1.	**Project reference:**	**Final report date:**	
	SPHR-UCL-PES-HIV	5th June, 2017	
2.	**Project title:**		
	Evaluation of the London-wide HIV Prevention Programme (LHPP)		
3.	**Lead investigators on project:**		
	Dr Fiona Burns, Reader in Sexual Health & HIV Medicine, Infection & Population Health, UCL Dr Alison Rodger, Reader in Infectious Diseases, Infection & Population Health, UCL		
	Other NIHR School collaborators (name, School for Primary Care/Social Care Research) on project:		
	N/A		
	Names and roles of others involved in project (e.g. include fixed term contract researchers and external collaborators / partners):		
	Professor Dame Anne Johnson, Professor of Infectious Disease, Infection & Population Health		
4.	**Project start date:**	**Project end date:**	**Duration:**
	15th August, 2015	31st March, 2017	19 months
5.	**Project objectives originally outlined in proposal:**		

PH Practice intervention to be evaluated

The HIV epidemic in the UK remains concentrated in London and in two at risk communities in particular; Men who have Sex with Men (MSM) and black African heterosexual men and women. The public practice intervention to be evaluated is the London-wide HIV Prevention Programme (LHPP), an evidence based behavioural intervention (using media, condom distribution, and outreach programmes) being established to interface with and complement the biomedical (test and treat) services commissioned by Local Authorities in clinics since 2013, to achieve a combination intervention package across London focused on the 2 communities at highest risk of HIV infection in the UK, MSM and black Africans. (http://www.londoncouncils.gov.uk/policylobbying/healthadultservices/publichealth/hivprevention/).

The overarching AIM of the LHPP is to reduce new HIV infections (incidence) and late diagnosis of HIV infection (and thus reduce the prevalence of those with undiagnosed HIV). The OBJECTIVES of the LHPP are to: (i) Increase HIV testing, (ii) Increase consistent condom use and (iii) Increase adoption of safer sexual behaviours

Aim & Objectives of the evaluation

The overall aim of this evaluation is to establish the extent to which the LHPP meets its aims and objectives as detailed above, and through what methods.

Evaluation Study Design

In line with the complex intervention evaluation approach advocated by MRC, the evaluation of the LHPP used a mixed methods research design.

The overarching AIM of the LHPP programme to reduce HIV incidence was assessed in this evaluation through the use of surveillance data (GUM clinic and HIV datasets) and data from two large scale community surveys in MSM and black Africans to assess trends in late diagnoses (CD4<350), the undiagnosed fraction and to derive calculations of trends in HIV incidence.

The OBJECTIVES of the LHPP were measured by a combination of the two large-scale cross-sectional surveys of the two target populations (MSM and black African) in a variety of social and community settings, clinic data and through qualitative work with focus group discussions in the two target populations.

The following table describes the sources of data used in the evaluation:

Objectives of LHPP	**Evaluation objective**	**Evaluation methods**
Increase HIV testing, consistent condom use and adoption of safer sex behaviours	Measure the extent of LHPP dissemination and penetration	Community surveys
Increase HIV testing	Assess the impact of the LHPP on HIV testing uptake and frequency	Community surveys, focus groups, analysis of routine data
Increase consistent condom use	Ascertain condom use and adoption of safer sex behaviours	Community surveys, focus groups
Increase adoption of safer sex behaviours		

Process evaluation is critical to understanding the impact (or otherwise) of the LHPP programme. This was assessed through the process records of those delivering the intervention, from the quantitative estimates of the penetration of the campaign through the community surveys and through the qualitative research (in-depth interviews).

6. Briefly describe and explain the reason(s) for any changes to the project originally outlined in proposal:

As the LHPP is a streamlined intervention with minimal staff, it was decided that the initial process evaluation framework would require some revisions. In addition, the LHPP targets primarily MSM with only some of the campaign targeted to black African men and women (there is no venue-based outreach or condom distribution scheme for black Africans). The process evaluation framework was revised as follows (as described in our earlier progress reports):

- to include the monitoring data provided by the outreach workers responsible for outreach work and condom distribution in MSM venues and events across London (quarterly monitoring reports produced by The GMI Partnership and The Freedoms Shop)
- to involve 20-25 in-depth interviews with key stakeholders involved in the LHPP, including the LHPP Steering Group members and providers of outreach, condom distribution and media/communications
- to limit information gathering from frontline staff to one time only (rather than repeated over time), as there are only 3 frontline staff members
- to include monitoring of communication and coordination processes in order to determine whether the programme is being implemented as intended (the evaluation did not have the expertise to conduct a full economic analysis and it was agreed at the Evaluation Steering Committee that a superficial analysis of resource expenditure would not be useful)

We had originally planned to conduct an analysis of late HIV diagnosis data. It was decided not to pursue this analysis due to the prolonged interval to be expected between increasing testing and observing any change in CD4 count at diagnosis. Any analysis was unlikely to be sensitive enough to detect a change during the period studied and using HIV testing data instead was

thought to be a more timely way of measuring the impact of the *Do It London* campaign. With this in mind, we conducted analyses incorporating other datasets that were not included in our original proposal. As described below, we explored the possible impact of the LHPP on HIV testing in different settings through analysis of data from the Sentinel Surveillance of Blood Born Virus (SSBBV), The National HIV Self-Sampling Service, SH:24 (an online STI and HIV self-sampling service) and on the purchase of BioSURE HIV Self Tests via The Freedoms Shop.

7. Brief summary of methods, findings against objectives, and conclusions (2-4 pages max):

Methods:

a. Process evaluation

a.1 Key informant interviews – Interviews were planned with 20-25 key informants who were purposively sampled to represent i) those providing the outreach, condom and campaign elements of the LHPP (provider informants) and ii), the 33 local authorities which funded the campaign, and organisations which provided external expertise (external informants). Individuals were asked to take part in a one-to-one interview lasting up to one hour. Interviews were based on a topic guide designed to apply to both provider and external informants. Audio recordings were transcribed verbatim, coded using NVivo software and analysed according to core themes from the topic guide and emerging themes.

a.2 Programme delivery - The Memorandum of Understanding (MOU) was reviewed to establish the extent to which LHPP governance structures correspond to those outlined in the MOU. The Service Specifications for i) Condom Distribution and Outreach, ii) Channel Strategy and Planning and (iii) Creative Media were reviewed to identify operational activities required of the contractors. Data from key informant interviews, performance data provided by the commissioned services and data from other sources were used to examine whether the activities appeared to be operating as intended.

b. Quantitative community surveys

We undertook two cross-sectional surveys with MSM and black Africans that followed on from previous surveys with these target groups. Behavioural and oral fluid surveillance data were collected in social and commercial venues frequented by gay and bisexual men and other MSM, and by black African men and women in London. Trained fieldworkers visited these venues at pre-determined times to recruit participants. Individuals were invited to complete an anonymous questionnaire designed for rapid self-completion and to provide an anonymous oral fluid specimen via the Intercept® i2he™ device (Orasure Technologies) to be tested for HIV antibodies.

b.1 Gay men's sexual health survey (GMSHS 2016) – Men were recruited in 22 bars, clubs, saunas and other social venues across London. The questionnaire was based on those used in previous surveys, in addition to questions specific to the LHPP. Survey data were analysed using Stata version 13.1. Ethical approval was obtained from Harrow NRES Committee (HRA) reference: 00/0158.

b.2 Survey of black African men and women (Mayisha 2016) - Suitable venues for recruitment were identified through a social mapping exercise and participants were recruited from 63 locations. The questionnaire was based on two previous Mayisha surveys (Fenton et al 2002, Sadler et al 2007) examining the sexual attitudes and lifestyles of black Africans in England, in addition to LHPP-specific questions. Participants were offered a £5 high street voucher as a token of appreciation. Data were analysed using Stata 14.2. Ethical approval was obtained from UCL Research Ethics Committee (9085/001).

c. Focus groups

Focus groups were planned with both gay and bisexual men, and with black African men and women. Recruitment took place via a range of channels, including those used by the LHPP campaign as well as other print and digital media. There were two rounds of focus groups (April 2016 and November 2016). Individuals were purposively sampled and screened to ensure maximum diversity and eligibility for the study. All participants provided written informed consent and were given a £25 high street voucher as a token of thanks for taking part. Topic guides explored the *Do It London* campaign, HIV testing and condom procurement. Gay and bisexual men also discussed the LHPP outreach and condom distribution. The audio

recordings were transcribed verbatim and coded using NVivo software. Data were analysed according to core themes in the topic guide and underlying themes which emerged from the discussions. Ethical approval was obtained from UCL Research Ethics Committee (ref: 8565/001).

d. Analysis of routine and other HIV testing data

d.1 Genitourinary Medicine Clinic Activity Dataset (GUMCAD) analysis - We examined GUMCAD data retrospectively over a period of 45 months (from January 2013 to September 2016) to examine the number of HIV tests undertaken in London GUM clinics during the first LHPP campaign in 2015 (18 May 2015 to 31 August 2015). Routine surveillance data are available for analysis in the June following the calendar year of data collection. This analysis was conducted at the end of 2016 and routine data for 2016 were therefore not available. An interrupted time series analysis (ITSA) and linear regression analyses were conducted.

d.2 Sentinel Surveillance of Blood Born Virus (SSBBV) analysis - General Practice HIV testing data, estimated to cover nearly half the HIV testing in General Practice in London was extracted and analysed using logistic and linear regression.

d.3 HIV self-sampling analysis - Data were extracted and analysed from the National HIV Self-Sampling Service on website clicks, kit orders, kits returned and reactive specimens coming via the LHPP website per month (November 2015 to December 2016).

d.4 SH:24 - SH:24 is an online STI and HIV self-sampling service. The service was commissioned for residents of Lambeth and Southwark from April 2015 and data on website clicks, kit orders, kits returned and reactive results coming via the LHPP website were analysed (April 2015 to December 2016).

d.5 The Freedoms Shop – BioSURE Self Tests - The BioSURE HIV Self Test is available for purchase online via The Freedoms Shop. Data on the number of website hits and kit orders coming via the LHPP website were analysed (April 2015 to December 2016).

Results (including findings in relation to the objectives):

Participants

Key informant interviews - The sample included 14 provider interviews and 12 interviews with external informants (Local Authority and other). Half the Local Authority informants were targeted and half were systematically selected, half represented inner and half outer London boroughs, and half were DsPH and half Sexual Health Commissioners.

GMSHS 2016 – From the 767 men recruited, a total of 723 were included in the analysis. The majority (79%) were of white ethnicity and their median age was 33 years. Men were born in 39 different countries but most were born in the UK (68%). London residents comprised 87% of participants and all London boroughs were represented. The highest proportion of men (34%) lived in South East London. Participants had high rates of employment (89%) and 74% reported 2 or more years of education after the age of 16 years.

Mayisha 2016 – From the 772 men and women recruited, a total of 604 were included in the analysis (292 women and 312 men). The majority were born in Africa, half in Western Africa (51%), a fifth in Eastern Africa (23%) and 17% in the UK. Men were significantly older than women (median age 35 vs 31 years, $p<0.01$). Most participants were employed (70% of women; 72% of men) and 15% of women and 18% of men born abroad had originally moved to the UK as a refugee/asylum seeker. The largest proportion lived in South East London (42%).

Focus groups - Six focus groups were conducted, three with gay and bisexual men, and three with black African men and women. ***MSM focus groups*** comprised four, six and five men. All identified as gay or bisexual. They were aged 21-61 years, with a median age of 38 years. All but one reported having an HIV test in the past year. ***Black African focus groups*** included a mixed group of nine participants (six women and three men), a group of seven women and a group of five men. All identified as black African—eight were UK-born and the rest were born in Sub-Saharan Africa. They were aged 19-62 years. Six reported having an HIV test in the past year and 13 had not tested in the past year.

Routine and other HIV testing service data - The GUMCAD analysis includes all patients attending London GUM clinics. The SSBBV analysis includes data collected by 6 participating sentinel laboratories in London. Data are included on clicks and orders which came via the LHPP website for the National HIV Self-Sampling Service, SH:24 and the BioSURE HIV Self

Test kit via The Freedoms Shop.

Process evaluation

Key informant interviews - The data are presented below under the key themes:

Favourable comparison with previous HIV prevention programme - The LHPP was favourably compared to its predecessor which lacked synchronisation and appropriate programme monitoring.

Communication - Clear channels of communication and joined up working among providers facilitated programme delivery. There were some issues with flow of information between the programme and the boroughs, and a missed opportunity for provider and external informants to feed their own expertise into programme.

Management of the LHPP – The LHPP programme management was excellent and the role of the programme manager was pivotal. Delivery partners could be held to account via the quarterly monitoring reports.

London HIV Prevention Steering Group (LHPSG) - There was some concern about the lack of scrutiny and support that provided by the LHPSG. The communication between the sub-regional representatives on the LHPSG and the boroughs was poorly defined.

Support for delivery of the LHPP - Some local authority informants felt supported in delivering the LHPP locally but others did not feel encouraged to do so. Not all funders were able to amplify the campaign locally but not all believed this to be their role.

Funding cuts to the programme - The funding available for the LHPP was significantly less than funding prior to 2013. Funding for core, organisational staff to support programme delivery was limited. While resources were stretched, informants generally believed the LHPP was "very streamlined, very effective".

London-wide delivery - There were challenges both in managing the expectations of 33 different London boroughs and in the practicalities of liaising with 33 boroughs. Key informants recognised the benefits of a London-wide programme.

Synchronisation with national campaign - Some key informants considered the limited alignment between the London and national HIV prevention programmes to be a missed opportunity.

Review of programme delivery

LHPP governance structures – The evaluation indicated that the LHPSG is operating as laid out in the MOU, but that the LHPP may benefit from amendment to this structure.

Performance data – The majority of targets for outreach were met in the first year and on target for the second. Targets for condoms and lubricant were not met in the first year – possibly due to closure of distribution venues - and had been adjusted for the second. The data indicated that the programme appeared to be operating as intended.

LHPP campaign – interaction and reaction

GMSHS 2016 - When prompted by images, a quarter of men said they recognised the *Do It London* campaign. Participants living South East London were most likely to recognise the campaign. The most commonly reported place to see the campaign was on London Transport (52%), followed by social media (23%) and inside a venue (21%). Among the 168 men who recognised the campaign, half reported taking action after seeing it. The most commonly reported actions were thinking about and discussing HIV testing, visiting the *Do It London* website, using condoms and visiting a sexual health clinic. Thirty individuals reported having an HIV test (4%).

Mayisha 2016 – When prompted, 40% of women and 47% of men reported seeing the campaign. As with GMSHS 2016, participants who lived in South East London were the most likely to recognise the campaign and London Transport was also the most likely location (52%). This was consistent across the London regions. Among the 230 participants who had seen the campaign, half reported taking some action, the most common being visiting the *Do It London* website, using condoms and discussing the campaign.

Focus groups – The general feeling across focus group participants was that the text-based

nature campaign made it impersonal and that it did not stand out or draw their attention. Black African women, in particular, felt uncomfortable with some of the messaging relating to sexual practices.

Key informant interviews – By comparison, many of the key informant participants spoke very positively about the campaign and commented on the strength of the *Do It London* brand.

LHPP outreach and condoms – interaction and reaction

GMSHS 2016 - Around one in three participants had seen the condom and lubricant packs in venues across London. Of those, 17% had taken a pack and a further 26% had used one.

Focus groups – While some of the MSM participants recognised the *Do It London* condom and lubricant packs, only one man had engaged in any discussion with a prevention coordinator.

Outcomes relating to the LHPP programme

Analysis of routine and other HIV testing data – d.1 The ITSA analysis of GUMCAD data showed significant increases in HIV testing at GUM clinics during the first HIV testing campaign (Summer 2015) for MSM ($p<.001$) and black African men ($p<.001$). However, these increases disappeared in the regression analysis when we adjusted for other campaigns, seasonal and secular trends. Adjusted regression indicated that HIV tests were significantly higher in the post-campaign phase for black African men ($p=.001$) and women ($p=.045$). **d.2** The analysis of SSBBV data found no significant effect on HIV testing at GP surgeries. **d.3** The proportion of London self-sampling returned tests that were directly linked to the LHPP webpage ranged from 0.44% to a peak of 25% in June 2016 during the summer testing campaign. **d.4** A total of 215 visits to the SH:24 website came via the LHPP website between April 2015 and December 2016. **d.5** There were a total of 4,102 visits to The Freedoms Shop website via the LHPP webpage between April 2015 and December 2016. From those hits, 23 orders for BioSURE kits were placed, representing 9% of all orders from London residents over that time.

GMSHS 2016 – Most men (96%) reported ever having an HIV test. More than two thirds said they had tested in the last year and 39% in the last three months. The most popular site for testing remains GUM clinics where 80% of men had their last test, followed by the GP (9%). The proportion of men reporting living with HIV ranged from 11% in North Central London to 7% in North West London. More than half of men (60%) reported condomless anal intercourse in the last 3 months. A quarter of men, reported exclusive serosorting (choosing sexual partners thought to have the same HIV status as themselves). One fifth reported being diagnosed with an STI in the last year and 21% reported chemsex (sexual activity under the influence of recreational drugs) in the last year. While Post Exposure Prophylaxis (PEP) had been used by 15% of men, 6% reported ever using Pre-exposure Prophylaxis (PrEP) and 4% were currently using PrEP.

Mayisha 2016 - The majority of men and women reported having only opposite sex partners (90% and 91%, respectively) and 52% of women and 42% of men had one sexual partner in the past year. Condomless last sex with a partner with a different or unknown HIV status was reported by 11% of men and 9% of women. Men were more likely than women to have ever had an STI (23% vs 15%, $p=0.01$). Most had ever had an HIV test (73% of women; 69% of men), but men were significantly less likely to have tested in the past year (26% vs 35%). The proportion reporting living with HIV was 7% among both men and women. GUM clinics were the most popular testing site (40% of women; 37% of men), followed by GP (27% of women; 35% of men, $p<0.01$). Most participants had no knowledge of PrEP (74% of women; 77% of men). Shops and pharmacies were the most popular place to buy condoms.

Focus groups – MSM mostly tested for HIV at GUM clinics because they provided a calm, safe environment and a one-stop-shop where you could get more than an HIV test. As described above, some black African men and women preferred to test at the GP where it could be incorporated into a regular check-up. Participants in both target groups described an initial barrier to first going for an HIV test and black African men and women, in particular, felt that HIV testing needed to be further normalised. The MSM participants felt that the *Do It London* campaign might serve as a reminder to have an HIV test. They felt that bulk buying condoms from The Freedoms Shop was a cost-effective option whereas some of the black African men did not think they would buy condoms online, particularly the larger packs. Participants in both

target groups acknowledged the benefits of the self-testing BioSURE kits as a more private alternative to HIV testing for some people, but they expressed concerns about the cost (£29.99) and the implications of a positive result without the support of appropriate professionals.

Conclusions:

The findings from our analysis of GUMCAD data showed some effect of the *Do It London* campaign on HIV testing. There were significant increases in HIV testing at GUM clinics during the first HIV testing campaign (Summer 2015) for MSM and black African men. These increases disappeared when we adjusted for other campaigns, seasonal and secular trends, but adjusted analyses also indicated that HIV tests were significantly higher post-campaign among black African men and women.

We found that one quarter of GMSHS 2016 participants recognised the *Do It London* campaign and 40% of Mayisha 2016 participants did so. Our findings on campaign recognition for black Africans were similar to those reported by the independent marketing research commissioned for the LHPP (55% of black African men and 37% of black African women). However, the marketing research found that 46% of MSM recognised the *Do It London* campaign and this is likely to be due to differences in sampling. Participants to both GMSHS 2016 and Mayisha 2016 were most likely to have seen the campaign on London Transport which suggests that further analysis of use of media channels would be beneficial.

About half the participants in GMSHS 2016 and Mayisha 2016 who had seen the campaign had taken some action afterwards. Both samples, particularly MSM, had already extremely high reports of testing for HIV which indicates that the LHPP might be less likely to impact on behaviour change in this area. However, the focus group data suggests that seeing the advertisements may raise awareness and contribute to the process of getting tested.

While focus group participants described the impersonal nature of the *Do It London* campaign, the key informants' more positive response is likely to be influenced by their experience of HIV prevention campaigning and other research that indicates potential issues around stereotyping, stigmatisation and exclusion if photographic or other images of people are used in campaigns.

The findings from the process evaluation indicated that, on the whole, the LHPP was operating as intended and working effectively, even in the face of funding cuts. Overall, key stakeholders recognised the value of a London-wide programme in spite of the associated issues.

8. Plain English Summary (400 words max)
Please provide a summary of the project, including background, findings and conclusions:

HIV in the UK is concentrated in London and the people most at risk are men who have sex with men (MSM) and black African men and women. Recent data from Public Health England has shown that almost half of all HIV diagnoses in the UK are in London. In 2013, the leaders of all 33 London boroughs recognised the need for an HIV prevention programme for Londoners. The London-wide HIV Prevention Programme (LHPP) was established to encourage people to get tested for HIV, use condoms regularly and practice safe sex. The *Do It London* campaign was developed as part the programme.

Researchers at University College London and Public Health England got together to investigate the impact of *Do It London* and find out whether the programme was achieving its goals. They used a range of research methods, including surveys and focus groups with MSM and black Africans in London, interviews with people responsible for delivering and funding the programme, analysis of HIV testing data from sexual health clinics and GP practices in London, and examination of London's HIV self-testing and self-sampling programmes.

The most popular place to get an HIV test is the sexual health clinic, followed by the GP. More than two thirds of MSM said they had been tested for HIV in the past year. Black African men were less likely than black African women to have had an HIV test in the past year (26% vs 35%).

The campaign does not use images of people to avoid stereotyping and stigmatisation but the focus groups found this rather impersonal. However, data from sexual health clinics showed that more black Africans had an HIV test after the *Do It London* testing campaign in 2015 -

	although this effect was not found for MSM. In addition, one quarter of MSM and two fifths of black Africans surveyed recognised the advertising from the campaign. About half those who recognised it said the campaign had influenced their behaviour and the focus groups suggested that *Do It London* may raise awareness and contribute to the process of getting tested for HIV. The LHPP was operating effectively in the face of funding cuts and the value of a programme for London was recognised.
9.	**Keywords** **Please provide up to 8 keywords that relate to the research undertaken in this study:**
	HIV, Public Health, Prevention, Intervention, Evaluation research
10.	**Dissemination – please detail planned or published articles in peer-reviewed journals (including web links):**
	Academic Dissemination • The evaluation team presented a poster to the SPHR Annual Scientific Meeting on 10th March 2016 in Newcastle, describing the methodology for the evaluation • Alison Rodger gave an oral presentation at the SPHR Annual Scientific Meeting on 23rd March 2017 in London, describing some preliminary findings from the evaluation • The report that we have prepared for dissemination among practitioners (described below) will also be available online to academics • We have submitted an abstract to IAS 2017 on the results of GMSHS 2016. We have drafted papers on the results of GMSHS 2016 and Mayisha 2016 which will shortly be submitted to high impact peer-reviewed journals Non-academic dissemination • A policy briefing was presented to the LHPP Steering Group in February 2016 to inform members and key stakeholders of the principal elements of the evaluation, timeline and progress to date • A progress report was presented to the LHPP Steering Group in August 2016 (and attached to our September Evaluation Interim Progress Report) • A final report describing the findings from the evaluation will be disseminated among the DsPH and sexual health commissioners from all 33 boroughs. We plan to hold a dissemination event when the report is finalised and will invite key stakeholders from public health and PHE. • We have held face-to-face meetings and provided regular progress reports to the LHPP Steering Group over the course of the project. This is chaired by Julie Billett who is a Director of Public Health (DPH) and attended by five DsPH who represent the DsPH for the all 33 London boroughs, with one representative from each of the five sub-regional groupings • There is a description of the LHPP evaluation on the UCL website under the relevant research groups (www.ucl.ac.uk/iph/research/sexualhealthandhiv and www.ucl.ac.uk/iph/research/hivbiostatistics) • There is an additional website for the Mayisha 2016 survey: mayisha.wixsite.com/mayisha2016 News and Social Media As the LHPP contains a significant media component, we included mainstream social media to recruit for our focus groups. Multiple channels were used to inform members of the public

about our research. Gay and bisexual men were recruited for our focus groups via Facebook, Twitter, Boyz magazine (print and online versions), Scruff (online dating app), LGBT groups, posters at local universities and flyers distributed by fieldworkers. Black African men and women were recruited via Facebook, Twitter and Trumpet magazine, local universities, clubs and organisations (such as Black Pride, Zimbabwe Association) and flyers distributed by fieldworkers.

11. Public and practitioner involvement
Please provide comment on your experiences, any changes made and lessons drawn:

Public and practitioner involvement has enriched our project. The public has been involved in our research as members of our Community Advisory Group. This included three men who represented the gay and bisexual community and three individuals representing black African communities. We also employed a Community Consultant for the purpose of engaging the black African community to implement the Mayisha survey and support the fieldworkers.

Altogether, over one and a half thousand individuals were recruited for our two cross-sectional surveys from 84 sites across London, over a period of just a few weeks. This was achieved by careful mapping of venues where these two hard-to-reach groups might be engaged in the research and comprehensive training of fieldworkers, with input from our Community Consultant.

In addition to the formal collaboration described above, public health practitioners have contributed valuable data to our research as key informants. We conducted interviews with those responsible for providing the LHPP (outreach, condom procurement and campaign delivery), as well as DsPH and sexual health commissioners from the London boroughs which fund the LHPP.

This project was a collaboration between Drs Fiona Burns and Alison Rodger (co-leads based at UCL), Professor Anne Johnson (SPHR lead investigator, UCL), Drs Anthony Nardone and Paul Crook (PHE), Dr Julie Billett (Director of Public Health, London Boroughs of Camden and Islington) and Paul Steinberg (Senior Strategic Lead for the LHPP, London borough of Lambeth). PHE and the other public health practice partners have been fully engaged throughout the duration of the project. Meetings of the project Core Management Team were held every two weeks, including the two lead investigators, Anthony Nardone and three researchers who were responsible for the various components of the study. One of these was a part-time Senior Scientist based at PHE who led on one of the large-scale cross-sectional surveys (for MSM) and on surveillance data analysis on HIV testing and GUMCAD. The LHPP Evaluation Steering Committee met three times over the course of the project and its membership included Paul Crook, Julie Billet and Paul Steinberg. All collaborators are co-authors on the final report on the LHPP evaluation.

12. What impact has the research already achieved or what might it achieve? (i.e. policy, practice, academic):

The LHPP has been funded for an additional two years (2017 – 2019) and the findings from our evaluation will be used to modify future iterations of the campaign, as well as informing the operation of the programme.

As part of the LHPP evaluation, we conducted two large-scale cross-sectional surveys among the key at-risk for HIV populations in the UK – MSM and black African heterosexual men and women. In addition to quantifying LHPP recognition and response, these surveys will provide valuable epidemiological data that will contribute to the evidence base for HIV prevention more broadly.

This project was funded by the National Institute for Health Research School for Public Health Research (SPHR-UCL-PES-HIV)