HIV prevention

Peer led HIV prevention among homosexual men in Britain

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Expanding the evidence base

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mention controlled trials and
behavioural interventions in the
same breadth can generate sufficient
heat to cause spontaneous combustion.
Nowhere is this more evident than in
the field of sexual health promotion. But our
experience suggests that, for those who
can stand the heat, controlled trials can
also generate an expanded evidence base
for HIV prevention.

Controlled trials conducted in the
United States provide persuasive evi-
dence that peer education can bring
about a significant reduction in high risk
sexual behaviour among homosexual
men. For example, peer educators re-
cruited from “gay” bars in small towns
made a significant impact upon sexual
behaviour at a community level.1–3 The
proportion of homosexual men who
engaged in unprotected anal intercourse
(UAI) decreased by about one third
following the peer led intervention
whereas no change was observed among
men using bars in towns without the
intervention (controls). The Mpower-
ment project in California and Oregon
also reported a significant reduction in
the frequency of unprotected anal inter-
course with both regular and casual
partners following a peer led
intervention.1–3

These peer education programmes
drew on a diffusion of innovation model
whereby popular opinion leaders en-
gaged in conversation with other homo-
sexual men to promote HIV risk
reduction.4–7 According to this model,
behaviour change initially adopted and
endorsed by the opinion leaders gradu-
ally diffuses throughout the population.
The model is well suited to community
level HIV prevention campaigns that
typically require the initiation, diffusion,
and long term maintenance of behaviour
change.4

Encouraging as the North American
studies are, however, it cannot be as-
sumed that their findings are directly
transferable to the United Kingdom, nor
from small towns to large metropolitan
areas. None the less, a systematic review
undertaken in the mid-1990s of behav-
ioural interventions for HIV prevention
found the US research around peer edu-
cation promising.5 The authors of the
systematic review recommended that
interventions using peer educators be
formulated and evaluated in the United
Kingdom in methodologically sound
trials. In response, two community based
trials—one in London the other in
Scotland—were developed, quite inde-
pendently, to determine whether it was
possible to transfer this model of peer
education from the United States to the
United Kingdom.

One of the criteria for methodological
soundness laid down by the systematic
review was that the interventions should
be evaluated by means of a randomised
ter intervention. This created enormous
controversy. On the one hand it was
argued that health promotion interven-
tions should be evaluated with the same
degree of rigour as clinical or pharma-
caceutical interventions by means of ran-
domised controlled trials. On the other
hand, it was suggested that this ap-
proach would restrict the evaluation to a
limited range of outcome measures and
ignore the processes that underlie health
promotion. Indeed, one of the criticisms
levelled against randomised controlled
trials is that they fail to provide insight
into important qualitative aspects of an
intervention such as feasibility, transfer-
ability, practical constraints, and cultural
adaptation.8 Rather than rejecting con-
trolled trials outright, however, we be-
lieve a middle way exists which draws on
the strengths of both quantitative and
qualitative research methodologies. Inte-
grating process evaluation into the de-
sign of a controlled trial can generate
both outcome data as well as providing
insight into important qualitative as-
pects of the intervention.

In both London and Scotland, peer
education programmes were developed
between 1997–9 with the aim of reduc-
ing the frequency of high risk sexual
behaviour among homosexual men and
increasing the uptake of HIV testing or
sexual health services. They were evalu-
ated by means of controlled trials with
outcome and process evaluation running
in tandem.10–12

In Scotland, the intervention group
comprised homosexual men using bars
in Glasgow while the control group was
made up of homosexual men using bars
in Edinburgh (five exclusively gay bars in
each city). There is very little movement
of men between the gay scenes of
Glasgow and Edinburgh so the cities
provided relatively discrete environ-
ments where the intervention could be
introduced into one city but not the
other.

Within central London, five gyms were
identified with a large homosexual
membership. People tend to go regularly
to only one gym so these gyms provided
discrete environments where a peer led
intervention could be introduced into
tone but not into others. While it would
have been desirable to evaluate a peer led
intervention in gay bars in London, it
would have been difficult to create
distinct intervention and control groups
because of the movement of patrons
between bars (known as “contamina-
tion”).

In London and Scotland, the impact of
peer education was evaluated by distrib-
uting anonymous self administered ques-
tionnaires to both the intervention
and control groups at baseline and
follow up. Detailed information was col-
lected on sexual risk behaviour, HIV
testing, or uptake of sexual health
services. Both studies came up with
identical findings. The peer education
programmes had no significant impact
on sexual risk behaviour, HIV testing, or
service uptake at a community level.13–14

There were no significant differences
between intervention and control groups
in the rate of change over time on any of
the predetermined outcomes.

Other models of peer education could succeed in
Britain

Why did peer led interventions, shown
to be effective in the United States, fail to
have any significant impact at a commu-
nity level on the risk behaviours of
homosexual men in London or Glasgow?
Process evaluation threw light on this
question.15 In both studies attrition was
an important factor. Recruiting and
retaining peer educators proved to be
more difficult than originally envisaged.
For example, in London, only one in five
potential peer educators initially identi-
fied remained with the project to the
end. Problems in recruiting enough peer
educators in Glasgow resulted in people
being recruited from local gay organisa-
tions and being paid for their time. Peer
educators also reported barriers to com-
munication. They found it difficult to
talk about sex with complete strangers,
although talking about sexual health
(for example, where to go for a test) was
clearer. Interestingly, in London, some of
the peer educators said they could imag-
ine the intervention working better in
small towns rather than a big city, where approaching a stranger may be interpreted as a sexual advance.

An additional factor in London was that the critical mass for diffusion was never established—only 3% of men surveyed said they had spoken to a peer educator during the intervention period. Rather than peer education not working in London, it simply didn’t happen. On the other hand, in Glasgow, nearly a third of homosexual men surveyed said they had spoken to a peer educator. Yet still no significant community impact was seen when comparing Glasgow with Edinburgh even though intervention effects on HIV testing and hepatitis B vaccination were apparent for men reporting direct contact with peer educators.

These studies demonstrate that it is possible to successfully conduct controlled trials to evaluate behavioural interventions in Britain. By integrating process evaluation into the trial design from the very start we were better able to understand and interpret the outcomes. Conducted independently in London and Scotland, these studies provide us with an expanded evidence base for resource allocation, policy formulation, and planning HIV prevention programmes. It appears that a model of peer education found to be successful in small US towns may not transfer directly to large metropolitan areas in the United Kingdom. Had we not conducted the trials we may still be delivering an intervention that clearly does not work in large cities. However, we should not entirely dismiss the possibility that other models of peer education could succeed in Britain, especially in small towns comparable to the small US towns where the model was first evaluated. There is certainly an urgent need for innovative and effective sexual health promotion programmes in such communities which would address local epidemics of gonorrhoea and syphilis as well as the response to HIV in an age of effective antiretroviral treatments. A nationwide trial evaluating other models of peer led sexual health promotion in small British towns would expand the evidence base further—evidence which could contribute to the development and implementation of the national strategy for sexual health and HIV.

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