



Theory of Change and Logic Model for an Outreach Programme for Gay, Bisexual and Other Men Who Have Sex with Men



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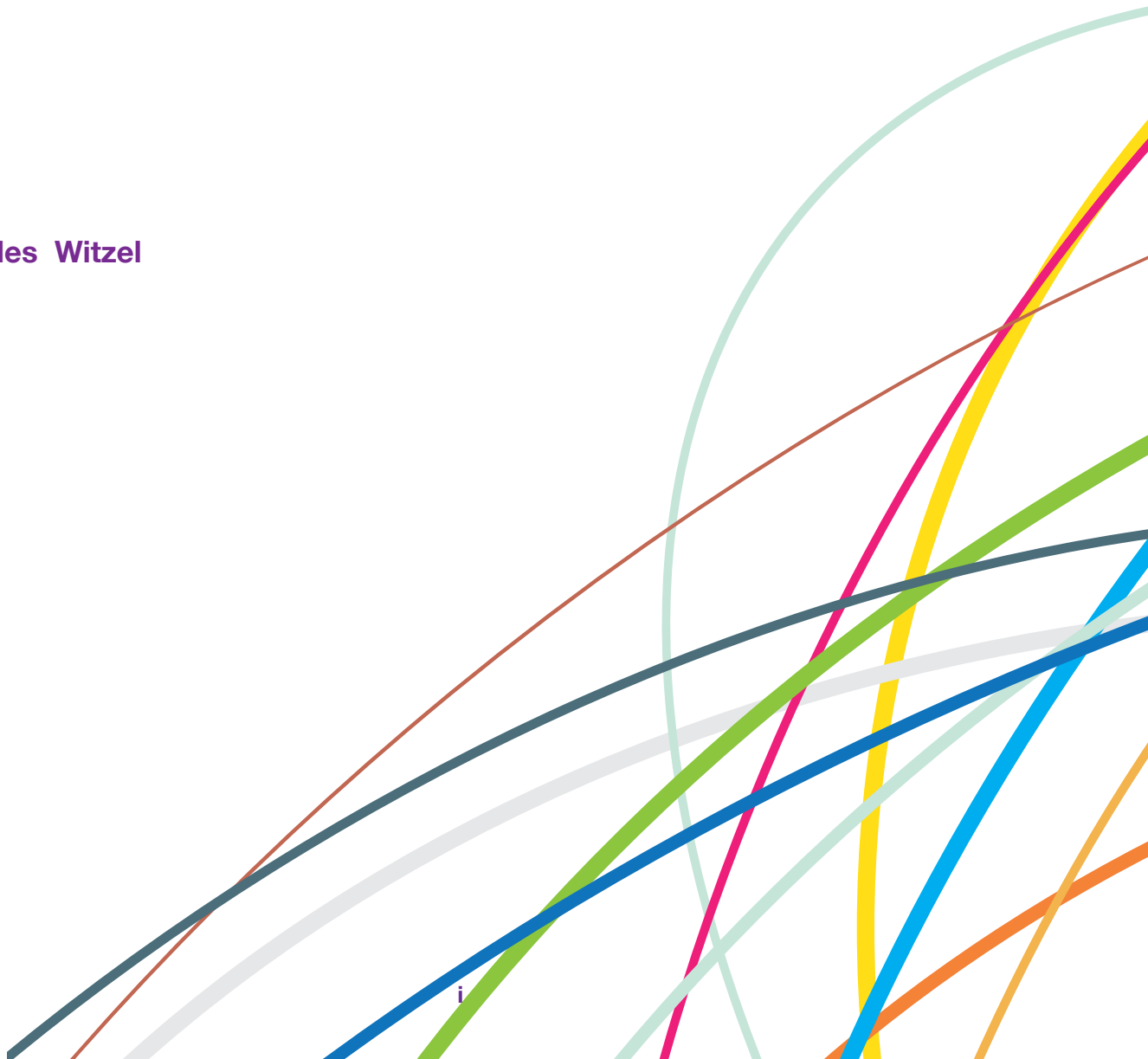
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T. Charles Witzel

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About the HSE Sexual Health & Crisis Pregnancy Programme

The HSE Sexual Health & Crisis Pregnancy Programme (SHCPP) is part of the Strategic Planning and Transformation Function of the HSE and is responsible for implementing the National Sexual Health Strategy (2015–2020) and relevant actions. The aims of the national strategy are to improve sexual health and wellbeing and to reduce negative sexual health outcomes. A key focus of the strategy is the prevention of negative sexual health outcomes and the promotion of equitable, accessible and high-quality sexual health services, which are tailored and targeted to need. The strategy recognises the importance of sexual health intelligence and evidence-based information to guide the development and delivery of sexual health services.

About HIV Ireland

HIV Ireland is a voluntary organisation working to improve conditions for people living with or affected by HIV in Ireland since 1987. From the outset, we have been to the forefront of many innovative initiatives aimed at addressing community health and wellbeing needs relative to HIV and AIDS in Ireland.

The MSM Programme at HIV Ireland is a suite of peer-driven community-level interventions which aim to achieve a reduction in the acquisition of HIV and STIs and an overall improvement of sexual health and wellbeing among gay, bisexual and other men who have sex with men (MSM). We devise sex-positive, judgement-free and harm reduction-based resources, services and supports where the needs of gay, bisexual and MSM have or can be identified. The programme strives to be inclusive of the diverse identities within the community of gay, bisexual and MSM and to incorporate the experiences of both HIV-positive and HIV-negative men. Our peer-led Community Outreach Service aims to connect with gay, bi and MSM where they meet to socialise and/or have sex. Our team of peer sexual health outreach workers offer information, support, resources and referrals relating to HIV, STIs and sexual health & wellbeing needs.

Foreword by Helen Deely

I am really pleased to introduce this logic model and theory of change for the HIV Ireland MSM Outreach Programme.

The MSM outreach programme model was evaluated positively in 2018 and the final report included a number of recommendations to support future service development and improvement. One of the key recommendations proposed in the evaluation report was the development of a logic model to provide a clear and well-defined description of the aims, objectives and scope of the programme, which in turn would inform a programme manual and a monitoring and evaluation framework to support service implementation.

We are really pleased with this report, which uses the COM-B model of behaviour change to frame and define the programme.

The process to develop this logic model involved working closely with a number of key contributors. I would like to thank the report's author, T. Charles Witzel for his professional and collaborative approach and generosity in leading on this process.

I would also like to acknowledge our key stakeholders, who took time and effort to contribute to the development of the logic model: Adam Shanley – HIV Ireland; Diego Caixeta – HIV Ireland and HSE Gay Men's Health Service; Siobhán O'Dea – HSE Gay Men's Health Service; Niall Mulligan - HIV Ireland; Dr Derval Igoe – HSE Health Protection Surveillance Centre and Noel Sutton – Gay Health Network.

I would like to acknowledge Maeve O'Brien from the SHCPP who led out on commissioning and management of the programme evaluation and the development of this logic model. I would also like to thank Caroline Hurley SHCPP for her important contributions to the process and Owen Brennan SHCPP for providing invaluable support throughout the process.



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About the Author

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Before his career in academia, Charlie worked in various capacities in sexual health in the UK and in West Africa developing and delivering health promotion, harm reduction and peer support services in the voluntary sector.

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1. Background

1.1 Context

The HIV epidemic in men who have sex with men (MSM) in the Republic of Ireland remains a public health challenge. After falling to a low of 105 new HIV diagnoses in MSM in 2008, this number has steadily increased from 158 in 2013 to 293 in 2018 (1, 2). Approximately 42% of HIV notifications in Ireland were amongst those who had been previously diagnosed in other countries (2). Alongside this there has also been a sharp increase in bacterial sexually transmitted infections (STIs) in MSM (3). This enduring syndemic may be amenable to a multi-level combination prevention approach, combining biomedical, behavioural, social and legal intervention strategies (4).

The 2017 European Men Who Have Sex with Men Internet Survey (EMIS 2017) found pronounced HIV-prevention need among Irish MSM (5). Condomless anal intercourse (CAI) with non-steady partners within the preceding 12 months was reported by 54%. HIV testing was sub-optimal; overall 23% of respondents had not previously tested for HIV (5). Of the 70.4% whose most recent test was negative, 53% reported their last test as being more than a year previously (5). This indicates that a significant proportion do not test in line with the European Centre for Disease Prevention and Control's (ECDC) testing guidelines, which urge annual or 3-monthly testing depending on risk factors (6).

Reported STI testing in EMIS 2017 was also sub-optimal, with 55% of respondents having tested for an STI in the preceding 12 months, and 23% having tested more than 12 months preceding (5). Importantly 24% had never tested for an STI, indicating significant unmet need (5). In MISI 2015, another recent survey of MSM in Ireland, STI diagnoses were more likely in MSM who were unemployed and those who reported HIV-positive status, indicating a potential health equity issue and a further group with enhanced need pertaining to STI testing (7).

MISI 2015 demonstrated important knowledge gaps surrounding HIV and sexual health generally. These deficits were associated both with not having tested for HIV and with age: knowledge gaps around HIV decreased as age increased. Knowledge of post-exposure prophylaxis (PEP) was also low, especially amongst those under 25 and over 50 (7), although this has increased substantially with 86% of MSM in EMIS 2017 aware of pre-exposure prophylaxis (PrEP) (5). However, many in EMIS had knowledge gaps around PrEP, especially around intermittent dosing, of which only 19% had knowledge (5).

Chemsex, the use of specific drugs (mephedrone, methamphetamine, ketamine and GHB/GBL) in a sexual setting (8), is also an emerging issue in Ireland generally and Dublin specifically. Engagement in chemsex can present unique challenges relating to overdoses (especially from GHB/GBL); increases in blood-borne virus transmission through the sharing of needles or injecting equipment; the potential to increase HIV and STI transmission through CAI with multiple partners as well as general negative impacts on mental health (8–10). In the MISI survey 7% of MSM overall reported use of chemsex drugs in the 12 months preceding the survey, a figure which rose to 9% of MSM in Dublin (7). In EMIS 2017, 25% reported use of stimulant drugs to make sex last longer in the preceding 12 months (5). In MISI 2015, Chemsex was found to be more common among HIV-positive MSM, indicating this sub-group may have pronounced need for harm-reduction advice (7). Another study conducted amongst GMHS attendees found that 27% of the 90% of attendees who agreed to participate in the survey had used chemsex drugs in the preceding 12 months (11). Significant harms were identified by participants, including overdose from GHB/GBL and a dissatisfaction with the impact chemsex drugs were having on their lives (11). Encouragingly, one-third of chemsex-engaged MSM were interested in support around the issue (11).

Pre-exposure prophylaxis (PrEP) has been available since 4th November 2019 through a national programme which provides PrEP for no cost. PrEP eligibility for MSM includes: reported condomless anal sex with at least two partners over the last 6 months; reported or documented acute STI over last 12 months; reported or documented use of PEP in last 12 months; reported engagement in chemsex over last 6 months (12). Although numbers accessing PrEP are unclear, estimates suggest that 11.5% of MSM in Ireland might be eligible for PrEP but that only 1–3% would be likely to present for it should it become available on the health service (13). With appropriate intervention, uptake could be substantial now that it is available without charge, and MSM may have unmet needs around information on how to access.

An additional area of concern is the proportion of MSM whose initial HIV diagnosis occurred abroad who present for HIV testing services as a point of entry into HIV care (1). This has dual implications: firstly, these MSM may experience treatment interruption during their initial time in Ireland, perhaps with negative impacts on their health and the potential to lead to onwards transmissions. Secondly, this is a sub-optimal use of health service resources as this additional testing is not necessary for their entry to care.

Many of the deficits identified in EMIS 2017, MISI 2015 and other research can be addressed through outreach in combination with biomedical approaches to HIV prevention. Indeed, this has been underlined as a recommendation in the National Sexual Health Strategy 2015–2020 (3).

1.2 HIV Ireland MSM Outreach Programme

The Dublin based Gay Men's Health Service Outreach Programme was funded and developed as a response to the ongoing HIV outbreak among MSM. Initial pilot funding was provided by the HSE's Assistant National Director for Public Health and National Medical Officer of Health for a 6-month period. Following this, funding responsibility moved to the HSE Sexual Health and Crisis Pregnancy Programme for the period of the service evaluation. Following evaluation work, the programme moved to HIV Ireland and was renamed HIV Ireland MSM Outreach Programme.

In terms of activities, the HIV Ireland MSM Outreach Programme has four key interventions: online, venue-based and clinical outreach, and designated time for more intensive one-to-one interventions based in Outhouse, a community and resource centre for LGBT people. Advice on sexual health is provided through all channels, and resources (including condoms and lube) are distributed through venue outreach. Further community engagement activities include workshops, conference presentations, speaking engagements in third-level colleges and universities, as well as public engagement through the media and at conferences.

A recent evaluation of the service conducted by Comiskey et al. (2018) found that the pilot of the GMHS outreach was highly effective and efficient, but that additional organisational obstacles required amelioration in order to strengthen the service (14). They recommended that a logic model be developed to support delivery, necessitating the funding of this work. This logic model is intended for use in supporting cisgender MSM in Dublin, although can be adapted for other populations in other regions.

1.3 Behaviour-change model

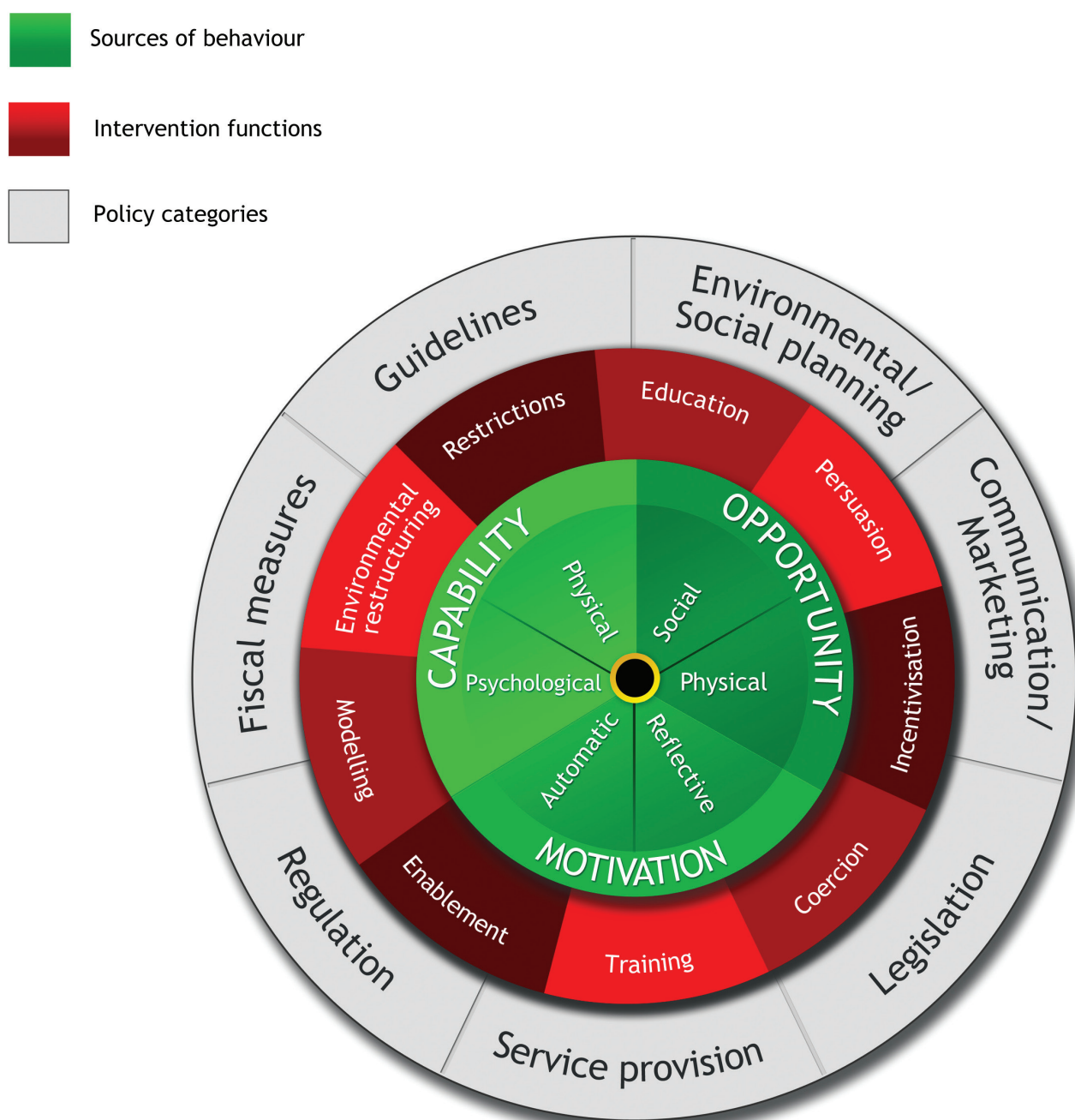
This theory of change uses the COM-B model of behaviour change as an underpinning principle.

The COM-B model was developed by Michie and colleagues as a novel way of describing an array of issues to examine when seeking to improve the design of behaviour-change interventions (15). It was developed under the premise that pre-existing models did not fully encompass the range of possible domains which could influence outcomes. In developing COM-B, Michie and colleagues consolidated theorised behaviour-change constructs, interventions and policy approaches from 19 frameworks to create a structured system with inter-related levels (15).

At its most basic, the COM-B model asserts that capability, opportunity and motivation interact with each other to shape behaviour, which also interacts with those three factors (see Figure 1) (15). Each of these is divided further into additional domains to more comprehensively represent the ways in which behaviour is influenced. According to Michie et al. (15):

Capability is defined as the individual's psychological and physical capacity to engage in the activity concerned. It includes having the necessary knowledge and skills. Motivation is defined as all those brain processes that energise and direct behaviour, not just goals and conscious decision-making. It includes habitual processes, emotional responding, as well as analytical decision-making. Opportunity is defined as all the factors that lie outside the individual that make the behaviour possible or prompt it (Michie et al., 2011).

Figure 1: COM-B model of behaviour change (Michie et al., 2011)



COM-B also articulates a series of intervention functions which can be used in targeting alterations in these domains, facilitating behaviour change. These are presented in the middle ring of Figure 1, which presents the range of intervention functions which may be useful in targeting specific determinants of behaviour. The outer ring, policy categories, presents the range of policy and legislative responses available. Table 1 defines intervention functions (with examples).

Table 1: COM-B interventions (Michie et al., 2011)

Interventions	Definition	Examples
Education	Increasing knowledge or understanding	Providing information to promote healthy eating
Persuasion	Using communication to induce positive or negative feelings or stimulate action	Using imagery to motivate increases in physical activity
Incentivisation	Creating expectation or reward	Using prize draws to induce attempts to stop smoking
Coercion	Creating expectation of punishment or cost	Raising the financial cost to reduce excessive alcohol consumption
Training	Imparting skills	Advanced driver training to increase safe driving
Restriction	Using rules to reduce the opportunity to engage in the target behaviour (or to increase the target behaviour by reducing the opportunity to engage in competing behaviours)	Prohibiting sales of solvents to people under 18 to reduce use for intoxication
Environmental restructuring	Changing the physical or social context	Providing on-screen prompts for GPs to ask about smoking behaviour
Modelling	Providing an example for people to aspire to or imitate	Using TV drama scenes involving safe sex practices to increase condom use
Enablement	Increasing means/reducing barriers to increase capability or opportunity ¹	Behavioural support for smoking cessation, medication for cognitive deficits, surgery to reduce obesity, prostheses to promote physical activity

Table 2 articulates the interventions' relationship to COM-B domains.

Table 2: Relationships between COM-B domains and interventions (Michie et al., 2011)

Model of behaviour: sources	Education	Persuasion	Incentivisation	Coercion	Training	Restriction	Environmental restructuring	Modelling	Enablement
C-Ph					✓				✓
C-Ps	✓				✓				✓
M-Re	✓	✓	✓	✓					
M-Au		✓	✓	✓			✓	✓	✓
O-Ph						✓	✓		✓
O-So						✓	✓		✓

*C-Ph: Capability (Physical); C-Ps: Capability (Psychological); M-Re: Motivation (Reflective); M-Au: Motivation (Automatic); O-Ph: Opportunity (Physical); O-So: Opportunity Social.

2. Methods

The development of this theory of change and logic model has followed a four-step process, beginning with programme familiarisation and ending with analysis. The most important component was a one-day workshop with relevant stakeholders.

2.1 Programme familiarisation

The first step involved familiarisation with the programme and its constituent parts. All relevant and accessible service documentation was reviewed, including the most recent evaluation report. Notes on these were produced, summarising the available evidence and developing an overview of programme function. This step clarified key domains of enquiry for the generation of new data to support the theory.

In order to facilitate improved understanding of the structures and context of service delivery, an organigram (see Figure 2) was developed in consultation with the HSE Sexual Health and Crisis Pregnancy and Sexual Health Programme.

Figure 2: Organigram



2.2 Stakeholder engagement

Interviews were conducted with key stakeholders and those responsible for service delivery. These interviews were both face-to-face and remote depending on availability. This enabled the development of insights into the expectations of the programme held by various stakeholders, and the identification of common understandings and where these understandings diverged across groups. Notes were taken during these interviews.

2.3 Participatory workshop

The third step was a participatory workshop with key individuals responsible for service delivery and other relevant stakeholders. In line with the approach outlined by the Aspen Institute¹ (Anderson, 2009), this day-long event:

- Identified the long-term outcome(s)
- Developed understandings of pathways of change
- Defined interventions
- Mapped likely paths to operationalising outcomes
- Articulated assumptions about interconnectedness
- Identified required inputs.

This was achieved through a series of exercises building consensus regarding the interventions being delivered; the programme and its boundaries and outcomes; and the hypothesised mechanisms of change and their interrelatedness. Context was also explored in-depth through documenting assets and deficits which may impact on service delivery. Inputs, ideal structures and management were discussed in order to identify any changes in organisational structures which may be needed to support delivery. Data were captured through note taking, flip charts, and photographing the outcomes of the activities.

2.4 Analysis

Service documents, interview notes and workshop notes were collated into word files covering specific service elements including management and programme structures; inputs; online outreach; venue-based outreach; clinic presence and Outhouse in-depth peer support. The pathways to change were developed in the participatory workshop and required no further analysis beyond clarification, although data from each intervention document were compared for comprehensiveness.

¹ The Aspen Institute is a nonpartisan think tank for values-based leadership and the exchange of ideas (see aspeninstitute.org).

3. Theory of change

This section presents the theory of change developed in the participatory workshop and through further analysis. It begins by providing implementation context, describing assets and deficits for MSM in Dublin, before moving on to describe aims, outcomes and the relationship between them. The pathway mapping diagram which underpins relationships between these components can be found in Appendix 1.

3.1 Assets and deficits for MSM

In order to design relevant interventions and theorise their behavioural mechanisms, it is important to have an understanding of the strengths and vulnerabilities of a population group or community. Multiple relevant assets and deficits were identified in the workshop. These ranged from interpersonal factors to features of marginalisation.

Assets which were considered to provide a supportive environment for interventions include: kinship and intergenerational friendship; a strong and engaged community, especially following the equal marriage referendum; knowledge around the importance of HIV testing; willingness to engage, participate and have challenging conversations; strength within the migrant community and a feeling of empathy due to a shared history of oppression.

Deficits which were amenable to change or which required consideration in planning included: challenges relating to peri-urban MSM; issues relating to chemsex; criminalisation of clients of sex workers; stigma surrounding homosexuality; homelessness; vulnerability to HIV/STIs; knowledge deficits; challenges and isolation associated with the direct provision system for asylum seeker MSM and health inequalities faced by subgroups of MSM (e.g. travellers and migrants).

3.2 Programme aim

During the workshop, two long-term aims for the outreach programme were developed. The achievement of these constitutes success over the lifetime of the project. These aims have since been combined into one meta-aim to emphasise that they are interconnected and interdependent. This aim recognises that the outreach programme as a whole cannot be considered in isolation; rather it serves to complement other interventions beyond the scope of the service, including biomedical and psychosocial initiatives. This also underlines that outreach has a function in improving wellbeing more broadly, rather than viewing sexual health in a narrow epidemiological sense. The aim is therefore to:

- Contribute to a reduction in HIV/STI transmission among diverse communities of MSM while improving their resilience, sexual health and wellbeing.

Six objectives support this aim; these were designed during the intervention manual-development process and represent the activities which must be undertaken to achieve the service aim and outcomes.

Objectives

1. Increase knowledge and awareness of HIV and STIs and promote the use of risk reduction, testing services, new prevention technologies (PrEP, PEP, U=U), and condoms and lube.

2. Challenge and reduce stigmas amongst MSM including homophobia, transphobia, racism, sex work, and STI- and HIV-related stigma.
3. Engage distinct groups with pronounced needs including migrants (especially Latin American MSM), men with low educational attainment and sex workers.
4. Reduce harms related to chemsex by providing peer support, resources and appropriate referrals.
5. Respond to emerging trends (such as outbreaks) by rapidly engaging with new priorities and disseminating relevant information.
6. Provide appropriate peer support and onwards referrals to increase personal resilience.

3.3 Intermediate outcomes

For the programme aim of the service to be reached, several intermediate outcomes must first be achieved. Should all of these intermediate outcomes be met, it follows that the programme aim should also be met. Reflecting the programme aim of the service, these intermediate outcomes are a mix of clinical/epidemiological and holistic wellbeing outcomes:

1. Greater HIV/STI testing uptake and frequency.
2. Increased uptake of preventative options (vaccinations, PrEP, PEP, TasP, condoms and harm reduction).
3. Improvements in self-efficacy relating to confidence, self-esteem and autonomy.
4. Increases in social inclusion.

The first two are necessary to achieve the first part of the aim, and recognise that the services offered must be maintained (and in some cases developed further) in order for this to be met. The third and fourth intermediate outcomes are the necessary preconditions for the second component of the programme aim, underlining the importance of self-efficacy and social inclusion to resilience and wellbeing.

3.4 Short-term outcomes

Eight short-term outcomes were identified which are necessary in achieving the intermediate outcomes, and thus the programme aim. These short-term outcomes can be understood to be direct results of the outreach interventions and indeed are the focus of the day-to-day activities of the outreach service. Again, reflecting the programme aim, these are broadly divided into focused epidemiological outcomes and more holistic wellbeing outcomes.

The short-term outcomes are therefore:

1. Increased awareness of HIV/STI testing options
2. Reduced HIV/STI testing barriers (fear, lack of risk perception)
3. Increased awareness, knowledge and motivation to use preventative options and to practice harm reduction
4. Rapid increases in awareness of outbreaks
5. Improvements in condom/lube and harm-reduction supply access
6. Greater capacity to manage life-changing events
7. Improved knowledge and service access for marginalised groups
8. Reductions in stigma.

3.5 Interventions

In this section the interventions are discussed in turn, providing a brief description of the approach taken, then discussing the behaviour-change pathways and the interventions' relationships with outcomes. All interventions have short-term outcomes 7 and 8 in common: improved knowledge and service access for marginalised groups and reductions in stigma. Availability of all interventions in Spanish and Portuguese and the availability of Man2Man materials in a range of languages further facilitates the achievement of short-term outcome 7 by engaging with migrant groups, including those who sell sex. In all interactions outreach workers focus on combatting stigma.

3.5.1 Online outreach

Online outreach has been the primary focus of the programme, providing MSM with relevant information and support across a range of online platforms. The outreach workers have a presence on Grindr, Scruff and Planet Romeo. Each profile identifies itself as HIV Ireland run, offering support and advice. A passive approach has been employed on Scruff and Grindr, relying on individuals to contact the team with their questions and support needs surrounding sexual health. Relationship building has been an integral part of the successful delivery of this intervention and has facilitated a continuous presence through the reduction in frequency of the outreach team having profiles de-activated for violating terms of use. Hostility from companies running apps is a key barrier in delivering this type of intervention and maintaining these relationships is crucial.

Support on these apps is entirely service-user led: content, questions and length of engagement is responsive to service-user need and the issues individuals present with. Outreach workers then use these text-based engagements as an opportunity to achieve the aims of the service. In contrast to this approach, Planet Romeo outreach has been used largely to support sex workers, which has required a more active approach to engagement, with a worker proactively contacting individuals who identify themselves as selling sex. The success of this outreach also relies on word of mouth and a trust within the community that has taken time to build. Thus, although useful for a range of MSM, this intervention can be understood as especially useful for reaching peri-urban MSM with issues surrounding disclosure and for engaging sex workers with health services. This is also a useful intervention for MSM engaged in chemsex who may have disclosure concerns around their drug use, or simple questions regarding harm-reduction advice and/or techniques. This intervention can also be useful for signposting and referring HIV-positive migrant MSM who are aware of their infections but not yet in care in Ireland into services.

Online outreach itself works to provide knowledge and skills for MSM. The intervention alters motivation (reflective and automatic) by providing what is termed 'training' in the COM-B model: essentially to help develop skills in service access. It also employs persuasion to alter social opportunity, providing a supportive environment for the uptake of new prevention technologies and HIV testing. This persuasion also serves to reduce service and testing barriers related to fear and stigma.

The short-term outcomes associated with online outreach include: 1) increased awareness of testing options; 2) reduced testing barriers (e.g. fear, lack of risk perception) and 3) increased awareness, knowledge and motivation to use preventative options (vaccinations, PrEP, PEP, TasP, condoms and harm-reduction).

3.5.2 Clinical presence

Outreach workers have provided additional support staff in sexual health clinics to help address non-clinical issues beyond the role of the doctors or nurses. This outreach also supports the clinic staff generally when they are facing capacity issues and complex patients. Outreach workers are able to use this as an opportunity to bring in individuals identified through online outreach or Outhouse in-depth peer support and support them through undergoing HIV and STI testing, acting as a chaperone through clinical services. Alongside this, outreach workers are also able to provide more intensive behaviour-change interventions to patients in clinical settings, beyond what the clinical staff are able to do because of constraints related to time, capacity and skills. Given the high prevalence of previous chemsex engagement identified in prior research, this intervention presents an excellent opportunity to engage in more in-depth behaviour-change work with those looking for support. This intervention is additionally useful for linking MSM who sell sex into clinical services, and supporting individuals with additional issues regarding stigma and disclosure as well as MSM accessing the clinical service who have behaviour-change needs.

This clinic-based outreach works to impart knowledge and offer support around issues related to sexual health and HIV; to provide an environment in which MSM who face additional barriers are able to access the clinical service; and to provide material support including condoms, lube and safe injection

packs for chemsex. Capability (psychological and physical) is increased by providing education and access to physical resources (enablement). Motivation (reflective) is addressed by providing education and persuasion to alter sub-optimal health behaviours. Motivation (automatic) is improved by altering the social context of the clinical service through the presence of peer outreach workers, an approach termed 'environmental restructuring' in COM-B.

The short-term outcomes associated with the clinical presence outreach are: 2) reduced HIV/STI testing barriers; 3) increased awareness, knowledge and motivation to use preventative options and 5) improvements in condom, lube and harm-reduction supply access.

3.5.3 Venue-based outreach

Traditionally venue-based outreach has been the mainstay of HIV-prevention initiatives for MSM. While it remains an important component, changes in the way in which MSM socialise have somewhat lessened the centrality of this approach, shifting the focus of this work to very brief talking interventions which provide information in a focused way and the provision of safer-sex resources and supplies through dispensers. Venue-based outreach occurs in bars, clubs, sex on premise venues (SOPVs) and public sex environments (PSEs). Venue-based outreach in this programme is most appropriate for providing information about relevant outbreaks which may be occurring in the target population as well as brief information about testing opportunities and other existing services including the Outhouse interventions. The provision of safer-sex supplies (condoms and lube) is facilitated by the provision of dispensers in key venues. This intervention is a general, non-targeted endeavour and is conceptualised to benefit large sections of the community through increasing access to resources and relevant information.

In order to improve health-seeking behaviour through the imparting of knowledge of outbreaks, this intervention provides education and persuasion, thus enhancing reflective and automatic motivation. The presence of condom and lube dispensers improve motivation (automatic) and opportunity (physical) to adopt or maintain protective behaviours through environmental restructuring. The provision of resources (condoms and lube) is a form of enablement, which works to increase capability (physical) and opportunity (physical).

The short-term outcomes associated with venue-based outreach are: 1) increased awareness of HIV/STI testing; 3) increased awareness, knowledge and use of preventative options; 4) rapid increases in knowledge of outbreaks; and 5) improvements in condom and lube access.

3.5.4 Outhouse in-depth peer support

Specific time is allotted each week for face-to-face sessions for individuals requiring additional support beyond what is provided through other interventions. As such, this intervention primarily provides a higher level of support, specifically for those with the greatest need and the most pronounced barriers around accessing services. These sessions are reactive to service-user needs; the length and focus is determined by the presenting issues but is usually around 45 minutes. The outreach workers are trained in motivational interviewing, which may be used to better support these individuals. Motivational interview training could be considered for new outreach workers also. Candidates for this additional support can be identified primarily through clinical pathways and online outreach. Venue-based outreach may also occasionally be useful in reaching this group. Those with needs beyond the scope of this intervention can also be referred to other appropriate services, perhaps with additional support from the outreach workers. This dedicated time has also become a useful opportunity to engage MSM who sell sex, who use it as an opportunity to pick up safer-sex supplies, as well as to provide support to MSM engaged in chemsex. Generally speaking, people who sell sex, MSM with significant issues surrounding disclosure and/or rurality, and MSM from minority groups (e.g. travellers, migrants, refugees) are especially likely to benefit from this intervention.

This intervention works to enhance individuals' health-seeking behaviour, self-care practices and resilience. It does so by working through all the COM-B domains, depending on the end-user's need. As such it is flexible and client focused. The intervention functions of interest include enablement (through the provision of resources); education (through advice and the imparting of knowledge); persuasion (communicating positive or negative feelings to encourage action); training (imparting specific skills) and modelling (providing an example for individuals).

Any of the short-term outcomes can be associated with this intervention depending on the presenting issues of the service user and content of the interaction.

3.6 Inputs

This theory of change requires inputs and resources to achieve short-term and intermediate outcomes as well as the ultimate aim. These inputs and resources can be roughly divided into organisational inputs, staff inputs and resources.

3.6.1 Organisational inputs

Stable funding is required to ensure that service continuity can be maintained. This is of key importance for maintaining the profile of the service, and for keeping marginalised groups engaged with the interventions. This will also support staff in continuing strategic service development to best achieve the outcomes described. Management structures must also be maintained, including buy-in from key stakeholders and relevant actors in the sector. Policy inputs were previously provided by the outbreak response group and the Gay Health Network (GHN). In the future this will move to the yet-to-be-formed MSM Sexual Health Committee under the SHCPP while also maintaining input from the GHN.

3.6.2 Staff inputs

Staff time and skills are the most important component of delivering the HIV Ireland MSM outreach service effectively. Indeed, without effective, well-supported staff, none of the outcomes will be achieved.

In order to support staff in delivering an effective service, salaried contracts which include annual leave and sick pay are vital. This will support staff and help combat burnout. Basic, standardised levels of training enable staff to work effectively. Clinical and outreach supervision provides a space for staff members to discuss difficult cases in a supportive environment, helping to combat burnout. It is also crucial to maintain a range of language skills on the programme in order to engage with migrant MSM.

3.6.3 Resources

Appropriate technological resources are a requirement of service delivery. These include mobile phones and credit for use in outreach, and also organisational email addresses for client contact and referrals. Material resources such as condoms, lube and harm-reduction packs are central in providing materials to support behaviour change (or maintenance). Written resources such as Man2Man leaflets (available in multiple languages) are a key distribution item.

4. Logic model

The logic model (Figure 3 below) presents a visual depiction of the described theory of change. It begins by clarifying what inputs are required for service delivery, before listing the interventions. Short-term, intermediate and long-term outcomes are then described. Relevant assumptions and external factors which may impact on success are also defined in this model.

Figure 3: Logic model

Inputs	Interventions	Short-term outcomes	Intermediate outcomes	Long-term outcomes
Stable funding Management structures Contracted staff time (salary, annual leave and sick time provision) Basic, standardised level of training (reflected in job descriptions) Clinical supervision Learning about best practice Material resources (condoms, lube, harm-reduction packs) Technological resources (phones, email addresses) Information resources (Man2Man leaflets etc) Policy (outbreak response group, GHN)	Online outreach Clinical presence Venue-based outreach (bars, clubs, SOPVs & PSEs) Outhouse in-depth peer support	Increased awareness of HIV/STI testing options Reduced testing barriers (fear, lack of risk perception) Increased awareness, knowledge and motivation to use preventative options and practice harm reduction Rapid increases in knowledge of outbreaks Improvements in condom/lube & harm-reduction supply access Greater capacity to manage life-changing events Improved knowledge and service access for marginalised groups Reductions in stigma	Greater testing uptake and frequency Increased uptake of preventative options (vaccinations, PrEP, PEP, TasP, condoms & harm reduction) Improvements in self-efficacy relating to confidence, self-esteem and autonomy Increases in social inclusion	Contribute to a reduction in HIV/STI transmission among diverse communities of MSM while improving their resilience, sexual health and wellbeing
Assumptions: clinic access remains consistent or expands, venues remain supportive, MSM community remains amenable to engagement.		External factors: supportive political climate continues, resources not diverted solely to biomedical prevention, continued community buy-in to programme.		

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Appendix 1: Pathway mapping

