



Public Health  
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# **Black and minority ethnic men who have sex with men**

## **Project evaluation and systematic review**

# Acknowledgments

This evaluation was commissioned to De Montfort University by Public Health England with funding from the MAC AIDS Foundation to examine approaches to sexual health behavioural change interventions among black and minority ethnic men who have sex with men.

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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## Executive summary

Public Health England (PHE) has been funded by the MAC AIDS Foundation to deliver a programme of focused work to improve the health and wellbeing of black and minority ethnic (BME) men who have sex with men (MSM).

PHE's wider work on the health and wellbeing of gay, bisexual and other men who have sex with men has identified a trio of interacting health inequalities which disproportionately affect these men, these are: (i) sexual health and HIV, (ii) mental health and wellbeing and alcohol, and (iii) drug and tobacco use. The work to develop the MSM health and wellbeing framework identified that in most areas BME MSM experience even more extreme inequalities than their white MSM counterparts. This may well be a result of the compound impacts of discrimination based on ethnicity and sexual orientation from multiple communities and dimensions.

The BME MSM project provides an opportunity to increase the organisational understanding of the relationships between compound identity and health inequalities as well as increasing the visibility of these issues across the health and social care sector. Key outcomes for the project include improving the support for BME MSM through health and social care and community sector services as well as increasing the evidence base for interventions targeted at this specific community group

The project has four key components:

- increasing understanding of BME MSM identity, health and social care needs and access issues among BME, lesbian, gay, bisexual and transgender (LGBT) and faith third sector organisations and leaders through three structured and interconnected learning sets
- increase understanding of sexual orientation and minority identity among healthcare professionals through an e-learning module
- increase the potential for visibility of BME LGBT people through boosting the relevant contents of the NHS and PHE image bank
- pilot and evaluate five different models of direct intervention for BME MSM

### Advisory committee

As part of this work, PHE established an advisory committee with representatives from a broad range of BME, LGBT public and private sector organisations and academics. During the meetings, the advisory board focused on the three distinct but overlapping areas in which gay, bisexual and other MSM bear a disproportionate burden of ill health:

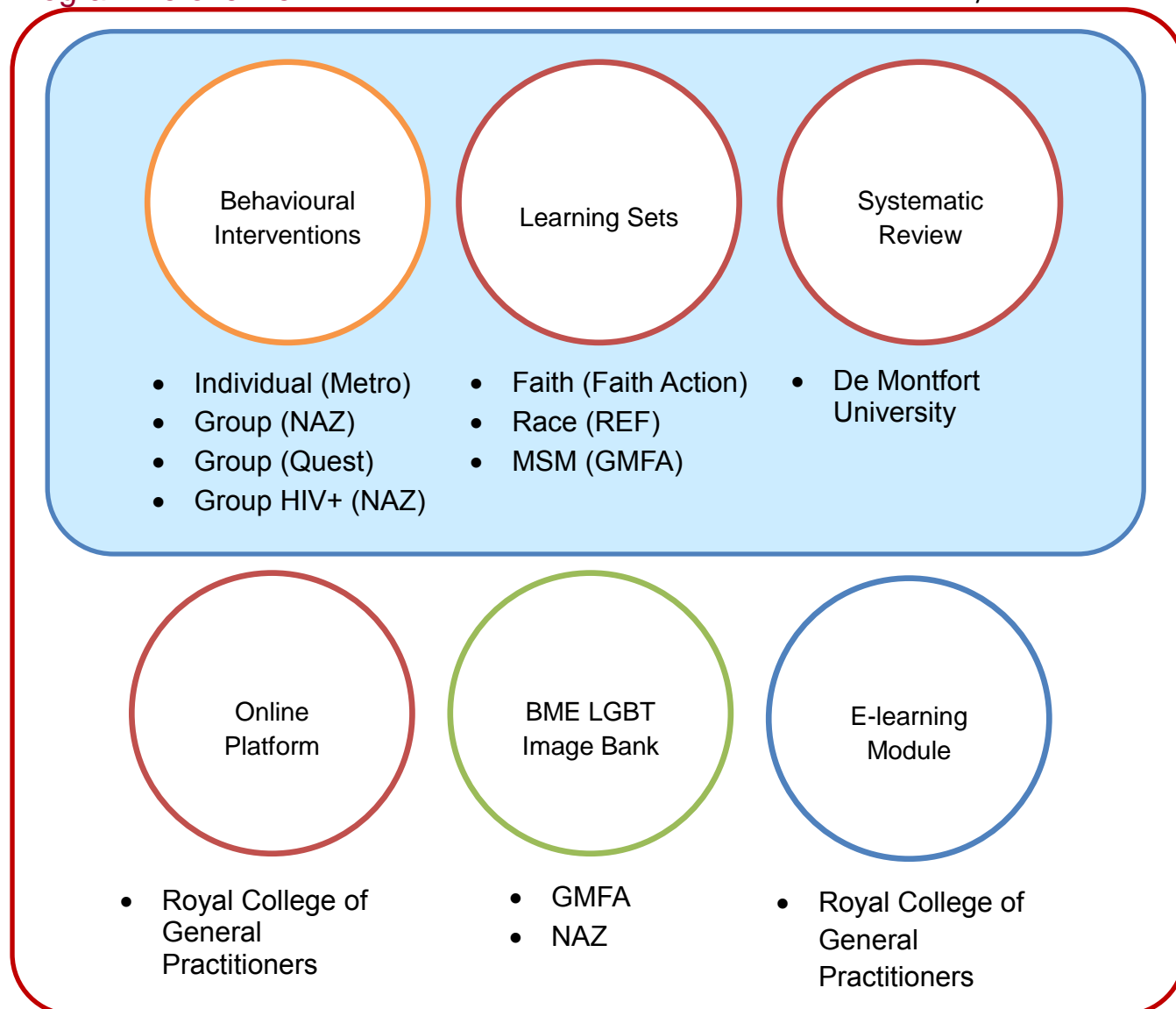
- mental health
- drugs, alcohol and tobacco

- sexual health and HIV

By identifying and tackling the structural and direct determinants behind this trio, the project aims to reduce these specific inequalities and to improve the health and wellbeing of BME MSM. It is PHE's vision for all MSM to enjoy long healthy lives and to have respectful, fulfilling social and sexual relationships.

## Programme overview

Advisory Committee



# 1. Introduction and context

This evaluation was commissioned by PHE with funding from the MAC AIDS Foundation to examine approaches to sexual health behavioural change interventions among black and minority ethnic (BME) men who have sex with men (MSM).

## 1.1 Incidence and prevalence of HIV among MSM in the UK

MSM continue to be the group most affected by HIV infection (PHE report, 2015a). Estimates suggest that 62,880 MSM are living with HIV in the UK, and that an estimated 7,200 MSM living with HIV are unaware of their serostatus. In the general population, approximately four men in 1,000 are living with HIV; by contrast, among MSM aged 15-59, 59 men per 1,000 are living with HIV. MSM constituted 55% of all new HIV diagnoses in 2014 (PHE, 2015a). HIV prevalence is highest in areas of deprivation in England and particularly in London. Poverty alongside individual, social and structural factors including migration and HIV stigma and discrimination contribute to sexual health inequalities.

## 1.2 HIV diagnoses and transmission among BME MSM

Data from PHE, over the past decade, indicates that men of white ethnicity comprise 84% (38,429 of 45,679) of cases of newly diagnosed MSM with HIV in the UK with a route of exposure through sex with men (PHE, 2015b). By comparison, 14.6% of the total number of men diagnosed (6,654 of 45,679) are among BME men who are exposed in this way. There is also a more than 82% increase of new HIV diagnoses among Other and mixed heritage MSM (242 to 442). Increasing proportions of BME MSM who have been diagnosed with HIV have been seen for care: among black Caribbean men there is more than 100% increase (408 in 2005 to 837 in 2014) while among black African men the increase is 126% (267 to 605). Forty-five per cent of people in England seen for HIV care live in London (PHE, 2015b).

## 1.3 Defining MSM

The term 'men who have sex with men' (MSM) was first introduced in the early 1990s (Doll et al 1992) to recognise that both theorising and intervening in the arena of men's sexual health needs to incorporate men who do not self-identify as gay or bisexual. Therefore alongside men who describe themselves as gay and bisexual, it includes heterosexually-identified men who regularly or periodically engage in sexual behaviours with other men, male sex workers and men who prefer not to adopt 'fixed' labels of sexual identity and orientation for personal and/or cultural reasons. The use of the term 'MSM' allows public health agencies to develop interventions and initiatives which are more inclusive and which are less likely to alienate men who are not comfortable with being identified with/as gay or bisexual. While the term has its own limitations, it recognises the importance of including and accessing more 'hidden' populations of men who have sex with men, especially in communities and countries where same-sex sexual

behaviours are illegal and/or highly stigmatised (Beyrer et al 2012). These considerations are especially important in relation to black and minority ethnic men who may be more likely to come from contexts where homosexuality is prohibited or censored.

## 1.4 Defining BME Men

Britain has a long-standing history of cultural diversity which reflects both its geography and its history. BME men are defined in the UK according to the following six ethnic group categories: black Caribbean, black African, black other, south Asian (Indian, Bangladeshi, Pakistani), south east Asian (described as oriental), and dual heritage (described as mixed). However, our evaluation also includes a relatively recent minority group in the UK, namely Spanish and Portuguese-speaking Latin American men.

## 1.5 HIV risks and inequalities

Despite the increasing incidence of HIV among BME MSM, there is relatively little UK research about their distinct risks and health behaviours and the scant data available is contradictory. Research by Dougan et al 2005 and Soni et al 2008 reported greater levels of condomless anal sex and rates of sexually transmitted infections among British BME MSM (compared to white MSM). However, a meta-analysis of HIV infection in BME MSM which includes data from the UK alongside data from Canada and the US found that BME MSM engaged in fewer risk behaviours, reported less unprotected anal intercourse, had fewer male partners and more condom use during anal sex than other MSM (Millet et al 2012). However, this analysis shows that regardless of their greater likelihood of adopting safer sex behaviours, BME MSM were three times more likely to test HIV positive and six times more likely to have an undiagnosed HIV infection than other MSM (Millet et al 2012). These findings may indicate health inequalities between BME MSM and their white MSM counterparts because early diagnosis and entry into care improves clinical outcomes. The meta-analysis revealed important differences in HIV risk between MSM in the UK and the USA and underlines the caution required in transferring international research and epidemiological data to a British context:

- BME MSM are more likely than white MSM to test HIV-positive or to ever have had a sexually transmitted infection (STI)
- BME men in the UK, unlike in Canada and the US, were more likely to have a history of substance misuse
- UK black MSM were more likely to have been tested for HIV, but less likely to have heard of post-exposure prophylaxis (PEP) or pre-exposure prophylaxis (PrEP) for HIV prevention than white MSM
- among HIV-positive MSM, UK black MSM were less likely to have access to antiretroviral therapy (ART) than white MSM and less likely to use ART when available

## 2. Scheme of work

As a key national public health agency, PHE is committed to promoting and protecting public health and to addressing health inequalities in society. The BME MSM project, which forms part of PHE work on tackling health inequalities among lesbian, gay, bisexual and trans populations, set out to:

- enhance understanding of BME MSM identity, health and social care needs among BME, LGBT and faith third sector organisations in a series of learning sets
- pilot models of direct behaviour change interventions for BME MSM aimed at reducing sexual health risk behaviour and building resilience

Using a multi-methodological approach and drawing upon theories from the social sciences, the present evaluation set out to:

- establish an evidence base for health and wellbeing interventions for BME MSM in a systematic review (see section 3)
- evaluate the impact of the interventions on BME MSM, as well as the cost-effectiveness of these interventions (section 4)
- assess the impact of the learning sets on community organisations' understandings of issues relevant to BME MSM (section 5)

## 3. Systematic review

### 3.1 Summary

A protocol for the systematic review was developed following current 'best practice' guidelines (Shamseer et al 2015). The reviewers searched three databases (PubMed, Scopus and PsychInfo) on 16 November 2015 using a combination of search terms: MSM, men who have sex with men and women (MSMW), gay, bisexual, homosexual; BME, black, African, Caribbean, Latin,\* Asian; HIV, AIDS, sexual, evaluation, intervention, training, program,\* implementation. Research articles published in peer-reviewed academic sources alongside interim findings from on-going studies and in press articles. The interventions included were specifically designed for BME/BME, black/African Americans, Hispanic/Latinos, and Asian and Pacific Islanders MSM/MSMW. Behavioural outcomes related to sexual behaviour were included as well as HIV/AIDS and other STIs knowledge outcomes. Studies conducted in English in countries with black and minority ethnic populations were included. One previous systematic review had been carried out by Maulsby and colleagues in 2013 which focused on efficacy data of 12 intervention studies all undertaken within the US. Studies included in Maulsby et al's review were not included in the current review to avoid duplication.

Using the search terms and search engines outlined systematic search of literature identified 173 potentially relevant studies conducted over a period of 20 years. Most of these studies were undertaken in the US with far fewer studies from other countries. Upon careful screening the majority of the studies identified were excluded from the final



analysis because they were not relevant, did not include or report outcomes from an intervention or were not specifically focused on the communities of interest. Seventeen studies were therefore included in the final analysis which is summarised below. (A more detailed account of the search strategies is available from the authors on request).

Study participants were of African-American, Latino (Spanish speaking) and Asian Pacific islander (API) heritage. Men were drawn from the predominantly urban communities of New York, San Francisco, Los Angeles, Toronto, Chicago and Baltimore. Some studies were targeted to particular sub-populations of MSM communities including the African-American House Ball community, Mexican farmworkers, young MSM of colour, behaviourally bisexual men, injection drug-using MSM and BME men who had experienced sexual abuse. Participants included men of HIV-negative, positive and unknown status. Typically, men were recruited through convenience sampling, assessed for eligibility by screening interview and randomly assigned to an intervention or a control group. Study sample sizes ranged from 40-503 participants.

Studies adopted diverse theoretical perspectives and domains of interest that ranged from psycho-social concerns, HIV testing to the assessment of stress biomarkers through cortisol levels in urine samples. Themes included men's social context: social isolation, migration, stigma and oppression, developing a positive identity, body image, social support; HIV prevention, risk reduction and condom use; lifestyle concerns: diet, smoking and exercise; positive sexual behaviour.

The studies revealed innovative and diverse approaches to HIV prevention interventions. Seven studies used group-based approaches; one study used individual sessions while another used a combination of group-based and individual sessions. Three studies adopted the popular opinion leader intervention modelled on the work of Kelly (1991), which provides training for peer leaders to enable them to use social networks to deliver HIV prevention messages. This approach was used in particular to deliver risk reduction messages to 'clandestine' or marginalised groups such as Mexican farmworkers and the House Ball community.

Six studies were conducted among Latino/Spanish speaking populations, seven studies were undertaken among black/African-American communities, one of API and two studies included Latino and black/African American men. Strategies adopted to ensure the cultural sensitivity of interventions included developing collaborative partnerships with a range of community-based organisations such as health centres catering for LGBT communities alongside organisations for particular ethnic or cultural groups (eg, the Centre for Spanish Speaking Peoples). In some studies, Spanish constituted the working language of the research team: the advisory committee meetings and interventions were all conducted in Spanish. Methods included the use of culturally appropriate materials such as a commissioned video, sexual diaries, word association, problem solving, analysis of Spanish proverbs, surveys, interviews and focus groups. Five studies were informed by the work of Diaz, some of them adapted or used the programme he developed in the handbook 'Hermanos de luna y sol'.

### 3.2 Research funding and participant incentives

Twelve studies provided incentives (some modest, some larger sums) to retain participants at key stages in the intervention with a final reimbursement for completion of the full cycle. Participants were also offered food, subway tokens or the opportunity to take part in a raffle. Studies were conducted over a period ranging from four months to four years.

### 3.3 Design

All of the studies included in the review had a focus on HIV and STI prevention and reduction. Twelve of the 17 studies were behavioural intervention projects, four were intervention development projects and one is an ongoing intervention in a UK context.

Seven out of the 12 efficacy studies used a randomised controlled trial (RCT) design in which participants were randomly allocated to the experimental or the control condition. Two used a pre-post design, two used a repeated cross-sectional design and one used a mixed design of repeated cross-sectional and RCT designs. Of the seven RCT studies, three (Harawa, Choi, O'Donnell) had an intervention experimental condition and a wait-list or a non-attention condition where participants did not undergo an intervention. Four out of the seven RCT efficacy studies had a sophisticated design in which participants were assigned to either an experimental condition which was focused on sexual health behavioural intervention (the main goal of the study), or a 'control' condition which was in two cases addressing general health concerns (Jemmott, Williams) or had a different structure than the experimental intervention (Harawa, Tobin). The length and number of sessions varied across the studies, from a single 45-60 minute intervention (O'Donnell) to an intervention with twice weekly two-hour sessions over a three-week period (Tobin).

### 3.4 Primary and secondary outcomes

In eight of the 12 efficacy studies, the primary outcomes assessed were: unprotected anal intercourse (UAI), unprotected anal and vaginal intercourse (UAVI) and condom protected intercourse (CPI). Six of the 12 studies used the risk behaviour outcome measure of reductions in the number of sexual partners between pre and post intervention. Secondary outcome measures included reductions in sex under the influence of substances (2), increased HIV testing (2), HIV/AIDS knowledge and HIV risk-behaviour knowledge (1) and psychological and social constructs of human behaviour (3). One study (Williams) assessed UAVI alongside bio-physical markers to ascertain stress levels.

### 3.5 Approach taken

We conducted a qualitative synthesis of the data from the 12 efficacy studies and considered this the most appropriate due to the heterogeneity of the studies. This

approach was used in previous systematic reviews and is comparable to that taken by Maulsby et al (2013).

### 3.6 Results

A total 11 studies reported statistically significant results in at least one of the outcomes assessed. Nine out of the 12 efficacy studies reported positive results in unprotected anal intercourse (UAI), number of sexual partners, or in both of these measures. Five of the 12 studies reported reductions in UAI (Adam, Carballo-Diequez, O'Donnell, Tobin, Williams). Six out of 12 reported reductions in number of sexual partners (Choi, Harawa, O'Donnell, Vega, Williams, Young). These sexual behaviours are considered to have the highest risk of HIV transmission and of other STIs. In three studies, the reductions in UAI and in the number of sexual partners occurred in both the efficacy arm of the intervention and in the control group, thus rendering the interventions less conclusive in terms of effectiveness (Williams, Jemmott, Carballo-Diequez).

The sole one-to-one intervention (Jemmott) included in this review found significant declines in UAI or condom use. These reductions occurred overall and there were no differences between the two conditions. Five RCT studies (Choi, Harawa, Jemmott, O'Donnell, Vega) showed behavioural change in comparison to the control condition. Two RCTs showed significant results across the overall sample (Carballo-Diequez, Williams). Two studies which showed low to moderate effectiveness used the popular opinion leader model with a pre-post design (Somerville, Hosek). However, a pre-post study by Vega reported significant reductions in number of sexual partners, in high-risk sexual behaviours (ie, UAI) and increases in HIV/AIDS knowledge. The specific intervention used social identity theory as an elaborate framework informing the tasks and activities of the intervention condition.

We have also identified a number of intervention development studies. These studies either report the initial stages of designing effective behavioural intervention studies, are pilot study projects or are reviews discussing approaches to better HIV prevention and sexual health awareness. In detail, these projects are exploring the applicability of innovative practices in delivering either prevention or behavioural change approaches. It is important to note here the promising results from the pilot study in regards to PrEP adherence among young black MSM (Daughtridge).

### 3.7 Discussion

The overall results of this review indicate moderate to high efficacy of behavioural change interventions in black African, Latino and API men in a North American context. The majority of the interventions showed reductions in sexual behaviours which constituted the primary outcomes of interest.

Interventions in this review which showed positive behavioural changes included black, Latino and API participants. Some of the studies reported extensive preparatory work to ensure the cultural sensitivity of the interventions, including the developing of specific culturally sensitive materials. Further, the majority of the successful studies focused on

psychosocial domains of interest underpinned by rigorous theoretical frameworks. This integrated programme of work coupled with a long-term commitment (as the majority of the interventions ran for a long period of time) alongside financial incentives was effective in yielding statistically important results.

However, it is important to highlight our systematic review has not produced any intervention projects within a UK context despite the particular issues pertaining to British BME MSM. Clearly, research is required in this aspect.

In order for future interventions to be successful in a UK context, there is an imperative need to acknowledge this cultural sensitivity, as materials developed as part of these studies with Hispanic Latino communities for example, may not be relevant to the UK BME communities (ie, Brazilian/Portuguese speaking communities, South Asian communities, African-Caribbean communities, etc). Further, the interventions should be informed by the individuals, members of these groups for which they are designed and should be structured on a long-term basis.

## 4. Interventions delivered by partner agencies

### 4.1. Overall objectives and methods

The interventions set out to promote positive changes on the following dimensions: sexual identity, sexual risk behaviour, mental health, wellbeing, smoking status, alcohol use, recreational drug use, employment, social isolation and use of public services. Although some of the interventions emphasised some elements over others, as described in sections 4.2, 4.3 and 4.4, the overall aim of the interventions was to promote an improvement on each of these dimensions.

Accordingly, a quantitative evaluation tool was constructed to measure each of the constructs. Nine different scales were used. The:

- lesbian, gay and bisexual identity scale (LGBIS) which is a measure assessing theoretical constructs related to lesbian, gay, bisexual (LGB) identity (Mohr & Kendra, 2011)
- internalised homophobia scale (HIS) which is used to assess internalised sexual stigma (Herek & Glunt, 1995)
- sexual risk behaviour scale which is used to assess attitudes towards condom use and perceived susceptibility to HIV/AIDS (DeHart & Birkimer, 1998)
- the Identity principles measure which measures subjective perceptions of (a) self-esteem, (b) self-efficacy, (c) continuity, and (d) distinctiveness, in accordance with Identity Process Theory (Murtagh et al, 2014)

- WHO-5 well-being index which assesses subjective psychological well-being (Topp, Ostergaard, Sondergaard & Bech, 2015)
- social inclusion scale which was derived using four items from The European Quality of Life Study (Layte, Maitre & Whelan, 2010)
- scale for the measurement of attitudes towards alcohol which assesses risk-taking factors regarding alcohol (Francalanci et al, 2011)
- scale for the measurement of attitudes towards drugs which was derived by using items from the previous scale (Francalanci et al, 2011)
- use of public services measure which was created to investigate use and perceived availability of public services
- independent items were created in order to explore specific sexual acts (enacted and intended). Items were included to tap into demographic constructs, such as age, HIV status, employment status, etc

This tool was administered to intervention participants once before the intervention began and then once again after the intervention had concluded. Responses on each of the aforementioned scales were compared using the t-test statistical technique. Only statistically significant differences between participant scores on each of the variables of interest were interpreted as potential improvements. Given the small sample sizes (indicated in sections 4.2, 4.3, and 4.4), the acceptable statistical significance level was set at <0.10.

In addition, one focus group was conducted for each intervention group to examine qualitatively its impact for participants. The focus group interview schedule tapped into participants' perceptions of the aforementioned foci of the interventions. Thematic analysis was used to ascertain the overarching themes that summarised the content of the focus group data. The results of the quantitative and qualitative research strands are summarised below.

## 4.2. NAZ: sexual health for everyone

### 4.2.1. Brief description of underlying approach and nature of the intervention

NAZ offers the Selfie intervention for BME MSM, which aims to inform MSM about their sexual health, empower them to take control over their sexual health and decision-making, and to develop a positive sexual identity. An overall aim of the programme is to enhance the social and psychological wellbeing of participants. As the biggest BME sexual health charity in the UK, NAZ works with several BME communities. The following Selfie groups were evaluated as part of the current project: (1) NAZ Latina which works with Spanish-speaking communities, (2) NAZ Vidas which works with the Portuguese-speaking communities, (3) NAZ Men which works with black and dual heritage communities, and (4) NAZ Asia which works with South Asian communities. NAZ Latina and NAZ Vidas held separate sessions for HIV- and HIV+ MSM. NAZ Men and NAZ Asia held sessions for HIV- MSM only. The NAZ Latina, NAZ Vidas and NAZ Man HIV+ and HIV- Selfie programmes included seven sessions over a period of seven weeks. The NAZ Asian HIV- Selfie programme included five topics that were covered intensively over

two full days. The following areas were covered to varying degrees in all of the sessions: (1) sexual health, (2) addictive behaviours, (3) identity, (4) self-esteem and wellbeing, (5) leadership and self-development, (6) relationships and intimacy, (7) religion, (8) anger management, (9) nutrition. The theoretical approach draws upon tenets of Counselling Psychology and there was some input from the lead psychosexual therapist at NAZ. Each workshop was facilitated by a staff member at NAZ (eg, the psychosexual therapist, or the NAZ Vidas co-ordinator) or an external volunteer (eg, an HIV doctor, a nutritionist).

The entire NAZ programme in its current form costs around £28,072 to facilitate in London. This includes programme salaries (including project manager and project worker costs) of £14,056; program supply costs (including support group cost/project activities, outreach work, rapid HIV testing, resource development, course development and one-to-one therapeutic counselling) of £9,303 which are covered by NAZ internally; administrative costs (including rent, management staff, IT and telephone, stationery and postage and housekeeping) of £4,503; and miscellaneous costs (including insurance, staff travel, peer educator travel expenses, and staff and volunteer training) of £210.

#### 4.2.2. Data collected

For the quantitative component, a total of 33 BME MSM completed pre-intervention and post-intervention questionnaires. Four defined themselves as African, three as Caribbean, one as Indian, six as Pakistani, 15 as Latino/Hispanic, one as mixed white/black heritage, and two as other. Seventeen individuals were HIV-, 12 were HIV+, and four were unaware of their status.

For the qualitative component, there was a focus group for each of the selfie programmes. Five men participated in the HIV+ NAZ Latina group, ten in the HIV- NAZ Latina group, six in the HIV+ NAZ Vidas group, four in the HIV- NAZ Men group, and six in the HIV- NAZ Asia group.

#### 4.2.3. Findings from the quantitative data

In view of the similar content across all of the Selfie programmes, the quantitative data was not split by ethnic group but rather analysed as a single cohort. A comparison of the pre-intervention and post-intervention data from the 33 men using the t-test statistical technique exhibited statistically significant improvements on measures of attitudes towards condom use, sexual risk-taking, attitudes towards alcohol, sense of continuity, perceived access to public services, and participation in 'chemsex' (drug use in sexualised settings). In general, there were no significant changes in reported or intended sexual behaviours.

#### 4.2.4. Findings from the qualitative data

Analyses of the qualitative focus group data revealed three consistent themes:

*Invaluable source of sexual health information.* Participants reported perceiving greater access to important sexual health information to which they would not ordinarily have

access. Participants across all of the cohorts hoped to modify their sexual risk-taking behaviours in view of the information they obtained regarding the prevalence and transmission of STIs among MSM. The Portuguese-speaking cohort in particular derived information about the potential risks of using recreational drugs in sexualized settings, which was useful particularly for HIV-positive MSM concerned about the risks surrounding interactions between their HIV medication and recreational drugs. Crucially, all of the Portuguese and Spanish-speaking cohorts greatly benefitted from the delivery of this important information in their own language, given that many reported difficulties in communicating in English and expressed anxiety about having to discuss their sexual health with monolingual English-speaking healthcare professionals.

*Re-thinking the value appended to sexual identity.* Most respondents described the challenges of identifying as gay in their communities, which in some cases led to internalized homophobia, but reported that the Selfie sessions had enabled them to re-evaluate their sexual identities in more positive and accepting ways. The sessions had reportedly exposed them to more positive imagery of their sexual identities, which enabled them to view it in a more affirmative manner. This led the black and Latin American participants, in particular, to seek closer ties with other MSM in their respective ethnic communities, which provided a sense of social identity. Participants overwhelmingly identified an improvement in their sense of self-esteem on the basis of their sexual identity since beginning the programme.

*Coping with depression.* Most participants described past and ongoing experiences of anxiety and depression, which they attributed to homophobia and/or HIV diagnosis. However, participation in the Selfie programme provided the 'resources' for beginning to coping with depression (primarily through the derivation of social support). Experiences of homophobia had led some individuals to feel marginalized but the selfie groups provided a supportive network which reportedly decreased feelings of anxiety and depression. HIV-positive respondents in particular expressed their pleasure at the ability to attend sessions tailored to those living with HIV, in which they felt more comfortable disclosing their experiences of living with depression. A key aspect of the Selfie programmes is the encouragement of sexual health leadership roles among participants so that they can further promote sexual health in their respective communities. The qualitative data suggested that this scheme provided some individuals with increased self-efficacy and, thus, a further boost to their wellbeing.

#### 4.2.5. Conclusions

The Selfie programme provided a space that was construed by participants as being socially and psychologically 'safe'. In view of reported experiences of homophobia and racism, this safe space was key for promoting wellbeing and for encouraging thinking and discussion in the important area of sexual health. Moreover, it was clear that many of the participants had had little exposure to positive imagery concerning sexual identity and to important sexual health information prior to their engagement with the intervention. The affirmative sexual identity imagery and sexual health information were communicated in

highly effective ways in participants' own languages (eg, Spanish, Portuguese, Urdu), which had a discernibly positive impact on them. Overall, the data suggest significant improvements particularly in the domain of psychological wellbeing with some evidence of improvement on attitudes towards health behaviours.

### 4.3. GMI Partnership and Africa Advocacy Foundation (AAF)

#### 4.3.1. Brief description of underlying approach and nature of intervention

The GMI Partnership is made up of three London based organisations (METRO Charity, Positive East and Spectra (formally known as West London Gay Men's Project)). The evaluation team's primary contact was METRO Charity. The GMI Partnership and AAF take a holistic approach to the health of MSM offering support in HIV prevention, testing and care alongside mental health and other well-being services. GMI Partnership and AAF's ethos is of helping people to become self-reliant and autonomous. They have an established Pan-London profile and take referrals from other HIV services for MSM and services for BAME communities. The initial intention was to offer six sessions of cognitive behavioural therapy (CBT) to 30 individuals but because the nine domains specified in the tender require a holistic intervention, a client-led approach was deemed appropriate. Integrative counselling combines a number of approaches including mindfulness, CBT and acceptance therapy, and requires a longer period of counselling. Thus, more sessions were needed which they were provided in two separate groups. The first consisted of 12 individual sessions whereas the second one had eight sessions.

The entire programme in its current form costs around £14,000 to facilitate in London. This includes staff costs (including all add-ons, such as national insurance/pensions/management) of £10,483; clinical supervision costs of £2000; volunteer recruitment and other expenses of £600; and partner agency promotional activity costs of £317. It has to be noted that individual interventions have a higher cost compared to group interventions. This higher cost can be attributed to the specific format of these interventions with issues pertaining to time and level of commitment.

#### 4.3.2. Participants

MSM were contacted through outreach and clinic teams and 12 MSM took part in and completed either eight or 12 individual sessions. Men's ethnicity or heritage included Caribbean (5), South Asian (5) and African (3).

#### 4.3.3. Data collected

Twelve men contributed baseline data and completed post-intervention measures. Four men contributed short qualitative evaluation forms, post-intervention. Individual interviews were conducted with both facilitators.



#### 4.3.4. Findings from quantitative data

A comparison of the pre-intervention and post-intervention data from the 12 men who completed measures on both occasions showed significant improvements on measures of psychological wellbeing and self-efficacy. Generally there were not significant changes in reported or intended health behaviours relating to safer sex or substance use.

#### 4.3.5. Findings from qualitative data

*Unique challenges.* BME MSM from abroad deal with considerable adversity. When they access Metro's services, they are often coping with multiple issues: accommodation needs take precedence above general wellbeing. While among white British communities, there is increasing recognition of the need to take time for oneself, in some cultures, there is a belief that people should be stoical. Men's reasons for accessing the intervention included: substance misuse, fears about coming out to family and friends, depression and HIV diagnosis, the conflict between cultural expectations, marriage, family and identity as a gay man.

*Positive views of intervention.* Participants felt they were treated professionally and with respect. The counsellor communicated positivity and made practical suggestions; for example, about ways of dealing with stress. Participants valued the non-judgemental approach taken, others appreciated the safe space for reflection where they did not feel embarrassed or stupid, while another felt that the service was culturally appropriate. Because the intervention was person-centred, participants were able to address other aspects of their lives that impacted upon their sexual health. This holistic approach might not have been possible through a CBT time-limited intervention.

*Potential issues.* Few limitations were identified by participants although there were challenges in managing evaluating the intervention within the time-frame of the project as the initial assessment took three weeks to organise for some men. Accessibility posed something of a barrier for one man who needed to travel across London to attend the service. Another would have liked to access additional sessions.

#### 4.3.6. Conclusions

The service offered was very accommodating. There was a low attrition rate as most men completed the intervention. However, satisfaction rates were difficult to estimate as a low number (n=4) of participants offered qualitative feedback. Efforts to recruit BME counsellors were not successful as there is a limited pool of suitably qualified BME professionals. This required more sessions which had implications for recruitment, as fewer professionals and participants were able to commit to up to 12 sessions. Thus, a cohort of 15 individuals was deemed more achievable. Follow-up data are needed to establish whether changes to health behaviours are sustained. However, individual interventions may be effective health behavioural interventions.

## 4.4. The Quest

### 4.4.1. Brief description of underlying approach and nature of intervention

The Quest is a social enterprise offering a number of personal development programmes and events for gay men. The Quest Programme is an intervention which aims to strengthen the resilience and wellbeing of gay men. Participation in the programme lasts around a month but centres on an intensive weekend of workshops and follow-up integration day (around three weeks later). These elements are supported by various 'homework' tasks preceding and following the workshop. The theoretical approach is eclectic drawing from various tenets from both coaching and counselling psychology and more specifically the shame-resilience model developed by Brown (2007). The core workshop is facilitated by two certified life coaches and group facilitators who are supported by three volunteer assistants (who have previously been through the workshops themselves). Workshops do not focus directly on health but rather encourage men to become more 'authentic' and to explore their motives for maladaptive behaviours. Each Quest programme in its current form (two facilitators, three assistants, up to 20 participants) costs around £4740 to facilitate in London and £6090 outside (because of subsidised rate in London).

### 4.4.2. Participants

Four workshops aimed specifically at BME gay men took place in 2015 (three in London and one in Manchester). Men were from a wide variety of ethnic, cultural and religious backgrounds and were of various ages (19-50 years) and incomes although most were educated to degree level. A small number disclosed being HIV+ and a majority had accessed prior psychological support from other organisations.

Men paid a commitment fee of £20 or £40 (dependent on income) which was refunded post-participation. Ninety-six men expressed an interest in taking part, 55 signed up for a workshop and 46 completed the workshop phase. Thirty-three attended an integration session. Recruitment was considerably lower in Manchester and most data was collected on men who attended one of the three London-based workshops.

### 4.4.3. Data collected

Thirty-six men contributed baseline data, 26 completed post-intervention measures and 14 men participated in one of two focus groups held in April and September. Hour-long individual interviews were conducted in person with facilitators in September 2015.

### 4.4.4. Findings from quantitative data

A comparison of the pre-intervention and post-intervention data from the 26 men who completed measures on both occasions showed significant improvements on measures of internalised homophobia, self-esteem, self-efficacy and psychological well-being. Generally there were not significant changes in reported or intended health behaviours

relating to safer sex or substance use but intention to engage in chemsex was significantly reduced and reported use of alcohol was statistically significant.

#### 4.4.5. Findings from qualitative data

Qualitative analyses revealed a number of consistent themes around the unique challenges facing BME gay men and their views about the intervention.

*Unique challenges.* Participants discussed their experiences of exclusion and racism, 'exoticisation' and 'fetishism' within the gay community. Many men struggled to integrate their sexual and ethnic identities and felt 'split'. Accounts of shame and self-stigma were common. Several had experienced trauma, violence or abuse and felt isolated from both other BME gay men and their families and communities.

*Positive views of intervention.* Participants were mostly very positive. They felt they were developing meaningful non-sexual relationships with other gay men and explored issues around intimacy and 'dysfunctional' use of sex. They developed strategies to address issues around poor psychological wellbeing and felt that through increased self-acceptance they would make better health-related choices around sex. They found the workshops emotionally challenging but felt that these took place in a safe space.

*Potential issues.* Participants found the marketing of the programme intriguing and attractive but abstract and uninformative. Some would have preferred smaller group sizes and a small number questioned the appropriateness of one of the facilitators being white. Despite awareness of some of the follow-up opportunities for continued peer support which The Quest offer, some of the men expressed worries that they may struggle to maintain commitments they had made to change unhealthy behaviours during the programme once their participation had ended.

#### 4.4.6. Conclusions

Qualitative and quantitative data were consistent on benefits to psychological wellbeing post-intervention. Follow-up data on maintenance of positive developments would be very helpful. Participants were disproportionately educated and this may suggest that the approach and marketing is currently targeted at this group. However, the development of a rationalised version that maintains the key 'live ingredients' could potentially be explored. The Quest recruited very close to target and had a very low attrition rate.

#### 4.5. Conclusions and implications of interventions

The qualitative component of the evaluation demonstrates some of the social and psychological challenges associated with BME MSM identity. Across the three interventions, participants highlighted the conflicts that they faced as a result of being BME MSM. Participants described difficulties surrounding coming out and constructing a positive sexual identity, as a result of perceived homophobia, as well as the perceived threat of racism and exclusion due to their BME identity. In their qualitative accounts, participants expressed the perceived benefits of the interventions, such as its function as

a source of sexual health information and as a medium for promoting more positive understandings of sexual identity. The interventions were invariably successful in inducing improvements in psychological domain. Both the individual and group-based interventions led to significant improvements in psychological wellbeing and related constructs that are known to contribute to psychological wellbeing, such as self-esteem, self-efficacy and a sense of continuity. The Quest, in particular, which focuses on encouraging feelings of identity authenticity, was successful in reducing feelings of internalised homophobia, which the present project and previous research have both identified as a key factor underpinning decreased wellbeing among BME MSM (Quinn et al, 2015). Moreover, decreasing internalised homophobia has been found to reduce sexual risk-taking behaviours (Quinn et al, 2015; Ross et al, 2013).

The NAZ interventions were successful in promoting more favourable attitudes towards condoms and alcohol use, both of which have been linked to greater susceptibility to STIs, including HIV (Reisner et al, 2010). Both the NAZ and the Quest interventions led to improvements in either current or intended engagement in chemsex, which has also been linked to STI susceptibility (Bourne et al, 2014). Alcohol and substance misuse, as well engagement in chemsex, have been explained at least partially in terms of escapism and decreased wellbeing (Bourne et al, 2014). It would appear that the sustained focus on (and success in) developing psychological wellbeing in all three of the interventions might have induced favourable changes to attitudes towards alcohol and substance use. However, it is noteworthy that none of the interventions produced measurable changes to current or intended sexual behaviours and there was no evidence in the qualitative data that participants had modified their sexual risk-taking behaviour as a result of their participation in the interventions. Although attitudes and behaviour are at least partially linked (Eagly & Chaiken, 1998), there is no direct evidence that this will necessarily lead to less sexual risk-taking. It is therefore suggested the future interventions do focus more forcefully on promoting positive sexual health behaviours among BME MSM.

## 5. Action learning sets

### 5.1. Overall objectives and Methods

The evaluation team's aims and objectives were to evaluate the impact of a series of action learning sets (ALS) run by third sector organisations to raise awareness of the needs of gay, bisexual and MSM from BME groups, to understand better their statutory obligations and to share suggested practice in order to improve service provision. Three organisations – The Gay Men's Health Charity (GMFA), Race Equality Foundation (REF) and FaithAction – were funded to develop and deliver a series of four sessions for other agencies and organisations working in the same field (LGBT health, ethnicity and faith) and to deliver two joint sessions. It was anticipated that some organisations (especially those located some distance from London) would participate virtually. The aim was for 15

organisations to be involved in each ALS. We have evaluated these sessions' impacts with regard to familiarity with sexuality concepts; the challenges BME MSM are facing; practical skills for engaging with the community and collaboration of the three cohorts.

## 5.2. Evaluation methods

A mixed approach of both qualitative and quantitative methods was chosen in order to acquire a holistic understanding of the impacts of the ALS.

An evaluation instrument using a semantic differential method consisting of 21 items was produced and administered to participants before the start of the first session and after the final session. The measure was designed to explore the organisations' understandings in several core issues pertaining to awareness with regard to sexual health needs, discrimination issues and identity challenges of BME MSM. The creation of the measure was theoretically informed. The data were analysed to investigate differences in responses before the first and after the final learning set and were analysed using SPSS statistical software.

The qualitative data were collected using a multiple methods approach primarily for pragmatic reasons as discussed further later. These means of data collection included focus group discussions (n=1), one-to-one and telephone interviews with participants (n=4) and facilitators (n=4) and, finally, short open-ended questionnaires (n=6). They were analysed using qualitative content analysis.

## 5.3. GMFA

### 5.3.1 Aims and objectives

The ALS delivered were facilitated by an experienced facilitator from PACE, an LGBT mental health charity group. The aims and objective of the specific ALS were to improve confidence in working with BME LGBT and better meet the needs of the population allowing for better health and wellbeing outcomes.

### 5.3.2. Structure

The design was a combination of a classic ASL and a broader educational/training workshop. The structure of the sessions was designed as to allow participants to engage in an interactive procedure whereby they would return to their respective organisations and implement any gained knowledge or skills. The set involved four separate sessions during which the facilitators and participants explored a number of domains/topics. The aims were to ensure that BME individuals are welcomed to and are given access to LGBT organisations' services; BME staff and volunteers are recruited; BME experiences in the participants' day to day work are acknowledged; LGBT asylum seekers' special requirements are recognised; and BME needs are incorporated in LGBT organisations' policies. An indirect result of this strand of ALS was the design and delivery of a number of secondary outcomes related to these domains/topics (ie, a special issue of FS

magazine on racism within the 'gay scene'). A consultant was also hired to help with the ALS. The sessions were delivered in London.

### 5.3.3. Participants

Participants were from a wide variety of organisations focusing on LGBT population service provision. Participants included persons with a managerial position, staff workers and volunteers within participant organisations. Eighteen participants attended the first session, whereas six took part in the last session. Participants representing organisations sometimes changed across sessions.

### 5.3.4. Findings from quantitative data

Twelve participants filled the baseline evaluation forms. However, only four offered fully completed forms before and after the sessions. Participants reported significantly improved awareness in relation to the number of BME MSM using their organisation's services. The findings support the absence of anything specifically related to BME MSM in the majority of the organisations with regard to policy statements and services offered to BME MSM.

### 5.3.5. Findings from qualitative data

The participants agreed the sessions were well facilitated; it was a forum of networking and a safe place for exchanging knowledge and best practice. However, there was a feeling that the design of the sets was too structured. The organisations which had more experience with BME MSM service provision reported they were not given sufficient opportunities to share their practice. Although a third of the attendees were from a BME background, some of the participants reported lack of ethnic diversity as a barrier for allowing further learning opportunities. Despite sustained efforts by the facilitators and the evaluation team, it was very difficult to collect adequate evaluation data in this set.

### 5.3.6. Conclusions

Sessions were professionally run and allowed a forum for networking. Some of the participants we spoke to felt the approach was too top-down and the set felt very 'London-centric' with no funding made available to enable leads from groups outside London to attend. Participation was consistent during the first three sessions; however, it declined considerably between the third and fourth sessions. Data capture proved difficult because of attrition and attendance by different individuals representing the same organisation

## 5.4. REF

### 5.4.1. Aims and objectives

The REF action learning sets were designed in order to accommodate participants from ethnicity related organisations/charities. The aims of the ALS offered by REF included investigating terms with regard to BME MSM; exploring the legal requirements; understanding the unique challenges faced by the population and enhancing skills of providing services in an individual and organisational level.

#### 5.4.2. Structure

The format of the ALS was based on previous work and projects delivered by the organisation and it was structured around five sessions with four to six weeks intervals. They had a flexible approach, as the agenda of each session was based on feedback delivered by the participants from the previous session. All five sessions were delivered in London.

#### 5.4.3. Participants

The participants were from a diverse background. Senior staff members, junior staff members and trustees took part in the sessions. Participant organisations were from all over England. They came from diverse ethnic backgrounds. The ALS started and ended with 13 participants. The travel expenses for the participants were covered.

#### 5.4.4. Findings from quantitative data

Twenty-one participants completed the baseline evaluation forms (after sessions 1 and 2) and ten participants offered completed versions – before and after. Comparison of the pre-intervention and post-intervention data from the ten participants who completed measures on both occasions did not show significant improvements on any of the items of interest. High item means were observed at pre-evaluation which may explain the absence of any statistically significant change after post-evaluation.

#### 5.4.5. Findings from qualitative data

Qualitative analyses revealed a number of understandings around the perspectives of the persons/organisations participating. Individual interviews with participants revealed that the REF ALS were perceived as well facilitated and organised. The sessions allowed participants/organisations to share knowledge, exchange best practice, as well as to create collaborations. The diversity of the participants/organisations allowed for a more holistic approach on the issues pertaining to the needs of BME MSM. The ethnic/racial diversity of participants was seen as extremely beneficial and it was perceived as a successful addition.

#### 5.4.6. Conclusions

Sessions were well organised and allowed for a forum for networking and for exchanging information, knowledge and expertise. The participants agreed that the facilitators relinquished control which allowed for a participant-led discussion of the topics. The travel expenses were covered and the recruitment was based on a diversity of

backgrounds. This allowed for a holistic understanding of the topics explored. However, some participants did not enter the sessions from the onset. This and the problematic administration of the evaluation forms might explain the discrepancy between the quantitative and qualitative data.

## 5.5. FaithAction

### 5.5.1. Aims and objectives

The main aim of the FaithAction learning sets was to design a training series to provide an opportunity to participants from faith communities to engage in a dialogue over the matter, thus raising awareness and improving the level of care, support and pastoral service for BME MSM.

### 5.5.2. Structure

The ALS from FaithAction were designed in a way as to engage with the topic of BME MSM within a 'safe environment'. They set some original goals with regard to approaching this sensitive topic including a focus on the health issues faced by BME MSM and how faith organisations can play a positive role in addressing these. They offered a space of full anonymity to the participants as well as a promise not to pressure towards any sort of doctrine change. The four sessions were delivered in London.

### 5.5.3. Participants

The participants were mainly from multiple Christian denominations, with a Hindu and a Muslim faith organisation representatives also present. The same nine individuals took part during the entire length of the ALS. They were offered £100 as an incentive for each session they attended, which facilitated full retention. Additionally, two extra skype-only sessions were held with Muslim participants, independently from the ALS. Unfortunately, we were not able to collect any meaningful data from this group, thus we have not evaluated the impacts of these extra sessions.

### 5.5.4. Findings from quantitative data

Nine participants completed the evaluation forms at baseline and seven participants offered full completed questionnaires after the final session. The analysis revealed significant improvements in only one domain: understanding and fulfilling the statutory requirements relating to BME MSM. There were no improvements in all other items. Further, the data indicate a continued lack of awareness for the specific needs pertaining to this population.

### 5.5.5. Findings from qualitative data

The participants were reluctant in sharing their opinions for the evaluation and it proved very difficult for the evaluation team to collect meaningful qualitative data despite



assistance from facilitators. The analysis of these data revealed complete *unfamiliarity* with the topic, which is consistent with the quantitative data. Despite participating in the set most participants continued to question the need for a project like this within their communities, deeming any further work on the subject *unnecessary*. Some clearly experienced high levels of discomfort and some participants were highly *defensive* as they felt they are in an *antagonistic* position with the LGBT community. However, they had positive views on the facilitation aspect and the informative nature of the sessions.

### 5.5.6. Conclusions

The sessions were well facilitated and allowed for a safe place for the participants to engage in dialogue with regard to this population. There was a clear reluctance and discomfort to taking part, as BME MSM individuals are not a clear target population for this community of interest. Financial incentives were offered as part of the project which allowed for full retention. The same participants took part in all four sessions. However, there was a lack of interest in engaging with participants from the other two sessions.

### 5.6. Joint learning sets

Two joint sessions were incorporated in the project as a forum of an inter-cohort collaboration. Joint session 1 took part during the delivery of the individual sets, whereas Joint session 2 immediately after the final session of the last cohort.

Participants were generally *critical* of the joint sessions. They perceived it as an additional session without clear objectives which was primarily led by facilitators, rather than participants themselves. They reported that it also introduced a new set of people with what were perceived as conflicting agendas and they were described as unsatisfying as the groups were on a different level of ALS delivery. Both joint sessions, and specifically the second one, were not attended equally from all three cohorts which did not allow for the inter-group dialogue which they were designed for. Members of faith organisations were especially reluctant to participate. Suggestions for an official social event rather than a structured session were offered.

### 5.7. Conclusions and Implications of ALS

This evaluation has produced some significant themes with regard to the effectiveness of the ALS, separately and in an overall context.

*Collaboration.* The space created by the three charities was an opportunity for service providers from diverse organisations to assemble and *share knowledge, disseminate best practice*, pool resources and collaborate. This forum allowed for *implementing* changes, gaining feedback and amending activities and provision of services—especially within the ethnicity cohort, and in a lesser degree within the sexuality strand. However, this was not the case for the faith group.

*Basic understandings.* The ALS allowed for *basic understandings* and reduction of ignorance in relation to the needs of BME MSM – something which was present in all

three strands. Themes related to identity, behaviour, familiarity with terms, sexual and general health needs and visibility were identified as crucial and explored as such.

*Challenges.* There was a *difficulty for retaining interest* and participation without incentives. The groups which chose to reimburse travel expenses of participants had a more consistent and diverse physical presence/attendance. Further, there was difficulty in creating an intergroup dialogue, since all the groups worked independently with a different time-schedule, format, participants and agenda. The inter-group exchange of ideas did not materialise. The faith cohort was not willing to further engage with the topic as the service providers within that community deem it unnecessary. Finally, there was a difficulty in collecting both quantitative and qualitative data for meaningful analysis for the evaluation.

*Conclusions/ recommendations.* The specific format *yielded only low to moderate results*. To make similar future interventions more successful, there is an imperative need for designing *fewer but longer training sessions* within which the experts and the novice service providers alike can educate and be educated in the specific needs of BME MSM. An event of this sort can allow for further enhancement of the work conducted within these workshops. This should be coupled with *diverse participation*. The service providers with years of experience of delivering services to BME communities and within this specific socio-cultural context should have a more prominent role. Service providers for the LGBT community who have expertise in a sexual identity and behaviour context should also have an input. However, it needs to be noted that many in the faith community charities are *not ready to engage* in work within the MSM community. Thus, a more open-minded approach and fora of inter-group debates should be offered. All communities should be allowed to express their points of view with respect to antagonistic perspectives. A shorter, simpler evaluation instrument is advised to collect data from a larger percentage of participants.

Future training events should also address the geographic discrepancy of London-oriented projects. Incentives and opportunities should be accessible to charities and organisations from outside London. This will allow for *improved inclusiveness* and *equitable dispersion* of social and financial capital.

## 6. Conclusions

The systematic review revealed a paucity of research into behavioural interventions among BME MSM in the UK and the rest of Europe and, thus, it focused largely on North American studies that included a variety of BME groups not previously discussed in Maulsby et al's (2013) systematic review of black MSM in the US. The review demonstrated a moderate to high efficacy of the behavioural change interventions among BME MSM in the North American context. Conversely, there was less observable behavioural change among BME MSM in the current interventions during the course of

the current evaluation, although there were discernible changes to various psychological constructs, such as self-esteem and psychological wellbeing across the interventions, and to attitudes towards relevant health behaviours. The interventions delivered by all three partners show that benefits can be made to wellbeing but that psychotherapeutic/coaching approaches do not necessarily lead directly to “quick fixes” in risky health behaviours. In various scientific accounts of behaviour change, attitudinal change has been identified as a key starting-point (eg, Eagly & Chaiken, 1998). It is therefore possible that follow-up data would reveal measurable behavioural change in the future, in view of the observed changes in attitudes in the present evaluation. It is also consistent with recent research that the positive changes illustrated across many interventions in relation to better psychological well-being, reduced internalised homophobia, improved self-efficacy and reduced intentions to use drugs and alcohol generally and in sexualised settings might combine to lead to fewer risky sexual practices in future (Ross et al, 2013). Given the time frame of the present evaluation, the collection of follow up data to measure long-term change was not possible, but further research is required to examine the mechanisms of behaviour change among BME MSM more fully.

It appears that there were few discernible differences in the social, psychological and behavioural benefits afforded by the individual intervention (led by Metro) and the two group-based interventions (by NAZ and the Quest). However, the group-level interventions did provide several participants with enhanced feelings of inclusion, acceptance and belonging and with an opportunity to socialise with other BMS MSM. Indeed, there was much discussion of the sessions as a ‘safe space’ for meeting other BME MSM and for discussing issues relevant to their wellbeing. In previous research, enhanced feelings of interpersonal acceptance have been linked to less sexual risk-taking (Halkitis, 2012). Furthermore, in these safe spaces, BME MSM reported exposure to more positive images of their sexual identity and to linguistically and culturally accessible sexual health information which they hitherto had been unable to access. However, the individual-level interventions may well constitute an important intervention approach for BME MSM who present more severe psychological issues and who are not yet ready to disclose their sexual identity to other BME MSM. In short, there is evidence that the interventions provided tangible benefits to BME MSM but further research is required to ascertain the duration of the positive effects, particularly for risk-taking behaviour. Many of the interventions relied at least partially on the work of volunteer staff and well-established networks. It is essential that there is robust training and supervision of these individuals and mechanisms to ensure that their goodwill is not exploited. Developing similar interventions in new locations may face challenges in these regards without appropriate funding.

The action learning sets were generally well organised and facilitated an exchange of information, knowledge and expertise. It induced limited changes in participants’ awareness of issues pertinent to BME MSM, focussing mainly on awareness of the number of BME MSM using the organisation’s services (LGBT organisations), and understanding of the statutory requirements relating to BME MSM (faith organisations). Participants in the REF learning set generally scored high on the baseline variables,

which may explain the absence of any changes between times 1 and 2. The evaluation of the action learning sets demonstrated some of the enduring problems in encouraging faith leaders to accept and discuss MSM. Indeed, few members of the Faith Action learning set were willing to participate in the qualitative component of the evaluation, citing discomfort in discussing issues relating to BME MSM. This is an important concern given that in much previous research BME MSM of religious faith have reported marginalisation from their respective religious communities which can result in threats to social and psychological wellbeing (Jaspal, 2012; Jaspal & Cinnirella, 2010). There may be reluctance to engage with BME MSM and the issues that challenge their social, psychological and physical health. It is necessary to continue to engage with faith groups, communities and leaders. Furthermore, future action learning sets would need to balance top-down and 'grass roots' approaches, in order to accommodate the views and needs of the participating organisations. Some improvement to the structure of the action learning sets could be beneficial, as an intensive single day event might be easier to attend and, thus, more accessible to participants. Given the attrition rate, some participant incentive may boost participant recruitment and retention. Future work needs to look at how 'expertise' from beyond London can be incorporated and how organisations outside London can be included in a meaningful way.

### 6.1. Cost effectiveness

The NAZ intervention currently consists of six Selfie programmes: HIV+ NAZ Latina; HIV- NAZ Latina; HIV+ NAZ Vidas; HIV- NAZ Vidas; HIV+ NAZ Asia; HIV- NAZ Asia. Each Selfie programme costs £4678.60 to run (£28,072/6). If each Selfie programme is attended by 15 participants, this works out at £311.91 per person.

The Metro intervention currently costs £14,000 to run. If the intervention works with 15 participants, this works out at £933.30 per person.

The Quest intervention currently costs £4740 to facilitate in London and £6090 to facilitate outside of London. If the programme is attended by 15 participants, this works out at £316 per person in London, and at £406 per person outside of London. Significant expansion in the number of sessions offered would require training of additional facilitators.

In view of the overall shared benefits that each of the three interventions provide, focussed largely on psychological constructs, it would appear that the group-based interventions are the most cost-effective. The NAZ and the Quest interventions are comparable in terms of cost and have their own benefits in terms of 'added value' NAZ is able to connect its participants with in-house counselling and HIV testing services which, collectively, make a positive impact on the health and wellbeing of its clients, while The Quest offers ongoing support post-intervention through scheduling monthly social groups which facilitates ongoing peer support.

### 6.2. Recommendations

On the basis of the present evaluation, the following recommendations are offered:

- the present evaluation constitutes one of the first known studies of a series of interventions targeting BME MSM in the UK, as demonstrated in the systematic review outlined at the beginning of this report. There is a need for further research into interventions which this population, particularly examining the lasting affects of the interventions for risk-taking behaviours in this population
- the focus on providing sexual health information in participants' own languages and in ways that were meaningful to them in some of the interventions was clearly very beneficial for the BME MSM who participated in them, because of their reported lack of knowledge surrounding sexual health. The systematic review also noted the importance of cultural sensitivity in predicting successful behaviour change. This culturally and linguistically sensitive approach should be emulated in interventions targeting BME MSM
- it is vital to continue to engage with faith communities, organisations and leaders and to do so in creative ways that are likely to yield participation and engagement on their part. The importance of religious faith in many BME communities has been observed. This identity should be available to those who desire it
- the interventions were successful in promoting attitudinal change and improvements in the psychological domain. More engagement with behaviour change is necessary. This may require more theoretically informed approaches, which proved to be the most effective behaviour change approaches in the systematic review. On the whole, the interventions did not appear to be underpinned by robust theories from the social and behavioural sciences

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