (though not all projects were able to collect this data).
- **3 online tools** were developed.

There were a couple of instances where projects where able to meet, or exceed, the targets they set for key metrics such as reach and HIV tests completed, though other projects were too ambitious about what could be achieved in the timeframe available to them. Broadly speaking, the projects were able to reach the audiences they identified as key targets.

It is worth noting that the outputs secured by projects and the Fund are likely to be underestimated in a number of cases as a result of methodological challenges in data capture. The exception to this is the number of HIV tests conducted and reactive tests secured – both of which were well documented by projects for whom this was a focus.

Enablers and barriers to implementation

Projects faced a number of enablers and barriers to implementation which are summarised here.

Securing the engagement of particular communities was found to be more effective if **key influencers from the community** were involved given their comprehension of the cultural sensitivities required. It was also suggested that people were positively influenced by other members in their community coming forward and discussing HIV or taking a test

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themselves. Some projects faced the challenge of overcoming **linguistic barriers**. This was again aided by the involvement of community leaders who could engage in individuals' first language, and also by the use of translators, but this was a greater challenge for projects which engaged with multiple communities.

A **partnership approach** was beneficial to some of the projects, allowing organisations to encourage buy-in from relevant organisations and make the implementation process smoother. Building on pre-existing relationships also made the implementation process faster for a number of projects.

Many of the projects had to spend a great deal of time **securing the involvement of other organisations/individuals** – primarily as a result of the stigma associated with HIV. Some projects were able to overcome these barriers through broadening the scope of their work (such as *HIV Testing in the Workplace* which offered other health tests alongside HIV tests), whilst for others it simply took time to build these relationships. Some projects commented on the credibility afforded to their work through being **associated with PHE**; recognising it helped with securing buy-in.

Some projects found the **timelines to be challenging** for reasons other than securing engagement – these tended to result from delays in software design, getting clinical governance in place (in the case of *Talk and Test*), and securing sub-contracting arrangements (in the case of *My HIV Prevention Strategy Tool*).

Time was also needed by some projects to build up trust with the communities they sought to engage. Some individuals showed reticence to be tested for HIV due to fears about having their HIV status divulged, or implications of testing on their immigration status. Overcoming these barriers to engagement required the use of **skilled staff and volunteers** who could work sensitively with the community and allay fears about being tested. Indeed, some of the projects were reliant on having a large field force of staff and volunteers to help run events, conduct tests and so on. A **lack of staff** (and in one case the number of testing kits available) was a limiting factor in the reach of some projects.

Summary outcomes and impacts of projects

Each project has primarily contributed to the evidence base around reducing the impact of HIV in the following ways:

- **HIV Testing in the Workplace:** This project has shown that HIV testing in the workplace is considered acceptable by employees. Offering HIV tests alongside other health checks appears to be a way to normalise it and encourage uptake. The project has shown some promise for the use of text messages as an adjunct to health promotion activities.

- **Interactive Digital Contact Slip**: This project has demonstrated that the targets for HIV partner notification as put forward by BHIVA and others is made more achievable through the use of an interactive, digital contact slip.

- **Let's Stop HIV:** This project was the first dedicated HIV and sexual health project aiming to meet the needs of the Latin American community. It has shown that it is possible to engage a community on the subject of HIV despite it being a highly stigmatised issue.

- **My HIV Prevention Strategy Tool:** Qualitative work with MSM suggested a relatively poor knowledge of PrEP among non-users, coupled with initial negativity towards it, meaning guidance on the use of PrEP is a welcome aspect in sexual health decision making. The tool is yet to be piloted and thus its reception with (and impact on) the target audience is not yet known.

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- **Sauna Online Assessment Project:** This project has shown that it is possible to secure co-operation from sauna owners and sex-on-premises in health promotion activities. It also points to the potential benefits for greater co-creation of interventions with businesses involved.
- **Talk and Test:** This project has demonstrated the feasibility and effectiveness of POCT delivered within community settings by non-clinical staff.
- **Testing Faith:** This project has shown the potential for collaborating with faith leaders to deliver sexual health promotion and HIV prevention to Black African communities. Given the known challenges of working with this audience, this project points to a number of practical suggestions for securing engagement with faith leaders.

Outcomes and impacts for project beneficiaries

Six of the seven Cohort 1 projects had the intention of **improving knowledge about HIV** for individuals engaging with their project. Five of the projects could point to improved HIV knowledge (either self-reported or tested knowledge), with the sixth project not yet in the position to gauge its impact on users' knowledge. Less commonly captured as part of the evaluations was a shift in **understanding and attitudes towards HIV** among project beneficiaries. However, such shifts were observed in a number of cases – primarily where the projects lead to greater normalisation of HIV and testing through exposure to the issue and discussion of it.

Many of the Cohort 1 projects would like to see sustained **changes in behaviour** as a result of their work with, for example, project beneficiaries practicing safer sexual behaviours. Capturing such an outcome is challenging and thus there are limited examples of behaviour change which the evaluation can point to.

A number of the projects had a specific objective to **test individuals for HIV**. Projects did this with reasonable success and were able to test individuals who had never previously been tested. Whilst positive to see a large number of HIV tests being completed as part of Cohort 1 projects, there is limited evidence to suggest project beneficiaries intend to be tested again in future.

An unintended outcome for some project beneficiaries has been the more **holistic consideration of their health and wellbeing** beyond the focus on HIV.

Outcomes and impacts for Voluntary and Community Sector (VCS) organisations

Though the projects were principally designed with project beneficiaries in mind, there are a number of outcomes and impacts for the VCS organisations themselves. Many projects saw the Fund as an opportunity to **provide a proof of concept** that could not be done without the investment and piloting process. Linked to this, some project leads talked about the Fund helping to **demonstrate the value of VCS organisations**.

Some organisations felt they have positively benefited from the Fund through an **increased profile** as a result of their work. For others, it was specifically the **increased recognition with PHE** which they benefited from and which was a key motivator for applying to the Fund rather than alternative funding streams.

Many project leads acknowledged that a core outcome of the Fund for their organisation was the ability to **pursue projects they might not have otherwise**. Similarly, some commented that alternative funding streams tended to be either prescriptive about project scope and/or broad in their target audiences meaning it was a challenge to secure funding for more 'niche' groups such as MSM.

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A key outcome for the funded organisations was the **partnerships established** through their projects. In some instances, the Fund made organisations aware of other organisations they had not previously come across; gave them better knowledge of the work being completed by organisations they had known previously but not in depth; strengthened partnerships already in place; or established new working partnerships.

Outcomes and impacts for Local Authorities/local health economies

There are few examples from Cohort 1 of direct outcomes and impacts of the Fund for Local Authorities. Whilst each project sought the support of Local Authorities at the bidding stage, most did not have ongoing engagement with them. For some projects, the regional or national nature of their work limited the significance of their relationships with local commissioners. Indeed, Local Authorities may not always be the most appropriate funders of projects (if, for example, the project has a national or regional focus, or needs to be commissioned at scale), meaning the impact of the Fund on Local Authorities is very much dependent on the mix of projects funded.

Outcomes and impacts for the Fund/PHE

In general, the Fund has been very **positively received** (by both project leads and evaluators alike) with an intention to reapply for further funding expressed by some organisations.

Taking the number of reactive tests secured as a marker of success (given it was well evidenced by the five projects which focused on testing), a rate of **18 in 1,000** has been achieved overall – much higher than the cost-effectiveness threshold of 1 diagnosis per 1,000 tests as adopted by BHIVA and NICE.

Project legacy

All seven projects would like to see a continuation of their work, and both they and their evaluators could see the potential for their activities to be replicated, scaled-up, or both. Core to continuing the projects was the need to secure additional funding – this was to cover staff activities, ongoing software licensing/development/maintenance, marketing, and HIV testing equipment among other expenses. As far as it is known, four of the seven projects are actively seeking alternative funding streams at present. Two of the projects are not actively seeking funding opportunities themselves, believing they require PHE to support a national adoption of their work. Other projects are building on the momentum of their work and are continuing to establish new partnerships.

Lessons learnt for projects

A small number of projects needed to secure the **engagement of businesses** as part of their delivery model and found the following helpful in doing so: broadening the scope of project work beyond solely focusing on HIV; recruiting someone with expertise in engaging HR and Occupational Health teams; securing buy-in from senior personnel within the organisations; emphasising PHE's endorsement; clearly articulating the benefits of co-operation; easing anxieties that association with the project could have adverse consequences; and considering the potential for co-creation.

Engaging faith leaders created a different set of challenges. Overcoming these in future may involve: working to reduce the time demands placed on individuals who have a wealth of pre-existing commitments; aligning training with faith leaders' existing calendars/planning cycles; ensuring promotional material emphasises leaders' 'duty of care' responsibilities; providing clear messaging on local statistics for HIV prevalence and risk to dissuade views held that HIV is not of relevance to leaders' communities; and recruiting leaders through a snowballing approach such that individuals are reached by personal contacts who are known and trusted.

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In terms of project planning and management, a number of lessons can be drawn: **project ambitions** may need to be better aligned to timeframes, acknowledging the number and extent of delays experienced; remaining **flexible** and adapting the project has shown to be beneficial in a number of cases; projects may benefit from the creation of a **multi-agency steering group** to facilitate implementation; many projects emphasised the importance of working in **partnership** and drawing on the knowledge and networks of local community organisations; making sure that clear and **robust referral pathways** and signposting are in place; and making sure data collection mechanisms are in place to **evidence the impact** of projects (as far as methodologically possible).

Lessons learnt for PHE

Cohort 1 has shown the importance of providing **greater clarity around PHE's role** in the Fund. For example, some projects – assuming they were able to provide encouraging pilot data – were expecting PHE to fund the project further to enable it to move beyond testing, or to up-scale it/replicate it elsewhere. This was particularly the case where projects were not geographically bound and thus national funding and support would be required given local commissioners were unlikely to invest in a project that had wide benefits outside their local health economy. It may be beneficial for PHE to ask projects to articulate (as part of their bid) possible future funding arrangements should the project be proven a success, to ensure expectations are not misaligned at the application stage. Similarly, some projects were expecting PHE to do more to facilitate conversations with commissioners upon project completion, and to 'open doors' for projects to establish relationships both within PHE but also with other key national bodies where relevant. Projects identified PHE's endorsement as aiding their credibility, though one project experienced some uncertainty about what could or could not be said with respect to PHE's involvement – clarity on this matter would be helpful.

Where projects secured media coverage of their work, they believe it stimulated community interest in the programme. Some projects suggested that **more publicity** around the project, driven by PHE, would help extend its reach and assist in engaging communities and organisations with their work.

A number of projects would have benefited from a **longer timeframe** over which to implement and imbed their work. A year was considered to be a very short length of time for a proof of concept – especially where the project was heavily reliant on digital/software development and/or the fostering of relationships with communities or businesses. The full impact of the Fund will not be recognised given some projects (by necessity) spent a far greater time on their set-up rather than delivery (as evidenced by those not reaching their target outputs).

Some projects **questioned the need to secure Local Authority support** as part of the bidding process. Some questioned it on the basis of their Local Authority(ies) having little engagement with the project following the initial bidding process, but others felt that their project (due to its regional or national nature) could not be aligned to particular Local Authorities. It may be, however, that endorsement from Local Authorities is important from PHE's perspective as a hallmark of the quality of projects funded.

Projects were able to point to a couple of procedural aspects of the Fund which they believe would benefit from being amended: mainly stemming from a desire for **greater networking opportunities** facilitated by PHE, and **greater monitoring** of projects' progress. On the whole, feedback on the **application process was very positive**, despite some projects facing a delay in receipt of funding.

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The main potential disbenefit of the Fund identified through the evaluation is the risk that fragile relationships are negatively impacted – either through interactions themselves, or through a lack of continued investment in relationships beyond the end of the project lifecycle.

Next steps

PHE have funded a second cohort of 13 projects which are currently underway and are intended for completion in late 2017. A third cohort of projects will be funded in 2017.

The overarching evaluation will continue throughout 2017 and into 2018. It will involve several stages including the provision of evaluation guidance, and an evaluation of the Cohort 2 projects.

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1 The HIV Prevention Innovation Fund

The Fund's aims and objectives

It is estimated that there are over 100,000 people living with HIV in the UK (101,200 as of 2015), of whom it is thought 13% remain undiagnosed, with rates of late diagnosis high[1]. Diagnoses of HIV are particularly high among specific communities, such as men who have sex with men (MSM) and Black African communities[2]. Public Health England (PHE) has published a strategy, the 'Health Promotion Strategic Action Plan for Sexual Health, Reproductive Health and HIV 2016-2019'[3], which sets out ambitions to decrease HIV incidence in the populations most at risk of new infection and reduce rates of late and undiagnosed HIV in the most affected communities.

As part of this ambition, the HIV Prevention Innovation Fund was set up by PHE to support voluntary sector organisations reduce the impact of HIV through innovative interventions targeting groups most affected by HIV. Funding was allocated to the first cohort of seven projects in 2015 and it is these projects which form the focus of this report. A second cohort of 13 projects have been awarded funding in late 2016 and are at the early stages of implementation.

PHE sought to fund projects which would contribute to the overarching aim of the Fund, and which had the potential to: be replicated and to be scaled-up; strengthen local partnership working; impact on national and local prevention practice; and which were considered feasible, achievable and offered value for money.

The Fund's Theory of Change

The Theory of Change below depicts what the Fund and its projects are anticipated to deliver and the processes by which this is expected to happen. The theory is a means to communicate a shared understanding of what success looks like, in a way that can be measured, and it forms the basis of the overarching evaluation. Both Cohorts 1 and 2 have been involved in shaping the Theory of Change and thus it reflects projects' own experiences.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/602942/HIV_in_the_UK_report.pdf

[2] http://www.nat.org.uk/we-inform/HIV-statistics/UK-statistics

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488090/SRHandHIVStrategicPlan_211215.pdf

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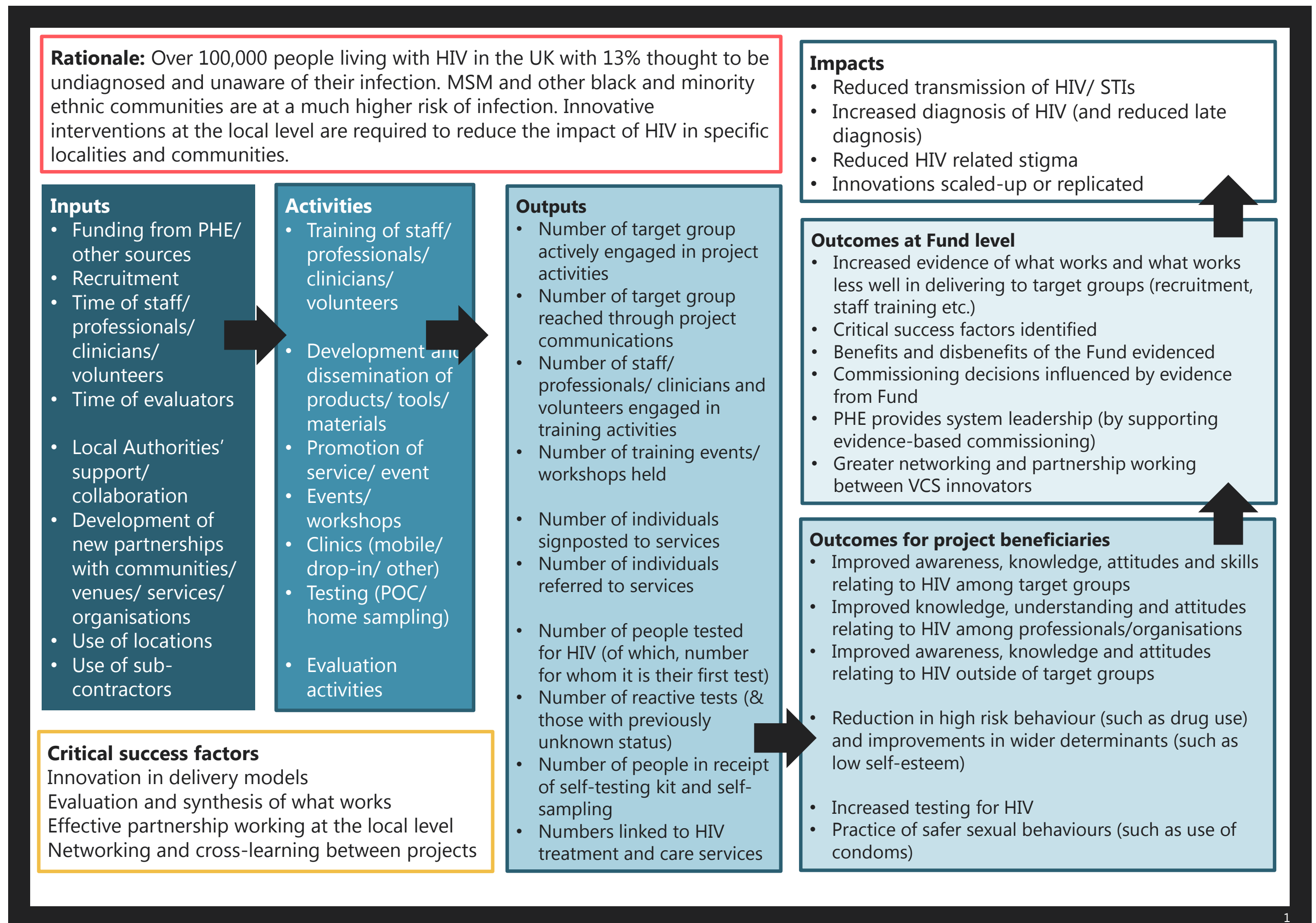
Figure 1.1: Theory of Change



2 The evaluation

Evaluation aims and objectives

PHE commissioned Ipsos MORI to undertake a process and impact evaluation of the Innovation Fund and its projects. There are a number of specific objectives within the overarching evaluation – not all of which are addressed in this report but will be addressed over the duration of the evaluation:

- Assess how individual projects have been implemented and how well they have met their outcomes and delivered on the overall objectives of the Innovation Fund;
- Provide recommendations on areas for improvement within the application and decision making process to ensure the Fund is able to select projects that deliver against its aims and objectives;
- Understand any barriers to implementation and to improve future delivery of the Fund;
- Capture any associated benefits or disbenefits of the Fund;
- Assess how well the Fund has stimulated innovation;
- Assess how well the Fund has supported projects that can be scaled-up and implemented more widely;
- Assess how well projects have contributed to developing local partnerships; and
- Compare the effectiveness of projects in targeting and engaging their relevant population groups.

Evaluation methodology

With the aims and objectives outlined above in mind, this report aims to evidence the achievements of (and lessons learnt) from the Cohort 1 projects. A number of evaluation activities have been completed to generate the evidence for this report:

- Review of evaluation reports: Each project has been tasked with compiling their own evaluation report providing greater detail on activities and achievements than is presented here. Two of the seven evaluation reports are yet to be finalised, though interim reports were studied instead.
- Depth interviews with project leads: Each project lead was interviewed as part of the evaluation to provide an understanding of the implementation process, the extent to which projects achieved what they set out to do, the reasons why they may/may not have met their stated goals, and provide learning about what has made their project more or less successful.
- Depth interviews with evaluators: Evaluators were interviewed to provide a more independent assessment of the subject issues listed above.

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The overarching evaluation will continue and will involve several stages including an evaluation of the Cohort 2 projects. As well as repeating the evaluation activities aforementioned, it is anticipated that subsequent activities will include:

- Depth interviews with panel members: Seeking to understand their view of the application and selection process and what improvements could be made, looking to understand the impact of project selection on the Fund overall.
- Depth interviews with non- and unsuccessful bidders: To understand reasons for not bidding, experiences of applying and what organisations have done in the absence of funding from PHE.
- Qualitative case studies: We plan to complete in-depth case studies with five projects from Cohort 2 to secure a more rounded picture of these projects' impact, speaking with 5-6 individuals per case study (such as the project lead, evaluator, frontline staff, delivery partners and commissioners).

This report

This report is structured around the Theory of Change such that Chapter 3 looks at project activities and inputs; Chapter 4 covers the outputs secured by projects; Chapter 5 discusses the outcomes and impacts evidenced by projects (for project beneficiaries, VCS organisations, Local Authorities, and PHE itself); Chapter 6 discusses the legacy of Cohort 1 projects; Chapter 7 looks at the lessons learnt both at the project level and for PHE; and the report concludes with a discussion of the next steps in Chapter 8.

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3 Project activities and inputs

This chapter provides an overview of the interventions undertaken by Cohort 1, explaining the activities completed, before giving consideration to the inputs they required. It looks principally at the direct costs and indirect staffing costs occurred throughout the projects, considering how this compared to expectations.

Project activities

The table below outlines the key aspects of the projects funded as part of Cohort 1.

Table 3.1: Summary of Cohort 1 projects

Project name	Organisation	Activity	Target audience	Primary location
HIV Testing in the Workplace	Well for Living partnership	Workplace health events including HIV testing and text message follow-up	Black African, low waged, shift workers	East Midlands to South East – along the M1
Interactive Digital Contact Slip	SXT Health CIC	Interactive, digital contact slip for partner notification of HIV and STIs	MSM and BME communities	N/A (online)
Let's Stop HIV	NAZ	HIV awareness raising and testing events with Latin American communities	Latin American communities	Lambeth, Southwark, Haringey, Kensington and Chelsea, Brent
My HIV Prevention Strategy Tool	GMFA/Sigma Research	Online decision making tool to assist in choosing HIV prevention strategies	MSM	N/A (online)
Sauna Online Assessment Project	Trade Sexual Health	Online assessment tool and training for 'excellence certification' with saunas	Sauna owners and staff	Leicester
Talk and Test	LGBT Foundation/BHA for Equality	POCT and wellbeing assessments in community settings	MSM and Black African communities	Manchester and Salford
Testing Faith	NAZ partnership	Engagement and training of faith leaders for them to create sexual health plans and HIV engagement and testing events for their congregations	Faith leaders and Black African communities	London, Luton, Bradford, Wakefield

The section below provides greater detail on the individual projects and the activities they undertook as part of their intervention.

HIV Testing in the Workplace (Well for Living partnership)

This project was developed from an existing partnership of organisations across the East Midlands and South East and was co-ordinated by Well for Living, a community support organisation[4]. This project involved workplace interventions in the form of health and wellbeing events, including HIV testing in distribution centres along the M1 from the East Midlands to the South East, targeting low waged workers on shifts with long hours and migrant workers. The project builds upon work the partnership has previously conducted in delivering HIV testing within the community, however workplace testing for HIV had not been undertaken at this scale before.

Each health and wellbeing event involved a range of health checks offered to employees within the workplace, including HIV testing but also tests of Body Mass Index (BMI), blood sugar, blood pressure and cholesterol. A text messaging intervention was incorporated into the events, whereby employees could voluntarily provide their mobile phone numbers at the event, and would then receive a total of 15 text messages over a month providing information on various health issues.

Interactive Digital Contact Slip (SXT Health CIC)

This project involved the development, launch and rollout of an interactive digital contact slip for anonymous partner notification of HIV and STIs. The tool alerts partners of the index patient, either via email or text and anonymously if preferred, that they may be at risk of an infection and should visit a clinic for testing. Partners are directed to find a local testing service through the SXT website. The tool is designed so providers can track which partners have been told and tested. It is possible for providers to verify the attendance of partners at clinic even if they have not signed-up to use the tool. As part of the project, a number of providers have trialled the tool for free.

Let's Stop HIV (NAZ)

Let's Stop HIV was aimed at raising awareness and providing HIV testing to Latin American (Spanish & Portuguese speaking) communities in five London boroughs: Lambeth, Haringey, Southwark, Brent, and Kensington and Chelsea. The premise behind the project was to tackle the low levels of awareness, knowledge and understanding of HIV in Latin American communities that could put them at greater risk of infection, recognising the high level of stigma attached to HIV within this community.

The project involved holding information-based training workshops in existing Latin American organisations, which provided information on HIV and HIV treatment, as well as giving people the opportunity to test for HIV. In total 10 organisations agreed to engage with the project including commercial, governmental, faith-based and community agencies. The events were led by Spanish and Portuguese-speaking health coordinators from NAZ. At each event, Spanish and Portuguese speaking volunteers distributed and conducted HIV tests; having been trained on how to do so.

My HIV Prevention Strategy Tool (GMFA in partnership with Sigma Research)

This project was a collaboration between GMFA and Sigma Research in the creation of an online decision making tool to assist MSM in deciding which HIV prevention strategy is best for them. The intention was to develop and pilot the tool, creating a specification for its potential rollout in future.

[4] The partner organisations were as follows: Well for Life, STaSS, Sunrise Family Support (SfS), Leicestershire AIDS Support Services (LASS), African Institute for Social Development (AISD), Embrace Life Luton, Design Redefined.

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Individuals face a number of decisions about whether or not to use PrEP, condoms, both or neither, in addition to the option of avoiding anal sex. The premise behind this tool is to take a person-centred approach, identifying the best HIV prevention strategy for individuals depending on the value they place on attributes of different prevention strategies, as well as their likelihood to adhere, and the available evidence of the effectiveness of such strategies. Users of the tool are signposted to another a number of relevant websites following completion. The tool was based on a similar tool used to assist women in their choice of contraception[5]. The views of 30 MSM fed into the development of the tool through four focus groups.

The project has encountered a number of delays – most notably a delay of eight months before a sub-contract could be put in place between GMFA and Sigma Research, and challenges faced in trying to operationalise the intended functions of the tool through the software employed. The intention remains to pilot the tool on GMFA's website, surveying users to secure feedback on their experience and perceptions of the tool. It is expected that the tool will be available online as part of the pilot until the end of 2017. The date from when it is live depends on the speed at which the present prototype can be cognitively tested and refined.

Sauna Online Assessment Project (Trade Sexual Health)

This project was to create an online assessment tool for 'excellence certification' with men's saunas around the country, and to pilot this tool at three saunas in Leicester. The premise behind the project was the desire to promote greater collaboration between men's saunas and sexual health agencies in the promotion of good sexual health outcomes and HIV prevention among sauna users.

The excellence certification comprised an audit checklist around issues such as health and safety, hygiene, staff knowledge on HIV and health promotion accessibility, accompanied by online training for staff. The possible certification levels created were Gold (highest), Silver, and Bronze (lowest). The project involved close collaboration with sauna owners to secure buy-in. Three Leicester saunas completed the certification process (one securing Gold and two Silver) though one withdrew from the project. Through working with Yorkshire MESMAC, a fourth sauna was recruited to the project outside the Leicester area.

Talk and Test (LGBT Foundation in partnership with BHA for Equality)

Talk and Test offers Point of Care Testing (POCT) to MSM and Black African communities in community settings across Greater Manchester. The project was led by the LGBT Foundation and BHA for Equality, but with support from a steering group[6]. The LGBT Foundation delivered a drop-in service twice a week at the LGBT Foundation Community Resource Centre in central Manchester, and drop-in clinics at the University of Salford and Langworthy Cornerstone in Salford. BHA for Equality established eight regular community-based HIV testing sites for Black Africans in high prevalence areas across five Greater Manchester boroughs. They used an outreach approach where community engagement and development workers had to raise awareness of HIV.

Testing Faith (NAZ partnership)

The *Testing Faith* project was a collaboration between three sexual health charities across different regions in the country: Centre for All Families Positive Health (CAFPH) based in Luton, Yorkshire MESMAC based in Bradford and Leeds and NAZ based in London. This project involved engaging faith leaders (leaders of Christian and Muslim congregations) in an HIV

[5] http://www.fpa.org.uk/contraception-help/my-contraception-tool

[6] Which included Manchester City Council, Salford City Council, Bridgewater Community Healthcare NHS Foundation Trust and PHE North West

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intervention programme. The rationale of *Testing Faith* was to reach Black African communities using the influence that faith leaders have in the community. It comprised three stages: engaging faith leaders in a one or two-day training course reviewing the epidemiology of HIV, HIV treatment and prevention in relation to prayer, meeting people with HIV and an examination of stigma and the role of faith institutions in challenging this. The faith leaders were then supported to develop simple sexual health plans for their congregations. And faith leaders were encouraged and supported to put their sexual health plans into practice by holding events for their congregations at which people were offered HIV testing.

Project inputs

In total, PHE awarded £501,463 across the seven projects, with funds ranging from £55,000 to £100,000, and an average grant of just over £70,000. Five of the projects were awarded the full funding requested. Two of the projects were given 97% and 75% of the funds requested.

The proportion of funding spent on direct costs as opposed to staff costs varied hugely across the projects; reflecting the diversity in project activities. Not all projects chose to cover internal staffing costs through the grant but chose to allocate staff time to the project which was unaccounted for by the grant (with, for example, one project having 8 hours a week dedicated to it but not accounted for in the costing and grant award). PHE should be mindful of this given the costs associated with some projects may not reflect the true cost of time spent on them. Similarly, one evaluator chose to offer time pro-bono to the project given they themselves were personally and professionally committed to the development of the HIV evidence-base.

At the time of writing, four of the projects were able to provide information on the actual direct and staff costs incurred through their work (noting that some staff time is not accounted for as aforementioned). Two of these projects spent the grant money allocated to them exactly. Two of the projects underspent in the order of 6% and 10%.

On average, 9% of the grant was allocated at the bidding stage towards the evaluation, though variance was wide from less than 1% to 17%. For the three projects able to provide their actual spend on monitoring and evaluation, they spent 1%, 12% and 18% of their awarded funding on this aspect (very similar to their anticipated level of spend).

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4 Project outputs

This chapter looks at the key outputs achieved by each project, and by the Fund at an overall level. The outputs are all quantitative metrics, based on the Theory of Change and the target outputs articulated by projects themselves. Chapter 5 goes on to examine the outcomes and impacts achieved by each project; taking a more qualitative look at issues such as the extent to which project beneficiaries demonstrated increased knowledge about HIV and the extent to which attitudinal shifts regarding HIV were observed. This chapter goes on to examine the challenges and enablers projects have faced in implementation.

Across the seven projects, a core output for all was the number of individuals who were, in some way, engaged in their work. Another core output for five of the projects was the number of individuals tested for HIV (and alongside this, the proportion testing for the first time, and the number of reactive tests). Overall, the projects were able to achieve the following:

- They **engaged 5,404 individuals** as a result of their work.
- **156 organisations were involved** in some way with the seven projects: this includes delivery partners, Local Authorities, businesses, providers, evaluators and other organisations.
- **76 events** were held by the three projects for whom this was a core output.
- **1,826 HIV tests were conducted** by the five projects who provided testing, with **37% of these being first time tests**.
- Overall, **33 reactive tests** were identified (18 in 1,000 tests).
- **501 individuals have been referred on** to a health service (though not all projects were able to collect this data).
- **3 online tools** were developed.

The subsequent table shows the outputs secured by individual projects. Data are only shown where it is believed to be relevant for that particular project. In some instances, the data are missing or believed to be incomplete – not all metrics were captured by each project, and some data are yet to be provided to Ipsos MORI.

Some projects faced methodological challenges which has limited their ability to fully measure their outputs. Evaluators were not always involved at the start of projects meaning they were not set up to capture the full range of outputs. For example, the reach of *Testing Faith* is greater than that shown here but data on the number of people attending events organised by the faith leaders themselves was not captured. Similarly, some outputs are methodologically difficult to capture such as the number of individuals who go on to receive treatment for HIV. The outputs secured by projects and the Fund are therefore likely to be underestimated in a number of cases, with the exception of the number of HIV tests conducted and reactive tests secured – both of which were well documented by projects for whom this was a focus.

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Table 4.1: **Project outputs achieved**

Metric	Fund overall	By project		Target	Notes
Numbers engaged (approximate only)	5,404	HIV Testing in the Workplace	776	2,000	Refers to event attendees
		Interactive Digital Contact Slip[7]	231	Not specified (N/S)	132 index patients + 99 partners contacted
		Let's Stop HIV	3,581	N/S	2,056 though outreach + 1,525 through presentations[8]
		My HIV Prevention Strategy Tool	30	500-1,000 to pilot tool	Tool not yet live. 30 attended focus groups
		Sauna Online Assessment Project	8	N/S	Sauna owners and staff completing training
		Talk and Test	722	100	426 LGBT, c.296 BHA
		Testing Faith	56	60 faith leaders	Refers to faith leaders. Excludes numbers attending the awareness raising and testing events that happened after
Number of organisations engaged with	145	HIV Testing in the Workplace	18	N/S	Events held at 11 organisations + 6 project partners + evaluator
		Interactive Digital Contact Slip	76	N/S	14 providers using routinely + 60 providers signed-off a partner + website developer + evaluator
		Let's Stop HIV	14	20	13 participating organisations + evaluator
		My HIV Prevention Strategy Tool	1	N/S	Delivery partner
		Sauna Online Assessment Project	7	4	4 saunas + website developers + partner + evaluator
		Talk and Test	26	N/S	19 testing sites + 7 steering group organisations
		Testing Faith	3	N/S	2 deliver partners + evaluator
Number of Local Authorities engaged	13 (accounting for overlap)	HIV Testing in the Workplace	5	N/A	Overlap: Luton
		Interactive Digital Contact Slip	2	N/A	Overlap: Lambeth, Southwark
		Let's Stop HIV	4	N/A	Overlap: Lambeth, Southwark, Kensington & Chelsea
		My HIV Prevention Strategy Tool	1	N/A	Overlap: Kensington & Chelsea
		Sauna Online Assessment Project	1	N/A	
		Talk and Test	2	N/A	
		Testing Faith	3	N/A	Overlap: Luton, Lambeth

[7] Note data up to date as of 19th March 2017 for Interactive Digital Contact Slip

[8] Excludes the 150,000 reached through press/media, the 28,000 condoms and 9,200 leaflets distributed

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Metric	Fund overall	By project		Target	Notes
Number of events held	76	HIV Testing in the Workplace	20	20	
		Let's Stop HIV	30	30	
		Testing Faith	26	N/S	5 training sessions and 21 held by faith leaders
Number of people tested for HIV	1,826	HIV Testing in the Workplace	426	300	Target of 15 per event and 20 events. 405 tests at events, 21 self-reported tests via text
		Interactive Digital Contact Slip	24	N/S	Refers to partners verified by SXT (17 verified at clinic, 7 self-declared)
		Let's Stop HIV	562	600	
		Talk and Test	578	1,000	LGBT: 426 and BHA: 152
		Testing Faith	236	600	Target refers to tested or referred
% tested for the first time	37%	HIV Testing in the Workplace	75%	N/S	
		Interactive Digital Contact Slip	Unknown	N/S	
		Let's Stop HIV	32%	N/S	
		Talk and Test	32%	N/S	LGBT: 16% and BHA: 76%
		Testing Faith	Unknown	50%	
Number of reactive HIV tests	33 (18 in 1,000 tests)	HIV Testing in the Workplace	0	N/S	
		Interactive Digital Contact Slip	4 (167 in 1,000 tests)	N/S	Expected from partners verified and tested
		Let's Stop HIV	19 (34 in 1,000 tests)	N/S	17 confirmations and 2 new
		Talk and Test	9 (16 in 1,000 tests)	N/S	All 9 LGBT so 21 in 1,000 tests
		Testing Faith	1 (4 in 1,000 tests)	N/S	
Numbers of people referred on to another service	501	HIV Testing in the Workplace	Unknown	N/S	
		Let's Stop HIV	Unknown	200	
		Talk and Test	106	N/S	LGBT: 92 and BHA: 14
		Testing Faith	395	600	Target refers to tested or referred
Number of people receiving treatment	6	HIV Testing in the Workplace	Unknown	N/S	
		Interactive Digital Contact Slip	Unknown	N/S	
		Let's Stop HIV	5 known	N/S	
		Talk and Test	Unknown	N/S	
		Testing Faith	1 known	N/S	
Number of online tools developed	3	Interactive Digital Contact Slip	1	1	
		My HIV Prevention Strategy Tool	1	1	Still undergoing development
		Sauna Online Assessment Project	1	1	
Number of publications and conferences	5	Interactive Digital Contact Slip	5	N/S	3 presentations (one oral and two poster); two publications and two being prepared

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Looking at the five projects which had HIV testing as a core deliverable, the following costs per test and per reactive test have been achieved:[9]

- HIV Testing in the Workplace: £189 per test (including the 21 self-reported tests from the text messaging service), no reactive tests
- Interactive Digital Contact Slip: £2,293 per test (for partners verified by SXT), £13,757 per reactive test, 167 in 1,000 tests
- Let's Stop HIV: £108 per test, £3,202 per reactive test, 35 in 1,000 tests
- Talk and Test: £155 per test, £9,961 per reactive test, 16 in 1,000 tests
- Testing Faith: £318 per test, £75,000 per reactive test, 4 in 1,000 tests

The costs above do not reflect the true cost per test/per reactive test, given they are based on the full funding allocated and therefore include the set-up costs, evaluation costs, staff time and so on (indeed the delivery cost per test for projects is substantially less than the costs shown above). However, looking at the costs in this way gives a sense of the economies of scale associated with different delivery models and how well targeted the projects are at communities most at risk of HIV. Whilst these five projects focused on HIV testing as a core output, it is recognised that many other outcomes and impacts were intended and many had a much broader focus, encompassing educational and attitudinal work. It is also recognised that many of the projects had extended set-up phases, resulting in shortened delivery phases which will have limited the number of tests completed. With longer delivery phases, it is fully expected that the costs per test would decline.

Let's Stop HIV appears to be particularly well targeted given the high proportion of reactive tests, and the volume of tests completed suggesting this to be a cost-effective delivery mechanism (or at least one with relatively limited set-up costs). Whilst the cost per test initially appears high for the *Interactive Digital Contact Slip*, there are considerable set-up costs associated with an online tool such as this which is designed to be used at scale, and the cost only reflects partners verified through SXT (not index patients tested). The high proportion of reactive tests reaffirms partner notification to be highly effective at targeting those most likely to be at risk from HIV[10].

Meeting targets

There are a couple of instances where projects were able to outperform the targets they set for themselves. *HIV Testing in the Workplace* completed 405 HIV tests versus a target of 300 (135% of target achieved). This is despite having a lower number of event attendees compared to expectations at the project start (776 attendees compared to the 2,000 anticipated). As subsequently explained in this report, this project found engaging with businesses a challenge, but once permitted to host events the demand for HIV testing outstripped the number of tests available – and thus it could have gone on to complete more tests that the number shown here.

Let's Stop HIV was just shy of meeting its target number of HIV tests (562 of the 600 target set). *Testing Faith* completed 236 tests against a target of 600 – though this target was for individuals to either be tested or referred on for testing and

[9] Note these figures are based on the number of tests completed, number of reactive tests and total project spend. Where final project spend is unknown, the allocated grant amount has been used for calculations.

[10] http://www.bhiva.org/documents/Publications/May-2012-HIV-Partner-Notification.pdf

thus it is not possible to gauge actual versus target performance. *Talk and Test* was able to complete 577 HIV tests, suggesting the original target of 1,000 was too ambitious. Most of these tests were completed through LGBT Foundation with MSM (428) rather than with Black African communities through BHA for Equality (152) – the latter experienced slower progress given the difficulties of engaging this community on the subject of HIV (as explored further later in this report).

Few other targets were set by projects and thus the evaluation is unable to compare actual versus predicted success for many of the metrics shown.

Broadly speaking, it appears that the projects have been able to reach the audiences they identified as key targets:

- HIV Testing in the Workplace: A broadly even split of males and females attended the workplace events, and chose to take an HIV test. 30% of event attendees (who responded to the survey) were classified as migrant workers (defined as having a country of birth outside the UK), representing 50 different countries. 16% of respondents were from Eastern Europe and 5% from sub-Saharan Africa. Attendees from sub-Saharan Africa were particularly likely to take an HIV test (64% did so) with 35% of Eastern European attendees choosing to take a test. The majority of attendees reported themselves to be heterosexual (97%). A very high proportion of individuals who took a test did so for the first time (75%).

- Interactive Digital Contact Slip: The tool is not targeted at specific demographics, though the following is known about the HIV index patients recorded: the majority are male (69%), half (50%) identify as MSM, 45% describe themselves as White and 28% are from a Black ethnic background.

- Let's Stop HIV: The vast majority of tests (95%) were with Latin Americans, with small numbers of Portuguese, Spanish and Black African individuals also tested. The majority of individuals tested were heterosexual (77%), thus reflecting the target audience of this project. Information was not collected on the profile of attendees, though it is thought individuals from the following countries were involved in the Portuguese element of the project: Angola, Brazil, England, Guinea-Bissau, Mozambique, Portugal, Timor Leste.

- Talk and Test: This project appeared to engage its target audience. The HIV tests carried out by LGBT Foundation were predominantly carried out with individuals describing themselves as White (81%), with the majority from Manchester (54%), followed by Salford (13%). 86% of all tests carried out by BHA for Equality were carried out with people describing themselves as Black African. Other individuals described themselves as Asian, including people from Pakistan, India, Afghanistan and Iran. 20% of tests were carried out with women. 73% of people attending the service were split approximately equally between Bolton and Manchester, 19% came from Salford with a small number from Oldham and Rochdale.

- Testing Faith: Little is known about the profile of individuals reached through this project, though it is thought that individuals from the following countries were reached by the project: Congo, Gambia, Ghana, Jamaica, Malawi, Nigeria, Oman, South Africa, St Lucia, Sudan, Zambia and Zimbabwe.

Enablers and barriers to implementation

Across the projects there were some common factors that enabled, or challenged their implementation. These are given consideration in the discussion below.

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A community based approach

In the projects that delivered on-site testing, getting a specific community on board (and influencing them to have a test) was felt to be more effective if key influencers from the community were involved. The project leads and volunteers for *Let's Stop HIV* were members of the same community the project was trying to target (Latin Americans); the same is true for *Talk and Test* (targeting the Black African community). Both emphasised the importance of understanding the culture of a group of individuals, the places where they meet, where they're working, and the cultural sensitivities in accessing a hard to reach community.

"The involvement of community members [was key]. The two co-ordinating are from Brazilian and Colombian communities. That's really helpful, because it does enable communication in a way that's culturally sensitive, culturally informed, an element of trust that can be established relatively quickly." Project evaluator – Let's Stop HIV

"I feel comfortable receiving services from people who understand my culture, my community and the challenges we face as BME." Service user – Talk and Test (BHA for Equality)

It was also suggested that people might be more encouraged to take a test if they were influenced by other members in their community coming forward and discussing HIV or taking a test themselves. This was effective in breaking down the barriers in these communities. BHA for Equality gave the example of a pastor who volunteered himself and his wife to take a test to encourage his congregation to do the same; they suggested that leaders in the community can go a long way to reducing the stigma associated with HIV. *Testing Faith* found that once they had got one or two faith leaders on board then others were easy to recruit to training events.

"BME groups have a sense of collectivity and community so if one person tests then others will. You can use that as an advantage – if you've got one person then you can use that to try and get others to test." Project lead – Talk and Test (BHA for Equality)

Overcoming language barriers

For projects engaging with communities for whom English was not their first language (notably *Let's Stop HIV, Talk and Test, HIV Testing in the Workplace*) this represented a key challenge to successful delivery. For example, language barriers meant some people involved in *HIV Testing in the Workplace* were unable to use the text messaging service due to poor reading and writing skills in English. BHA for Equality had to use interpreters and think proactively about the resources they were distributing as, for instance, the questionnaires used were too complicated for some members of the community. Again, using members of the community to lead on the project helped. However, where projects engaged with multiple communities this was more of a challenge.

"The linguistic knowledge and expertise is fundamental – being understood by the people we're trying to target. Many clients don't speak English at all which is a barrier to their engagement with health issues." Project evaluator – Let's Stop HIV

Working effectively with partners

A partnership approach was beneficial to some of the projects, allowing organisations to encourage buy-in from relevant organisations and make the implementation process smoother. *Talk and Test,* for example, established a steering group at

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the very beginning of the project that shaped the intervention which meant that a range of stakeholders were engaged early on. This assisted them in the bidding process, identifying the right venues for the testing sites, getting clinical governance in place, and making sure the learnings of the project were widely disseminated.

"We put a lot of time into strategic thinking on who needs to be around the table. We started the partnership before the bid...I think that's a real innovation to capture as it's very different to other funders."
Project lead – Talk and Test (LGBT Foundation)

Other projects had existing partnerships in place which meant that the projects were able to get off the ground more quickly. For example, *HIV Testing in the Workplace* was delivered by a partnership of seven charities and community organisations that had been working together for a number of years meaning their links were already well established. NAZ also delivered *Testing Faith* in collaboration with two other charities, and said that the support networks that this offered were 'fundamental'.

Getting buy-in from collaborators

Getting external organisations on board was a challenge, and many of the projects had to spend a great deal of time at project inception securing the involvement of other organisations. The stigma associated with HIV played a large factor in this, and projects found that many organisations were reluctant to engage on the subject matter. For example, the *HIV Testing in the Workplace* found it a challenge initially trying to convince workplaces to allow HIV tests to happen on their premises; to make it more acceptable for the workplaces, the team delivered diabetes and body mass index tests as well, offering workplaces a more holistic health check offer. Nonetheless, four companies dropped out after initially agreeing to host the health events, of which two gave the reason that HIV screening was not a necessary and appropriate service to offer their employees, with some concerns raised about possible reputation risks.

"At one time it didn't look like we would get any events. There's still quite a lot of stigma. So HR might agree it but then their big comms team would come down and go 'oh no, we don't want any bad publicity'."
Project lead – HIV Testing in the Workplace

Let's Stop HIV experienced similar challenges getting organisations to agree to host awareness raising events because of the stigma surrounding HIV – and some organisations did not allow the events to happen on their premises because of the connotations associated with HIV. As a result, they did not manage to get as many organisations to sign up to the events as they wanted, however this did not affect the number of events they were able to host as they did more than one in some organisations. Likewise, *Testing Faith* had to overcome concerns from faith leaders about discussing sexual practice with their congregations.

"They didn't want to get involved thinking we were trying to promote sex within their churches outside marriage...And then you'll try and talk about gay communities: 'we don't talk about that in our churches', so it's very difficult because of what HIV is associated with." Project lead – Testing Faith

Projects therefore had to spend a considerable amount of time getting the different organisations involved in order to deliver their intervention. *Let's Stop HIV* felt that more time to build relationships would have resulted in greater success. Likewise, retrospectively, the *Testing Faith* team felt that a two-year timeframe would have been more effective to allow faith leaders to schedule in time to engage with the various stages of the project, as they found that many of the faith leaders already had busy schedules that prevented them from taking part.

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"For you to come and implement something at the beginning of the year, they've already got a busy schedule." Project lead – Testing Faith

SXT did not get as many clinics trialling the Interactive Digital Contact Slip as initially hoped. This was, in part, thought to be as a result of bureaucracy in the system and where initial progress was stalled by individuals higher up the chain. It was also suggested that the performance targets set for clinics encouraged a focus on high volumes of testing rather than *targeted* testing to secure a high rate of positive diagnoses, and thus the benefits of patient notification on the cost of diagnosis were not always fully grasped.

"There are lots of people who have the power to say no who hold sway, there are lots of people who need to approve it, there is a sense of a bureaucratic quicksand that you lose projects in". Project lead – Interactive Digital Contact Slip

Additionally, the team working on the *Sauna Online Assessment Tool* found they needed to work hard with some of the sauna owners to encourage them to consider their health promotion responsibilities.

"Saunas have been reluctant to do that health promotion side, sauna owners don't understand the importance and why…working with sauna owners is a very difficult and time consuming task." Project lead – Sauna Online Assessment Project

Endorsement from PHE

The credibility afforded by having PHE's name associated with projects also assisted implementation, although it was suggested that more could be done to make use of PHE's involvement in future projects. For example, *HIV Testing in the Workplace* found that companies were more willing to collaborate because they knew PHE had funded the project. However, overall they had difficulty in obtaining a response and permission from potential companies, and felt that future initiatives would benefit from even greater official support from national organisations such as PHE. Other projects also felt that PHE's branding gave authenticity to their work though the benefit of PHE's involvement was not always maximised. For instance, it was suggested that more information could be made available publicly about the Fund and its projects to encourage partnership-working across the cohort and enable more effective implementation.

"It was run by Public Health England, so it gave us a kind of credibility" Company representative – HIV Testing in the Workplace

Encouraging beneficiaries to use the services

With some target audiences, considerable time was needed to build trust about the process of taking a test and treatment for HIV. *Let's Stop HIV* reported a reluctance among the community because of fears about having their HIV status divulged, and for some individuals their fear of testing for HIV was linked to implications for their immigration status. Projects made use of highly skilled staff and volunteers who could work sensitively with the community and allay fears about being tested.

"Another challenge is working with communities with a great amount of stigma regarding sexual health so approaching those kind of people can be a challenge. The team just has to approach conversations sensitively." Project lead – Talk and Test (BHA for Equality)

Resourcing the events

Not all projects reported encouraging individuals to test to be a challenge – *HIV Testing in the Workplace* ran out of tests at a number of events because demand exceeded expectations. Had more HIV tests been available, a greater number of tests could have been completed.

It was also pointed out that sufficient staff need to be available to run the events in an efficient manner and to meet the demand. Likewise, it was noted that the staff needed to be well trained, knowledgeable, confident and competent to deliver a good service. This was also something raised by *Talk and Test* and *Let's Stop HIV*, both of whom spent time at the beginning of the projects to train volunteers to ensure the team of testers felt confident delivering the service. Both BHA for Equality and the *HIV Testing in the Workplace* team felt that if they had time to train individuals to conduct the tests, then they would have been able to deliver more tests in a greater range of locations.

"If you had more staff you could offer it in a lot more places. A test can take up to an hour so you might be doing tests from 11-3pm, so if you want lots of numbers then it's about building the capacity of the people." Project lead – Talk and Test (BHA for Equality)

Challenging time frames

Many of the projects reported unforeseen time delays in implementing their projects, for a range of reasons. The *My HIV Prevention Tool* was significantly delayed due to challenges around contracting. Two of the projects' websites or online tools had technical difficulties that they had not accounted for, which impacted timings. The website for the *Sauna Online Assessment Tool* took longer than expected of the challenge getting the audit to work in terms of setting where the boundaries should be. And the *My HIV Prevention Tool* faced further delays because of technical challenges presented by the software.

"The 'fiddly-ness' of the software which I hadn't used before so I went round the houses quite a lot trying to get that to work, it took longer than I was anticipating". Delivery partner – My HIV Prevention Tool

Getting clinical governance in place for *Talk and Test* was a big challenge, and meant that the expected timescales for the project had to be delayed by three months. This was largely because they had no precedent, and POCT had not been carried out by a voluntary organisation in Manchester before. To get clinical governance they had to work with a healthcare provider to develop an operating manual to specify how testing services would be set up (including details such as the need for wipe clean surfaces, running water, storage in a fridge). They also did a lot of work at the beginning of the project mapping out referral pathways; this involved contacting local sexual health clinics and ensuring they knew the opening hours, and who to speak with etc.

"Because voluntary organisations hadn't delivered POCT before it was the unknown and it was really challenging getting clinical governance for it. We wrote in a two month set up phase, and for different reasons it took about five months to set it up." Project lead – Talk and Test (LGBT Foundation)

Many of the projects were also dependent on building up contact and relationships with the community or other organisations. They pointed out that this takes time, and some projects felt that they would have had more success if they had a longer timeframe than one year. For example, the project lead of *Let's Stop HIV* had only just begun to see the benefit of building up contacts over time – as many organisations which had initially refused to help with the awareness raising events were now more positive about getting involved. As discussed above, *HIV Testing in the Workplace* found it

challenging getting companies on board within the time scales, and *Testing Faith* felt they would have benefited from more time to build relationships with faith leaders, particularly because their schedules get booked up early on.

"Overall I think the project was too short. I think if they'd had another six months, they would have broken through that target. They might even have doubled the target. Because I think this type of work is about the softer stuff – it's about building the relationship to facilitate the testing." Project evaluator – Testing Faith

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5 Outcomes and impacts

This chapter focuses on the outcomes and impacts achieved by the Cohort 1 projects – taking each beneficiary group in turn. Initially however, a summary is provided on what each project uniquely contributes to the evidence base around reducing the impact of HIV.

Project specific outcomes and impacts

- HIV Testing in the Workplace: This project has shown that HIV testing in the workplace is considered acceptable by employees – over half (52%) of event attendees took an optional HIV test and the vast majority {96% of 705 individuals) indicated that it was acceptable to include HIV testing as part of a workplace health check. There is some suggestion that offering the HIV test alongside other health checks is a way to normalise it and encourage uptake. The project has shown some promise for the use of text messages as an adjunct to health promotion given 60% of all attendees signed-up to receive them, and 21 out of 80 (26%) people who replied to the texted question on HIV testing, reported that they had sought an HIV test subsequent to attending the workplace event.

- Interactive Digital Contact Slip: This project has demonstrated that the target of 0.6[11] for HIV partner notification as put forward by BHIVA and others[12] is more achievable through the use of an interactive, digital contact slip (detail is provided later in this chapter).

- Let's Stop HIV: This project was the first dedicated HIV and sexual health project aiming to meet the needs of the Latin American community. It has shown that it is possible to engage a community on the subject of HIV despite it being a highly stigmatised issue with cultural practices limiting open dialogue about sexual practices.

- My HIV Prevention Strategy Tool: Qualitative work with MSM suggested a relatively poor knowledge of PrEP among non-users, coupled with initial negativity towards it; reflecting other literature in this area[13]. Given this, guidance on the use of PrEP was seen as a welcome aspect in sexual health decision making. The tool is yet to be piloted and thus its reception with (and impact on) the target audience is not yet known.

- Sauna Online Assessment Project: This project has shown that it is possible to secure co-operation from sauna owners and sex-on-premises in health promotion activities. It also emphasises the importance of handling relationships sensitively, recognising health promotion may not be of primary importance to sauna owners. It also points to the potential benefits for greater co-creation of interventions with businesses involved.

- Talk and Test: This project has demonstrated the feasibility and effectiveness of POCT delivered within community settings by non-clinical staff. The levels of reactive tests captured by the LGBT Foundation, and the proportion of individuals testing for the first time with BHA for Equality, demonstrate the appropriateness of a community-based approach for the MSM and Black African communities in Greater Manchester. Commissioners have since integrated POCT as part of the Greater Manchester Sexual Health tender, and LGBT Foundation, BHA for Equality and George House Trust were awarded the contract as the Positive for Sexual Health Partnership (PaSH).

[11] 60 partners seen and tested for every 100 HIV diagnoses

[12] http://www.bhiva.org/documents/Publications/HIV_Partner_Notification_Standards_2015.pdf

[13] https://www.cogentoa.com/article/10.1080/2331205X.2016.1256850.pdf

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- Testing Faith: This project has shown the potential for collaborating with faith leaders to deliver sexual health promotion and HIV prevention to Black African communities. Given the known challenges of working with this audience, this project points to a number of practical suggestions for securing engagement such as building engagement through networking opportunities, and aligning work with leaders' yearly planning cycles.

For project beneficiaries

As documented in the Fund's Theory of Change, there are a number of intended outcomes for individuals, professionals and organisations that engage with the funded projects. Primarily these relate to improved awareness, knowledge, attitudes and skills relating to HIV, alongside increased testing for HIV, the practice of safer sexual behaviours and the reduction in high risk behaviours. These are discussed in turn below.

Improved awareness and knowledge of HIV

Six of the seven Cohort 1 projects had the intention of improving knowledge about HIV for individuals engaging with their project. Some of the projects explicitly tested this knowledge – for example, *Let's Stop HIV* and the *Sauna Online Assessment Project* used an adapted version of the HIV Knowledge Questionnaire (Carey & Schroder, 2002). Others asked for self-reported improvements in knowledge. Five of the projects could point to improved HIV knowledge (with *My HIV Prevention Strategy Tool* not yet in the position to test its impact on users' knowledge).

- For *Talk and Test*, a very high proportion of service attendees said they felt 'more informed about HIV and testing as a result of using the service' (92% of 360 LGBT service attendees, and 100% of 151 BHA service attendees). And a high level of agreement was seen with a number of knowledge statements such as, 'My knowledge of how HIV is passed on has improved' (91% of 376 LGBT service attendees, and 90% of 152 BHA service attendees), and 'I feel more able to negotiate using condoms with sexual partners' (79% of 367 LGBT service attendees, and 99% of 151 BHA service attendees).

  "I was truly educated and had my knowledge brought up to date." Service user – Talk and Test

- For *Let's Stop HIV*, 60% of Spanish-speaking clients received a 'high' score for HIV knowledge (11% a 'medium' and 29% a 'low' score based on 91 individuals), and 48% of Spanish-speaking clients received a 'high' score (27% a 'medium' and 25% a 'low' score based on 132 individuals)[14]. Given the typically low levels of HIV knowledge in Latin American communities, these results suggest a higher than anticipated level of knowledge among event attendees.

- Users of the Gold certified sauna in the *Sauna Online Assessment Project* demonstrated greater HIV prevention knowledge and recorded engaging in less sexual risk-taking compared to users of the Silver certified saunas. For example, 10% of users were unaware of their HIV status (compared to 29% and 33% at the Silver certified saunas) and 59% had heard of PrEP (compared to 36% and 46% at the Silver certified saunas). This pattern was observed across a number of measures and is unlikely to have occurred by chance but rather may reflect the stronger culture of sexual health promotion and HIV prevention present at the Gold sauna.

- Though knowledge of HIV was not explicitly tested as part of *HIV Testing in the Workplace*, 80% of 585 event attendees felt they had learnt something new about their health as a result of the event.

[14] Here a high score was taken by the project evaluator to be 75% or above, medium 50-74% and low 0-25%

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- Similarly, *Testing Faith* did not explicitly measure changes in the knowledge of faith leaders as a result of its work, though it was shown to improve some leaders' attitudes (see below) which, by necessity, would have been achieved through securing a better knowledge of HIV.

Improved understanding and attitudes relating to HIV

Less commonly captured as part of the evaluations was a shift in understanding and attitudes towards HIV among project beneficiaries. However, such shifts were observed in a number of cases.

Beneficiaries of *Let's Stop HIV* commented on the project's ability to draw attention to HIV and provide a forum within which it could be discussed in a socially and culturally sensitive way. By curbing the silence around HIV in Latin American communities, the subject matter became less stigmatised. Similarly, *HIV Testing in the Workplace* resulted in HIV testing being normalised by virtue of it being included as part of the workplace health events – something which many of the participating workplaces said they would not have previously considered.

"People in our community would rather not talk about this openly so it becomes difficult with the HIV thing because you can never mention it but [they] found a way of talking about it so people can feel OK about this and that." Participating organisation – Let's Stop HIV

"I just wanted to say thank you, in 2014 my son was diagnosed with HIV and I have found this hard to deal with. The Healthy Hub Roadshow experience has given me the confidence to speak with him and reconnect with him." Event attendee – HIV Testing in the Workplace

Testing Faith identified improvements in the self-reported attitudes towards HIV held by faith leaders. Positive shifts were observed for the 38 faith leaders who completed a pre- and post-training survey on metrics such as, 'discussing sex encourages immoral behaviour', 'the frequent use of condoms is a sign of promiscuity', and 'if a member of my family was living with HIV, I would want it to be a secret'. Attendees talked about the events being 'enlightening' and powerful'.

"When I went for the course my perceptions changed totally… I found it very impactful, very educational." Faith leader – Testing Faith

"A middle aged African pastor was sat in tears because he was so moved and so enlightened by what he had learnt, and how they felt so sorry about how they had mistreated people in their church because they thought they were doing the right thing by saying 'you have HIV, stay away from people'… They genuinely didn't think that they could shake hands with somebody with HIV and not get HIV. So this is really big, it's really big stuff." Project evaluator – Testing Faith

Improved skills were also qualitatively noted for the *Sauna Online Assessment Project*, with one of the sauna managers feeling more confident in their ability to discuss sexual health and HIV with their customers as a result of the online training they completed.

"As my customers talk to me a lot about a whole range of issues, the online training has increased my confidence around sexual health and HIV, as well as other areas, like personal safety." Sauna manager – Sauna Online Assessment Project

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Claimed behaviour change

Many of the Cohort 1 projects would like to see sustained changes in behaviour as a result of their work with, for example, project beneficiaries practicing safer sexual behaviours, however capturing such an outcome presents many challenges and thus there are limited examples of behaviour change which the evaluation can point to.

Some positive case studies were gathered as part of projects' own evaluations. For example, a *Talk and Test* service user claimed he wanted to use condoms in future following his sexual health wellbeing assessment and negative HIV test (which he sought having engaged in what he called 'riskier sex'). Or an event attendee who has proactively taken steps to build his social networks and mental wellbeing after engaging with *Let's Stop HIV* and confirming his positive diagnosis.

"Think I had a very good in-depth chat about reason for my risks, and insight to change/move on." Service user – Talk and Test (LGBT Foundation)

Testing Faith observed changes in the behaviour of faith leaders who went on to organise 21 HIV awareness raising and testing sessions with their own congregations off the back of the training and support they had received.

HIV Testing in the Workplace asked event attendees if they would go on to make changes to their health or health behaviours as a result of the workplace event – two-thirds of whom claimed they would (67% of 676 attendees).

Increased HIV testing

A number of the projects had a specific objective to test individuals for HIV. As discussed in Chapter 4, projects did this with reasonable success and were able to test individuals who had never previously been tested. Qualitatively, feedback from project leads and beneficiaries suggests the projects had an instrumental role in encouraging people to test by making it more acceptable to do so.

"A year ago nobody would have agreed to it [an HIV test] but now they are saying 'yes' to it and this is down to the awareness and the knowledge that they [NAZ] have given to our community." Participating organisation – Let's Stop HIV

"NAZ's testing service has had an enormous impact and I can see it in my clinic. New people arrive and they've been linked into the system through NAZ, thanks to this project." Sexual health consultant physician – Let's Stop HIV

In the case of the *Interactive Digital Contact Slip*, increased HIV testing has been facilitated through making partner notification easier and anonymous (not always the case with alternative forms of partner notification), with the hope that a greater number of partners are notified and therefore tested than would be the case otherwise. Of the 124 index HIV patients captured by SXT, 62 partners have been seen and tested giving a KPI of 0.55 (55 partners seen and tested for every 100 index patients diagnosed), with 39% of partners being verified by SXT (as opposed to partner testing being reported by the index patient)[15]. This compares favourably to the average KPI of 0.47 identified through Rayment et al's audit of 169 clinics[16].

[15] Data correct as of 19 March 2017

[16] Rayment et al. An effective strategy to diagnose HIV infection: findings from a national audit of HIV partner notification outcomes in sexual health and infectious disease clinics in the UK. Sex Transm Infect 2017 93(2) 94-99

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Whilst positive to see a large number of HIV tests being completed as part of Cohort 1 projects, there is limited evidence to suggest project beneficiaries intend to be tested again in future. *Talk and Test* was the only project to explicitly ask about future testing intentions – and the overwhelming majority of service users claimed they were 'more likely to test in the future as a result of using the service' (97% of 150 LGBT service users and 100% of 89 BHA service users).

Consideration of broader health and wellbeing

An unintended outcome for project beneficiaries has been the more holistic consideration of their health and wellbeing beyond the focus on HIV. *HIV Testing in the Workplace* is an obvious example of this, whereby attendees had the opportunity to check various aspects of their health alongside testing for HIV, with many appreciating the convenience of doing so, and nearly all saying they would attend a similar workplace health event again (99% of 741 attendees).

"It's excellent, because with GPs it takes time to book an appointment. Sometimes 2-3 weeks. But here, it's so easy." Event attendee – HIV Testing in the Workplace

Talk and Test also evolved their service delivery model to discuss health and wellbeing more broadly with users, recognising the benefits of exploring more deeply individuals' issues, needs and motivations for taking an HIV test.

"Very friendly, professional staff. It shows an interest in the field they work in. It is so nice to know we have people like this to support us." Service user – Talk and Test (LGBT Foundation)

For VCS organisations

The Fund's projects are principally designed with project beneficiaries in mind, though there are a number of outcomes and impacts for the VCS organisations themselves.

Many projects saw the Fund as an opportunity to provide a proof of concept that could not be done without the investment and piloting process. For example, SXT has been able to generate the data it required to demonstrate the value of an interactive digital contact slip and this is facilitating discussions with commissioners and clinics about the tool's value. For LGBT Foundation and BHA for Equality, the project has been able to show that voluntary sector delivered POCT is an important part of the sexual health system. The project has, in part, contributed to commissioners requiring the successful provider of a recent sexual health services tender to provide clinical governance for POCT to be delivered by LGBT Foundation and BHA for Equality. Linked to this, some of the project leads interviewed talked about the Fund helping to alleviate the suspicion of commissioning VCS organisations, and believe the Fund has helped demonstrate the value of VCS organisations.

"We've proved that this sector [VCS] is quite capable of delivering these kinds of health checks." Project lead – HIV Testing in the Workplace

Some organisations felt they have positively benefited from the Fund through an increased profile as a result of their work. For others, it was specifically the increased recognition with PHE that was a key motivator for applying to the Fund rather than alternative funding streams.

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"It's had a huge impact because we are getting a lot of work...people recognise NAZ and are appreciating the work NAZ does in the communities." Project lead – Testing Faith

"There are other things I could have applied to but the reason why I wanted to do it with PHE was because the public health story needs PHE to know about it and this is the best way of getting them to know about it." Project lead – Interactive Digital Contact Slip

Many project leads acknowledged that a core outcome of the Fund for their organisation was the ability to pursue projects they might not have otherwise. For some, this was a really exciting opportunity to complete a project which was conceived many years ago but which required a funder willing to invest in a novel and innovative approach. Similarly, some commented that alternative funding streams tended to be either prescriptive about project scope and/or broad in their target audiences meaning it was a challenge to secure funding for more 'niche' groups such as MSM.

"Other funding streams have a mandate and an agenda for what they want but with the Innovation Fund you can be as creative as you want which is why it appeals to us." Project lead – My HIV Prevention Strategy Tool

"I've been looking for funding for years but it never really fitted the criteria because it was really difficult to get HIV specific funding, and also [the project] was very targeted at MSM communities." Project lead – Sauna Online Assessment Project

A key outcome for the funded organisations was the partnerships established through their projects. In some instances, the Fund made organisations aware of other organisations they had not previously come across; gave them better knowledge of the work being completed by organisations they had known previously but not in depth; strengthened partnerships already in place; or established new working partnerships.

For example, NAZ had worked with CAFPH before but they worked for the first time with Yorkshire MESMAC on *Testing Faith*; *HIV Testing in the Workplace*, this was made possible by drawing on the strong partnerships already in place across the sector and regions; and it was the first time GMFA and Sigma Research had worked together on an externally funded project. For LGBT Foundation and BHA for Equality, their steering group which brought together seven different organisations, including commissioners, was considered a fundamental component to the success of the project.

"It [the Fund] has brought a lot of organisations closer together, you get an idea and you see who is good at doing what." Project lead – My HIV Prevention Strategy Tool

"Partnership working has been a crucial aspect of making the project a success." Project evaluator – Talk and Test

For Local Authorities/the local health economy

There are few examples from Cohort 1 of direct outcomes and impacts of the Fund for Local Authorities. Whilst each project sought the support of Local Authorities at the bidding stage, most did not have ongoing engagement with them (with the exception of *Talk and Test* for whom commissioners made up part of their steering group). For some projects (predominantly the digital ones including *My HIV Prevention Strategy Tool* and the *Interactive Digital Contact Slip*), the regional or national nature of their work limited the significance of their relationships with local commissioners. Indeed,

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Local Authorities may not always be the most appropriate funders of projects (if, for example, the project has a national or regional focus, or needs to be commissioned at scale), meaning the impact of the Fund on Local Authorities is very much dependent on the mix of projects funded. This is discussed further in Chapter 7.

For the Fund/PHE

Through funding Cohort 1's work, PHE has facilitated a host of outcomes and impacts for project beneficiaries and VCS organisations as aforementioned. Taking the number of people tested for HIV, and the number of reactive tests, as key and commonly measured outputs, PHE has achieved:

- A cost per HIV test of £198 (£360,895[17] divided by 1,826 tests)
- A cost per reactive HIV test of £10,936 (£360,895 divided by 33 reactive tests)
- 18 reactive tests in 1,000 tests.

These figures should not be interpreted in isolation given many projects had a broader set of objectives to shift perceptions/build relationships and so on besides secure a high level of HIV testing. Additionally, many projects were limited in the time they had available to see the full potential of their work come to fruition. Much of the cost invested by PHE initially is in the set-up and testing of projects whereas it could be expected than once up and running, the cost per HIV test (and reactive test) would fall. Furthermore, it is acknowledged that as an *innovation* fund, the primary focus for projects has been on trialling and testing implementation rather than service delivery and thus higher costs of testing would be expected as a result. That said, securing a reactive test rate of 18 in 1,000 tests is much higher than the cost-effectiveness threshold of 1 diagnosis per 1,000 tests as adopted by BHIVA and NICE. The cost per reactive test secured as part of the Fund is higher than in a number of scenarios identified by Ong et al (2016)[18] but lower than the £18,800 per diagnosis in tests performed by GPs[19].

In general, the Fund has been very positively received with an intention to reapply for further funding expressed by some organisations. Whilst project leads are likely to comment favourably on the Fund given they have been in receipt of funding, project evaluators provided a more independent assessment of the Fund, and also spoke highly of it, appreciating the focus on innovation.

"It's not just about HIV prevention, but specifically about innovative approaches. It's the only Fund I know that's interested in funding risky projects and that's needed – we've tried many of the conventional projects [to reduce the impact of HIV] and now we need really creative approaches." Project evaluator – Let's Stop HIV and Sauna Online Assessment Project

[17] The final project spend for the 5 projects explicitly focusing on HIV testing. Where final project spend is unknown, the allocated grant amount is used for calculations.

[18] Ong et al (2016) 'Estimated cost per HIV infection diagnosed through routine HIV testing offered in acute general medical admission units and general practice settings in England', HIV Medicine, 17(4):247-54

[19] This study found the cost per new HIV diagnosis (at a positivity rate of 2/1000 tests) was £3,230 in acute general medical admission units and £7,930 in GPs for tests performed by a Band 3 staff member, and £5,940 in acute general medical admission units and £18,800 in GPs for tests performed by either hospital consultants or GPs.

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Outcomes and impacts not yet evidenced

A number of outcomes and impacts of the Fund are not yet evidenced, and indeed generating such evidence in the future may prove challenging. However, some of the issues identified below may be addressed through the provision of greater evaluation guidance to subsequent Cohorts.

- Outputs: In places, data has not always been collected by projects which would have proved useful for evaluation purposes. This does limit somewhat the extent to which the full impact of the Fund can be measured.
- Attitudes: Projects were better able to capture changes in HIV knowledge but there was a less systematic approach to capturing changes in attitudes as a result of their work.
- Behaviour change: Projects did not have mechanisms in place to track the behaviour of beneficiaries and capture the long-term impacts of their work.
- Transferability: It is not yet possible to know if the outcomes and impacts seen for particular target audiences would be transferable to other audiences, with the same being true for transferring projects to different localities.

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6 Project legacy

A key pre-requisite for securing funding from the Fund was the potential for projects to be scaled-up or replicated if shown to be effective. The final part of this chapter looks at the future plans for each project.

All seven projects would like to see a continuation of their work, and both they and their evaluators could see the potential for their activities to be replicated, scaled-up, or both. Projects that were geographically bound (such as *HIV Testing in the Workplace* and *Sauna Online Assessment Project*) saw the potential for their activities to be undertaken in different geographies, whilst projects without geographical boundaries (*Interactive Digital Contact Slip* and *My HIV Prevention Strategy Tool*) talked about scaling the projects in due course. Some projects (such as *Let's Stop HIV*, *Talk and Test*, and *Testing Faith*) talked of the potential to scale-up their work in the current location, believing they had not yet reached their full potential, whilst also commenting on the potential for their work to be replicated elsewhere.

Core to continuing the projects was the need to secure additional funding – this was to cover staff activities, ongoing software licensing/ development/ maintenance, marketing, and testing equipment among other expenses. As far as it is known, four of the seven projects are actively seeking alternative funding streams at present. *My HIV Prevention Strategy Tool* is not yet in the position to apply for additional funding given it is yet to pilot the tool. Two of the projects are not actively seeking funding opportunities themselves as they have hopes for PHE to support a national adoption of their work. Other projects are building on the momentum of their work, continuing to establish new partnerships.

HIV Testing in the Workplace (Well for Living partnership)

Following the 20 workplace based health and wellbeing events funded by the Innovation Fund, the Well for Living partnership intends to approach workplaces directly to see if they would be willing to pay for the partnership to host an event in their workplace. The feasibility of this is currently being investigated but it could be a next step for the project. The partnership has also secured funding separately to develop a toolkit which could be given to employers, providing information about HIV/testing including key learnings from this project.

The project lead and evaluator think that this type of intervention could be replicated quite easily in different contexts, including various workplaces and also within prisons. For example, Well for Living are currently in discussion with a bus transport company about providing health checks for staff. Findings from the project will be presented at the British HIV Association in April this year.

It is less certain how easy it would be for the project to secure funding from a local commissioner / Local Authority going forward, due to the regional nature of the project. The events held as part of this project spanned across several Local Authorities, and the project found that the beneficiaries (the employees taking part in each event) often travelled great distances to get to work, as such the project does not quite fit into a system based on local commissioning of services.

Interactive Digital Contact Slip (SXT Health CIC)

SXT are planning to scale this project further through a greater number of providers purchasing the Interactive Digital Contact Slip to support their delivery of partner notification. The data generated through the programme thus far is assisting in these discussions to demonstrate the potential benefits of the tool. 14 providers are routinely using the tool as of March-17. SXT is looking to sign service level agreements with many of these providers to continue use of the tool beyond the project as funded by PHE. In addition, SXT has jointly bid with SH24 (a local home sampling provider) for the

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e-tender of the Pan London Sexual Health Transformation Project, the outcome of which is imminent[20]. Further funding of the tool will be required for future software developments, and to raise awareness of the tool in the gay press.

Let's Stop HIV (NAZ)

Though there are no fixed plans to continue *Let's Stop HIV*, it is certainly the intention for NAZ to continue delivering this intervention, and they are currently looking at funding options. There was agreement from both the project lead and the evaluator that this intervention needed a longer term approach to ensure it met its full potential – particularly because a lot of the work involved building up relationships and trust with community organisations in which the outreach events took place. There has been some demand from partner organisations for NAZ to continue delivering the outreach events and testing service, suggesting there is appetite for the project to continue. The success of the project had also meant that new organisations are now interested in taking part when they had initially been reticent.

Based on the success of this project, the evaluator believes it could be used as a model for engaging other communities at risk of HIV. This might include Latin American communities elsewhere in London and the UK, but also this community based approach could be used as a model to engage other kinds of communities in London and elsewhere. The project also demonstrated that HIV is not the sole sexual health concern associated with the Latin American community, and any future work could benefit the community by having a focus on a range of sexually transmitted infections rather than just HIV.

My HIV Prevention Strategy Tool (GMFA in partnership with Sigma Research)

The project is not designed to be replicated but rather scaled-up, with the tool being available for use on a greater number of websites. At present the focus is on piloting and refining the tool, with plans for the future of the tool currently vague and dependent on results generated through the pilot. Ongoing financial commitments will be required to cover costs associated with the software licencing, marketing, and ongoing maintenance of the tool to ensure it remains based on the best available evidence, and is adapted to reflect changes in policy and practice (for example, if PrEP were to become available on the NHS). Should there be appetite for doing so, the tool could become available on other websites besides GMFA's. A greater unknown at this stage is how the tool could be of use to the NHS – the prevention strategies identified as most suitable for individuals may not marry with how decision-making is approached in the NHS with, for example, individuals recommended to make use of PrEP not meeting NHS eligibility criteria for it (were it to become available on the NHS).

Sauna Online Assessment Project (Trade Sexual Health)

This project has worked with all the men's saunas in Leicester therefore there are no ambitions to scale the project further within Leicester, but rather there are hopes to see the model of delivery replicated elsewhere around the country. Rather than individual commissioners funding the project for their local area, it is envisaged that national funding would be required to maximise the impact of the project. This would cover ongoing maintenance costs of the tool (making sure it continues to be based on current evidence and best practice). Irrespective of possible future funding arrangements, it is likely that local organisations would be needed to broker relationships with sauna owners.

[20] Since the time of writing, the consortium including SXT was unsuccessful in their bid.

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Talk and Test (LGBT Foundation in partnership with BHA for Equality)

The LGBT Foundation and BHA for Equality plan to continue POCT after this project and expand it to deliver more testing opportunities to the community. They also want to do more work to identify the best times and places in which to deliver POCT, for example, they have been asked by some local saunas about delivering POCT on their premises. Their work with Salford University has also developed a new and ongoing partnership for LGBT Foundation, and they are in initial conversations about exploring potential areas of further joint working with use of online technologies as interventions around sexual health.

BHA for Equality have plans to continue with their model of POCT. They want to focus on developing resources that will help in the delivery of testing – such as translating them into different languages, develop the skills of the staff delivering the tests, offer staff supervision so they can share their experiences and reflect on their practices in testing. They would like to develop a model of community based POCT so it can inform future interventions. Though this project was delivered in Greater Manchester, the project leads agree that it is a model that could be picked up and used elsewhere, particularly for areas that are not already doing POCT.

Testing Faith (NAZ partnership)

The *Testing Faith* project team are hopeful that the project will continue in future. There is potential for this project to be replicated with other large and influential faith groups in different parts of the UK. For example, NAZ have disseminated information and findings from this project in Scotland with faith leaders, who have expressed a desire to do similar work. Local and national media coverage of *Testing Faith* has stimulated interest in the project. Since finishing *Testing Faith* the project team have reported having faith groups approach them requesting them to go into their organisations and support more sexual health training and events, evidencing that there is an appetite among the faith community for this type of intervention.

However, the partnership has not yet secured funding from elsewhere to continue the project. The project team also thinks that it may be difficult to find funding for this project from local commissioners as it has covered multiple Local Authority areas.

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7 Lessons learnt

In this chapter, consideration is given to the lessons which can be taken from Cohort 1's experiences of the Fund. The lessons are looked at from the perspective of projects themselves and from the perspective of PHE and its own role in administering the Fund. The highly individual lessons from each project are covered in their own evaluation reports. The discussion below looks to draw upon lessons that apply across more than one project or cover likely challenges to be incurred by future projects.

For projects

Engaging businesses

A small number of projects needed to secure the engagement of businesses as part of their delivery models. This presented some challenges as mentioned in Chapter 4, though projects identified several mechanisms through which better engagement was achieved.

HIV Testing in the Workplace overcame much initial scepticism about offering HIV testing to employees by broadening the scope of health tests offered so the events did not focus solely on HIV. They also recruited specifically for someone to engage with HR and Occupational Health teams when liaising with the workplaces – it was said this individual had specialist communication skills which were not present in the voluntary organisations themselves and which was a powerful asset in engaging with the businesses concerned. The team also learnt the importance of securing buy-in from senior personnel within the organisations to avoid securing agreement from particular individuals or teams which did not align with senior views. The team also believe that emphasising PHE's endorsement of the project to prospective companies was important in giving the project credibility.

"To make it more acceptable for the workplaces we put HIV alongside diabetes and body mass index…it became more holistic. And we had to take those steps, otherwise we wouldn't have got in. We did it early on as it was becoming quite clear that you couldn't do just HIV." Project lead – HIV Testing in the Workplace

The *Sauna Online Assessment Project* already had pre-existing relationships in place with sauna owners which greatly facilitated the process of securing engagement. However, through the course of delivering the project, Trade staff were reminded that health promotion is not considered a core business activity for the saunas and thus they needed to be very mindful of the saunas' need to focus on revenue and customer satisfaction in the interactions they had with them. This meant working closely with the sauna owners to clearly articulate the benefits of promoting sexual health to clients, and easing the owners' anxieties that association with the project could adversely affect them. The project also revealed the potential for co-creation to assist in securing engagement with activities – the sauna which withdrew from the project stated their lack of input into the project design as one of the reasons for no longer wanting to be part of the programme.

"We shouldn't be adverse to including and involving businesses in HIV prevention because when there is transparency it is possible to secure the agreement and involvement of these kinds of organisations… This project is good because it demonstrates we can involve some of the key stakeholders we would normally think of as expressing some trepidation at being involved." Project evaluator – Sauna Online Assessment Project

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Engaging faith leaders and communities

Testing Faith identified a number of challenges – but also solutions – to securing the involvement of faith leaders. One of the issues faced was the ability to secure time from faith leaders who claimed to be very time-poor due to a wealth of pre-existing commitments. Potential solutions as suggested by the faith leaders themselves would be to shorten the training sessions to take place over one (not two) days, arrange some sessions to take place on Saturdays, allow representatives to attend in place of the faith leaders themselves, and provide long lead times for training sessions. The project team also thought engagement with the programme would have been aided through aligning the training with faith leaders' existing calendars/planning cycles; ensuring promotional material emphasised the 'duty of care' responsibilities of faith leaders to support the health and wellbeing of their communities; providing clear messaging on local statistics for HIV prevalence and risk to dissuade views held that HIV is not of relevance to leaders' communities; and recruiting leaders through a snowballing approach such that individuals are invited to attend training by personal contacts who are known and trusted.

As shown by *Let's Stop HIV*, the involvement of community members in outreach work with targeted communities is a critical factor for success (particularly where they are able to converse in native languages). This was also shown by BHA for Equality (*Talk and Test*), who emphasised the importance of delivering tests in the community by members of the community, and being able to build up trust and confidence over a period of time.

"[The project has] highlighted that the avenues through which people access testing needs to be flexible and adaptable and it can't all be centralised through a sexual health clinic. For our BME community we need to be in the community." Project lead – Talk and Test (BHA for Equality)

Project planning and management

As has been mentioned elsewhere in this report, many of the projects were challenged by the timeframes over which they were expected to implement their intervention. The delays tended to concentrate around the time-intensive and slow development of relationships with both communities and businesses alike, the need to secure clinical governance (in the case of *Talk and Test*), and the challenges posed by software developments. If project timelines are not extended beyond a year, projects' ambitions for delivery may need to be scaled-back.

Further advice offered by Cohort 1 projects is the need to remain adaptable as projects progress. *Talk and Test*, for instance, changed venues and opening hours to encourage higher attendance of their services. Similarly, they recognised that service users were presenting with a range of complex additional needs and thus they broadened the scope of their service model to provide a deeper exploration of the issues, needs and motivations for individuals taking an HIV test. *HIV Testing in the Workplace* ran two smaller events initially before pausing to refine and standardise many of their processes which benefited the subsequent events.

Talk and Test were the only project to set up a formal steering group as part of their implementation. This was particularly crucial for the project given the nature of their intervention, however future projects may also benefit from such oversight. *Talk and Test* believe the multi-agency steering group (which included commissioners and clinicians) gave stakeholders a shared sense of ownership for the project, fostered system leadership, and helped increase the profile of the initiative. Indeed, it was recognised by *Testing Faith* that their work would have been facilitated had they put in place a steering group with representation from faith leaders of different religions and from different locations.

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Many of the projects demonstrate the importance of working in partnership to achieve ambitions and the benefits of delivery models which make use of local community organisations. *HIV Testing in the Workplace* adopted a delivery model which made use of local community organisations – in doing so, partners from diverse community groups could contribute their knowledge and expertise to the design and delivery of the project. Similarly, *Testing Faith* found the work of their regional support colleagues was invaluable in supporting local implementation. For *Talk and Test*, working with partners facilitated the operational aspects of the project such as securing pathways for reactive patients across Greater Manchester and securing whole system engagement with the work.

Many of the projects recognised the need to ensure there were clear and robust referral pathways in place for when reactive tests were identified. Similarly, it was important for projects to ensure they could meet users' information needs through appropriate sign-posting where relevant.

As discussed elsewhere in this report, there are some limitations to the evaluation evidence projects were able to amass. Whilst there are clearly a number of methodological challenges presented by the work being completed, having data to evidence the projects' achievements is highly valuable in ongoing discussions about future funding and commissioning arrangements (as evidenced by the *Interactive Digital Contact Slip Project*). Project evaluations should be prioritised and thought given to how best to evidence projects' success from the outset.

For PHE

The above discussion provides a number of lessons for PHE but this section of the report focuses specifically on lessons learnt affecting PHE's own role in delivering the Fund[21].

Clarity on the Fund and PHE's role

A small number of the evaluation interviews identified a tension between the existence of the Fund as a means through which to pilot innovative ideas versus service delivery in the prevention of HIV. This led some to hope that PHE remained focused on fostering and supporting new ideas in HIV prevention (with the expectation being that a number of projects should be shown not to work) rather than becoming preoccupied with delivering on HIV prevention in how the success of projects was determined.

"If you had 10 projects you wouldn't expect all of them to work if they were all innovative ideas. If everything was a success, there would be no risk involved… I think there might be confusion within the Fund about whether what it is trying to do is foster new ideas of whether it is trying to service HIV prevention needs. It's not an HIV prevention fund, it is intended to foster new interventions."

A small handful of interviews also pointed to the importance of PHE providing endorsement of their project – this was a means to secure credibility when approaching organisations for their buy-in or involvement. One project found their use of PHE's logo to be questioned by a member of PHE staff not involved in the Fund. Greater clarity may therefore be required for projects (and for PHE staff internally) on what they can, and cannot, say about PHE's involvement and endorsement of their work.

Again, PHE may need to provide better clarity around their involvement following completion of the projects to ensure expectations are aligned. Some projects – assuming they were able to provide encouraging pilot data – were fully

[21] Note, not all quotes in this section have been attributed to provide anonymity in the feedback.

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expecting PHE to fund the project further to enable it to move beyond testing, or to up-scale it/replicate it elsewhere. This was particularly the case where projects were not geographically bound and thus national funding and support would be required given local commissioners were unlikely to invest in a project that had wide benefits outside their local health economy. Some projects felt that if PHE had invested this far in their work, it made sense for that funding arrangement to continue. If PHE is unable or unlikely to provide further funding of projects, there is a need to ensure expectations are not misaligned at the application stage regarding future funding arrangements. It may be beneficial for PHE to ask projects to articulate (as part of their bid) possible future funding arrangements should the project be proven a success.

"You'd think PHE would like to know if something does work, how can they make sure it doesn't just die on the vine?"

"If you do find something is successful then how do you maintain it [if you don't fund projects further]? We know there are other avenues out there but something which has been created by PHE should probably be funded by PHE [in the future]!"

"If our Local Authority turned round and said they'd fund it, it doesn't add much as it's just Leicester involved. It needs to be something that is funded nationally, to talk to our commissioners doesn't really do anything" Project lead – Sauna Online Assessment Project

In a similar vein, some projects were expecting PHE to do more to facilitate conversations with commissioners upon project completion, and to 'open doors' for projects to establish relationships both within PHE but also with other key national bodies where relevant.

Publicising the Fund

Where projects have secured media coverage of their work (*Testing Faith*, *Let's Stop HIV*), they believe community interest in the programme has been stimulated. Some projects suggested that more publicity around the project, driven by PHE, would help extend its reach and assist in engaging communities and organisations with their work.

Similarly, some projects have presented (or have plans to present) their work at national conferences and/or to submit academic papers for journal publication. These activities are important for establishing credibility and gaining exposure to potential funders and service commissioners. PHE's assistance in such matters would be welcomed by projects.

Project requirements

Whilst this might be out of scope for PHE, the evaluation has shown that a number of projects would have benefited from a longer timeframe over which to implement and imbed their work (in particular *My HIV Prevention Strategy Tool*, *Testing Faith*, and *HIV Testing in the Workplace*) (or indeed that they were overly optimistic about what they could achieve in the timeframe afforded to them). A year was considered to be a very short length of time for a proof of concept – especially where the project was heavily reliant on digital/software development and/or the fostering of relationships with communities or businesses. The full impact of the Fund will not be recognised given some projects (by necessity) spent a far greater time on their set-up rather than delivery (as evidenced by many not reaching their target outputs).

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"The project didn't start until May so we haven't done a full term. We are on track to achieve what we wanted. If we did have the full year, I think we would have met our target."

"The timeframe was an issue. Looking on reflection at our project, it would have been better to have a longer time period to complete it rather than a year."

Another requirement of projects which was questioned quite extensively in the evaluation interviews was the need to secure Local Authority support as part of the bidding process. Some questioned it on the basis of the Local Authority having little engagement with the project following the initial bidding process, but most others felt that their project (due to its regional or national nature) could not be aligned to particular Local Authorities. For *My HIV Prevention Strategy Tool*, the need to align their work with a particular Local Authority was, to some degree, counter-productive as the tool would ideally be developed with a broader set of potential users other than those based in particular London boroughs. It may be, however, that endorsement from Local Authorities is important from PHE's perspective as a hallmark of the quality of projects funded.

"That was the difficulty, because this was a regional project. To just pick one Local Authority to support it doesn't work."

"It's very restrictive, especially for a body like GMFA who are not borough specific but who are national and in some cases international. A lot of issues are not localised." Project lead – My HIV Prevention Strategy Tool

"Local government as a co-signer doesn't really mean much."

Whilst all projects who have disclosed their final direct and indirect costs were able to keep within the budget allocated to them by PHE, there were a number of examples where individuals' time (including those of evaluators) was given for 'free' or unaccounted for in the projects' indirect costs. This potentially has repercussions regarding the sustainability of certain projects, and the need for projects to be co-funded if PHE is unable to provide greater funds for their work.

Procedural aspects of the Fund

Projects were able to point to a couple of procedural aspects of the Fund which they believe would benefit from being amended. Mentioned by a number of different projects was the desire for greater networking within the Cohort(s) to be facilitated by PHE. At its most basic this could be greater information provided online about the other funded projects and associated contact details. But projects were also interested in other networking opportunities which would allow them to exchange models of working, challenges faced and overcome – believing they could have better supported one another to maximise their impact.

"I really didn't get a sense that we were networking and supporting each other... I think a lot of the synergies that could have happened over the last year haven't happened."

"I think there should be a website hosting updates from all the projects. Because when we went down to London we all looked at each other and said 'well, could we have supported them to do a better job?'"

Alongside greater networking, some projects felt PHE could have been more proactive in its monitoring of the projects' progress (recognising that it was likely to be resources which limited PHE's ability to do this). Projects were very positive

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about their interactions with PHE – and they felt they would have benefited from more discussions with the central PHE team as part of progress monitoring.

One project hoped their Cohort could be concluded through a larger conference or presentation setting which had a wide audience including project beneficiaries and partners (so they could see the full impact of their involvement) as well as commissioners to help facilitate subsequent discussions about funding arrangements.

In terms of the application process, feedback was very positive with individuals claiming the barriers to entry to be small, the process to be efficient, and the feedback/discussions to be welcome. Some projects did incur delays in the receipt of funding which shortened their testing periods, and in one instance meant the VCS organisation had to outlay direct costs prior to receiving funding.

Project evaluations

There are a number of challenges presented by the need to evaluate the work of projects – there is a need to trade valuable budget between project implementation and evaluation; there are methodological challenges presented by the nature of some of the interventions; and the diversity of projects makes standardised approaches to evaluation difficult. Given these challenges, projects have managed to collect pilot data (on some, not all metrics) to provide an indication of success, though the full impact of the Fund will not be recognised through the data collected.

PHE has a crucial role in ensuring projects seek to secure evaluation support as early as possible, emphasising the importance of being able to demonstrate project achievements and learnings, and the need for clear evaluation aims and objectives. There is also a role for PHE to provide clearer guidance on data collection requirements up front, seeking a more standardised approach to data fields generated where possible. This PHE is looking to do through the ongoing programme evaluation and the imminent guidance to be issued to Cohort 2 and future projects (see Chapter 8).

If, however, PHE was looking to provide further funding for projects, it would be desirable for more rigorous evaluation studies to be completed so projects are better able to robustly show that their interventions have produced the intended outcomes and impacts. This would inevitably require a higher evaluation spend than projects can presently afford.

Potential disbenefits of the Fund

This report has highlighted a number of benefits afforded by the Fund. As with all programmes, there are some potential disbenefits associated with the Fund which are discussed here. The full extent of potential disbenefits is not yet known given the Fund is still relatively immature and will be looked at further as part of the ongoing programme evaluation.

A potential risk for the Fund is commissioners disinvest from initiatives as a result of the perceived success of projects. This does not appear to be a risk for Cohort 1 given most of the project have been solely funded by PHE. At this stage, the evaluation findings are unable to point to where projects targeting particular audiences, or those of a particular nature, are considered less successful given the highly individualised nature of their interventions. Thus, it is unlikely commissioning decisions about work outside of the Fund will be affected by the work of Cohort 1 projects. It should also be remembered that by its very nature of being an innovation fund, organisations are piloting innovative ideas – some of which may not necessarily warrant ongoing development and investment.

Another area of potential risk concerns the fragility of relationships. As acknowledged by the *Sauna Online Assessment Project*, some of the partnerships build up through the Fund can be relatively fragile. In this instance, Trade Sexual Health

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had to be very careful to establish and maintain positive working relationships with sauna owners – with the risk being that these relationships (built up prior to implementing the tool) could deteriorate if handled insensitively.

Related to this, a number of projects highlighted the risk that relationships built with considerable effort through the project lifespan may suffer from a lack of continued investment in the project. There is a desire among projects (most notably the *Sauna Online Assessment Project*, and *Testing Faith*) to ensure these relationships continue beyond the end of the project but this may be a challenge if funding cannot be found to continue the projects. There is therefore a risk that relationships are damaged by an inability to continue building upon them.

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8 Next steps

In this final chapter, we give a brief overview of the Cohort 2 projects and discuss next steps for the application for Cohort 3 and the evaluation.

Cohort 2 projects

PHE have funded a second cohort of projects for 2016 – 2017. These projects are currently ongoing and are intended for completion in late 2017, after which independent evaluations for each project will be produced followed by an overarching evaluation similar to this report. The table below outlines each of the Cohort 2 projects.

Table 8.1: Cohort 2 projects

Project name	Organisation	Activity	Target audience	Intervention setting
Chemsex Open Access Support Team	Addaction	Drop-in sessions, one-to-one support and outreach harm reduction advice, therapy and signposting	Men who partake in chemsex	Various healthcare settings
cliniQ	cliniQ	Engaging transgender communities in HIV testing in sex-on-premises venues. Promoting hormone monitoring services. Publishing sexual health promotion materials	Trans people	Publications and sex-on-premises venues
Community Conversations: Reshaping the African Dialogue	NAZ	Developing a web series providing insight into the lives of people coping with issues around HIV and sexual health. Community events screening the series and providing signposting to local services	Black African communities	Online/community events
Digital Vending Technology and HIV Self-Testing in MSM sex-on-premises	The Martin Fisher Foundation	Electronic vending of HIV self-testing kits and promotion of this	MSM	The Brighton Sauna
Friday/Monday	Terrence Higgins Trust	Online hub including assessment tool, group work, online counselling and triage and referral to services	MSM – specifically those with issues around drugs and alcohol	Online tool
HIV Prevention for Deaf People	SignHealth	Educating deaf 16-18 year olds at school and adults involved in existing projects and deaf clubs, producing online videos in British Sign Language about HIV prevention	Deaf people	A school and various community settings
In the Community	OutREACH Cumbria	Pharmacists trained in sexual health discussions and providing HIV testing within pharmacies	All patients	Pharmacies
LOLS – Laugh Out Loud against Stigma	KwaAfrica	Events with comedy and motivational speaking to provoke debate, raise awareness of HIV/AIDS and other STDs, promote uptake of testing	Black African communities	Events/shows and online campaign
Love Tenderly, Act Justly II	Catholics for AIDS Prevention and Support (CAPS)	Online training resource providing HIV educational tools from a UK Christian perspective	Christian faith communities including pastors, lay leaders, at-risk individuals	Christian faith communities/online

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Reaching Out	Lifeline Project	Drop-in sessions for MSM, sexual behaviour training sessions for staff, provision of HIV testing and referrals to sexual health services	MSM – specifically substance users	Drug and alcohol treatment services
Sex Week on National Prison Radio	Prison Radio Association	Radio programme providing information and advice to prisoners	Prisoners	Prisons
Web-chat Remote Access	Positive Action	Online web chat (video conferencing) portal developed providing HIV prevention support for marginalised communities	Marginalised MSM and Black African communities, and isolated people living with HIV	Online web-chat
Welcome Hear	Yorkshire MESMAC	Outreach one to ones, group workshops, HIV testing and support in hostel	Refugees/migrants, particularly MSM and African women	Hostel for refugees

Cohort 3

A third cohort is due to be funded by PHE. It is anticipated that these projects will be selected in July/August 2017 with projects to start in September/October 2017.

Upcoming evaluation activities

While this report has focused on an evaluation of the Cohort 1 projects, the overarching evaluation is continuing throughout 2017 and into 2018. The next evaluation output will be an evaluation guidance document, designed to provide guidance to Cohort 2 and subsequent cohorts around evaluation requirements and suggestions for design, data collection and reporting.

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