Effective Sexual Health Promotion

A Toolkit for Primary Care Trusts and others working in the field of promoting Good Sexual Health and HIV Prevention

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Contents

Introduction

1.   Many people are now taking on sexual health promotion and HIV prevention roles in their work settings. These can, for example, be linked into health, education or social services, in the voluntary and community sector or in agencies such as Youth Offending Teams, Probation, those that deal with Homeless and Roofless people or drugs, alcohol and mental health services.

2.   What is often lacking, however, is a good "route map" for those taking on these roles. Although there is much sexual health promotion theory and research available around sexual and reproductive health, HIV and Sex and Relationships Education, we are singularly lacking tools, which suggest practical strategies. We need to know how best to develop sensitive, effective and relevant work with a wide range of different communities and groups who present an equally wide number of sexual health support and HIV prevention needs, based in a multiplicity of settings.

3.   Because systematic and on-going training about sexual health promotion and HIV prevention is limited, all too often those working in the field have to improvise rather than drawing from a consistent and deeply rooted practice base, grounded in evidence of effectiveness.

4.   This Toolkit, therefore, aims:

   •   To give some practical ideas for first routes into this work.

   •   To offer some thoughts on how to broach these issues in practice.

   •   To suggest some possible opportunities to put the promotion of sexual health and HIV prevention on the agenda, without necessarily needing massive new resources or in-depth training.

   •   To set out a range of methodologies using both new and tried-and-tested approaches.

   •   To suggest ways of re-framing current work which enhance its sexual health promotion and HIV prevention elements.

5.   In other words, it provides a range of practical, usable tools which can be adapted to particular work settings, client groups and service users and our own levels of confidence, experience and skills.

6.   The ideas presented here can be used as themes which you may want to vary, according to your own assessment of local needs. So use these ideas as starting, and not end, points

Notes on using the Toolkit

Who is this toolkit for?

1.   This toolkit has been developed in response to the first national strategy for sexual health and HIV, and the implementation action plan published by the Department of Health in June 2002. It represents a wide range of interests and views within sexual health and health promotion and HIV prevention.

2.   The toolkit has been designed for all those responsible for sexual health promotion and the implementation of the national strategy at local level. This may include Primary Care Trust (PCT) sexual health teams, health promotion specialists, professionals doing health promotion work in genito-urinary medicine (GUM) and contraceptive services, those with links to sexual health issues within local authorities, and service providers in the statutory, voluntary and community sector organisations.

A word about terminology

3.   Throughout this resource the term 'sexual health promotion' is used to encompass HIV prevention, any work which promotes positive sexual health, work to reducing unintended pregnancies including teenage pregnancy, Sex and Relationships education, initiatives to bring about changes in prejudice, stigma and discrimination and general awareness-raising work.

Using the toolkit

4.   There are two elements to the Toolkit – a published document (Sections 1 and 2) plus a web resource (Sections 3, 4 and 5). This published document provides an introduction to sexual health promotion in the context of the national strategy for sexual health and HIV and the Ottawa Charter on Public Health. It sets out some of the core processes and methods used in sexual health promotion.

This document is designed to be used in conjunction with the Health Promotion Toolkit: Good Practice and Practical Guidance available at the Department of Health website at www.doh.gov.uk.

5.   This website gives guidance on some of the very practical aspects of sexual health promotion – such as positively promoting condom use and building self-esteem and doing this work in primary care settings. It offers action tips for working with some groups and communities who are particularly vulnerable in terms of their sexual health needs. The website also offers a holistic model of sexual health and some definitions along with case studies illustrating the practical application at local level of the principles and approaches explored in this toolkit. Finally, it provides further reading and contacts for organisations who can offer more information and support.

6.   This toolkit should be used in conjunction with *Effective Commissioning of Sexual Health and HIV Services: A Sexual Health and HIV Commissioning Toolkit for Primary Care Trusts and Local Authorities* and the recommended standards for HIV services as they are published, as means of providing best quality, appropriate health promotion services at local level to those who need them.

7.   A clear limitation of a Toolkit such as this is that it can never hope to be absolutely comprehensive. So the needs of certain groups – for example those of lesbians and bisexual women (apart from in Section 3.7 on Women and Girls), of people in the mental health system, of young children, of homeless people and of transgender and transsexual people are not specifically addressed here.

8.   However, it should be said that the ideas presented here and on the website are simply offered as a taster – pointers to working with *some* of the groups whose needs are relevant for sexual health promotion. Some of the ideas and strategies could also be taken as starting points for work with other groups not directly addressed here and are applicable to a broad spectrum of work settings. Also, although many points refer explicitly to sexual health service provision, this resource is about much more than that. In addition, it encompasses suggestions and ideas, for example, for group-work, community development, outreach, training, education and information giving.

Section One – Part One: Setting the Scene – National Strategy for Sexual Health and HIV and The Ottawa Charter

National strategy for sexual health and HIV

1.   The key driver of the Government's measures to improve sexual health in England is the National Strategy for Sexual Health and HIV, which was published by the Department of Health in July 2001. The Government is committed to improving sexual health and reducing health inequalities, and recognises the direct links between sexual ill health, poverty, poor housing, unemployment, discrimination and other forms of social exclusion. It was backed by investment of £47.5 million to support a range of initiatives set out in the strategy.

2.   The main aims of the strategy are to:

  •   reduce the transmission of HIV and STIs;

  •   reduce the prevalence of undiagnosed HIV and STIs;

  •   reduce unintended pregnancy rates;

  •   improve health and social care for people living with HIV; and

  •   reduce the stigma associated with HIV and STIs.

3.   Chapter 3 identifies gay men and African communities as the priority groups for HIV prevention and the role HIV treatment and care services can play in HIV prevention. For gay men, the Department of Health contracts with the Terrence Higgins Trust to undertake the Community HIV and AIDS Prevention Strategy (CHAPS). A key output from CHAPS is the *Making it Count* planning framework which the strategy recommends as the model for gay men's HIV prevention.

4.   The strategy announced a new public awareness information campaign on sexually transmitted infections (STIs) for the general public which led to the launch in November 2002 of the Sex Lottery national campaign. The importance of establishing the evidence base for HIV and STI prevention is highlighted in the strategy and a summary of the Health Development Agency's work in taking this forward is set out in Section 1.4.

5.   The strategy also sets out how the importance of local co-ordination in both the planning, and provision, of sexual health promotion. *Effective health promotion strategies should address local needs and involve specialists such as social workers and youth workers.*

6.   This toolkit builds on the strategy and includes ways to help establish links with other agencies and successfully co-ordinate group activities. It also reflects the principal that effective interventions should be based on sound evidence of effectiveness.

7.   The national strategy also identifies the need for local strategies to respond to the specific health promotion needs of local populations of groups that may need more specific interventions. This may be because they are at higher risk, are particularly vulnerable or have particular access requirements. The needs of the following should be assessed:

- Young people, especially those in, or leaving, care

- Black and ethnic minority groups

- Gay and bisexual men

- Injecting drug users

- Adults and children living with HIV and other people affected by HIV

- Sex workers and

- People in prisons and youth offending establishments.

8. You will find practical information on working with these groups, plus others, in this toolkit (particularly the web based resource). You will also find information on developing and implementing local strategies for sexual health promotion.

9. The National Strategy for Sexual Health and HIV together with the Implementation Action Plan are available from the Department of Health website at www.doh.gov.uk, where you will also find other current information relating to national sexual health and HIV policy.

Commissioning sexual health services

10. The Department of Health has published a separate toolkit for those involved in commissioning sexual health services *"Effective commissioning of sexual health and HIV services: A sexual health and HIV commissioning toolkit for Primary Care Trusts and local authorities"* is available from the Department of Health website at www.doh.gov.uk. This toolkit provides practical guidance including information on funding arrangements, different models for commissioning, and improving access to sexual health services.

The Ottawa Charter

11. In 1986 the World Health Organization adopted a major international charter to promote and support developments in Public Health. This offers us a clear and cogent framework for the design and delivery of best practice in terms of promoting health, supporting sexual health and preventing HIV. The five areas of activity specified in the Ottawa Charter are:

- Building healthy public policy

- Creating environments that are supportive of public health

- Developing personal and social skills related to sexual health and HIV

- Building on the evidence base and developing staff skills/knowledge/attitudes

- Strengthening community action

12.   All of these play their part in sexual health promotion and, in different ways, are relevant to the content of this Toolkit. Some ways in which these admirable principles actually translate into best sexual health promotion practice are, for example:

Building healthy public policy that promotes sexual health and prevents HIV at local and national levels and that addresses inequalities

13.   Traditionally much health education and sexual health promotion focused solely on individual 'lifestyle' issues rather than acknowledging the social, political and economic factors which impact on and shape health at community and individual levels. Addressing these issues at a wider or 'macro' level ensures that the social and political determinants of health are seen as being as important as individual choices, decisions and behaviours. Indeed, by doing this we acknowledge that supposedly 'individual' choices are not taken in a vacuum, but are profoundly influenced by the whole context in which people live their lives.

14.   In the Toolkit this principle translates into work such as:

        Section Two   Developing and implementing a local Sexual Health and HIV Strategy Multi-agency working

        Section Three   Working with particularly vulnerable groups

Creating environments that are supportive of public health

15.   Research consistently shows that many vulnerable groups are apprehensive about using services for fear of being at the receiving end of judgmental attitudes. They may be anxious about feeling awkward and out-of-place, for example men who assume contraception services are female-only territory. One of the challenges to face therefore is to reverse such negative situations. Creating positively supportive environments is a key task in sexual health promotion.

16.   In all of this the word 'environment' is not taken to mean just the physical space, but the broader world in which people live. Support for sexual health can be flagged up, for example, by the provision of condom machines or information in service-based or other settings as well as via outreach and detached work within the community.

17.   In the Toolkit this translates into work such as

        Section Three   Building self-esteem and thinking about how the environments in clinical services can contribute to this both for service users and staff.
Influencing the 'social climate' in which attitudes to sexual health are formed.

        Section Four   Developing positive, proactive sexual health promotion activities in Primary Care and other clinical settings.
Work with marginalised and vulnerable groups which aims to assure them of their welcome if they use services, and of their rights to access these Information-giving and awareness-raising in a host of community-based settings.

        Section Five   Case Study on the Newcastle and North Tyneside Sexual Health Promotion Service which aims to create a *Thinking Environment* for staff, colleagues and service users which is safe, positive and welcoming to all.

Developing personal and social skills related to sexual health and HIV

18.   We have seen how the wider or 'macro' social and political factors can play their part in constructing a positive context for, or a negative impact on, sexual health promotion . However we also need to pay attention to the personal or 'micro' factors, played out at an individual level – issues of choices and decision-making, for example, of having the self-esteem and communication skills to negotiate condom use or contraception or to resist coercion and abuse and withstand the pressure to have unwanted sex.

19.   In the Toolkit this translates into work such as

   Section Three   Practical strategies for building self-esteem.
   Condom promotion. Specific skills development work with Gay and Bisexual men.

Building on the evidence base and developing staff skills/knowledge/attitudes

20.   As with any endeavour, if we are to be effective and bring about desirable change, we will need to root our work in the evidence base. This means drawing on the research available which tells us what 'works' and then skilling up staff and our organisations to deliver services, information and support in ways which reflect this learning.

21.   In the Toolkit this translates into work such as

   Section One   What the research tells us is effective.

   Section Two   Ways of expanding staff skills, knowledge and attitudes are explored for example in sections on group work and facilitation skills, outreach and detached work, working with the media and on developing and using resources and materials.

Strengthening community action

22.   A key method in sexual health promotion is supporting individuals, groups and communities in taking greater responsibility for their own sexual health. This involves building capacity within communities – particularly those that have historically felt disenfranchised and marginalised by services – with the aim of increasing people's self-esteem and their sense of control over their own health and well-being.

23.   In the Toolkit this translates into work such as

   Section Two   Group-work skills, outreach and detached work.

   Section Three   Community development approaches and methods for empowering marginalised communities exemplified in many parts of this section Skills development work in the gay and bisexual men's section.

Section One – Part Two:
What is Sexual Health Promotion?

1. The aim of Sexual Health Promotion

This can best be described as: "To improve the positive sexual health of the general population and to reduce inequalities in sexual health".

More specific aims may include:

- To reduce rates of new and undiagnosed HIV infection

- To reduce rates of Sexually Transmitted Infections

- To reduce unintended pregnancies

- To reduce psychosexual problems

- To facilitate more satisfying, fulfilling and pleasurable relationships

2 One definition of Sexual Health Promotion

Any activity which proactively and positively supports the sexual and emotional health and well-being of individuals, groups, communities and the wider public and reduced the risk of HIV transmission.

Including 'emotional health' in this acknowledges the strong link between people's emotional well-being – as demonstrated by their levels of self-esteem for example – and their ability to take control over the decisions and choices which will affect their sexual health.

3. Some of the objectives of Sexual Health Promotion

Particular objectives which support the aims outlined here and which can be undertaken with individuals, groups and communities include:

a. Awareness-Raising:

- Increasing awareness of the integral relationship between sexual health and emotional and mental health and enabling professionals in these fields to integrate this awareness into their practice

- Increasing public awareness of sexual health issues

- Increasing awareness of the importance of positive sexual and emotional relationships

b.   Information and Education:

- Increasing access to sexual health information, support and advice

- Increasing the levels of Sex and Relationships Education available to children and young people in particular and to the general population via lifelong learning strategies

- To offer opportunities for adults as well as young people to access Sex and Relationships Education and support regardless of their age or ability

c.   Development of Services and Service Providers:

- Increasing access to, and the effective use of, condoms and contraception

- Increasing access to, and uptake of, emergency contraception and abortion services

- Increasing access to, and uptake of, psychosexual and sexual health support services

- Increasing access to HIV and STI testing

- Supporting organisations, service providers and professional staff to play an active role in promoting sexual health

d.   Skills and capacity-building in individuals and communities:

- Enabling particularly vulnerable individuals, group and communities to take greater control over their sexual health

- Offering individuals, groups and communities opportunities to gain key relationship skills such as negotiation, communication, assertiveness, saying 'no' and decision-making

- Enhancing the self esteem and the emotional and mental health and well-being of individuals, groups and communities

4.   Methodologies for Sexual Health Promotion

Effectiveness

For sexual health promotion to be effective, the use of diverse methodologies is recommended with different individuals, groups or communities in order to respond sensitively and appropriately to their particular needs. Throughout all of these endeavours, it will be vital to draw on the literature and evidence which exists about what makes for effective interventions. Training and support opportunities will allow staff, teams and services to increase their understanding, skills and confidence in delivering and developing sexual health services and programmes with their service users.

Matching the Methodology to the Need

The methodology will need to be carefully chosen to 'match' the needs of the individual, group or community which is the audience or target group for the work.

Direct methodologies

The most frequently-used methods with communities, groups and individuals are:

- National and local ***media campaigns*** e.g. via the press or the Internet. The purpose of such campaigns is usually a) to raise public awareness and/or b) to target particularly vulnerable groups in terms of sexual health and HIV.

- ***Community development*** approaches which work with vulnerable and marginalised communities (e.g. gay and bisexual men, black & minority ethnic communities) to empower them and build capacity.

- ***Sex and Relationships Education*** in formal and informal education, youth and community settings.

- ***Group work*** – particularly with vulnerable groups such as young people in care, married men who have sex with men or teenage parents.

- Individual ***one-to-one work*** in a sexual health services setting with service users. This might, for example, be done via sexual health history-taking or by initiating discussions about sexual health in well-woman clinics and youth clinics. Or it may be done by non-clinical staff in community settings e.g. via case-work or one-off support to clients or group members.

- ***Condom distribution*** e.g. via Primary Care, youth workers, youth clinics, Family Planning Clinics, street-work with commercial sex workers or outreach work in cruising and cottaging areas.

- ***Publicising local sexual health services*** and encouraging uptake of these, particularly by those who have not traditionally been service-users.

- ***Detached and street-work*** to provide sexual health services, information and support to those not accessing these in mainstream settings.

- ***Peer education programmes*** e.g. with parents and carers, young people and gay and bisexual men.

- ***Outreach work*** – publicising and promoting sexual health services to groups, communities and individuals who might otherwise not be aware of them or confident enough to use them.

- ***Arts work*** – e.g. Theatre In Education, video making, puppets in primary schools, Children's Express writing or photography.

- ***Targeted work with particularly vulnerable groups*** e.g. with young women who may be abused through prostitution or with young gay men, to reduce the possibilities of sexual abuse and exploitation.

- ***Production and dissemination of materials*** e.g. leaflets, posters, videos, CD-ROMs, games and magazines to increase information and knowledge levels as well as stimulating uptake of services.

- ***Screening and testing*** e.g. for HIV and other Sexually Transmitted Infections.

- ***Promoting self-care*** e.g. via accessing over-the-counter emergency contraception, pregnancy testing, or self-examination for testicular cancer or breast lumps.

Indirect methodologies

These are ways of working with professionals, agencies and service-providers which have a positive knock-on effect for individuals and communities. Those used most frequently are:

- *Training courses and workshops* for staff to develop the necessary confidence and professional and personal skills to enable them to deliver this work effectively.

- *Conferences and seminars* at which models of good practice can be shared and new research disseminated.

- *Information dissemination* for example via up-dates, training resources, newsletters and new materials.

- *The development of policies and strategies* which positively support sexual health and HIV prevention. For example, these might include confidentiality policies, Sex and Relationship Education policies and local sexual health strategies.

- *Research* into most effective practice, including action-research projects. Also, dissemination of research findings from both national and international studies.

- *Work with commissioners* to enable them to be fully aware of the complexities of sexual health work and of the wider health needs of historically overlooked and marginalised groups.

- *Needs assessments*, for example through surveys or seeking the opinions of service-users or non-users and via action-research projects.

- *Promotion of strong inter-agency working.* Sexual health promotion is most likely to be effective when initiatives are multi-agency. Therefore joint working, inter-agency support and opportunities for shared training all make a positive contribution.

- *Support, consultancy and advice* to agencies, staff groups and individuals who are developing their own sexual health promotion functions.

- *Work with the voluntary/community sector* – this includes those working directly on sexual health issues (e.g. Gay Men's Health Centres, HIV awareness projects, young people's advice services) and those with a broader remit (e.g. Relate, Samaritans, Victim Support, Faith Groups and community-based mental health projects).

- *Media work* is vital since sexual health promotion, HIV Prevention and Sex and Relationships Education can all attract considerable coverage, which is not always balanced. A proactive approach to working with the media positively can help reduce the likelihood of this.

5.   Settings in which Sexual Health Promotion takes place

Sometimes the term 'sexual health promotion' is taken just to mean work done in clinical or surgery settings by service-providers to improve the sexual health of service-users. The reality is that it is a much more widespread activity than this – delivered by staff from many disciplines in many settings, both within the community and in statutory or service-based settings. These include:

- *Schools* e.g. via Sex and Relationships Education programmes, peer education projects, Theatre In Education (TIE), service outreach sessions (such as health drop-ins run by School Nurses) and dissemination of information materials.

- *Informal youth settings* e.g. youth centres via Sex and Relationships Education, Theatre In Education, peer education projects, group work, service outreach sessions and sexual health projects.

- *Clinics and surgeries* e.g. Family planning clinics, youth clinics, GUM clinics, community gynaecology, obs and gynae departments, Well Woman and Well Man clinics, travel clinics, primary care settings and other health services such as walk-in centres, mobile clinics, Accident & Emergency Departments and NHS Direct.

- *Support for parents and carers* in enabling them to feel comfortable talking with their children about sex and relationships e.g. via parents' peer education projects.

- *Residential care settings* – e.g. with young people in public care, people with learning difficulties, disabled people, older adults in residential care, people in prisons and young offenders' institutions, or in probation and bail hostels.

- *Further education, tertiary colleges, training colleges and universities.* This may be through work with Students' Unions, Peer Education projects such as MedSex, via provision of outreach sexual health services or dissemination of information materials and condoms.

- *Streets, parks and public sex environments.* Detached work takes place on the territory of the group being worked with – for example with young people congregating on garage forecourts or street corners, in parks and cruising areas used by men who have sex with men, or street-work with commercial sex workers. In these settings, information and support as well as outreach sexual health services and condom distribution can all be offered.

- *Pubs, clubs and recreation settings.* Similar detached work can be carried out to that described in the point above. Some pubs and clubs may be willing to have information displayed and to take regular condom "drop-offs" for customers.

- *Workplaces, including New Deal schemes and Connexions and Careers services.* Information can be distributed and work-place policies agreed with employers, for example about the provision of staff training, sexual health service sessions or condom machines in the toilets.

- *Private and retail sector, shops and hairdressers.* Some sexual health promotion projects have successfully targeted shopping areas or hairdressers for dissemination of information, needs assessment surveys or piloting new materials.

- *Community centres, voluntary, community and faith groups.* Much of the work described in the previous section on methodologies can be carried out with the voluntary sector or with community-based groups or Faith Groups.

Section One – Part Three: Guidelines for Good Practice in Sexual Health Promotion

1. First and foremost – the point on which our best endeavours will either rise or fall is the vital importance of drawing on the evidence base as the foundation and starting point for any new developments. So we need to ensure that any approaches we take have either been seen to work in the past, or are subject to rigorous evaluation to prove their efficacy. Section 1.4 summarises much of the current evidence of what works in practice.

2. Many of the following sections list references to ways and means of evaluating this work. So the evidence should overarch and underpin all activity – and it is in the context of this that the following guidelines are suggested.

3. Sexual health promotion is more likely to be effective, sensitive and appropriate in meeting the multiplicity of sexual health needs within communities, if the following are in place:

A clear and explicit values base

An ideal values base will:

- ***Ensure sexual health promotion is accessible to all.*** This means taking account of particular needs e.g. in terms of people whose first language is not English and people with visual or other sensory impairment.

- ***Affirm diversity*** e.g. in terms of sexuality, ethnicity, socio-economic factors, culture, age or ability. This understanding of diversity should be reflected in all practice, supporting the right to sexual health for all. In particular, attention should be paid to the needs of vulnerable or marginalised groups and communities and those who might suffer from discrimination or inequalities in sexual health.

- ***Ensure that individuals and groups are able to resist coercion.*** This should include equipping people with a belief in their sexual health rights and the skills to identify and avoid pressure, exploitation, abuse, harassment and bullying.

- ***Support the development of self-esteem.*** Self-esteem plays a vital role in enabling individuals, groups and communities to negotiate equally and to make choices and decisions which will enhance rather than detract from their sexual health and well-being.

- ***Build a clear sense of the rights*** of individuals, groups and communities to positive sexual health and to services which support this.

- ***Enable people to develop practical skills*** as key elements of sexual health and related decision-making. The most effective sexual health promotion aims to 'empower' individuals, groups and communities – particularly those who have traditionally felt less powerful than others. As part of this, best sexual health promotion practice aims to help people to take more control over their lives, their health and their bodies for example by acquiring practical skills such as negotiation or assertiveness.

- Be grounded in ***a positive and holistic model of sexuality and sexual health***. Such a model should reflect the vital importance of work at organisational, institutional, social and community levels as well as work with individuals and groups if the conditions for sexual health are to be created, sustained and supported. It should also be informed by a positive and holistic model of sex itself, acknowledging the vital part this plays in human experience and in many people's lives.

Supportive methods of working

In order to be consistent and congruent with the values base described above, methods used should:

- ***Promote collaborative and multi-agency work*** including partnerships with the voluntary and community sector.

- ***Actively counter and challenge discrimination, stigma and prejudice.***

- Acknowledge and support the ***rights and responsibilities*** of individuals, groups and communities in relation to their sexual health and well-being.

- ***Create opportunities for discussion***, reflection and exploration of issues, attitudes, values and beliefs in relation to sexual health.

- ***Be informed by a research and evidence base*** which draws on our knowledge about what has been demonstrated to be effective, in order to ensure the best use of finite resources.

- ***Engage people's intellect, experience, thoughts and feelings*** to create a positive culture, which is tolerant, affirming and celebratory about sexual health and sexuality as a vital element of human experience.

Services and support which are informed by these values

All sexual health services, support and sexual health promotion initiatives should:

- ***Be offered in non-judgmental, respectful and sensitive ways.***

- ***Provide clear, accurate, up-to-date information*** in attractive and accessible forms and language.

- ***Offer support*** and information which will enable people to make healthy sexual choices and relationships.

- ***Be provided by staff who are aware of the values base described here*** and who are trained, skilled and confident to work in ways which exemplify this.

Section One – Part Four: The Evidence Base

Evidence based planning and practice

1.   Decisions about policy and practice in the public sector are increasingly driven by consideration of the best available evidence – and this should be as true for sexual health promotion and HIV prevention as any other activity. Drawing together, analysing and synthesising evidence from individual evaluations is a central principle of evidence based practice.

2.   Reviews of effectiveness bring together large amounts of primary data which can be evaluated and summarised. This can identify statistically significant effects by comparing information from several evaluations. Although traditionally many systematic reviews have only included randomised controlled trials (RCTs)[1], increasingly they include other types of evidence, eg non randomised controlled trials and process evaluations[2] alongside outcome evaluations[3].

3.   Examination of the literature on 'what works' in a particular area can result in greater cost effectiveness (selecting the best value intervention) and overall impact (selecting the most appropriate intervention for a population). In addition, where local interventions are subsequently assessed and evaluated, the findings can be fed back into the evidence base, improving our understanding of what works and so helping us to improve the design and delivery of our interventions.

4.   This section gives, in brief, some findings about the effectiveness of interventions to reduce teenage pregnancy, STIs and HIV. However, because there are some important limitations to the findings reported here, it will be helpful to read the full documents, details of which are listed in the references at the end.

The Health Development Agency (HDA) evidence base

5.   The *National Strategy for Sexual Health and HIV* (DH, 2001) recognises the need for health promotion to be informed by evidence, but acknowledges that currently: "The evidence base for HIV and STI prevention is still dispersed and unsystematic" (para 3.18). It goes on to say that: "Effective commissioning of HIV/STI prevention needs up to date evidence of what and how different interventions work. The Department has commissioned the Health Development Agency (HDA) to draw together the available evidence, assess what works and make clear recommendations on future approaches. The Department will use that work to set the direction for local prevention activity" (para 3.19).

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1   where subjects in a population are randomly allocated into groups, usually called study and control groups, to receive or not to receive an intervention.

2   focuses on and measures the processes, activities and methods of planning and implementation. It covers issues of reach, quality, client satisfaction and cost. Both qualitative and quantitative research can be used in process evaluation.

3   measures the long term effects of health promotion interventions in achieving higher level goals like behaviour change and incidence.

6.   In 2002, the HDA, therefore, undertook to map and synthesise the best available review-level evidence for the effectiveness of sexual health interventions. The findings below are drawn from three separate HDA Evidence Briefings which aim to bring together learning from reviews and make the findings accessible to researchers, policy makers, and practitioners. These Briefings analyse and bring together the evidence from different reviews to highlight conflicting evidence and gaps in the evidence as well as suggesting possible explanations for different conclusions.

7.   It should be remembered though that the data considered by the Evidence Briefings that are summarised here – data from reviews – provides only a partial answer to 'what works' in our areas of interest. This may be, for example because potentially useful interventions or programmes have not been evaluated well enough, or their evaluations have not been published, and so findings that might be helpful to planners and practitioners are not yet available.

8.   Finally, it is important to note that considerable gaps in the evidence base were uncovered by our reviews of reviews with the result that many interventions are not represented at all in our practice recommendations. However, this should not be taken to mean that interventions not mentioned are ineffective, or that practitioners should limit themselves only to delivering the narrow range of interventions represented here. In other words, a gap in the evidence should not be confused with evidence of ineffectiveness.

HDA teenage pregnancy evidence base

9.   This review of reviews focused on interventions to prevent teenage pregnancy and improve outcomes for teenage parents (HDA 2002a). It indicates that the consensus on what works to prevent teenage pregnancy shows the following can be effective:

- school-based sex education, particularly when linked to contraceptive services, can delay sexual activity and reduce pregnancy rates

- community-based education, development and contraceptive services

- interventions which develop young people's education, vocational skills, interpersonal skills and confidence can increase contraceptive use and reduce pregnancy rates.

10.   These interventions and programmes are most likely to be effective if they:

- are based on theory, and have clear behavioural goals and outcomes

- focus on improving contraceptive use and at least one other behaviour likely to prevent pregnancy and STI transmission

- are long term

- tailor services to meet local needs, and target local high-risk groups

- have clear, unambiguous messages

- use participatory teaching methods

- are accessible (in terms of opening hours, location, and level of information provided) to young people

- use staff who have been trained and are committed to the programme and to working with young people

- whenever possible, respect young people's confidentiality and views

- are in place before young people become sexually active

- focus on both young women and young men

- foster an open, communicative atmosphere for talking about sex and sexuality.

11.   More rigorous research is needed to test these statements but the evidence also suggests that some young people visit community-based services, including GP surgeries, for information and advice about contraception. To ensure these services are acceptable and accessible to young people, staff in these settings will need ongoing training and development.

12.   There is currently very little research on young men regarding teenage pregnancy.

HDA HIV prevention evidence base

13.   This review of reviews focused on the priority populations for the sexual transmission of HIV in the UK, namely men who have sex with men, African communities, commercial sex workers, and people with HIV. It also covers HIV voluntary counselling and testing with all populations (HDA 2002b). It does not cover the role of condom effectiveness, post-exposure prophylaxis (PEP), microbicides, treatment of STIs, or male circumcision in reducing the sexual transmission of HIV. In particular, it is important to note the omission of clinic-based interventions other than voluntary counselling and testing. Furthermore, it does not cover interventions to prevent occupational, injecting drug use and mother-to-child transmission of HIV.

14.   For men who have sex with men, there is some evidence that community-level interventions involving peers and popular opinion leaders can be effective in influencing the sexual risk behaviours for men who have sex with men. There is also some evidence that (cognitive) behavioural group work, focusing on risk reduction, sexual negotiation and communication skills training (and rehearsal, for instance through role-play) can be effective. However, it is questionable how generalisable these kinds of interventions may be to the UK and/or non-white, non-educated men who have sex with men.

15.   The evidence from reviews suggests that interventions with men who have sex with men are more likely to be effective if they are:

- placed within the broader context of men's lives, addressing the range of factors which influence risk at both the personal level (eg knowledge, skills) and the structural level (eg discrimination towards gay men, gay community norms towards condoms)

- tailored and targeted to specific sub-populations of men who have sex with men, for instance black gay men and working class gay men

- multi-component (using small group work), focusing on risk reduction, sexual negotiation and communication skills training and rehearsal (eg through role-play or identifying 'triggers')

- There is some evidence that interventions delivered at the community level (particularly peer-led) can be effective in influencing the sexual risk behaviours for commercial sex workers.

16.   There is also some evidence to conclude that HIV counselling and testing can influence sexual risk behaviours among serodiscordant[4] couples, some injecting drug users (in particular those who learnt that they were seropositive), heterosexual men who learn that they are seropositive (when another component is provided alongside testing and counselling), and sexual health clinic attenders who learn that they are seropositive. However, the effects of a negative diagnosis are not clear: some suggest that it may lessen the sense of risk and lead to a false sense of security, perhaps increased risky behaviour. Therefore, the evidence currently available from reviews suggests that voluntary counselling and testing should be targeted only at high-risk individuals who are likely to test positive.

17.   We were unable to identify any review-level evidence from which to make policy and practice recommendations for HIV prevention with African communities and with people with HIV.

HDA STI prevention evidence base

18.   This review of reviews focused on interventions to reduce STIs, and covers partner notification and health promotion/educational interventions (HDA 2002c). It concludes that 'partner notification'[5] can newly detect STIs among partners and that in terms of numbers of partners presenting for medical evaluation, provider referral is more effective than patient referral. However, the evidence for this appears to be weaker in the case of STIs other than HIV/AIDS. Patient referral incurs less service costs, and in some circumstances may be more effective. Perhaps offering patients a choice is most appropriate. Simple forms of patient assistance directed at improving patient referral, such as a telephone call, can be effective. It is worth emphasizing that there are also potential harms to partner notification (eg in inciting domestic violence), however these need further investigation.

What is effective in health promotion and education?

19.   The evidence suggests that the main features of effective health promotion and education interventions are:

- Incorporation of theoretical models of behaviour change, or components of these models, as a basis for intervention development and implementation.

- Provision of basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse.

- Multi-faceted, including a number of components – such as skills development, motivation building and attitude change in addition to factual information. Information provision alone is insufficient to influence behaviour change. Personal and structural factors such as attitudes towards safer sex and condoms, motivation, the influence of significant others, wider social influences, as well as practical skills, all play an important part in the ability to change behaviour.

- Incorporate specific behavioural skills training, like how to use condoms.

- Based on a detailed understanding of background behaviours, beliefs and risk perceptions of the target population. Formative research can be useful in developing programmes which are appropriate to the target population in terms of age, gender, sexual experience and culture.

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4   where one partner is seropositive for HIV (ie infected with HIV) and the other is seronegative

5   process whereby the sex partners of patients diagnosed with an STI are informed of their exposure to infection and thus the need to visit a health service

- Use of peer educators, particularly with adolescent audiences. Some adolescents may be more comfortable receiving sexuality-related information from peers rather than adults, and peers may also have added credibility because of their perceived recent experience of the issues under discussion.

- Emphasis on promoting condom use, rather than abstinence. Telling people not to have sex is unlikely to be an effective intervention.

- Of appropriate duration. It requires considerable time and multiple activities to change long-established sexual risk-taking behaviour.

Building the evidence base for the future

20. Those involved in evaluating national or local interventions are in a position to contribute to an overall understanding of 'what works'. Wherever possible, local practitioners should attempt to monitor and evaluate their interventions in terms of their impact on the factors influencing risk behaviour (eg knowledge, attitudes, skills, access to services, availability of condoms, peer norms regarding safer sex and condom use), alongside any effect on behaviour itself. Looking at all of these outcomes together can help us to understand whether, how and why interventions are effective.

21. However, it is important to emphasise that single small-scale interventions are unlikely on their own to bring about changes in behaviour; instead, behavioural outcomes are more suitable for measuring the effects of large-scale multi-component interventions or programmes.

22. As formal academic evaluations tend to focus on a particularly narrow range of interventions, it is crucial that practitioners capture and report on their local activities so that this information can be mapped and synthesised in the future. The HDA has produced an evaluation resource for those working around teenage pregnancy (HDA 2002d), which will also be useful to any practitioners involved in evaluation. It identifies principles of project evaluation, and demonstrates how to apply these at different levels of practice (e.g. teenage pregnancy strategies or individual projects).

23. The HDA is also encouraging local professionals to send their monitoring and evaluation reports for inclusion on a database of sexual health 'grey literature' – these should be sent to: NHPIS, Health Development Agency, Freepost LON20535, London WC1V 7BR. The HDA is also keen to hear about ongoing sexual health research for inclusion on it's Research and Practice/Interests Database (RAPID) – see http://www.hda-online.org.uk/nhpis/ – and for citation in its bi-annual bulletin Current HIV Education Research (see http://www.hda-online.org.uk/html/nhpis/cher/index.html).

Section Two – Part One: Developing and Implementing a Local Sexual Health and HIV Prevention Strategy

1. Too often local health promotion strategies are developed in a flurry of motivation and good-will, but can often result in little changing in practice. But steps can be taken to ensure that a local sexual health and HIV strategy is strong and dynamic, a call to action rather than a well-meaning "wish-list". What follows is drawn from experience at a local level where strategies have already been successfully developed and implemented.

Skills and qualities of those leading

2. Undoubtedly, where strategies are successful, this usually results from having people leading the implementation process with the skills to help a multi-agency group function productively together. Experience of successful implementation has shown that these skills can include:

    - *The ability to mediate between strong interests and personalities.* It is vital to involve influential and key people in developing and delivering a sexual health and HIV Prevention strategy. However these very people – for instance commissioners and planners, heads of agencies, directors of services and lead consultants – are likely, by nature of their role, to have forceful ideas and styles. In order to ensure everyone gets their full say, those leading the process therefore need to be aware of this and to ensure no view, discipline or agency perspective prevails but that all are given respectful treatment and feel equal partners in the process.

    - *Being able to facilitate positive communication and co-operation.* Basic group-work and facilitation skills are helpful. In this context, these would include :

        – the capacity to help people work through difficulties and differences

        – the ability to enable the group to find an acceptable consensus

        – skill in structuring and running meetings and discussions in a way that everyone's contribution is heard and valued

        – mediation so that everyone can feel equal and respected within the group – even if there are vast differences of status outside it

        – Using basic meeting tools, such as doing a round of the group and hearing news or information items from everyone can be one way of working towards equalising the input and use of the 'airspace'.

    - *Not privileging any particular discipline or setting.* The very strength of a multi-agency group is in the variety of perspectives which are reflected and expressed within it. All too often in such groups, one or two of the most powerful agencies can dominate. So, for example, a medical model of sexual health can become the norm or the strategy can be interpreted as being solely concerned with the interests and needs of young people. For it to remain genuinely owned by all, particular efforts need to be made and a culture of openness and reciprocity has to be consciously fostered.

Developing the Local Sexual Health and HIV Prevention Strategy – and a Supporting Action Plan

3. ***The process of developing the strategy*** can be as important as the final document itself. This process can be an educational, awareness-raising experience for all those involved – and a chance to involve a whole range of people in the project of addressing sexual health and HIV prevention. It is an opportunity to reach out to as many groups as possible – whether in other services, such as Probation and Youth Offending Teams, New Deal schemes and Connexions or in the voluntary and community sector. This will allow you to start to engage as many people and agencies as possible – which means you are more likely to be able to get their active support in implementing action with their own clients and user groups. For this reason, it's a good idea not to rush or skimp this stage of strategy development as a well-managed process can be extremely productive in itself.

4. ***The leadership of the process is important*** – and it is useful to have two people for this process, one with a strategic planning or commissioning role and someone in an operational setting. This ensures that both perspectives, and the priorities of each, can be adequately reflected in the process. It also models positive co-working across these boundaries which sometimes can be seen to act as barriers.

5. Early on in the process, ***all key players need to be identified*** and then continually consulted and involved at every stage. As well as those in health settings this should also, of course, encompass colleagues in education, social services, the youth service and voluntary and community-based organisations. It is also helpful to include people involved in related fields such as social regeneration, housing, further education and religious and faith groups.

6. Ensure as many agencies, service providers and potential service-users as possible have the opportunity to shape the final strategy. To accomplish this, ***consultation mechanisms such as facilitated workshops and focus groups*** are helpful as well as paper consultations via questionnaires or request for comments on drafts.

7. If a strategy is being developed, this should be accompanied by ***an action plan*** identifying lead responsibilities and time-scales. Too many strategies, after their completion, have failed to deliver because they lack this. In fact, if there is not the time and capacity to develop a full strategy, drawing up the action plan should take priority.

8. The strategy needs to be driven by ***explicit values***. Some ideas for these are given in the list of guidelines for good practice set out in Section 1.3. Getting these values agreed and in place can in itself be a positive and developmental part of the process. The facilitated workshop suggested earlier can be an excellent setting for doing this, enabling the group to come to a collective agreement, which everyone can sign up to, about the strategy's values framework.

9. ***Every effort should be made to link this strategy to other local initiatives.*** The obvious example is the Local Teenage Pregnancy Action Plan, but others would be Health Improvement Plans, Mental Health Plans, Children's Plans and Regeneration Plans. Congruence and consistency between these is important if all of them are to contribute to meeting the community's sexual health and HIV prevention needs.

10. ***Continue to apply the model above to implementing and monitoring the Strategy.*** This is the "make or break" stage in determining its effectiveness. The proliferation of strategies at a local level can engender a kind of "strategy-fatigue", a scepticism about whether these will ever be linked to real change. It is therefore vital to design action plans and implementation processes as robust and dynamic as the strategy itself – and to continue applying all the stages outlined above to putting this into practice.

Implementing the strategy

11.   Various methods of implementation and examples of good practice have emerged to aid the effectiveness of local strategies. The following are suggested as possible tools to achieve implementation:

12.   ***Set up a strategy implementation group.*** This may comprise some or all of the original strategy development group but will have a much wider representation. Spend some time setting this group up well – perhaps with a facilitated away-day. This can give participants the opportunity:

- to share perspectives and information about areas of work

- to agree ways of working together and positive ways of communicating

- to reflect on how to ensure everyone feels able to contribute equally.

13.   People only get actively involved in a group and invest in it if they enjoy it and see some purpose in its work. So making this group welcoming with discussions which are lively and interesting rather than simply business-driven has a real effect in terms of it becoming a positive and proactive force for change.

14.   ***Invite representation from all relevant local agencies.*** This will include Social Services, Education and Connexions/the Youth Service as well as sexual health service providers such as GU Medicine, Family Planning, the Youth Clinic, Primary Care Practitioners and PCTs and Sexual Health Promotion and HIV Prevention Specialists. The voluntary and community sectors need to be well-represented, with faith groups and service users also involved wherever possible. Make sure that the individuals attending are people with a real interest in, and concern for, sexual health and that everyone can sign up to the strategy's values framework. It is important at this stage to try to get people involved who have authority and influence in their organisations, while at the same time not being so over-stretched that they will not be able to prioritise meetings. If you do have someone at this level nominally on board, encourage them to send a senior deputy in their absence.

15.   Also, ***expand the group as and when new needs emerge*** – or new interest is expressed in it. There is a delicate balance to be struck here. On the one hand, those agencies on the Implementation Group are likely to be the services which most actively engage in implementing the action plan so it is a good idea to have as many represented as possible. On the other hand, to have meetings of 20 or more people minimises the enjoyment and the effect of the meetings for everyone. One of the solutions to this dilemma is suggested in the next point.

16.   Some of the actions and projects identified in the Action Plan are best taken forward by ***task-focused working groups*** overseen by – and reporting to – the main Implementation Group. This means the core Implementation Group can stay quite small and not become too unwieldy, while involving people from many more organisations by becoming involved in working groups. For example sub-groups of the Implementation Group set up in one local area are: A Tertiary College working group, a Chlamydia Steering Group, a group organising a Sexual Health Conference for Social Services, and an STI Prevention group. Making these working groups time-limited and task-focused means that people can make a finite commitment to them and are therefore more likely to opt in.

17.   The constant ***development of joint tasks and projects*** ensures that the Implementation Group experiences a sense of positive achievements. So in one area, work arising from their Implementation Group has included the development of a local sexual health services Directory, Sexual Health Conferences run for Social Services and for the Community Health Trust and a "Christmas Sex" campaign publicising how to access emergency contraception and condoms over the Christmas holiday. Running projects of this kind ensures that the Group has a sense of achievement when the task is successfully completed – a conference has been run or a new resource produced. Once the Group

members start to take pride in their work, there is a whole new level of investment in the effectiveness and continuation of the group – and the strategy it is there to implement.

18.   ***Multi-agency funding bids*** can be made from this basis to support new initiatives arising from the strategy's implementation. Whether this relates to occasional slippage bids or to applications for major allocations from regeneration budgets, the fact that the Implementation Group demonstrates positive "joined-up" ways of working means that applications for funding are likely to be more favourably viewed than more isolationist bids. So for example one local Implementation Group lobbied for a more effective budget for condoms to be distributed from Primary Care settings, an initiative which was successful in being allocated considerable funding.

19.   Sub-groups and working groups allow ***many entry points for people to become involved*** in implementing the strategy and give people practical experience of joint working. Some people in the Implementation Group – such as Consultants in Public Health, GU Medicine and Family Planning, the Teenage Pregnancy Co-ordinator or Sexual Health Promotion and HIV Prevention Specialists, will already be steeped in the work and many aspects of sexual health. For others – perhaps coming from one perspective such as gay men's support groups in the community or Youth Offending Teams – involvement in the main Group or a task-focused working group will allow them to become more familiar with broader sexual health matters. This develops skills, understanding and information about sexual health across a whole range of agencies – which in turn is likely to result in more effective working at grass-roots practitioner level, benefiting the wider community.

20.   Many ***opportunities for joint training and professional development*** are created by working closely together. These can include seminars organised to increase people's knowledge of newly emerging issues – such as female genital mutilation, child abuse through prostitution or homophobic bullying. Or they may be aimed at encouraging people to share their areas of particular expertise and models of excellent practice. It may be appropriate to bring in outside speakers, agencies and facilitators or to use the Group's own resources. Feedback sessions can be arranged when someone from the Group has attended a national or international conference or training event – for example arranging a workshop by people who attended the International AIDS Conference reporting their learning from this. Whatever the topic or arrangements, learning together and sharing skills is a great way to build group cohesiveness.

21.   ***Information production and dissemination*** can be co-ordinated by the Implementation Group and new locally-based materials can be produced from this base. Within the group, there are likely to be members with expertise in resource production. So harness this to produce new materials to meet emerging needs.

22.   Working in this co-ordinated way can enable ***the targeting of less actively-involved agencies*** and can offer them support in developing sexual health promotion initiatives. There will always be some services or agencies who are more actively represented within the Implementation Group than others – because sexual health is their core business. However, it is also possible to use involvement in the Group and its working groups as a way of inviting more peripheral agencies on board, so increasing the reach of sexual health work into other organisations. One way of doing this is to set up a sexual health and HIV prevention "Link Workers" group, inviting all local agencies with a possible interest – from Relate and the Samaritans through to drugs or alcohol education services. By offering training events and workshops, networking opportunities and information-sharing, such a group can build capacity in member organisations, who may not have previously seen sexual health and HIV prevention as part of their role or remit.

23. **PR, press, media and dissemination work can be undertaken** by the Implementation Group. Sexual health and HIV work can often attract interest and the attention of people and organisations who wish to limit people's access to information on sexual health. For this reason, and to pre-empt negative coverage of sexual health and HIV prevention initiatives, it can be helpful to gain the support of the local media and to work in partnership with them. This can be done, for example, by sending out press releases about new work and offering stories and photo-opportunities wherever possible. In this way, the Implementation Group can become an effective agent for raising public awareness of sexual health and HIV and taking on an educational role. See Section 2.5 for more on this.

24. **An approach, which is person-centred**, credible and works well on an inter-personal basis is vital for building and sustaining positive relationships. A key to success lies in paying as much attention to setting up a group whose members can work well together, and are respectful of each other, as to the Strategy itself. This may involve, for instance, a workshop agreeing guidelines for how the group and its members are going to work together or exploring how a group environment can be created which can elicit the best and most positive thinking from all involved.

25. As much attention needs to be given to **social and educational models of health** as to medical and clinical issues. Equal respect and status should be accorded to both approaches, seeing them as complementary and supportive of one another rather than oppositional or competitive. We are seeing the development of a health agenda which recognises the importance of addressing health inequalities – and, within these, inequalities in sexual health.

26. In the light of this and the focus on social inclusion issues, it is necessary to **take a holistic view** rather than having a limited concept of sexual health and HIV prevention which is only about treatment and care, contraception services and responses to disease and dysfunction. Clearly these are key elements, but there are many more factors also to be addressed – such as issues of self-esteem and emotional development, of communication and negotiation, of power, stigma and discrimination – which have just as vital a role to play. Keeping both in balance – and acknowledging the constant inter-play between the two – is likely to result in the most effective action. A holistic model of sexual health and sexuality is available on the website which accompanies this toolkit.

27. **The development and implementation of a Strategy Action Plan has a snowball effect.** This happens because successful initiatives build motivation in individuals and agencies. This in turn leads to the development of more successful projects – further increasing motivation and enthusiasm for the work. So nothing succeeds like success – and this Section has aimed to lay out the many key elements which need to be in place in order to make such success achievable.

Section Two – Part Two:
An Inter-Agency Approach – Making It Work

1.   There are many challenges to meet in the task of preventing HIV and promoting positive sexual health, emotional well-being and self-esteem. If we are to be effective, therefore, all of those whose work roles involve them in any aspect of sexual health should be encouraged and empowered to work as closely together as possible. This will help to make the best possible use of finite resources as well as ensuring that everyone – no matter how historically marginalised or socially excluded – has access to broad and comprehensive responses to their sexual health needs.

The benefits of joint working

For service users

- It increases their choices and options about how they receive health services, opportunities for personal development, information, education and emotional support from – and in what settings.

- The services which are developed through such joint initiatives are more likely to be flexible, sensitive, appropriate and relevant to people's needs – in other words, delivered in the right way, at the right time, in the right place, by the right people.

- It increases the number of significant, supportive professionals available to people, with a role to play in promoting their sexual health and well-being.

- They are offered a wider range of settings in which they can access sexual health and HIV services, thereby increasing the likelihood that they *will* access them in at least one of these.

For Professionals and Service Providers

- They can gain new skills from each other. For example, health professionals can develop outreach and detached work skills, and non-health staff can increase their knowledge of clinical sexual health and HIV issues and services.

- By working closely together and pooling their client networks, they are able to contact more people who experience health inequalities and may not traditionally use health services.

- Some professional staff will be more comfortable than others about raising issues related to sexual health, HIV, relationships and sexuality with clients or service users. Joint working means other professionals can learn from them and so increases the likelihood of person-centred approaches and services rather than ones which are solely problem-focused.

- Staff who may feel isolated can gain support, a "sounding board" and key allies in what can be stressful work.

For Managers, Planners and Service Commissioners

- Joint working offers a more effective use of finite resources.

- It also provides access to community-based health needs assessments which can provide invaluable data to inform commissioning and planning processes.

- It is more likely to be successful in achieving the desired outcomes – i.e. positively supporting the health of all, as well as meeting sexual health and HIV prevention targets set both nationally and locally.

Some of the barriers to joint working

2.   We need to be aware that, in developing closer joint working, we are moving beyond traditional, historical boundaries and divisions. This is a visionary and potentially extremely productive way of developing more holistic responses to people's sexual health and HIV prevention needs. However, it is also helpful to recognise that it may cause some ripples, anxieties and resistance.

3.   That is the nature of change – and while it is no reason not to pursue developmental ways of working, it is sensible to recognise and acknowledge the possible blocks and barriers. In this way they can be sensitively managed and overcome, rather than sabotaging important new initiatives. So, all of the following can be powerful factors in inhibiting effective joint working. While you will probably not encounter all of these, most will be likely to encounter **some**.

- ***Competitiveness for resources.*** When services may be suffering cuts in already finite and limited resources, everyone involved can have a sense that there is "not enough to go 'round" rather than believing that sharing resources is to *everyone's* benefit.

- ***Lack of time for joint planning.*** Planning is an essential pre-requisite to the success of any project, but is especially important when working across agency boundaries.

- ***Stereotypes, myths and assumptions.*** It is commonplace for staff from different organisational cultures to construct or inherit stereotypes about others. Even where these are not true, they can provide powerful barriers to trust.

- ***Lack of management support*** for the work. Even where practitioners at the grass roots work well together, their managers may be constrained by some of the practical or attitudinal barriers listed here, and so may be negative or obstructive.

- ***Professionals polarised*** – for example into "medical" or "social" models of sexual health.

- ***Cultural and organisational differences.*** Along with protectionism, insecurity and "ownership" of certain client groups, these can present major hurdles. The good news, however, is that all that is necessary to transcend these is a shift of perceptions and a more open attitude.

- ***A lack of awareness and understanding of each others' working roles*** in relation to HIV prevention and the promotion of sexual health and emotional well-being.

Moving beyond the barriers

4.   While these points may all contain some grain of truth, the fact is – as many models of good practice testify- that it **is** possible to resolve and move beyond them, and that doing so is to everyone's advantage. Many of these blocks can be overcome by a few hours spent together, learning from each other's

experience, sharing information and gaining new perspectives. This can be done at informal meetings, joint workshops or events specifically set up to promote networking. You could arrange meetings with your managers to discuss the benefits to both services – and to your client groups – of working in this way. You could draw on some of the points made here under the *Benefits of Joint Working*. At this meeting, it will be helpful to get agreement for the joint planning time which is essential for any project's success.

5.   Make sure you provide both sets of managers with regular reports of your work, to keep them supportive of the process. You could also perhaps offer to run workshops for other colleagues and agencies to spread the word about the benefits of inter-agency work and its positive outcomes. Also remember that working together in this way can sometimes attract specific joint project funding. Together you may be able to make a stronger case for funding than either individual service can.

What to do next?

6.   If you are feeling at all isolated in this work, have not got well-established links with others doing sexual health work or generally want to explore the possibilities of some inter-agency work, it's worth making links with others with a sexual health promotion role and arranging to meet. These staff could, for example, include:

Health Advisers at GUM Clinics	*Youth workers and Connexions staff*
Counsellors	*Staff in Psychosexual Services*
Learning Mentors	*Residential Care Workers*
Community Midwives	*Sure Start Staff Plus*
Health Promotion Specialists	*PSHE Teachers*
Family Planning Clinic staff	*School Nurses*
Practice Nurses and GPs	*Health Visitors*
Youth Offending Teams	*Drug and Alcohol Workers*

7.   At an initial meeting, you could discuss:

- What do your current work roles entail and what settings and environments do you work in?

- Which groups of people are you in touch with and what are their main concerns about sexual health and HIV?

- Do you have links with your local Primary Care Trust and if not, how could you establish these? For example, inviting their sexual health and HIV strategy lead, lead on the Health Improvement Plan or on Teenage Pregnancy along to meet you could provide a positive starting point. Since these groups have very demanding agendas, thinking of ways in which you could help them to meet some of their objectives and offering them some tangible work or resources is the most likely way of ensuring you can develop strong partnerships.

- Do you have shared training needs and, if so, could you set up some training for yourselves and a multi-agency group of colleagues?

- Are there any resources you could share? These might include venues, sessional staffing, transport or educational materials. The more effectively you jointly use resources, the more there will be to go round.

- Have you any ideas for an introductory piece of joint work, as a pilot to explore the benefits of working together? Be sure to build an evaluation process into this from the outset, so you will have the evidence if necessary to argue for support for further initiatives of this kind.

- Are there any pockets of funding that either or both of you could access to support getting this work off the ground?

Section Two – Part Three: Project Design and Management

What is a project?

1.   The delivery of much sexual health promotion is done via projects. This term is loosely used to cover a multitude of activities, but some characteristics of sexual health projects are as follows (though most projects will not meet *all* these criteria):

- Short-term funding for a time-limited piece of work which is not intended to extend further.

- A pilot period – perhaps of a new methodology, work with a new group, work in a specific geographical area or with a particular agency.

- Work which is tested out for a certain length of time – often two or three years – before it may be absorbed into mainstream activity, depending on the effectiveness of the pilot stage evaluation.

- A discrete piece of work – with clear aims, objectives, timetable and outcomes set in advance. For example conducting a needs assessment or the production of a new video or service directory. On completion of the task, the project finishes having achieved the outcomes anticipated.

- A piece of work of fixed duration run by temporary staff – perhaps seconded from another agency, recruited on a short-term basis or on placement from a course.

The advantages of project work

2.   Some of the advantages of project work are:

- New methodologies can be tested without making a long-term commitment to them. This means that those which have not evaluated as positively effective can be discontinued while further funding can be sought for ones which have proved their worth.

- New funding is often easier to acquire for project work than long-term work.

- A whole range of methods can be trialled through projects, rather than having to commit to just one or two ways of working from the outset and putting all the available resources into these.

- Ongoing resources can be sought and allocated on the basis of proven effectiveness.

- In having "a beginning, a middle and an end", and also some tangible outcomes, projects can be satisfying for staff who often do not get to see any immediate fruits from their work, because of the gradual changes involved in long-term work as such as community development.

The disadvantages of project work

3.   The disadvantages of project work can include:

- Projects are often not sustainable in the long-term.

- Good work can be lost if the project time-table draws to an end and with it the funding.

- Inability to bring the work into the mainstream.

- Lessons which have been learnt from a project, or the models of good practice which have been developed through it, can too easily be lost when it draws to a close.

- Sexual health promotion requires change in deeply-ingrained behaviours and attitudes and this is only likely to happen over a long period of time. It is therefore an unrealistic aim for short-term projects.

- Recruiting and keeping project staff can be difficult because of the short-term nature of the work.

Guidelines for projects

In drawing up outlines for projects, these guidelines may be helpful:

Projects should address current or emergent needs

4.   Wherever possible and appropriate, a needs assessment should precede the development of a project.

- Could you do this formally – for example through some local research or a survey such as a Gay Men's Needs Assessment conducted via focus groups, interviews, and questionnaires?

- Or is it more appropriate for it to be done informally, through building up impressions and understanding? For example, extensive work with colleagues in Primary Care Teams may result in a clear picture of their needs for resources, training and support in developing appropriate sexual health and HIV provision. Much of the work of good sexual health promotion draws on 'soft evidence' – not hard demographic or epidemiological statistics and trends, but an overall intelligence for example about a community, a methodology, a group or service users or trends in social attitudes and awareness. As part of the whole picture of 'evidence', these have a valuable part to play.

Projects must have a set of clear and explicit aims and objectives

5.   What are yours? Aims and objectives should be drawn up to the "SMART" specification, in other words they should be singular, manageable, achievable, realistic and time-scaled. The overall purpose of the project should be expressed in its aim – for example: "To conduct an STI awareness campaign with young men".

Objectives which will seek to achieve this aim might include

- "To increase awareness of Chlamydia and uptake of screening"; "To develop a peer education outreach initiative with young men in a range of settings including schools and youth justice"; "To train a number of teachers and youth workers to support this work"; and "To involve young men in the production and dissemination of a leaflet about STIs and their prevention through condom use".

- Breaking the project's objectives down into "manageable chunks" in this way makes approaching the tasks less daunting and sets a clear base-line against which progress can be measured and outcomes evaluated.

Time-scale

6.   It is essential to have a clear time-scale for the work. A timetable should be drawn up on what needs to have happened and by when. What are your externally or self-imposed deadlines? This will include any key committee meeting dates or publication deadlines.

7.   Could you produce a "flow" chart of which tasks run alongside each other, which cannot be started until others have been completed and so on? It may be wise to listen to counsels for caution at this stage. Too many projects flounder on unrealistic timetables which assume everything will happen in the shortest possible times, when in fact the converse is too often true.

Role analysis

8.   Everyone involved in the design and delivery of the project will benefit from a clear role analysis in advance. Some questions which should be addressed include:

- Who will be involved at what stages and what will their allotted tasks be?

- Who needs information about the project? Where will your key allies be?

- Can you consider the role of planners and managers as well as the project workers themselves?

9.   It will also be helpful to think about organisational and corporate roles as well as those of individual staff. So, for example in a Sexual Health project with adults with mental health problems, what will the role of the Community Mental Health Trust and its Board be? The work is likely to be best supported if everyone directly or indirectly involved in the project is clear about <u>who</u> is carrying out <u>which</u> roles. This will both facilitate good communication and mean that people will have clear understandings of what is expected of them, as well as what contribution they can expect from other staff and agencies.

Team building

10.   This is usually an essential building-block to effective working. Have you given careful consideration to the project's preparatory stages? These are crucial – for example it may be important to ensure project staff spend some time together at this stage, unless they are very used to co-working. Even if this is the case, some team-building in relation to the particular new task and project they are embarking on will doubtless more than re-pay itself as the work progresses. It can waste a huge amount of time later in the project's life if this stage is skimped and not taken seriously – maybe because of the lack of management will, or perhaps because people assume they already have a shared perspective.

11.   Can you put aside two or three visioning and planning days early on? Even if it seems a self-indulgent luxury, this is likely to reap huge rewards later. This time can be usefully spent agreeing a values base for the work, exploring key attitudes, discussing what support you need and can offer, developing appropriate methodologies for the project, working out communication systems and anticipating how to handle "worst case scenarios". Without being melodramatic, it is hard to over-estimate the potentially negative consequences of *not* committing this time at this stage, and the positive effects of making this small investment.

Publicity/PR issues

12.   Occasionally more innovative health promotion projects, particularly for some groups, may well attract negative media publicity. But there some steps you could take from the outset prevent or reduce the impact locally of negative or inaccurate publicity.

  •   Could you develop a media strategy? See Section 2.5 on "Positive Media Management" for more ideas. Using the media pro-actively as a potential partner rather than a threat to be feared can allow you to capitalise on all sorts of awareness-raising and information-giving opportunities. In other words, educational work can be done via partnership with the press.

  •   How can you plan press releases into the time-tabling process? Decide what your most effective publicity materials will be – and think about whether staff or community members involved in the work could benefit from some media training in order to ensure media possibilities are maximised.

  •   Can you ensure that your project publicity and PR work starts at home within your own organisations, where there may be a battle of hearts and minds to be won and potential allies to be courted? Could you do presentations for your policy-makers and Board members? Can you discuss these issues with your senior managers and bring them along with you? What about seeking out and using advocates and allies at the highest possible points within your organisation?

Resources

13.   Apart from the finance which has been secured for the project, what other resources will be needed to support the work? These might, for example, include venues for groups, training or the delivery of new services. Or it may be that there is a need for transport to enable groups, volunteers or staff to get to events or residentials. Perhaps the work will call for part-time sessional staff to support the project workers or maybe you will need the input of external consultants, trainers or researchers. Whatever the resources necessary, it will be helpful – and cost-effective – to think creatively about whether these can be found cost-free or at least at low cost.

14.   Could you explore the possibility of your partner agencies contributing something in kind – perhaps a meeting room, or training venue, in-house training or research staff, the use of a minibus or staff seconded part-time to the work? Whatever can be brought in without cost will free up extra resources for other aspects of the project.

Costings

15.   What is the allotted budget? And how can the best possible use be made of this? See para 14 above for ideas on ways to keep costs down by tapping into the resources of partner agencies.

16.   If there is no allotted budget, what does it need to be? Draw up a detailed breakdown of anticipated costs and remember the lessons from point 3 on time-scales and do not under-estimate the project's financial requirements. There is a fine balance to be struck here between being so financially ambitious that any project bid will look greedy and profligate, and being so frugal that staff will be hampered by not having the necessary financial minimum to deliver on the aims and objectives set.

17.   As in paras 13 and 14 on resources, it may be possible to be creative around finance. Is there any potential for raising external funding, for example, from local or national charities, trust funds or

organisational slippage at the end of the financial year? Or could you attract donations – for example of cinema tickets, shop tokens or free goods which can be used to pay volunteers "in kind" for their contribution?

18.   Maybe there is the potential to generate income from the project? Take the example of making a video with people with sensory impairment about their sexual health support needs, as a training tool for service providers. The final product could be sold nationally as well as distributed widely at a local level to improve the delivery of sensitive and appropriate services. In this way income can be fed back into new developments. However, remember that this will necessitate gaining the agreement of your organisation's management that any income generated in such a way will be reinvested in sexual health promotion.

Training implications

19.   Are the workers involved in the project likely to have specific preparatory training needs and, if so, what are they? Some of the implications here will be similar to those in para 10 about team-building, because giving adequate time and resources to this stage will reap positive dividends later in the project's life.

20.   How can you ensure that the staff involved – along with any volunteers or community members – are asked to identify their training needs in the light of the roles they will be taking on? Although working on projects may be time-limited because of their finite nature, in this way it can have very positive spin-offs in terms of workers' opportunities for professional and personal development. As the project progresses, it will be important to flag up any further training needs identified in organisations, communities or among individual staff so these can be adequately addressed.

Methods

21.   Those involved in sexual health promotion initiatives now have a comprehensive range of methods to draw from, ensuring that the most appropriate should be used to meet the aims and objectives with the available time and resources.

- Were the intended methods fully described in the project's initial specification or is there some latitude to choose or adapt these during the project's life? Whichever, the success or failure of the work will depend on choosing the most appropriate methodologies. The choice is huge – anything from arts work through to training for self-advocacy, from peer education to detached work, from counselling to developing new materials. See Section **1.2 for more on the range of methods available**.

- Within the project's specification, would it be possible to try out sets of different methods? This would allow you to compare and contrast their effectiveness and to learn lessons which can be applied to other settings, groups or topics in the future.

Other agencies' involvement

22.   Is this a multi-agency project from its inception? For example, have other agencies been involved in drawing up the plans for the project, and attracting funding for it? If so, can you reflect this in structures such as a multi-agency project steering group to ensure maximum involvement, support and a sense of shared "ownership"?

23.   If this is not a multi-agency project, during its lifetime can you involve other agencies in the work? If so, thought needs to be given on how to prepare them for this and to ensure they understand the learning and development opportunities for their organisations.

24.   Are other organisations likely to be affected by spin-offs from the work? For example, a men's sexual health project highlighting the importance of testicular self-examination may result in more men presenting with lumps or anxieties to their GPs.

25.   Does advance preparation work need to be done – for example publicity to Primary Care teams about the project, alerting them to the possibility of increased numbers of problems identified? If this is the case, it would be useful to consider whether there is scope for joint training events, information-giving, visioning or brainstorming between agencies with major or minor roles in supporting the project.

Record keeping

26.   What kind of records will be kept of the work during its delivery and what use will these be put to? For example, sometimes the purpose of recordings is to inform staff about what happened in aspects of the project they were not involved in, in other words as an internal communication tool.

27.   Would it be useful to keep quantitative records – for example of service users, people who accessed project information or events or of the numbers of materials distributed? All of this data provides important raw material when reports are being written or the project's effectiveness and impact is being assessed. Knowing what methods are going to be used for the evaluation is going to be crucial to deciding what recordings need to be made.

28.   Are there confidentiality issues which will also need to be addressed – for example if personal information is being recorded?

Feedback

29.   If the work involves clients and service users, how will their feedback be sought on their experience and how will this be collected, stored and analysed? If part of the project's initial design grew out of a needs assessment there may be an established body of information which can act as a baseline point of comparison for feedback on any changes the project has brought about. See para 4 above for more about this.

30.   Can mechanisms also be developed for gathering the ideas and opinions of agencies and staff involved in the project, even if only anecdotally? All of this data will be useful in determining the effectiveness and success of the work and can be used within the evaluation and final reports.

Monitoring and evaluation

31.   Evaluation is an important aspect of all sexual health promotion, but has a special importance in project work. This arises from the very nature of project work – for example, the fact it frequently only attracts short-term funding or is set up as a pilot for work which may potentially be mainstreamed, but only if and when its effectiveness has been demonstrated. Particularly careful consideration will therefore need to be given from the outset as to how the work will be assessed for impact.

   •   What mechanisms are being planned for the evaluation? Usually employing a number of methods will be most effective in order to present a rounded sense of the work's effect.

- How can you collect any relevant statistics such as numbers of materials or condoms distributed, numbers of staff and community members who have attended training sessions, numbers of outreach contacts made?

- What methods can you use for capturing the often most interesting and illustrative data which is likely to consist of the experience of service users, service providers, community members and community educators, recording their impressions of the changes brought about by the work? While it is almost impossible to determine the long-term impact of short-term work – on risky behaviours, say – it is possible to record people's current thinking and experiences along with any changes in this. Having an original base-line – maybe provided by an initial needs assessment – will offer a useful point of comparison.

- The explicit aims and objectives of the project explored in para 5 above offer the most important guide to its effectiveness, since if this aim has not been realised and these objectives have not been achieved, then the project must be seen to have failed. It is important, however, that the evaluation also records and captures any unintended outcomes of the work, which may not meet the initial expectations, but nonetheless achieve something significant. Indeed these may be even more significant than the intended outcomes initially anticipated.

- How will the work be reviewed and monitored during the project's lifetime – and how will the findings from this review process be used to fine-tune the project's next stages? There is little use in monitoring the work unless there is a feedback loop to allow the findings to inform and shape the work's further development.

Reporting

32.   Since the possible spin-offs from projects are so considerable – for example in terms of the work being "mainstreamed" or future resources being put into activity areas which have proven their effectiveness – the process of reporting is crucial.

- What kind of report will be produced and who should this be circulated to in order to maximise the project's potential impact and influence? It is worth noting here that there should be a deadline for the production and dissemination of such a report so it doesn't stretch into forever, as other priorities emerge for people's work time!

- How can the report be used to gain new allies, publicise the work and seek resources for the next stage of development if the need for this has been demonstrated?

Implications for future work

33.   Any piece of project work will usually highlight other needs and throw up other issues, so it has the potential to give rise to further projects as a result. Part of the value of project work is that it can show us what else needs to be developed as well as offering us potential methods for doing this.

- How will needs for further work be logged and fed into the appropriate systems? These might include the need for development of new services, responses to new needs identified in particular communities or the staff training needs highlighted by the work.

Section Two – Part Four: Some Group Work Tips

Many people who take on sexual health promotion roles will be working with groups. There are many excellent resources and training courses on groups and group-work, so this section only offers a few quick pointers to doing this work effectively. For anyone developing this work further, attending a group facilitators' course is highly recommended.

1. ***Be clear from the start – right from the initial publicity – about the aims and objectives of the group, the session or course.***
   Also be clear who the appropriate target audience will be for this. Doing this in advance cuts down the likelihood of people coming to the group for inappropriate reasons. However, it has to be said that no matter how rigorously and conscientiously you do this, it still often happens that someone has not read the publicity, or comes with other agendas. You therefore need to be clear in negotiating what the group or course can or cannot undertake to deliver.

2. ***Ensure the session is accessible to all – and consider any special needs.***
   These considerations will vary according to the target group (e.g. whether it is for other professionals or for members of the community). They will probably range from the suitability of the venue and the timing of the group to child-care arrangements and responding to the needs of people with special dietary requirements, on drug therapy regimes which may need supporting or with sensory impairment e.g. in need of a signer or induction loop.

3. ***Introduce a group agreement.***
   People are often anxious about being in groups and this is one way to reassure them that it will be a positive experience in a nurturing and safe environment. You can do this by introducing a pre-prepared set of group guidelines and asking the group to agree to these as a minimum (adding any others of their own which feel important to them). This mechanism is best if you are doing one short session with a group, for example. Or, for a longer piece of group-work, perhaps continuing over a number of weeks or months, you can make developing a group agreement part of the group's process. Things to be covered in group guidelines could include:

   - *there being no such thing as a silly question*

   - *deciding on levels of confidentiality within the group*

   - *agreeing to treat each other respectfully*

   - *giving positive attention*

   - *welcoming the diversity in the group*

   - *making it clear people can set their own limits*

   - *letting people know that it's ok to make mistakes*

   - *not judging people or putting them down*

4. ***Make sure one person or viewpoint does not dominate.***
    If some people are contributing a lot, ask "has anyone who hasn't spoken so far got anything they'd like to say?" or "What about other people?" to try to equalise the air-space. Taking contributions by going round the group, one at a time, also ensures one voice or view does not dominate.

5. ***Keep breaking into pairs and small groups.***
    This changes the pace and introduces some variety into the process. It also ensures that everyone gets a say, perhaps encouraging less confident participants who otherwise might not speak up in front of the whole group.

6. ***Vary the exercises and the pace.***
    As well as pairs and group work, have some activities which require moving around, some where people address scenarios or do problem-solving, some brainstorms (or as some people prefer "thought showers"), some time with people working on their own and some games, energisers and ice-breakers. Try not to spend too much time in the large group since this may result in only a few people (including yourself) speaking.

7. ***What if you are asked a question and you are unsure of the answer?***
    If this happens, you could ask the group what they think. This is also positive way of encouraging people's thinking and participating even if you *do* know the answer! If you don't know the answer to a question, it's fine to admit this. As a group-worker, you are a facilitator rather than an expert on all topics. Say you will find out or suggest where the group participants or person who asked the question could do so themselves.

8. ***What if someone voices a difficult opinion?***
    Unless this actually breaches the group agreement, ask the group for their responses. Ask the speaker to say more about why they feel that, or you can present an alternative view e.g. "on the other hand, many people might say that...." It is important not to lock horns with such a participant and get into an argument but to enable a range of different perspectives and opinions to be aired and for the group to stay safe for all involved.

9. ***Dealing with upset and anger.***
    If someone becomes upset during a session, acknowledge the feelings and offer them reassurance that these are welcome and that the group is a safe place for them. However, maintain the boundaries and be careful not to attempt counselling or therapeutic input in this setting – unless this is a therapy-based group. If it seems appropriate, offer them referrals on to support groups or services.

    Sometimes group participants can become angry – often without obvious cause, and in some instances this can be aimed at the facilitator or another group member. Acknowledge the anger, but do not engage with it. For example say "You seem to feel very strongly about this, can you say some more about what's going on for you?" This may enable them to make the links between any catalyst for these feelings in the group, the issue being dealt with or the process and their reaction to this. Whatever is going on and being acted out in this way, ensure for everyone's comfort and safety that the group agreement is kept (see point 3).

10. ***Check things out.***
    Ask the group if the content, style, pace and approach of the session is OK for them. It's important to keep checking out that they are getting what they want, and then that it's all right to move on. In this way both group-worker and participants share responsibility for the learning and the process, and group members are encouraged constantly to review what they need and whether they are getting it.

11.   ***Working with a co-facilitator.***
Think about whether you prefer to run a group on your own or whether you would benefit from working with someone else. As co-facilitators, you can share out responsibility for leading the process and observing the dynamics going on in the group. It may also be that you can each draw on separate areas of knowledge and expertise and you have someone you can trouble-shoot with if difficulties occur. On the other hand, facilitators' styles can differ markedly and this approach requires a great deal of time for preparing and de-briefing. You need to find the mode which is best for you and for the group.

12.   ***Evaluation of Group Work.***
Give some thought in advance to how you are going to evaluate the effectiveness of the group or course or session. Remember to use the aims and objectives you drew up at the outset to gauge whether the process was successful – i.e. did it deliver on meeting these? It is useful for both the facilitator or trainer *and* the group to contribute separate elements to the evaluation. Sometimes their perceptions will differ – for example the group may say they have enjoyed the session, whereas the facilitator realises in retrospect that it was quite cosy and that it would have been productive to challenge a bit more, encouraging participants to be aware of other viewpoints or ideas. You may also want to undertake a more quantitative evaluation process – for example breaking down the demographics of those who attended in terms perhaps of their age, gender, ethnic origin, disability or the agency or organisation they work for.

13.   ***Ending the session.***
Make sure all the issues which needed to be covered and addressed in the session or the course have been. If anyone has any outstanding issues left over, check that people have got some continuing support in place for dealing with these. This can be done, for example, by referring them on to other agencies or to further groups or courses. Give people the opportunity to end well, to reflect on their learning and to have the appropriate time to say their good-byes to the group, to each other and to you.

14.   ***Further work.***
Consider whether this session has demonstrated the need for further work – another session, perhaps, further training or a new group, and if so how to take this forward.

15.   ***Ensure you have good support and supervision in place.***
This provides you with a space where you can discuss and review any issues raised for you by running the group, the content covered or any aspect of the process. It is also important to have the opportunity for reflecting on the learning from each piece of group work. This ensures that the lessons learnt and new skills developed are incorporated into future work, rather than needing to be re-discovered afresh each time.

16.   ***Your own personal and professional development.***
Make sure you have your own opportunities in place for personal and professional development. Being a facilitator can be a demanding and rigorous role and as such those taking this on deserve every opportunity for appropriate development. So you might want to explore the possibility of doing a course in group-work, training or facilitation skills to bring your skills and confidence right up to date.

Section Two – Part Five: Positive Media Management

1. Fear of the press and unhelpful media coverage can often act as a barrier to starting this work – or to feeling confident and optimistic about it. The spectre of being splashed all over the front pages of a tabloid or a local paper probably haunts all those involved in sexual health promotion. However, this need not be the case. In fact, some people have found the short-term stress of media management in the long-term brings unexpectedly positive outcomes.

2. Fear of inaccurate or sensationalist media coverage should not inhibit innovative, evidence-based sexual health promotion. What follows in this section are some tips and hints on how to ensure you can get the most out of media coverage and use it for your own purposes – rather than get manipulated or disempowered by it.

Arrange for some media training

3. This might, for example, be organised for key members of local sexual groups such as Teenage Pregnancy Steering Groups or Sexual Health and HIV Strategy Groups. Rather than just leaving the quality of the coverage you attract to chance, having input from journalists who offer this training on the "tricks of the trade" can be invaluable. For example, you might find it helpful to have some tips on handling aggressive interviewers. These can include:

   • stick to your issues

   • don't be hi-jacked or side-tracked by interviewers' distracting red-herrings

   • don't "take the bait" of hostile and contentious questions

   • plan 20 second sound-bites which succinctly sum up what you want to say

   • develop "three polished pebbles" – simple, clear points you intend to make, whatever you're asked.

Give yourself time to think

4. Don't feel you need to respond at once to press enquiries, to defend your position or take the opportunity to make a point. In fact, it can be much more effective to take a contact number and call them back once you have had time to consider the issue. This allows you:

   • to think through the kind of responses you want to give

   • to take any advice you need

   • to muster supportive quotes from others

   • to have relevant research findings ready at your finger-tips

   • and generally to feel well-prepared for the encounter.

Identify and cultivate advocates for the work

5.   Preferably these advocates should be people who are positive, persuasive, articulate and confident. Remaining calm and unruffled under pressure is also an important attribute. Once you have found these people and they have agreed to take on an advocacy role with the press, make sure they are informed about your work. Keep them updated about any new developments and brief them about useful research findings, new trends and statistics and any other matters which they will be able to use to positive effect in their dealings with the press.

Check out the facts of the situation

6.   It is not unknown for some journalists to act on misinformation or to set hares running in order to create a story. Make sure you find out all the facts behind any supposed incident before responding so that you don't end up defending something that never happened, and by doing so create a story with its own momentum. Again, this is likely to mean that you will need to say you want time before answering questions to allow yourself to prepare – see point 2.

Use publicity positively for your own purposes

7.   If a short-term publicity crisis offers an opportunity to gain coverage for a project and take the limelight – then use it positively for your own purposes. Often it's not possible to have any power over what coverage you might attract and how a project is presented. However, you can take some control over the follow-up to this – and make sure you get the right to reply, for instance if you have been attacked. So, you could write an article putting the case for the work – or, even better, get service-users or involved community members (supportive parents, perhaps, or some peer educators or people living with HIV) to write it. Or you could encourage allies to write to the paper on your behalf – a flood of correspondence supporting excellent work on the Letters page may have even more impact than the initial press coverage.

Set up a media liaison person

8.   Make this role a clearing house for all enquiries and refer all approaches from the press to them. Don't let yourself be put under pressure to respond yourself or feel defensive, just make it clear who the appropriate person to speak to is. This is quite a common arrangement, and takes the pressure off people who do not feel equipped to deal with difficult questions. It will be useful for this media lead (or the advocates outlined in point 3) to have some specialist training on working with the media.

Be backed up by a policy or an agreed values statement

9.   No individual member of staff or sexual health promotion specialist should feel that they have to take responsibility on a personal basis for defending work which is under attack. Having a well worked-out values framework which is formally agreed by a multi-agency group or by the whole organisation is essential for this work. See Section 2.1 on Implementing a Local Sexual Health Strategy. In the context of contact with the media, with such a set of explicit values in place, you can feel confident that you are supported by this framework whatever you say.

10.   It can be useful to couch such a statement of values in the language of human rights or the building of self-esteem. As well as positively expressing the framework in which most sexual health promotion work

will take place , this also provides a sympathetic and easily intelligible starting point for people in understanding what you are trying to achieve. Also, presenting the work in this way means that if opponents are attempting to bring it into disrepute, it is harder for them to take a stand against "given goods" in society such as human rights or self-esteem.

Get to know the local press and do regular press releases for them

11.   Make a point of cultivating informed journalists and proactively seek their support and positive media coverage for your work. Offer them stories about new, interesting or curious issues – and help them build their links in the community by acting as a broker between them and community or voluntary groups you are working with who would welcome press coverage. Try to keep them regularly updated to keep the working relationship current and positive. Send them copies of new resources or reports you produce and contact them if there is national news (such as the rise in chlamydia figures or the decline in marriages) on which you want to offer a local angle.

12.   Or you could invite them along to meet staff and to do a "Day In the Life" story – perhaps about a Family Planning Clinic nurse, a Health Adviser, a community health project worker or a PSHE Advisory Teacher. Developing such positive working relationships creates a context in which any future difficulties or sensational stories can then be managed.

Take every opportunity

13.   Remember every piece of media coverage is a prime opportunity to educate the general public and to raise awareness of the importance of this work. Taking opportunities presented by the media can in the longer-term contribute to changing the culture of sexual health and the way it is viewed more widely by society, moving it in from the margins to become a more accepted, everyday and less sensationalised aspect of human experience.

Section Two – Part Six: Developing Materials and Information Resources

1. Be realistic about what resources can – and can't – do

Remember, materials like leaflets and posters do not in themselves actively promote health. For example few people probably ever negotiated safer sex, began using contraception or decided to come out as gay because of reading a leaflet. However, what they can do, is:

- **Reinforce messages.** For example, they can be useful to give to someone after a conversation or group-work experience, to remind them and re-motivate them when that initial contact is over.

- **Give practical information** and raise levels of understanding and awareness, and offer answers to people's most frequently asked questions.

- **Help people find sources of direct help** i.e. by publicising services, phone-lines and self-help groups.

- **Reassure people** about any anxieties they may have about accessing services – for example by stressing the fact that these are non-judgemental, confidential and free.

- **Encourage people to think in new ways** about sex, sexuality and relationships and their own sexual health.

2. Consider the needs and the audience

When you are thinking about designing an information resource, first of all consider the need and the audience and make sure your resource is relevant and applicable. If possible, get some feedback from the the intended audience either through individual discussions or focus groups.

3. Do some research on what already exists

Is it necessary to produce something new or can you access or buy in relevant materials? The benefit of doing this is that they are likely to be highly-designed and the work is already done for you. The disadvantage is that they may not be tailored specifically to your particular group, they will not publicise local services and you cannot include points that you particularly want to emphasise. It may be possible to reach a compromise, for example by using national resources and leaflets developed elsewhere but "customising" them by adding a sticker detailing local services or access points for help.

4. What medium will be best to get across your message?

You could produce posters or packs, videos, leaflets or small "credit-cards". When you are designing the materials bear in mind issues such as

- What is the target group's level of literacy skills?

- Do you need to produce the materials in community languages?

- Can you use visual images as well as the written word to get across the message?

- Do you need to think about producing large-print, Braille or taped versions of the materials?

5. Ensure you use a range of images to reflect the diversity of the possible audience for the materials

- Are black and ethnic minorities represented?

- Do you have images of older adults?

- Are the needs of disabled people and people with learning difficulties reflected?

- Do you acknowledge different sexualities?

- If the resource is a general one, are both men's and women's needs referred to?

6. Write in simple plain language and explain any technical words

Or use the technical words followed by the lay-terms e.g. "emergency contraception" (often called 'the morning-after pill')" or "myocardial infarction (usually called a 'heart attack')".

7. Involve the target group

If it's practicable involve representatives of the target audience in writing and designing materials. However, if for any reason – time or access or personnel – this is not possible, make sure you at least pilot and trial any first draft with the relevant groups. Then ensure the final version takes account of their feedback wherever possible.

8. Use positive, empowering messages

Wherever possible use positive, empowering messages which are reassuring and encouraging, rather than negative scare tactics. It's important to acknowledge that change can be hard, rather than taking a glib, lecturing or patronising tone. For example, you may want to suggest people reward themselves for making small changes and forgive themselves if they "relapse" to old habits – but then pick themselves up and try again.

9. Update materials regularly

Information resources date quickly and inaccurate information is worse than none-at-all. So it's important to update materials regularly and to ensure details such as telephone numbers and service times are up to date. Alternatively, rather than doing a major reprint if you still have out-of-date stocks, you can update these yourself by putting put stickers on which replace the original text with the latest information.

10. Small discreet formats may be best

Use small discreet formats for information people may be embarrassed to be seen carrying. This might for example include materials about sexual difficulties or erectile dysfunction, resources aimed at married gay men or at IV drug users. In fact, because of the nature of the issues we are dealing with in sexual health promotion, it is vital we are sensitive to finding ways in which people can access materials and information without feeling that this is too public. "Credit card"-sized information cards are good for this – and because they are very cheap, they can be produced in large quantities and be regularly updated.

11. Check notice boards and leaflet stocks regularly

All too often notice-boards display out-of-date materials or fading and curling old posters. A fresh, colourful and attractive display is much more likely to be used and to grab people's attention – in a positive way.

12. Make sure all staff have got stocks of up-to-date materials

Encourage staff to carry leaflets with them and to give materials out to service users, community groups, and individuals they work with. Watch out for any opportunity to disseminate materials. For example:

- Leave them in pubs, clubs and cafes (with proprietors' agreement).

- Negotiate with local shops to leave them on counters.

- Liase with colleagues in relevant settings such as schools and colleges, community and advice centres, libraries and sports centres to distribute them.

- Advertise them in the local press.

- Use "snowball" techniques – asking everyone who is given a leaflet to take one or two more to hand onto friends.

13. Evaluation of materials

When you evaluate the effectiveness of information resources and materials – remember to go back to the first point and only measure the impact against the original aims and the four key roles that these can play i.e.

•   supporting face to face work

•   giving practical information

•   raising awareness

•   helping people find direct services and support.

It is important to link the evaluation to what the materials set out to do. After all, it is pointless to evaluate such materials by assessing whether they have had an impact on changing people's behaviour – if this is not what they ever claimed to be able to achieve.

Section Two – Part Seven: Guidelines for Outreach and Detached Work

Why is there a need for detached and outreach work?

1.   Every year, millions of people find their way to sexual health services in a whole range of settings. However, sexual health promotion should address the needs of those who do not feel confident enough to access mainstream services or perhaps lack information about them or the motivation to use them. To achieve the goal of reducing sexual health inequalities, inventive approaches should be considered since it is paradoxically often those most in need, those most marginalised and vulnerable, who are least likely to use services.

2.   People at high risk of acquiring or transmitting sexual infections often make poor use of generic services where screening, treatment, hepatitis B vaccinations, condoms and risk reduction counselling are available to protect them. Factors such homelessness, transience and casual or anonymous sexual partners also make it difficult to notify those exposed to infection. For these reasons sexual health workers may decide to do targeted community-based initiatives to ensure that sexual health care and sexual health promotion initiatives reach the people who need them.

3.   One way of reaching such non-service users, is to go to where they live their lives – by using outreach methods, street-work and detached work. Setting up such initiatives takes some careful planning and forethought, however, and calls for particular approaches and skills from staff and organisations. This Section offers some starting points for this process.

What is outreach and detached work?

4.   Outreach and detached work involves making contact with individuals or groups on there own territory, rather than waiting for them to approach existing sexual health services of their own accord. These methods may be developed with the aim of promoting safer sex, delivering screening and/or treatment services directly and encouraging the uptake of existing services as well as additional specialist services – for example partner notification work by Health Advisers. The intention may also be to offer support for people's sexual health decision-making, and for building their positive sense of self-esteem and their relationship or negotiation skills. The work is undertaken directly with individuals, or groups of individuals, outside of an agency or clinic setting. For example this might be on streets, in pubs, saunas or drug houses or in cottaging and cruising areas such as parks and waste ground – sometimes known as 'Public Sex Environments' (or PSEs). Peripatetic detached and outreach work on the other hand is undertaken with – or through – community-based organisations such as schools, youth centres, residential care units, prisons or hostels.

Does targeting some groups mean "pointing the finger"?

5.   At-risk groups are targeted not to stigmatise and blame them, but in recognition of their particular needs – and the fact that they may be reluctant to access mainstream services. This reluctance may, for example stem from their fear that they – or their lifestyle – will be judged or disapproved of.

6.   In fact, however, most populations who are the focus of outreach work are usually appreciative of the attention, but there is always the danger that some may feel invaded, patronised or blamed. So clearly sensitive and respectful approaches are always required to avoid alienating the very people you are trying to reach. And if the work 'goes public' for example as a result of publications, lectures or media interviews, you should always be very careful not to say anything that could stigmatise or label those concerned.

How do we know there is a need for this work?

7.   Outreach projects demand a lot of worker time, particularly if working in pairs and it is important to ensure that the allocation of substantial resources to small sections of the population is justified. So before embarking on such work the need for this should be established by carrying out an initial pilot project. However, in doing this you bear in mind that such work often takes a long time to develop because it is offering support and services to groups and communities unfamiliar to receiving these.

8.   Managers need to understand this, and to support a lengthy pilot phase (6 months minimum, often longer) to establish need rather than pulling the plug on a project if it has not delivered high numbers within the first few weeks. This is a 'slow burn' methodology, but it is more than justified by the fact that it is probably the only one which is going to be effective in the long term in reaching the most marginalised individuals and groups. So before starting this work, be sure that resources are available to support it for as long as necessary since disaffected populations can understandably be alienated further if services appear to lose interest in them when the novelty of an intervention wears off.

What staff are best suited for outreach work?

9.   The effectiveness of outreach work probably stands or falls on the quality of the staff who are undertaking it – they need sensitivity, a respectful attitude towards the community they are working with, the tenacity to persevere when there are obstacles and common sense about risks and dangers without being alarmist about these. The most important factors in staff suitability are probably good communication skills, commitment, confidence, assertiveness and clear professional boundaries.

10.   A close match with the client group in terms of age, gender, sexuality and ethnicity can also make communication and acceptance easier. However, providing the staff have the skills and qualities listed above, this is by no means essential. So don't be put off trying to work with vulnerable groups just because no-one in the team has the right demographics.

How can safety issues best be addressed?

11.   Health workers may experience a sense of vulnerability when working out in the community where unpredictable, distressing and occasionally frightening situations can arise. Although these are not common – and in fact many projects run successfully for years without encountering such an event – it is nonetheless important to anticipate and minimise any potential risks. This can, for instance, be done by:

12.   *Being prepared.* Before embarking on outreach work, you need some understanding of the social, cultural, legal and epidemiological issues affecting the group you are planning to reach. Preparatory work and staff training are both invaluable as they provide the space to prepare for possible eventualities and to share your own feelings, beliefs and attitudes and the opportunity to resolve any difficulties these raise. If staff are going to be physically vulnerable, self-defence training will also be important and they should always carry personal alarms.

13.   *Working in pairs.* This is vital wherever there is a risk to safety, particularly on the streets, in the dark and in PSEs. As well as reducing risk, co-working provides useful emotional and psychological support in what can be stressful work and therefore is strongly recommended whenever possible. In fact, in most kinds of sexual health outreach being discussed here, work should really only be done in pairs. In such cases, time should always be planned in to debrief at the end of the outreach session, so there is the opportunity to reflect on what has happened and to learn any lessons for the future as well as giving each other support and feedback on the session.

14.   *Carrying a mobile*, with the keyed in number(s) of whoever you might call upon for assistance, such as your manager, the clinic, the police or a solicitor.

15.   *Keeping people informed.* Inform colleagues of where you are and time you will return, if working alone. Always report back to a colleague before going home. Inform the police if working on the streets. Negotiate the best means of making contact if help is needed.

16.   *Having clear boundaries.* If working in a mobile unit or drop-in centre, ensure that there are clearly understood rules, such as no drugs, alcohol, verbal or physical aggression and positive, respectful treatment of other users and staff. If working with a community you also belong to – for example in the case of gay men's workers working in PSEs or on the gay scene, be clear that you are not socialising or open to sexual encounters yourself in this setting.

17.   *Having safety protocols and procedures in place.* These will include being sure you are covered by the terms of your contract and your organisation's insurance and having protocols agreed with your line-manager. If there are any incidents where safety as been at risk, discuss these with your line manager and co-workers before undertaking further outreach sessions.

18.   *Support and supervision.* Working in this way can feel isolating and vulnerable if people lack a strong sense of support and a safe base they can return to, where they can gain encouragement and understanding. So systems need to be set up such as positive supervision for this aspect of work – either from a line manager of from an external specialist in this work area. Working at community level can be emotionally demanding because it brings raw exposure to the harshness of some people's lives. Professional dilemmas around confidentiality and child protection issues can be more challenging because there is a need to think quickly and act appropriately without the luxury of counselling rooms for private discussion and senior colleagues on hand for guidance. The informal style of outreach work can make it more difficult to maintain professional boundaries, particularly if working with your own social peer group in clubs or bars. For all these reasons, supervision – and the space for reflection and consideration it offers – is therefore essential to protect the safety of the worker and the client group.

19.   Learn as much as you can from the experience of others too- both positive and negative and wherever possible seek support and guidance from people who have developed similar work.

20.   *Never, ever be 'brave'.* Because this work can collect a kind of gritty glamour and cachet, it is vital never to be seduced by this into being heroic or taking on a 'Lone Ranger' persona. It is courageous enough just being outside the usual milieus and taking on a perhaps unfamiliar role. One useful principle to establish is for workers to trust their 'antennae' and to agree that if they have a sense of unease or danger, it is important to act on this and remove themselves from the situation rather than feeling foolish or that they are 'copping out' by doing so.

Setting up outreach and detached work

21.   As well as these safety measures, certain other things also need to be in place to ensure an effective initiative:

- Think about the need for this work – both in terms of the epidemiology and the entitlement of marginalised community to receive sexual health services and support.

- Have clear objectives from the start. Review these regularly in the light of experience, evaluation or epidemiological developments.

- Consider how you will evaluate from the outset to ensure that you notice, collect and record the necessary data for this.

- Ensure that the way you approach this work is respectful and supportive so it will not harm, alienate or further disempower the group you are aiming to reach.

- Identify places where the target group congregate, so they can be accessed on their own territory. For example commercial sex venues are often advertised in the local press and key bars and clubs can be identified by asking other members of the community where they meet.

- Find out if any other existing projects – such as drugs workers for example – are already doing outreach work with the target group and if so work together if at all possible.

- Liase with relevant statutory or voluntary organisations in contact with the client group. Explain what you will be doing, and why. Seek guidance, and ensure mutual referral policies are in place.

- Make sure you have an in-depth knowledge of the services you might want to refer people to so you can do this effectively and with accuracy. It would be even better to spend some time in these services beforehand yourself so when you refer someone you can tell them about what to expect and the service layout.

- Ensure any relevant sexual health services and clinic staff are aware and supportive of the work, particularly if outreach clients are to be given priority access or fast-tracked. Colleagues need to fully appreciate why this is necessary, because it potentially puts strain on them, and at first sight may appear unfair to other clinic users who don't get priority.

- Be aware of responsibilities concerning child protection and negotiate an acceptable policy with the local Area Child Protection Committee.

- Negotiate access with gatekeepers such as sauna, club, pub or bar owners and managers. Essentially, you are their guest, and must work in a way that is acceptable to the establishment as well as your client group. Emphasise the confidentiality policy. Once committed, be reliable, accessible and flexible to their needs. For commercial sex venues, ask how many women work there, and what the shift patterns are, so you can take enough supplies of condoms and information and visit during shift overlap, when there will be more workers present. Avoid interrupting the busiest times. For social venues – pubs, clubs and bars for instance – negotiate acceptable times and if at all possible see if you can have access to a quiet area where it may be possible to talk to people in confidence.

- It will be helpful to find cultural mediators if there are marked cultural or language differences between the client group and the outreach workers.

- Wherever possible take with you and distribute materials, including cards or leaflets specifically outlining sexual health services for the target group, leaflets with information about a range of sexual health issues and referral cards for other agencies. Leave these behind when you finish your outreach session as well – by doing so you can reach people you have not actually met.

- Some agencies make up and give out condom packs with a couple of condoms, some lubricant, information leaflets on effective condom use and cards advertising services. these can be left at PSEs, pubs or clubs for instance to continue the sexual health promotion work when staff themselves can't be there.

And remember – if no outreach work of this kind has been done with the group before, be patient – initial suspicion is understandable. Be prepared to start small and persist – individuals or venues that are initially resistant may become more amenable if they hear favourable reports from their peers or their clients.

Liaising with the police

22.   It is important to liase with the police if you are doing outreach work on the streets or in PSEs with groups whose actions may be outside the law. Be clear about the law, how it is enforced locally, and what there would be a duty to report. Police support is essential to avoid the work being undermined for example by sex workers being identified and arrested as a result of observed contact with the outreach service, the possession of distributed condoms being used as evidence of prostitution in court or increasing arrests at PSEs.

23.   Setting up positive partnerships with the police can be invaluable and a hostile attitude towards the police from outreach workers may exacerbate difficulties for the target group. The police can provide useful information about the client group and guidance on safety issues. For example "Ugly mug" schemes – in which sex workers and the police undertake to inform each other of dangerous punters – can be set up. Or joint initiatives have been developed in some areas to encourage reporting of homophobic attacks, with accompanying police training on this issue, to raise awareness and build support.

24.   A delicate balance needs to be achieved here, since if the relationship between the police and the target population is poor, outreach workers need to avoid appearing too close to the police, or they will not be trusted.

25.   Consider the risk of objections from local residents, and negotiate an acceptable plan of action to these with the police.

Making the first contact

26.   If the target population is likely to be apprehensive or hostile, get an introduction if you can for example from a community member, a cultural 'mediator', a bar or sauna owner or an established outreach worker

27.   Make sure you use an informal style that is open, friendly, approachable and non-threatening. State clearly who you are, where you are from, and why you are there. Be clear and confident that your purpose is legitimate and helpful to the people you are trying to contact. Don't be apologetic: this will arouse suspicion and create barriers, and avoid showing fear as this could be exploited and put your safety at risk.

28.   However, don't presume that acceptance and rapport will be instant: take your cue from the client, and be prepared to linger or move on accordingly.

29.   Work out how much time you have: you may need to be very concise if someone is busy looking out for punters, potential sexual partners or friends. Key words used as sound-bites (such as "condoms!") to grab attention can be useful, because they suggest that you intend to be brief.

30.   Offer something tangible that the client group wants, if possible: this could be shelter from the cold in an outreach bus, drinks, food, condoms, service 'credit cards', screening or simply someone to talk to.

31.   Exchange first names, if possible. Note any demographic or biographic details that may help identify the person in future, or give insight into their networks, perspectives, attitudes or beliefs. Avoid the temptation to ask too many personal questions because the person may feel interrogated or wary of how the information may be used. Exchanges should be conversational, respectful and casual.

32.   When you have set up a positive rapport, talk more about sexual health services. If discreet discussion is possible, ask about people's previous use of services, recent risks (for example through broken condoms) and any particular anxieties. You could set up a scheme where you can offer to book people clinic appointments. When you meet the person again it may be helpful to repeat the offer of services – without in any way being coercive. So, for example, it will be better to say "if you ever want an appointment just let me know and I will get you in" rather than "Shall I book you an appointment now?"

33.   Be aware that sexual health might not be a priority for the targeted individuals, and that too much focus on this may limit what rapport you can establish with them. Try to get as much insight as possible into the person's priorities and circumstances so you can understand how their sexual health may be compromised. Or a more effective way to reduce their sexual risk-taking may be to refer them on to agencies that can help with the underlying causes, such as addiction, debt, mental health problems, domestic violence or homelessness. However, in these cases it will be important to offer these agencies sexual health training, support and resources so they can feel confident and motivated to play a role in sexual health promotion.

Keeping records of outreach or detached work session

34.   Work out how you find it best to make recordings of the sessions – some people will do this in between contacts, to avoid important details will be forgotten and lost. Others will do this at the end of the session during the worker debriefing session. Make sure the individuals and groups you are working with do not see you making notes, since this would be likely to arouse suspicion and anxieties about confidentiality.

35.   Make sure though that you always write up a full report of each session, whenever you decide to do it. The records you keep should relate to your project's aims, objectives and evaluation criteria, and might for instance include:

• The number of individuals seen, per session

• Details of individuals seen, where possible. If you agree to book a clinic appointments for someone, try to get an address and telephone number for registration

• Particular issues raised during the session (such as violence, drug use, housing, pregnancy, forced sex) and thoughts on how to follow up on these, perhaps by liasing with other specialist agencies

- Risks identified such as unprotected sex or injecting drug use

- Other factors pre-disposing to risk such as coercion, homelessness, debt, addiction or mental health problems

- Condoms, lubricant and needles given out

- Information and advice given

- Referrals made to other agencies

- Clinic appointments offered/accepted/kept/outcome

- Any feedback you have heard on the outreach service or on other sexual health services – and feed this back to the services themselves where appropriate

- Any new needs emerging which should be considered for further action – also feed these back to services where relevant.

Evaluating outreach and detached work

36.   The extent to which our overall aims – such as the reduction of HIV transmission or other STIs – have been achieved by these kind of methods is almost impossible to estimate. For example, for HIV the long incubation period means we cannot make a direct cause-and-effect link and of course the multiplicity of other factors that could also influence risk have to be taken into account. As a result, process indicators are usually advocated as proxy measures of effectiveness. These would probably include:

- Number of sessions carried out over time

- Number of people offered risk reduction information and/or advice

- Number of people seen over time/ frequency of contact

- Average number of people seen per session

- Number of people offered risk reduction information and/or advice

- Number of people offered condoms, lubricant or needles

- Number of people offered STI screening and treatment advice/information

- Number of clinic appointments offered, booked and kept

- Number/types of STIs diagnosed and treated as a result of outreach

- Numbers of people referred to and subsequently attending other agencies.

- Contraception, emergency contraception, pregnancy testing or termination services accessed as a direct result of outreach appointments.

- Contacts of STI traced during outreach, or identified as a result of data gathered during outreach. Infections diagnosed and treated as a result.

- Costs (in terms of outreach worker time) per contact made and of other outcomes e.g. screenings secured, Hep B vaccines given, infections diagnosed or treated, condoms distributed

- Client feedback including comments and direct quotes on the service as well as feedback from other agencies and colleagues who may work with the same clients and from sexual health services about the impact of the outreach work on uptake by members of the groups targeted.

Lessons learned

37.   Part of the aim of outreach and detached work is to learn from the client group, for example about how services could be made more welcoming to them. You could gather this information – for example by survey, questionnaire, interview or impressionistic and anecdotal feedback from outreach workers. The questions asked could include:

- Is the outreach service valued by the client group?

- How could the outreach service be improved?

- How could sexual health services such as GUM or Family Planning be made more accessible?

- How could the sexual health of this particular client group be better supported?

38.   Ideally findings from such formal or informal research processes should be used to bring about changes identified as necessary – and these should in turn be fed back to the client group to let them know how their ideas contributed to these changes.

And finally...

39.   All of this may seem rather daunting work to embark on. So it is worth remembering that the experience of hundreds of sexual health and HIV prevention workers throughout the country – and of the groups, communities and individuals they have worked with – testify to the fact that this is an invaluable method to use. Indeed, if we are truly committed to reducing sexual health inequalities and adequately responding to the needs of the most marginalised and vulnerable groups in our society it is probably true to say that we cannot afford *not* to use it.

Section Two – Part Eight: Further Toolkit Resources

1.	This document is designed to be used in conjunction with the supporting information available on the Department of Health's Sexual Health and HIV Strategy website at www.doh.gov.uk.

2.	Here you will find additional web-based resources designed to support this toolkit. These include case studies which show how the principals in the toolkit have been put into practice, a list of further resources and contacts, a holistic model of sexual health and sexuality, and practical tips for:

	Condom promotion

	Building self-esteem

	General sexual health promotion

	Gay men

	Skills development for gay men

	Young people

	Women and girls

	Men and boys

	Black and minority ethnic groups

	African communities

	People in prisons or the criminal justice system

	Intravenous drug users

	People with HIV

	Commercial sex workers

	Older adults

	Disabled people – including both physical and sensory impairment

	People with learning difficulties

	Parents

	Primary care and clinical settings.

3.	You are free to print and circulate this material for use in training or health promotion activities, but please acknowledge the source when doing so.

Acknowledgements

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