



An Evaluation of the Gay Men's Health Service Outreach Programme



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About the Organisations

HSE Sexual Health & Crisis Pregnancy Programme

The HSE Sexual Health & Crisis Pregnancy Programme (SHCPP) is part of the Health & Wellbeing Division 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 to develop prevention approaches for groups who are at an increased risk of experiencing negative sexual health outcomes. Targeted education and outreach and increased access to condoms are among these prevention strategies. The strategy also recognises the importance of evidence informed planning and practice and sets out the need to support programme evaluations to improve delivery and development of sexual health services.

HSE Gay Men's Health Service

The HSE Gay Men's Health Service (GMHS) was established in Dublin in 1993. It is the only statutory public health service in Ireland that is specifically designed for gay men, bisexual men and other men who have sex with men (MSM). The GMHS is centrally involved in strategies to reduce the incidence of Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STIs) in the MSM community and beyond. The GMHS has a vital role in promoting sexual health and in delivering a clinical sexual health service to MSM.

Gay Health Network

The Gay Health Network (GHN) was established in 1994. The GHN is a network of organisations and individuals in Ireland that serve as an expert network for the promotion of HIV prevention and of sexual health and wellbeing among gay men, bisexual men and MSM. The main objectives of this peer-led organisation are to promote HIV prevention and sexual health awareness among MSM, both nationally and in specific communities; to address and challenge HIV-related stigma and discrimination; and to commission key research in the area of HIV and sexual health among MSM, including men living with HIV.

Foreword from Helen Deely, HSE Sexual Health & Crisis Pregnancy Programme Lead

I am really pleased to introduce this evaluation of the pilot outreach programme of the HSE's Gay Men's Health Service (GMHS).

The outreach programme was established in 2016 by the GMHS in partnership with the Gay Health Network (GHN) in response to an increase in STIs and HIV among men who have sex with men (MSM). Funding to establish the pilot programme was provided by the HSE's Assistant National Director for Public Health and National Medical Officer of Health, Dr Kevin Kelleher as part of the response.

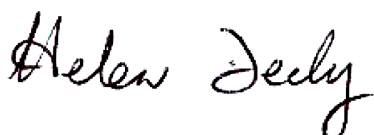
This evaluation identifies how the outreach programme has been successful in meeting its objectives. It has done so, for example, by linking up (both online and face-to-face) with MSM at higher risk, encouraging them to attend testing services and providing advice and support on a range of health-related issues. The outreach programme has also played an important role in ensuring that free condoms and lubricant are available in the main venues where MSM meet and socialise in Dublin. The report identifies a number of ways in which the outreach programme can be supported by way of improved governance and administrative support.

The HSE Sexual Health & Crisis Pregnancy Programme is responsible for the implementation of the National Sexual Health Strategy 2015–2020. Education and support initiatives such as this outreach programme are vital to achieving the strategy's objectives. I would like to acknowledge the important contribution that the hard work and commitment of the GMHS outreach programme team — Siobhán O'Dea, Noel Sutton, Adam Shanley and Diego Rodrigues Caixeta — has made to the establishment and success of the pilot outreach programme.

I would like to thank the research team led by Professor Catherine Comiskey in the School of Nursing and Midwifery, Trinity College Dublin, for documenting and evaluating the work of the programme, and for providing useful recommendations on how to best support the work of the outreach programme into the future. The research team includes Karen Galligan, Dr Prakashini Banka, Dave McDonagh and Síoban O'Brien Green.

I wish to express my gratitude to the project's Steering Committee for their expert support and advice throughout the process. The members of the Steering Committee are Siobhán O'Dea, GMHS; Noel Sutton, GHN; Dr. Derval Igoe, Health Protection Surveillance Centre; and T. Charles Witzel, Sigma Research, London School of Hygiene and Tropical Medicine.

I would also like to thank Maeve O'Brien, Research Manager with the SHCPP, for leading in the commissioning and management of this project — and Owen Brennan, Research Assistant, for providing invaluable support throughout the process.



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For this reason, the research team would like to thank the following:

- The HSE's Assistant National Director for Public Health and national Medical Officer of Health, Dr Kevin Kelleher for providing funding for the pilot outreach programme
- The HSE Sexual Health & Crisis Pregnancy Programme for providing funding and oversight for this evaluation
- The Steering Committee, which facilitated and monitored the evaluation of the outreach programme:
 - Dr Derval Igoe, HSE Health Protection and Surveillance Centre
 - Ms Siobhán O'Dea, HSE Gay Men's Health Service
 - Mr Noel Sutton, Gay Health Network
 - Mr T. Charles Witzel, Sigma Research, London School of Hygiene and Tropical Medicine
 - Ms Maeve O'Brien, HSE Sexual Health and Crisis Pregnancy Programme
- The dedicated outreach workers and staff who run the outreach programme
- Finally, we would also like to express our sincere gratitude to the individuals who agreed to take part in the evaluation process.

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Executive Summary

The Gay Men's Health Service (GMHS) outreach programme was established to address increases in the incidence of Human Immunodeficiency Virus (HIV) and sexually transmitted infections (STIs) among men who have sex with men (MSM). The GMHS is the only MSM-specific sexual health service in Ireland. The National Sexual Health Strategy 2015–2020 clearly identifies gay men, bisexual men and MSM as having an increased risk of poorer sexual health outcomes and of contracting STIs and HIV. Research has demonstrated the effectiveness of peer-led HIV-prevention interventions that target MSM.

The objectives of the GMHS outreach programme are to:

1. Promote the use of condoms and lube as an effective form of protection from the spread of STIs and HIV, and make condoms and lube available;
2. Increase knowledge and awareness about the signs and symptoms of STIs and HIV;
3. Increase awareness about and encourage use of local resources (STI and HIV testing services, information points etc.) for STI and HIV prevention, screening, testing and treatment;
4. Explore and discuss sexual risk assessment and risk reduction, including HIV prevention technologies (e.g. PEP, PrEP, undetectable viral load) and STI and HIV testing);
5. Refer to the Man2Man.ie website for information and/or location-based resources and services that are regionally specific and promote Man2Man.ie and other affiliated related campaigns and materials;
6. Reduce HIV-related stigma;
7. Encourage and support sexual consent and sexual respect, particularly in encounters initiated online;
8. Connect with subpopulations, migrant populations — especially Latin American MSM, and sex workers — in order to promote sex-positive encounters and encourage engagement with services.

Aims and Objectives of the Evaluation

The overarching aim was to provide an evaluation of the pilot outreach programme developed by the GMHS in partnership with the Gay Health Network (GHN) and funded by the Assistant National Director for Public Health and National Medical Officer of Health in the HSE. The HSE Sexual Health & Crisis Pregnancy Programme (SHCPP), which has overall responsibility for implementation of the National Sexual Health Strategy 2015–2020, provided funding and oversight for this evaluation.

The specific objectives of the evaluation were to:

1. Assess the ways that the eight objectives of the outreach programme were achieved.
2. Assess the ways in which the outreach programme was received by the target audience and other key stakeholders.
3. Assess the experience of the outreach programme in delivering the programme.
4. Identify critical success factors and key barriers in relation to implementation.
5. Make recommendations for improvements to current operational processes with a focus on resources and reporting data.

Design and Methods

A process and impact evaluation was designed within the context of an implementation-science framework. While the initial intention was to carry out a process and impact evaluation, it became apparent during the evaluation that it was very difficult to access service users, who were the intended key data sources for assessing the programme's impact. This difficulty, which is discussed in section 2.8, meant that the intended evaluation design (which focused on the use of service-user feedback to assess impact) could not be implemented. For this reason, the initial evaluative project evolved into a detailed summative and process evaluation.

The implementation-science framework enabled the objective identification of barriers and enablers to the delivery of the programme. A concurrent, multi-method study design was developed. The evaluation methods included:

- A quantitative analysis of service delivery data (online-outreach and venue-based data), which facilitated the evaluation of objectives one to seven of the GMHS outreach programme, and of how the programme was received by the target audience;
- A qualitative analysis of non-participant structured observation on-site, which provided data (information on how the programme was delivered and operational procedures) for objectives one, two, three, four and eight of the service;
- A qualitative documentary analysis of existing documentary evidence within the service, which provided further data on operational procedures, and on how the programme was delivered;
- A qualitative analysis of semi-structured interviews with key stakeholders, which provided further information that allowed the identification of the critical success factors and barriers from the perspective of the stakeholders.

Key Findings

The evaluation findings demonstrated that the outreach programme was delivering an efficient and effective service that met its eight objectives and operated in line with its stated code of governance. In terms of programme objectives one to eight, the summative evaluation found that the main topics addressed in the online outreach sessions were HIV, sexual behaviour and sexuality, STIs other than HIV, treatment and mental health, substance use and general information. The overarching topics that were most frequently discussed were STIs other than HIV and related treatment/counselling, followed by HIV and general information. Within topics discussed, HIV Pre-exposure prophylaxis (PrEP) and Post-exposure prophylaxis (PEP) were the most frequent individual subjects advised on. It was also found that the service was very efficient and provided on average twenty online individual interactions per week, or approximately one per hour.

In terms of enablers of implementation and the process evaluation, the service was greatly enabled by having nationally led, multi-sectoral collaboration and buy-in; skills in leadership to nurture relationship-building with external venues and stakeholders; careful staff selection with skill sets to respond to target group needs and a unanimous belief in the value of monitoring and evaluation. The key challenges to service development related to having to operate within the confines of ongoing uncertainty regarding (1) financial resourcing, with responsibility for the sustainability of the service unclear, and (2) operationalising of the resources. Furthermore, while leadership and governance were excellent in the early stages, as the delivery developed and progressed, a strong need emerged for improved administrative, management and governance structures and for improved clarity regarding the ownership and documentation of the service within the overall healthcare system.

Conclusions and Recommendations

In conclusion, the findings from the evaluation demonstrated that while a highly effective and efficient pilot outreach programme has been put in place, additional measures are needed to address risks or obstacles to sustainability and expansion. It was found that, to ensure the ongoing quality of the service experienced by both service users and staff, additional planning and resourcing in terms of governance, administrative structures, staffing and systems will be required.

Given the detailed findings set out in this report, considered alongside the international literature on best practice, the following key actions were recommended:

1. A logic model for the outreach programme should be developed in order to provide a clear and well-defined description of the aims, objectives and scope of the programme.
2. Existing structures and processes should be clearly documented. Using the logic model, a living manual for the programme is needed in order to ensure that the programme is measurable and accountable and can be both sustained and replicated with fidelity.

3. Given that the pilot service has moved from the initial start-up stage to the later implementation stage, which means that it is an established and running service, it is essential that clear and appropriate governance of such a service is established so that these governance structures can be replicated as necessary in another geographical setting.
4. The administrative, management and resourcing structures of the programme should be clarified and documented in order to enable these structures to be sustained beyond the pilot phase and to be replicated in additional settings.
5. The timing (working hours) of the outreach service delivery should be reviewed to ensure it remains fit for purpose. This may also necessitate a review of the way in which the outreach staff contracts are administered.
6. The use of the current social media platform for the online delivery of the programme should be reviewed in order to ensure that it remains fit for purpose outside of urban populations and among MSM who may not be active on MSM websites.
7. If the pilot outreach programme is to be mainstreamed, it is recommended that a structure is put in place to measure follow-up presentations from the online programme to the clinic or other setting for STI and HIV testing, treatment and advice. This will require the filling of the original outreach-service-manager post to ensure quality, integrity and fidelity to the programme model, administrative structures and governance and legal requirements. It is recommended that further details be obtained or that a collaboration is initiated with key personnel involved in the design and delivery of the Belfast model of service to ascertain how they developed their recording systems. Consideration should also be given to the establishment of a service users' forum to enable the ongoing fitness of purpose and assessment (as opposed to measurement) of impact from the perspective of the person using the services.
8. If the service is to be rolled out to other locations, sufficient time must be allocated to allow for venue-based-stakeholder buy-in and the provision of supplies. This will enable the necessary "invisible scaffolding" to be put in place to support the outreach programme at sites and venues.
9. Finally, it is recommended that a protocol should be established for accurate database management and data storage. Should the service be duplicated within other settings, a common, secure database structure and database management system would be required.

Further details on these actions and how they relate to the objectives of the evaluation are provided within the main report. Recommendations relating specifically to the outreach programme are included in recommendations 1,2,5,6. Recommendations for the wider governance are included within recommendations 3,4,7,8 and 9.

1. Introduction

This report provides an evaluation of the work carried out by the Gay Men's Health Service (GMHS) sexual health outreach programme. The report is based both on data collected by the outreach workers and on other data collected from a range of sources, including key stakeholder interviews and non-participant structured observation. Established in October 2016, the GMHS outreach programme was prompted by the increase in Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STIs) in men who have sex with men (MSM) in Ireland (MSM Outbreak Response Group, 2017).

1.1 Background and Context

The National Sexual Health Strategy 2015—2020 identifies gay men, bisexual men and men who have sex with men (MSM) but do not identify as gay or bisexual, as being at increased risk of poorer sexual health outcomes, including contracting STIs and HIV (Department of Health, 2015 p.31). The strategy highlights the epidemiological data related to new HIV cases in Ireland and notes the recent increase in HIV cases, many of which are occurring amongst MSM. The strategy also refers to migrants, sex workers and LGBT populations as being vulnerable in relation to experiencing negative sexual health outcomes (ibid., p.39).

The National Sexual Health Strategy 2015—2020 emphasises the relevance of sexual health promotion in challenging risk perceptions and stigma related to sexual health. Among the potential intervention measures identified in the strategy are targeted outreach and condom distribution. Targeted education and outreach is identified as a key recommendation for at risk groups in order to provide positive prevention and thereby mitigate potential negative sexual health outcomes. The Men Who Have Sex with Men Internet Survey Ireland (MISI) 2015 provides additional evidence to support the recommendations of the strategy and refers to condom-access issues, chemsex¹ and a proportion of MSM who have never tested for STIs or HIV (O'Donnell, Fitzgerald, Barrett, Quinlan & Igoe, 2016). The MISI survey findings provide a rationale for online and in-person outreach interventions to signpost to potential service users the STI and HIV testing and treatment services in Ireland, information on PEP and free condom and lubricant provision sites to MSM in Ireland (Ibid). The Health Protection Surveillance Centre's provisional data for 2017 on STI and HIV notifications in Ireland indicate, where mode of transmission is known, that MSM continue to be a population at increased risk of these infections (HSE, 2018a; HSE, 2018b).

1.2 Literature on MSM Outreach

Outreach work is defined as contacting or reaching out to a target group in their own setting or territory (EMCDDA, 2001). Given the often changing and emerging needs of vulnerable or difficult to access populations that it seeks to engage with, outreach is often characterised by high levels of responsiveness, flexibility and reflexivity in staff. Data from outreach work can be challenging

1 The use of drugs specifically for or during sex.

to capture and evaluate due to the diversity, variability and breadth of activities undertaken in a variety of environments (EMCDDA, 2001, p16).

However, studies have shown that outreach programmes are very important in the prevention of STIs and HIV among MSM. Research has shown that peer-led HIV prevention interventions targeting MSM are effective in the reduction of condomless anal intercourse (CAI), which in turn leads to reduced likelihood of contracting HIV (Ye, Yin, Amico, Simoni, & Vermund, 2014). A systematic review of evidence to inform HIV prevention interventions among MSM in Europe, finds that trained peer outreach demonstrates reductions in CAI and can act as a first point of contact for onward referral to STI and HIV testing (Strömdahl et al., 2015). The review highlights the acceptability of outreach among MSM and the need to provide condoms and lubricant in addition to promoting HIV testing and condom use (Strömdahl et al., 2015). Emerson and colleagues conducted an evaluation study of an outreach-testing programme in Belfast in 2017. The authors concluded that the outreach-testing programme is a very important initiative, reaching men at higher risk who very often would not otherwise have been tested. A high rate of infection was diagnosed among the service users. Over a period of six years, fewer vaccines were required, the percentage of HIV “never testers” dropped from 34% in 2009 to 14% in 2014 and six-monthly follow-up testing rates increased from 13% to 45%. The outreach testing programme has increased access to and raised the profile of the health services offered by genitourinary medicine (GUM) clinics (Emerson & Wilson, 2017). Another recent study of online outreach among MSM populations found that STI and HIV testing increased as a result of outreach work. Of the four hundred participants who took part in the study and received referred, 73.5% led to testing (Smith, White, & Ross, 2017).

1.3 About the GMHS Sexual Health Outreach Programme

1.3.1 Background

The GMHS outreach programme was established in October 2016 on a pilot basis. This was following the establishment of a multi-disciplinary response group under the HSE Health and Wellbeing Directorate, which aimed to address rising STI and HIV notifications via a range of preventative channels. Following the submission of a proposal for funding to the HSE by the GMHS and the GHN, funding was granted to establish a pilot outreach programme to increase awareness of STIs and HIV among MSM and to improve levels of testing. Although the GMHS had historically employed outreach staff, there were no paid outreach staff operating in this capacity at the time. The roles had ceased due to a cut in funding in 2009 and the remaining funds were allocated to the clinical component of the GMHS.

1.3.2 Programme Design and Establishment

In designing and establishing the new outreach programme, the GMHS outreach team was aware from the outset that the service model would need to reflect and respond to social and technological changes that had taken place that had affected how MSM interact. The GMHS staff and management dedicated time and space to plan and adapt the outreach service model to reflect these changes. The outreach team held three workshops between November 2016 and December 2017 to assess the emerging gaps and discuss future areas of work to inform the development of the programme. Consideration was given to how MSM used online spaces to meet and how an online presence of the programme was required to tap into this. The need for an online presence was supported by findings from research on chemsex in Dublin that indicated that an online presence could be valuable for outreach, given that 56% of respondents met their chemsex partners through phone apps or online (Glynn et al., 2018). Therefore, there was a clear need to move beyond the mainly venue-based and community model of outreach to MSM that had been predominant in the early 2000s to create an online presence on relevant websites and geo-spatial apps (National MSM STI and HIV Increase Response Subgroup, 2017). In planning the service, consideration was also given to the epidemiological data on STI and HIV notifications, which indicated that a specific focus was needed to engage Latin American MSM. The workshops also discussed the various information and referral sources and forms of training that outreach teams would require to appropriately address the needs of the service users.

1.3.3 Programme Aim, Objectives and Code of Governance

The overarching aim of the outreach programme is to deliver a peer led, sex-positive, information-and-resource service to the MSM community, with a view to engaging men in preventative services and encouraging them to avail of STI and HIV treatment and testing.

The objectives of the programme are to:

- Promote the use of condoms and lube as an effective form of protection from the spread of STIs and HIV, and make condoms and lube available.
- Increase knowledge and awareness about the signs and symptoms of STIs and HIV.
- Increase awareness and use of local resources (STI and HIV testing services, information points etc) for STI and HIV prevention, screening, testing and treatment and encourage attendance.
- Explore and discuss sexual risk-assessment and risk-reduction methods, including HIV prevention technologies (e.g. PEP, PrEP, undetectable viral load) and STI and HIV testing.
- Refer to the Man2Man.ie website for information and/or location-based resources and services that are regionally specific and promote Man2Man.ie and other affiliated related campaigns and materials.
- Reduce HIV-related stigma.

- Encourage and support sexual consent and sexual respect particularly in encounters initiated online.
- Connect with subpopulations and migrant populations, especially Latin American MSM, and with sex workers to promote sex-positive encounters and encourage engagement with services.

The outreach programme of work is delivered under a code of governance including a set of principles, which are as follows: sex positivity; client-centred service; harm reduction; and skills and capacity (the latter in relation to training and continuing professional development for the outreach team).

1.3.4 Service Delivery

The outreach team reports to the Manager of the Gay Men's Health Service. Since October 2016, a team of two outreach workers has been employed for 20 hours per week via an employment agency. One of these outreach workers speaks Spanish and Portuguese and has been instructed to focus on targeting Latin American men.

The funding was granted initially to employ three part-time outreach workers for a six-month period: two in Dublin, and one at a national level. Both Dublin posts were filled. A candidate was selected for the national role, but at time of appointment was unable to take up the role, which has since remained unfilled.

The team is tasked with developing and delivering a programme of outreach work in order to address existing and emerging needs that contribute to the current increase in HIV and other STIs among MSM. The outreach programme seeks to engage as many MSM as possible. The outreach programme is essentially delivered in two main strands: venue-based work and online work. As the pilot outreach programme developed in the early stages, the outreach team also began to have a presence at the GMHS during clinic times.

Venue-Based Outreach Work

The outreach team undertakes venue-based outreach work by targeting bars, clubs, public and semi-public sex environments, sex-on-premises venues and other settings in Dublin where MSM gather to socialise. The venue-based outreach programme is primarily a health promotion initiative and seeks to raise awareness that services (STI and HIV testing and treatment) and information (Man2Man.ie) are available should people feel they need them. The outreach team also stocks these venues with condoms and lube dispensers that are supplied by the HSE, thereby giving access to free condoms and lube. The process of venue-based outreach requires considerable engagement and negotiation with venue owners and managers to allow access and enable an outreach presence onsite. The outreach programme also has a presence at special events, such as Pride, Circuit Parties and SHAG Week.

Online Outreach

The outreach workers also have an online presence using android-based applications. Most MSM are online in some capacity, and many men find sexual partners on the internet. The outreach workers have therefore set up profiles on sites and apps such as Grindr, Growler, Scruff and Planet Romeo. The outreach workers post information about services and let men who are using the apps/ sites know that they are available to talk about sexual health and related services. The outreach team views the online approach as a particularly useful way of engaging men, because it is a safe place for them to express their concerns and ask questions.

An important function of the outreach team is to refer MSM to relevant services and resources. The range of referrals for MSM is broad and includes referrals for addiction services, for counselling, for help for victims of sexual violence, for clinical services and for other relevant services. As a result, the outreach team needs knowledge of the services available to their service users and practical information in relation to making and supporting a referral to these services. This may also include referral to services based outside Dublin for service users who do not live in Dublin but who are in contact with the GMHS outreach team.

1.4 Evaluation Aim and Objectives

The overarching aim of the current study was to provide an evaluation of the pilot outreach programme developed by the GMHS in partnership with the GHN and funded initially by the Assistant National Director for Public Health in the HSE. The HSE SHCPP, which has overall responsibility for implementation of the National Sexual Health Strategy 2015–2020, provided funding and oversight for this evaluation.

When the pilot outreach programme was being evaluated, it was vitally important to ensure that the evaluation process incorporated the overarching values, philosophy and context of the four strands of the code of governance: sex positivity, client centred service, harm reduction and skill building and capacity.

The specific objectives of the evaluation were to:

1. Assess the ways that the objectives of the programme were achieved.
2. Assess the ways in which the outreach programme was received by the target audience and other key stakeholders.
3. Assess the experience of the outreach programme in delivering the programme.
4. Identify critical success factors and key barriers in relation to implementation.
5. Make recommendations for improvements to current operational processes with a focus on resources and reporting data.

2. Methodology and Ethical Considerations

2.1 Introduction

To provide a comprehensive evaluation that was cognisant not only of the outreach programme's code of governance but also of the resource context within which the programme was situated, a process and impact evaluation was planned within the context of an implementation science framework. Implementation science can be defined as "the study of the process of implementing programmes and practices that have some evidence from the research field to suggest they are worth replicating. It is the study of how a practice that is evidence-based or evidence-informed gets translated to different, more diverse contexts in the real world" (Metz, Naoom, Halle, & Bartley, 2015, p. 1).

The work of Comiskey and colleagues was drawn upon because of its relevance to implementation within healthcare contexts (Comiskey et al., 2015; Comiskey & Sheehan, 2017; Sheehan, Comiskey, Williamson, & Mgutshini, 2015). However, while the initial intention was to carry out a process and impact evaluation, it became apparent during the evaluation that accessing the service users, who were the intended key data sources for assessing impact, was very difficult. This difficulty, which is discussed in section 2.8, meant that the intended evaluation design (which focused on the use of service-user feedback to assess impact) could not be implemented. For this reason, the initial evaluative project evolved into a detailed summative and process evaluation.

The implementation science framework enabled the objective identification of barriers and enablers to the delivery of the programme within the resource setting within which the programme was situated. The process evaluation provided information on the service-delivery and governance aspects of the programme, while the summative evaluation provided objective evidence supporting the eight objectives of the programme. The evaluation drew on the implementation-science literature of Burke and colleagues (Burke, Morris, & McGarrigle, 2012) and Fixsen and colleagues (Fixsen, Naoom, Blase, & Friedman, 2005). It also drew on previous evaluations and on lessons learned from studies conducted with similar audiences in London (Bonnell, Strange, Allen, & Barnett-Page, 2006) and Glasgow (Flowers & Hart, 1999; Hart, Williamson, & Flowers, 2004; Kelly et al., 2004).

2.2 Evaluation Design

A concurrent multi-method cross-sectional study design was conducted. Both qualitative and quantitative approaches were found to be appropriate. In consultation with the Steering Committee, a descriptive design was decided upon for the cross-sectional qualitative data. A quantitative cross-sectional design was found to be appropriate for the online outreach and service data.

2.3 Evaluation Methods and Data Analysis

The evaluation methods varied according to the five objectives of the evaluation. This is why a multi-method design was necessary. To be comprehensive and effective, the evaluation needed to encompass all of the following elements:

1. The evaluation needed to assess how the eight objectives of the programme were being achieved.
 - This required analysis of the service-reporting data both from the online outreach work and from the venue-based work.
 - This data was supplemented by on-site, non-participant observational data and the screen shots of service interactions with service users.
2. An assessment of how the target audience received the outreach programme was also required.
 - This assessment relied on key stakeholder interviews drawn from relevant stakeholder groups. The individuals interviewed included not only those responsible for the delivery of the services but also clinical and public-health professionals who, although not responsible for the service, have been linked to it.
 - Screen shots taken during service delivery were also used.
3. The experience of the outreach programme in delivering the programme needed to be evaluated.
 - Key stakeholder interviews were important in this context.
4. Critical success factors and key barriers in relation to implementation needed to be identified.
 - Documentary evidence, key stakeholder interviews and screen shots were used for this part of the evaluation, which was guided by the implementation-science framework.
5. The evaluation process needed to result in recommendations for improvements to current operational processes, with a focus on resources and reporting data.
 - Recommendations were made on the basis not only of the findings but also of the fuller context within which the programme was governed and operated.

In summary, the evaluation methods included:

- Quantitative analysis of service-delivery data (online outreach and venue-based outreach data from December 2016 to December 2017).
- Qualitative analysis of non-participant structured observation on-site (14 hours of observation).
- Qualitative analysis of semi-structured interviews with key stakeholders (7 participants)
- Qualitative documentary analysis of existing documentary evidence within 2017 from within the service (over 20 administrative documents)

2.4 Ethical and Other Considerations

The research team was aware of the challenges of conducting sensitive evaluations in real-life settings. The Steering Committee played a key role in facilitating initial researcher access to key stakeholders and relevant data sources. The research team also had extensive experience in the application of good research practice, of ethical clearance criteria and of Irish and EU data-protection legislation. Team members were familiar with the Trinity College Dublin Policy on Good Research Practice and with The World Medical Association's Declaration of Helsinki, which sets out ethical principles for the conduct of medical research involving human subjects. The study obtained ethical approval from Trinity College, The University of Dublin, in December 2017.

2.5 Service delivery data - Quantitative Data Management and Analysis

Quantitative analyses were conducted on the service-delivery data collected by the outreach workers in 2017. These data consist of records of actions and topics encountered by the outreach workers. Three excel databases were received by the research team for analysis purposes. They contained data on the actions carried out during online/phone and venue-based outreach work, and were recorded by each outreach worker.

Before the process of analysis commenced, the data were cleaned, checked for accuracy and prepared for quantitative analysis. From this exercise, it was evident that the third excel database received was a duplication of the previous two, combining the two categories of data (online/phone and venue-based outreach data) that they had recorded separately.

The first step of the cleaning process was to ensure that there was consistency within the data provided across both databases. The second step was to separate out each individual action recorded. For example, a single entry could combine information about clinic hours, details of appointments for testing and sexual health advice. Step three involved the categorisation of actions to (i) give an accurate reflection of all actions and topics documented and (ii) allow for more feasible reporting. Four researchers on the team conducted this step with the aim of ensuring consistency and accuracy.

Once the data had been cleaned and converted into the appropriate data type, the data were transferred into SPSS version 24 (IBM 2016) for analysis. To ensure anonymity of the outreach workers and to protect the confidentiality of their interactions with service users, identifying information was not included in the SPSS databases. A final data check was conducted in order to ensure that no errors had been made during the data transfer.

The final cleaned online/phone database had 907 separate entries of actions and topics. Episodes of service delivery were recorded and not individual cases or numbers of service users. Data was analysed for the period running from December 2016 to December 2017, inclusive. The venue-based database consisted of 81 entries and also covered the period from December 2016 until December 2017, inclusive.

Descriptive data analyses were conducted on all variables for both databases. Frequencies and percentages were reported, and mean and standard deviations were reported where possible (e.g. age). The data violated major assumptions for inferential tests, both parametric and non-parametric. The data type was not suitable for any parametric inferential tests and for some non-parametric tests. Low frequency count in individual cells meant that non-parametric tests of associations could not be used.

2.6 Non-Participant Observation

For the purpose of this study, it was agreed that the research team would engage in non-participant observation by shadowing the outreach team in the venues and by observing their work online. In total, six sessions of non-participant observation were carried out between February and May 2018 over a total of fourteen hours.

Venue Shadowing

The aim of the venue-based, non-participant observation was to shadow the outreach workers on their visits to venues; with a view to documenting how they approach their work and to gain a better understanding of how they deliver the health promotion initiative. The intention was to document the types of venues; the preparations and plans made prior to and following venue visits; and any other factors of interest. The field worker accompanied the outreach staff to five different venues between February and March 2018.

Online Shadowing

The shadowing of online work involved recording observations as the outreach workers provided sexual health information and guidance in response to issues raised by the MSM community through online communication methods with a view to documenting how the outreach team engages with men online and to understand more about the issues they encounter. The online methods used to engage with service users were SMS messaging, WhatsApp, phone calls, Facebook and the MSM social networking sites Grindr and Scruff. Interactions with the sex worker community were observed through the dating website Planet Romeo. In line with the terms

of the study's ethical approval, a fieldworker accompanied the outreach workers and recorded observations of the online outreach work, using a structured schedule (see Appendix 3).

2.7 Key Stakeholder Interviews

Seven key stakeholders took part in one-to-one interviews. The stakeholders who were asked to participate in this study were selected by the Steering Committee, as the key representatives of the establishment or implementation and ongoing running of the outreach programme. These key stakeholders ranged from national organisational governance-level representation to service managers and frontline outreach staff. Interviews ranged from twenty minutes to an hour and a half in duration. They yielded a total of five hours of audio recordings and eighty pages of transcribed text. The key stakeholders included the outreach programme team, including two outreach workers, the GMHS manager, the GHN lead and clinical experts in the area of HIV, STIs and public health.

Participants were asked their opinions on the different phases of development and roll-out of the outreach programme. Interviews concluded with questions about how the participants envisaged the future of the outreach programme. The following is an outline of the key topics participants were asked about during the interviews:

- Participants role in the setting up/management/running of the outreach programme
- The early stages of setting up the programme, including barriers and enablers
- The development of the programme and how it currently functions, including barriers and enablers
- The future of the programme over one-year, three- year and five-year periods
- The feasibility of expanding the programme to other locations

Details of the questions asked under each of these topics are available in Appendix 1.

Because these questions explored the experiences of the various service providers regarding the implementation and possible scaling up of the outreach programme, the analysis of the data was informed by the relevant components of the implementation-science literature.

Data arising from the key stakeholder interviews were analysed manually. A thematic analysis was also conducted. This thematic analysis was informed by the science-of-implementation framework's enablers and barriers, and guided by the methodology of Braun and Clarke (2006).

2.8 Issues with Recruiting Service Users

The initial intention for this study was to carry out a process and impact evaluation. During the evaluation process, however, it became apparent that it was very difficult to access the service-users, who were intended as the data sources for assessing the programme's impact. As a result, the intended evaluation design could not be implemented. This section articulates the challenges involved in recruiting service users.

Between six and eight service-user interviews were planned for this component of the study. In line with the study's ethical approval, which was received in December 2017, it was decided to inform service users of the study through the placement of posters and information leaflets both in the GMHS clinic and in other outreach settings. Following approval from the Steering Committee an incentive for service-users to participate was appropriate, this was included on posters and in the information leaflets. However, despite three separate recruitment phases during March, April and May 2018, it was not possible to obtain interviews with outreach service users. The section below highlights the issues that arose.

Initial Recruitment Phase: March 2018

When the recruitment process began, posters and information leaflets were located within the GMHS clinic on Baggot Street. During this recruitment phase, which extended over three weeks over March 2018, no participants were forthcoming. This issue was raised at a Steering Committee meeting, and the group discussed the possibility of changing the approach to data collection by using a questionnaire. It was decided not to use a questionnaire, however, as this would affect the depth of the data and would require additional ethical approval, which would impact significantly on the timeframe of the study.

Second Recruitment Phase: April 2018

As a result of the decision not to adopt the questionnaire method, the research team requested that the posters and information leaflets be distributed in the other outreach settings, as agreed previously, and that the research team, with the agreement of GMHS clinic management, attend the evening clinics to recruit potential participants. To facilitate this, one researcher was present in the clinic to hand out information leaflets and to engage with the service users as they arrived for their appointments. Two hundred leaflets were distributed over a ten-hour timeframe within a two-week period running in April 2018.

During this phase of recruitment potentially interested participants were considered eligible by being asked if they had engaged with the outreach programme. Ten potential participants expressed an interest in taking part in the interviews. Seven participants answered "yes" to the screening questions and were recruited to be interviewed about the outreach programme.

During this interview process, however, it was noted by the fieldworker that participants were not able to define the differences between the GMHS clinical service and the outreach service. There was an assumption that the presence of the outreach team at the GMHS clinic was part of the clinical service. This meant that although the interviewees were attending the GMHS clinic, they had not engaged directly with the outreach workers solely in an outreach capacity or online. This only became evident through the interview process. This is highlighted and discussed in Chapter 4.

Third Recruitment Phase: April–May 2018

The recruitment period was therefore extended for a further three weeks, running in April and May 2018, in order to recruit additional participants who had experienced a direct interaction with the outreach team. During this phase, posters and leaflets were distributed in the main outreach venues. Alongside this, outreach workers now began to actively notify online service users of the study. Online service users were notified of the study at the discretion of outreach workers. During this period, 145 interactions with service users were noted, and in 91 of these interactions, the outreach team informed service users about the study. Unfortunately, however, none of these 91 online service users decided to follow up and enquire about participation in the research.

During the three-week extension to the recruitment period, transcription and analysis were completed on the seven interviews with users of the wider clinical service, within which the outreach programme was managed and operated during clinic times. The interviews conducted with the GMHS clinic service users provided 85 minutes of audio and were transcribed into a 23-page Word document. The analysis was guided by the methodology of Braun and Clarke (2006), and themes and diagrams were produced using NVivo11. However, no additional service users were forthcoming from among those who had had a direct interaction with an outreach worker in an online outreach capacity. Moreover, the seven service-user interviews completed had captured only those who had engaged with the GMHS clinic, rather than those who had engaged with the outreach programme itself. The Steering Committee therefore decided to remove these service-user findings from the report. This action was taken to avoid any confusion of findings relating to the GMHS clinic with findings relating specifically to the outreach service. Fortunately, however, data on service-user engagement with outreach workers was available through the quantitative analysis of the online service-delivery databases, which covered the period from December 2016 to December 2017, and through the observation of 31 online interactions. Details of these can be found in Chapter 3.

2.9 Documentary Data – Qualitative

Over 20 administrative and service-delivery documents were reviewed and analysed for content. These documents consisted of minutes from team meetings, training reports, information leaflets and posters generated by the service, reports on the then current incidence of STIs and HIV and the need for a GMHS outreach programme, midterm review reports and other administrative documents.


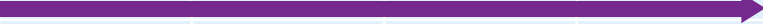
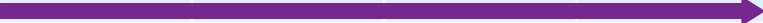
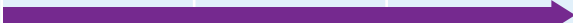


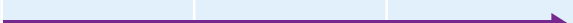
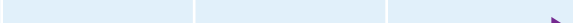
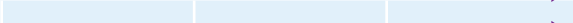
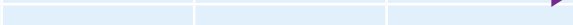
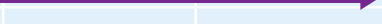
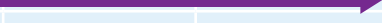
Finally, all data from the interviews, non-participant observation and documentary analysis were

used to assess implementation and to identify evidence of the presence or absence of the barriers and enablers within the implementation-science framework.

2.10 An Implementation-Science Framework

The findings from the various data sources were applied within the implementation-science framework. Comiskey and Sheehan (2017) have discussed the use of implementation science in healthcare. Referring to the key literature, they note that implementation has been described as “making it happen”, rather than simply “letting it happen” or “helping it happen”. Implementation science focuses on the strategies that can promote implementation success and on the theoretical underpinnings of these strategies. Metz, Naom, Halle, & Bartley (2005, p.1) define implementation science as “the study of the process of implementing programmes and practices that have some evidence from the research field to suggest they are worth replicating.” These authors further characterise implementation science as “the study of how a practice that is evidence-based or evidence-informed gets translated to different, more diverse contexts in the real world.” Much of the recent implementation-science research has focused on understanding factors that facilitate and hinder successful implementation. As illustrated in figure 1 below, Burke et al. (2012) provide an outline of common implementation enablers and the stages of implementation at which they are important to attend to during the implementation process.

Figure 1: Implementation enablers and stages (adapted from Burke, Morris and McGarrigle, 2012)

	Implementation Enablers	Stages of Implementation			
		1 Exploration	2 Installation	3 Initial Implementation	4 Full Implementation
					
1	Stakeholder consultation and buy-in				
2	Implementation champions				
3	Resources				
4	Leadership				
5	Implementation teams				
6	Implementation plans				
7	Staff capacity				
8	Organisational support				
9	Supportive organisational culture				
10	Communication				
11	Monitoring and evaluation				
12	Learning from experience				

Enablers and their stages are presented in figure 1, which is adapted from Burke, Morris and McGarrigle (2012).

According to Burke, Morris and McGarrigle (2012), barriers to implementation are grouped under three headings, namely, 1) the external environment, 2) vested interests, and 3) resistance to change. The framework in figure 1 above was used to summarise the process evaluation data arising from the multiple methods and to synthesise the findings on implementation. In summary, a post implementation, retrospective mapping of the process of implementation, against the framework for implementation enablers and barriers was employed.

The range of data sources captured in the study was selected to ensure that sufficient evidence would be available to adequately map the process of implementation of the outreach service against the contents of the framework. A triangulation approach was used to analyse all the data that was accessed. Triangulation is the continual process of collecting and cross-checking information. Using a combination of different methods and different data sources, a crosscheck was carried out to check for contradictions, conflicts or consensus between different data sources. At roundtable discussions involving the research team, the various data sets were repeatedly compared. This ensured that any inconsistencies in the data were identified. These roundtable discussions also ensured that the evidence for decisions about the presence or absence of particular enablers or barriers would emerge.

3. Results

3.1 Introduction

The following section presents the results from the evaluation in three formats.

- Section 3.2 provides an overview of the findings from the non-participant observation work carried out as part of the online and venue-based research.
- Section 3.3 presents the findings from the quantitative analysis of the service-delivery data, which consists of the online/phone and venue-based outreach data gathered between December 2016 and December 2017.
- Finally, section 3.4 provides an analysis of the documentary data, the key stakeholder data and the non-participant observation data within the context of the implementation-science framework. This section offers an overview across the stages from the initial set up to the ongoing running of the outreach programme.

3.2 Non-Participant Observation

This section contributes to the objective findings on whether or not the outreach service was meeting its eight stated objectives.

- The venue-based, non-participant observation involved shadowing the outreach staff as they attended the venues where MSM gather for social activity.
- Online non-participant observation involved shadowing the outreach teams as they linked with service users online.

In total, six venue-based and online sessions of non-participant observation were completed over a period of four months. For the venue-based work, outreach workers were accompanied by the researcher to five different venues to record their observations based the schedule set out in appendix 3. Online observation involved four individual shadowing sessions.

Venue-Based Work: An objective of the outreach programme is the provision of free condoms, lubricant and sexual health information resources in venues frequented by MSM in Dublin. This involves developing relationships with venue managers in order to make these available in locations within these venues. The observed venue-based activity involved servicing MSM meeting places, bars, clubs and sex-on-premises venues with condoms and lubricant.

The venues for outreach visits were based in Dublin city centre. The venues visited (during the non-participant observation sessions) were public bars and clubs, a sex shop with private

members' areas, a private sauna and an LGBT meeting place and café. Following each venue visit, the team contacted other venues within Dublin by text message to check stock levels. In response, venue managers indicated their requirements by text message, and stock was ordered by the outreach team. This clearly demonstrates that the team is working with the venues to enable them to have free condoms and lubricant available consistently.

The outreach team also has a presence at the GMHS during clinic times. A team member attends the clinic every Tuesday to support service users who do not have an appointment. That team member is available to discuss personal issues or other healthcare matters with service users. The Tuesday clinic is very busy. Although it does provide for non-appointment service users to attend, service users will be turned away if the clinic is at maximum capacity. If a service user is turned away but has a question or is in distress, a member of the outreach team is available to talk to clinic staff on the service user's behalf and will refer the issue to the clinic manager for a final decision. During the shadowing research, a service user presented at the clinic reception with a suspected STI that was not deemed urgent by the outreach worker. The outreach worker gave the service user an appointment for the next available clinic. This facilitated testing for an individual who, although deemed at risk, might not otherwise have returned for testing.

A summary of the non-participant observations carried out at five venues is given in tables 1 and 2 below.

Table 1: Venue-based, non-participant observation: occasion 1 (February 2018)

Venue	
Venue 1 - A bar and club, a popular meeting place for the LGBT community in Dublin	<ul style="list-style-type: none"> • The outreach worker brought a supply of condoms and lubricant and restocked two dispensers in the venue. • The venue has a small storage area, which was replenished with condoms and lubricant. • The outreach worker also checked the stock of health-promotion leaflets on a merchandising stand close to the entrance of the bar and then proceeded downstairs to check that the latest health-promotion posters were in position on the walls in the toilet area. • Merchandising of condoms, lubricant and health-promotion material is a weekly task for this venue. • During this visit, venue staff were not engaged by the outreach worker.
Venue 2 – A café that also serves as a popular LGBT meeting place	<ul style="list-style-type: none"> • The outreach worker sends weekly text messages to venues to check on stock levels. • The outreach worker logs on to a HSE website and places orders for condoms and lubricant for these venues in response to the venue requirements as notified through SMS messages. • This stock-replenishment process does not require a physical-venue visit from a team member and potentially could be remotely rolled out to any qualifying venue in the country.

Table 2: Venue-based non-participant observation: occasion 2 (March 2018)

Venue	
Venue 3 – A bar and club, a popular meeting place for the LGBT community in Dublin	<ul style="list-style-type: none"> • The outreach worker spoke to the venue manager to check if they required additional stocks of condoms and lubricant. • Following a check, the manager confirmed that the venue was running low on stocks of condoms and lubricants. The outreach worker said that he would return later that day with additional supplies. • To ensure that the venue's requirements were being fully met, the outreach team carried out a stock check. It was noted by the outreach worker that weekly deliveries of condoms, lubricant and health promotion material are required for this busy venue. • It appeared that this venue's staff require the outreach team to maintain a continuous supply of condoms and lubricant for distribution to patrons of that venue at all times.
Venue 4 – A private sauna and club for MSM	<ul style="list-style-type: none"> • The outreach worker spoke to the venue receptionist to check if they required additional stock of condoms and lubricant. • Following a check, the receptionist said they were running low. The outreach worker confirmed that he would return later that day with additional supplies. • To ensure that the venue's requirements were being fully met, a stock check was conducted by the outreach worker. • Weekly deliveries of condoms, lubricant and health promotion material are necessary for this busy venue. It appears that the venue's staff also require the outreach team to maintain the venue's supply of condoms and lubricant is available for distribution to patrons of that venue at all times.
Venue 5 – A retail store that sells sex toys and other sex-related material to the public (A private members club is located in an upstairs area to the rear of the premises.)	<ul style="list-style-type: none"> • The outreach worker spoke to the storeowner, who confirmed he needed stock of condoms and lubricant. • The owner said that he also needed merchandisers' dispensers for his private club and accompanied the outreach worker to a small private area to the rear of the retail store. • He brought the worker around the venue to point out where he will position the dispensers. The outreach worker confirmed that he would place an order for the dispensers and would return later that day with supplies of condoms and lubricant. • This appeared to be a low-volume venue and one that has adequate space for the storage of considerable stocks. Weekly deliveries may therefore not be required at this venue.

Online Work: The majority of hours (between 60% and 70%) worked by the outreach team are devoted to online activity carried out through social network sites (particularly Grindr and Scruff) and through conversations on WhatsApp and via SMS messaging. Grindr and Scruff are geolocation-based apps, which means the GMHS profile is only visible to a limited number of people at any one time when using these applications. For example, when a team member is logged on they must select a geolocation, such as Dublin 2. This means that only a limited number of people using the application in that location are able to view the GMHS profile. To access a wider population, the outreach team member has to change geolocation continually. On average, the team spends thirty minutes in any one location at any one time.

Table 3 below contains a breakdown of the work observed during the online shadowing sessions. Using screen shots provided by the outreach workers, table 4 provides a sample of the interventions with service users. A challenge that the outreach team faces when working online is the variability of interactions with service users. The observational sessions revealed that the numbers of interactions with individual service users varied between zero and six interactions during a single online session. This implied a significant amount of flexibility was required in how the outreach workers planned their work schedules. To maximise the efficiency of their time, online work is carried out in parallel including administrative tasks as replying to emails and updating the Google-form database, which documents interactions with service users. Analysis of interactions with service users also highlighted the depth of knowledge and understanding of sexual health issues that outreach workers require to provide the level of sexual health information the MSM community needs. Topics addressed can vary from a simple request for information on the availability of PrEP to in-depth questions about STI testing and prevention.

A further example of the flexibility and importance of the outreach service was found in its interactions with the sex-worker community. Many sex workers engaging with the service originate mainly from South America (and from Brazil in particular). To build trust and engage with this community, the outreach team needs to have appropriate language skills and an understanding of their needs. The outreach worker who speaks both Spanish and Portuguese has assumed a very proactive role with the sex workers by regularly contacting them individually through their profiles on Planet Romeo and reminding them to keep their vaccinations and STI testing up to date. This is a very time consuming task, but the outreach worker finds it effective. Following his observations of the sex workers' attendance at clinics, the outreach worker reported that a high level of regular STI testing was taking place. The outreach worker also reported that he had accompanied sex workers to the clinic in order to act as an interpreter during their communications with health-service professionals.

Table 3: Non-participant observation of online work

Venue	
Venue - GMHS clinic - February 2018	<ul style="list-style-type: none"> The outreach worker was located in an office close to the GMHS clinic where they monitor their mobile for online activity from service users. The outreach worker is also available during their shift to provide service-user interventions, if required by the nursing and medical staff of the clinic. During this observation, a man who had shared needles and had engaged in condomless anal intercourse chemsex presented at the clinic reception. The outreach worker was requested to attend to the service user who was at high risk of HIV infection. Following discussions with the service user, the outreach worker referred the service user to the PrEP clinic. The intervention lasted 20 minutes. The outreach worker then returned to the office, where he monitored his mobile phone for further service user-activity and also performed administrative tasks, entering data from new intervention with service users into the Google forms database. No other online interventions were observed.
Venue - Café and LGBT meeting place - March 2018	<ul style="list-style-type: none"> At 2.30 pm, the outreach worker logged on to the apps Grindr & Scruff. The latter app sends alerts; so continual monitoring of the app is not required. However, Grindr requires geolocation monitoring. Grindr geolocation was set to Bluebell, and the outreach worker responded to emails while waiting for contact on the apps. No service users made contact. So, at 3.00 pm, the geolocation was changed to Drumcondra. Again, no service users made contact. At 3.30 pm, the geolocation was changed to Pearse Street. No service users made contact. At 4.00 pm, the geolocation was changed to Dublin 2. No service users made contact. The session ended at 4.30 without any observed interactions having taken place.

Venue	
Venue - GMHS - May 2018	<ul style="list-style-type: none"> • The outreach worker reviewed two SMS messages and one WhatsApp message received earlier that day and four interactions on Grindr. • Three messages related to PrEP availability and information, and three messages related to STI information and testing. • There was one query from a transgender service user who required specific information of a personal nature.
Venue 2 - Café and LGBT meeting place - May 2018	<ul style="list-style-type: none"> • The outreach worker logged in to Planet Romeo, a dating website used by sex workers to display their profiles. • There were 46 profiles on the website. The outreach worker explained how he uses the site to individually engage the sex worker community. • The outreach worker noted that each sex worker is sent a personal email to enquire how they are and to remind them to keep their vaccinations up to date. No emails were sent during this observation. • Five Grindr interactions and one WhatsApp interactions were subsequently observed over a period of two hours. • One interaction involved a service-user discourse over a number of days. The issues raised during the discussions ranged from coming out to sexual violence, mental health and general health information.

Table 4 below provides examples of messages sent between outreach workers and service users. This provides examples of queries outreach workers encounter online.

Table 4: Examples of messages sent between outreach workers and service users

Two different examples of general queries	
Online query 1	Is the GMHS clinic open today for PrEP queries?
Outreach worker, response 1	Yes, we are open now. There are walk-in appointments until 12.00 noon today.
Online query 2	Hello. Where is free STI testing in Dublin?
Outreach worker, response 2	Yes, there is free STI and HIV testing at GMHS clinics on Mondays and Wednesdays. You can see the times of our clinics here: www.gmhs.ie
Two different examples of PrEP/PEP queries	
Online query 1	Hi there. Have you any idea when I can go to my local GP for PrEP? Is there a date when the new policy on PrEP in Ireland starts? Thanks for any info.
Outreach Worker response 1	Hi there. PrEP is available in pharmacies now. You can go to your local GP for a prescription, but it is really important that you receive the appropriate tests before taking the drug.
Online query 1	Understand. I've read the articles. Thanks. I'll start the process.
Online query 2	I have a question. Is it possible to get PrEP in the Republic of Ireland?

Outreach Worker response 2	Hi there. Yes it is. You can get PrEP from local pharmacies across Ireland, following a consultation and tests at a sexual health clinic. This is possible at GMHS on Thursday mornings. There's more information at www.gmhs.ie and www.getprep.online
Example of sexual behaviour query	
Online query	Hello. Is oral sex safe?
Outreach Worker response	Using a condom for oral sex can reduce the risk of STIs. Also, getting tested regularly for STIs is a good idea if you don't use condoms.
Example of STI query	
Online query	What are the symptoms of chlamydia or gonorrhoea?
Outreach Worker response	A lot of the time, there are no symptoms of these STIs, particularly in the throat. However, some people experience burning when peeing, itching and discharge. There's a full explanation of all STIs on the Man2Man website at www.man2man.ie
Example of HIV-testing query	
Online query	Hi. Is the immediate HIV test thing finished?
Outreach Worker response	KnowNow rapid HIV testing is still available in all of the venues quoted on their website www.knowhow.ie GMHS also offer a rapid test at their Monday quick clinic.

In summary, shadowing observations confirmed that the main activities of the outreach programme were venue-based and online work. The venue-based work involves developing and managing relationships with venue managers in order to ensure that condoms and lubricant are continually available to the MSM community in the social venues that MSM frequent. The shadowing demonstrated how the team is working with the venues to enable them to have free condoms and lubricant available consistently. The online work involves one-to-one engagements with individual service users in response to a variety of questions and issues. The responses to these questions and issues are given in a confidential and non-judgemental manner.

From the information gathered, it is clear that the delivery of the outreach programme involves a skilled, knowledgeable and flexible team with the ability to respond to the sexual health requirements of the MSM community. The data also shows how the outreach teams directly engage with a number of MSM who, due to their circumstances, may be at a greater risk of contracting STIs or HIV. Among these at-risk groups are sex workers, persons who inject drugs

(PWID), migrants, transgender women and men engaging in chemsex and condomless anal intercourse. The outreach team members experience great diversity in their work. They have to adapt and deal with a wide range of issues while managing with the limited capabilities of the online applications, which, despite their limitations, are popular and a necessary means of reaching MSM, particularly the hidden MSM community. There is also evidence that confirms the important role that outreach workers play in supporting and encouraging service users to access information from Man2Man.ie. The information provided in this way may, for example, enable and encourage service users to access testing services and attend clinics in line with their needs.

In conclusion, from the analysis of the non-participant observation data, it was clear that the outreach team are meeting objectives one to five of the eight objectives of the programme. There was ample evidence of the promotion and distribution of condoms and lube; of the raising of awareness about the signs, symptoms and nature of HIV and STIs; and of the relaying of important information about testing and risk. Service users were also provided with referral information on other websites. In terms of objectives six and seven, which relate to reducing HIV-related stigma and encouraging sexual respect, the manner in which the online interactions were conducted and the language and tone used all reflected these values. Finally, there was evidence that the outreach service met objective eight and connected with appropriate subpopulation.

During observation, no clear demarcation line appeared to exist between the different activities. Online work appeared as a constant feature of the provision of the outreach programme. Venues and outreach work in the clinic involved simultaneous monitoring of online and mobile phone interactions, while administration tasks were performed in parallel with online/mobile phone activity.

This section contributed to the objective evidence on whether or not, and how, the outreach service meeting its objectives. Section 3.4 on the implementation of the service within the wider context of the governance, management and administrative structures provides further details on the wider operational procedures of the current pilot service.

3.3 Quantitative Analysis of Service-Delivery Data

3.3.1 Introduction

The section provides a detailed analysis of quantitative data on users of the outreach programme and on the actions/topics that were addressed by outreach workers. This data primarily provides additional objective evidence to evaluate the eight programme objectives. It also contributed some evidence that is used to evaluate the operation and governance of the service in terms of timing and workload.

3.3.2 Online and phone Service-Delivery Data: Descriptive Information

The database consisted of 907 separate data entries, not individual cases (each of which is not necessarily restricted to a single case), made over the period from December 2016 to December 2017.² From the database, it was not possible to ascertain if an individual had contacted the outreach programme on more than one occasion during this time period. This database contained information on the outreach work conducted online or by phone. This outreach work included such activities as providing information, arranging appointments with service users, offering advice and arranging for stocks of condoms and lubricant to be collected.

Table 5 presents the findings on service delivery, which suggested that daytime shifts between 12.00 pm and 6.00 pm (n= 399, 48.4%) had higher proportions of online/phone interactions, whereas the least busy shift was the one between 7.30 am and 12.00 pm (n= 120, 14.6%).

Table 5 Shift times for online outreach work (n= 824)

Shift time	n	%
7.30 am to 12 pm	120	14.6
12.00 pm to 6.00 pm	399	48.4
6.00 pm to 9.00 pm	171	20.8
After 9.00 pm	134	16.3

Table 6 present findings on service-delivery interactions. Grindr was by far the most popular online platform used, and hosted 76.8% of interactions recorded (n= 682). Facebook was the least popular online platform used (0.6%), and email (0.9%) was only marginally above that.

Table 6: Online/phone interactions (n= 888)

Online/phone interactions	n	%
Grindr	682	76.8
WhatsApp	72	8.1
Scruff	48	5.4
Phone call	28	3.2
Planet Romeo	26	2.9
Text/MSG	19	2.1
Facebook	5	0.6
Email	8	0.9

² The number of entries (n) varies within this section due to missing responses.

Table 7 presents the service users' countries or regions of birth (where data was available). The majority of service users were from Ireland (n= 253, 57.6%) and Brazil (n= 156, 35.5%). The age of service users ranged between 17 and 67 years, with an average age of 31.9 (SD= 9.3) years.

Table 7: Online outreach work service users' place of birth (n= 437)

Place of birth	n	%
Ireland	253	57.6
Brazil	156	35.5
EU (excluding Ireland/UK)	10	2.3
Asia	6	1.4
Mexico	5	1.1
South America (excluding Brazil and Mexico)	2	0.5
UK	2	0.5
Africa	1	0.2
Australia	1	0.2
Middle East	1	0.2

Table 8 indicates that the majority of service users resided in County Dublin (98.4%) and that only a few service users resided in other counties, namely, Cavan, Limerick, Westmeath and Kildare.

Table 8: Service users' counties of residence (n= 503)

County	n	%
Dublin	495	98.4
Cavan	3	0.6
Limerick	2	0.4
Westmeath	2	0.4
Kildare	1	0.2

3.3.3 Online/Phone Database: Actions Carried Out by Outreach Workers

Table 9 below provides a breakdown of actions carried out by the outreach workers. Multiple actions were reported in the database for each entry. This is the case because any given service

user might have contacted the service for multiple reasons. In such cases, outreach workers listed the various actions taken as a single entry. While multiple actions were recorded, for the purpose of this analysis, only the main action was reported for each category.

The main categories were sexually transmitted infections (STIs)/treatment of STIs/mental health; HIV; general information; sexual behaviour/sexuality; and substance use. The first category in this list was the most frequent overarching topic discussed (34.7%) (n=313), followed by HIV and general information. Table 10 below shows that PrEP and PEP were the individual topics most frequently discussed.

Table 9: Overview of overall categories (n= 900)

Overall categories	n	%
Sexually transmitted infections (STIs)/ treatment of STIs /mental health	313	34.7
HIV	259	28.7
General information	192	21.5
Sexual behaviour/sexuality	109	12.1
Substance use	27	3

The category of sexually transmitted infections/treatment/mental health covered many subcategories about STIs, and treatment of other infections/conditions, such as syphilis and herpes. The questions asked related, for example, to treatment options for syphilis, mental health, follow-up appointments for treatment of other infections.

The HIV category covered the following subtopics: PrEP, PEP, HIV testing, sex and HIV, HIV treatment and other HIV concerns. Actions undertaken by outreach workers included the provision of information on diagnosis, fear of transmission and the side effects of medications. Queries about having sex with HIV-positive service users were also addressed.

The general information category covered a broad list of queries and actions. The queries in this category covered such matters as the opening hours of the clinic, appointments for testing or treatment, treatment follow-ups at the GMHS clinic, outreach, and what to expect at the GMHS clinic.

The sexual behaviour/sexuality category included subtopics on condoms and lubricant, sexual behaviour, sexuality and other concerns. Actions undertaken by outreach workers included the delivery of condoms and lubricant to different venues and the collection of condoms and lubricant.

Among the topics addressed or discussed under the substance use heading were the use of chemsex, drug use, needle exchange and the effects of using poppers.

Table 10: Primary actions and topics within the main categories (n= 900)

HIV category	n	%
HIV		
PrEP/PEP	200	77.2
Other HIV-related concerns	30	11.6
HIV testing	17	6.6
HIV treatment	8	3.1
Sex and HIV	4	1.5
Sexual behaviour/sexuality		
Sexual behaviours	53	48.6
Sexuality	28	25.7
Condoms and lubricant	19	17.4
Other	9	8.3
Sexually transmitted infections (STIs)/treatment/mental health		
General testing	135	43.1
General treatment and advice	88	28.1
Hepatitis	32	10.2
Syphilis	18	5.8
HPV	12	3.8
Chlamydia	8	2.6
Other infections and conditions	8	2.6
Gonorrhoea	7	2.2
Mental health	4	1.3
Herpes	1	0.3
Substance use		
Other drugs and general information	14	51.9
G	6	22.2
Chemsex	4	14.8
Poppers	2	7.4
Alcohol	1	3.7
General information		
General information about GMHS	119	62.0
Outreach information	26	13.5
Clinic information (GMHS)	23	12.0
Follow-up information (GMHS)	11	5.7
Personal-development course	8	4.2
Venues	5	2.6

While multiple actions were recorded for the purpose of analysis, only the main action was reported on within each category.

3.3.4 Venue database: Descriptive information

Eighty-one entries were made in the database between December 2016 and December 2017. This database contained information on the outreach work conducted at different venues. Among the activities recorded in the database are giving information, arranging appointments with service users and arranging for the distribution of condoms and lubricant.

Table 11 presents the findings on shift times. Forty shift periods were recorded. The service-delivery periods from 12.00 pm to 6.00 pm (52.5%) and from 6.00 pm to 9.00 pm (17.5%) remained popular.

Table 11: Shift times at venues (n= 40)

Shift time	n	%
7.30 am to 12 pm	0	0.0
12.00 pm to 6.00 pm	21	52.5
6.00 pm to 9.00 pm	7	17.5
After 9.00 pm	12	30.0

Table 12 present findings on the venues. The most frequently visited venues over the 12-month period were Pantibar (19.8%), Outhouse (17.3%), The Boiler House (16%) and The George (14.8%).

Table 12: Frequency of outreach work conducted at different venues and events (n= 81)

Venues	n	%
Pantibar	16	19.8
Outhouse	14	17.3
The Boilerhouse	13	16
The George	12	14.8
GMHS	9	11.1
GLAMworld	4	4.9
Mother	2	2.5
The Hub	2	2.5
Cafe	1	1.2
Drogheda LGBT Group	1	1.2
PrHomo	1	1.2
Dublin Pride	1	1.2
Mayo Pride	1	1.2
Sweatbox	1	1.2
Lisdoonvarna	1	1.2
Erotic Cinema	1	1.2
Outreach	1	1.2

The places of birth of service users were generally unknown. Table 13 presents the countries of birth where known. The majority of service users were from Ireland (n= 53.8%) and Brazil (n= 34.6%). The ages of service users ranged between 19 and 36, with an average of 28.8 (SD= 5.2). All service users lived in Dublin (100%). Note that n= 26, as the rest are missing values, i.e., the birthplace of the other services users are unknown.

Table 13: Venue service users' places of birth (n= 26)

Place of Birth	n	%
Ireland	14	53.8
Brazil	9	34.6
UK	1	3.8
EU (excluding Ireland/UK)	2	7.7

3.3.5 Venue Database: Actions Carried Out by Outreach Workers and Topics Discussed

Table 14 gives a breakdown of the key categories of actions/topics undertaken by outreach workers. Table 14 presents action 1 and action 2 categories. The most common topic for both action 1 and action 2 was condoms and lubricant.

Table 14: Primary (n=74) and secondary (n=45) actions and topics within the main categories for venue-based outreach

Categories	Action 1		Action 2	
HIV	n	%	n	%
PrEP/PEP	3	60.0	4	80.0
Other HIV concerns	2	40.0	0	0.0
Testing	0	0.0	1	20.0
Sexual behaviour/sexuality	n	%	n	%
Condoms and lubricant	41	89.1	37	94.9
Sexual behaviours	2	4.3	1	2.6
Sexuality	1	2.2	1	2.6
Other	2	4.3	0	0.0
Sexually transmitted infections/treatment/ mental health	n	%	n	%
Gonorrhoea	2	20.0	0	0.0
General testing	4	40.0	0	0.0
Other infections and conditions	3	30.0	0	0.0
Mental health	1	10.0	1	100.0
Substance use	n	%	n	%
Alcohol	1	20.0	0	0.0
Other drugs and general information	4	80.0	0	0.0
General information	n	%	n	%
General information about GMHS	8	100.0	0	0.0

3.4 Science of Implementation - Barriers and Enablers Results

Earlier sections provided objective evidence on whether or not the outreach service was meeting its eight stated objectives within its code of governance and principles. This section explores in greater depth the process of how the service operated, and the governance, management and administrative structures that provided the context within which this took place. To explore this, an implementation-science framework was used.

Within the implementation-science framework as outlined by Burke and colleagues (2012) in our methodology, we have observed that there are four stages to implementation, namely, (i) exploring and preparing, (ii) planning and resourcing, (iii) implementing and operationalising and (iv) embedding and evaluating. The GMHS outreach programme is currently at stage four, embedding and evaluating. Within these stages, ten enablers for successful implementation have been identified, and the study data, including documentary analysis, have been used to ascertain if these enablers were present, and to what extent.

The first three enablers are stakeholder consultation and buy-in, leadership and resources. For successful implementation, these three need to be present across the four implementation stages.

Throughout the stakeholder interviews, various stakeholders reported the positive role that the presence of a nationally led, multi-sectoral collaboration had on the setting up and rolling out of the outreach initiative.

KS Participant 3: "The big thing was the fact that we were all sitting at the table, this helped in lots of areas. We have been working on trying to address HIV/STIs over the last few years. So the multi-sectoral collaboration around the same table has been the big plus."

Reports of the HSE-led MSM outbreak-response group provided evidence of stakeholder support for the outreach service. This can be seen in the following extract:

'A national model for training to deliver peer-led outreach and interventions is required, including a clear definition of peer, according to the target population' (MSM outbreak response group, 2017, p. 16).

Similarly, interviews with senior stakeholders provided clear evidence of buy-in, leadership and resourcing, as evidenced in the following statement:

KS Participant 2: "There is evidence that outreach interventions do work so we kind of took that international evidence, that it does work, and it's worth investing in."

Another stakeholder also emphasised the benefits of the early resourcing and commented on how this enabled the prompt start-up of the service:

KS Participant 4: "[H]aving the resources there made life easy for the guys to hit the ground running."

In terms of stakeholders based within city venues, stakeholder buy-in was not initially present, but it was nurtured and developed by the outreach team's leadership. This was an ongoing process that evolved as the venue base expanded or as needs changed. Evidence for this can be seen in the minutes of team meetings:

Agenda item: Overview of gaps in Outreach Condom and lube distribution; Discussion: xxx is the only cinema on board at present. Consider looking at talking to other venues; Action: X and Y to approach xxx and the venue on xxx Street and xxx Street. (Minutes, 4/12/2017).

Finally, as the outreach programme embedded itself within the MSM community, there was clear evidence from the online sample of outreach conversations of service-user buy-in into the outreach programme as can be seen in the conversation extract reproduced below (table 15)."

Table15: Example of service-user appreciation

Example of service-user appreciation	
Outreach-worker response	Hey, can I help you with anything?
Online query	Not just yet. I wanted to say thank you for being there and offering your help.
Outreach-worker response	You're very welcome. Glad to hear you think it's useful.

There was clear leadership in the early stages of implementation; exploring and preparing; and planning and resourcing. This was evident from the quotes above on stakeholder buy-in. There was also clear ongoing clinical leadership across the stages of implementation as can be seen from the following statement, which was made by a clinical stakeholder:

KS Participant 1: "I would link with them (outreach workers) as regards teaching and education that they have the right facts to discuss with guys out there. Be it on social media or if they are discussing one on one in social venues like bars, so making sure that they have the correct clinical data"

There was evidence that management structures were generally operating well, though occasionally with some confusion in roles. Where governance or leadership may have faltered was in the later stages of implementation, and it was unclear who was responsible for the sustainability of the service. This was evident in many of the stakeholder interviews.

From the planning perspective, it was hard to see how the necessary financial resources could be sustained and this was frustrating for both management and staff.

KS Participant 1 "It's very frustrating because we can't say this is your job for the next 5 years or ten years which it should be and could be."

These sustainability challenges also affected operational matters, as can be seen from the following quote:

KS Participant 5: "Time and money are the two main things (barriers). I think it's also been difficult in that I feel from the very beginning that we have been firefighting and that is very hard to work in that type of environment. . . . [T]here is always this pressure-cooker effect to deliver".

While financial resources had been committed to the service in the short term, it did not seem easy to operationalise the financial arrangements within the outreach service, and this is a key point of learning for any future roll-out of the service. Evidence for this was found within the stakeholder interviews, as the following quote illustrates:

KS Participant 4: "I suppose one of the problems with that was the monies and the management was [sic] coming through the GMHS, but there was nobody within the service there who had experience of managing an outreach programme. And so, one of the biggest problems at the beginning was around accountability."

Further challenges with administering the financial resources of the service arose when team members needed to purchase equipment, such as mobile phones, on a one-off basis:

KS Participant 4: "[S]ome of the other barriers were in just getting simple things, like being able to equip guys with mobile phones or being able to equip them with anything at all that they needed, was huge."

Similar difficulties arose when team members needed to use late-night taxis to get home from venues in which they had been working:

KS Participant 6: "[outreach worker] started out doing venue work initially..., for point of safety leaving a night club at 2 am or whatever it might have been 1 am [outreach worker] had

taxi vouchers but like that . . . it didn't work out properly at all when [outreach worker] rang the taxi company it actually ended up taking 3 hours to send a taxi [outreach worker's] way and so that again impeded on [outreach worker's] ability to do it because [outreach worker] were saying look you know [outreach worker] are being paid to be in a venue for an hour and a half and then were standing outside in a cold street for 2 hours before [outreach worker] gets a taxi [outreach worker] don't have to pay for, it's just not practical, so again [outreach worker] started to kind of, you know . . . there wasn't any real kind of structure to work off there."

In terms of implementation teams, plans, staff capacity and organisational support and culture, there was clear planning of staff activities, training and support. Evidence for this can be seen in early documents planning and describing the MSM outreach-response action plan (MSM outbreak response group, 2017), in the MSM sexual outreach plan (2016-2017), in the outreach job descriptions, in the advertising and awareness-initiatives literature on GHB/GBL, in the ongoing review and design of the initial interaction forms, in the responses to vulnerable groups and in the ongoing training of existing outreach staff to ensure their ongoing continuing professional practice and development.

However, this latter aspect of training, while of great benefit may have confused the role of the outreach service and its role in relation to the clinic service. This merging of training and service contribution can be seen in the quote below:

KS Participant 5: "So what we did was [outreach worker x] and [outreach worker y] were here, so they would have an opportunity to have an outreach impact intervention with people at the same time as doing the HIV test and send them off to the nurse to get their STI screen and then when they would come back from the STI screen, their rapid HIV test results would be ready."

The extent to which the outreach service made referrals to or otherwise linked up with other services was also evident from the online interactions as shown in the table 16 below:

Table 16: Example of interaction between outreach service and clinic service

Example of rapid HIV testing query	
Online query	Hi, is the immediate HIV test thing finished?
Outreach Worker response	KnowNow rapid HIV testing is still available in all of the venues quoted on their website www.knowhow.ie . GMHS also offer a rapid test at their Monday quick clinic

The further excerpt below of this conversation also demonstrates the sex-positivity and harm-reduction ethos that underpins the service and its communications.

Table 17: Example of sex-positivity and harm reduction ethos

Response to HIV-testing query	
Online query	Thanks. Have an appointment booked anyway. Drunken mistake.
Outreach Worker response	They happen, don't feel bad about it. You're doing everything right now by getting tested. Let me know if I can do anything else to help.

Although there was a clear commitment to ongoing staff capacity-building, this was on occasion reactive to need rather than planned. While this demonstrated a willingness, vision and responsiveness to an often rapidly developing environment, it did result in further administrative or operational challenges in terms of resourcing, as can the following quote illustrates:

KS Participant 5: "We have looked regularly along the way at their education and training, any opportunities that they think would help and we look and see if we can fund or support in any way or facilitate the hours to go and do what they would need to."

Moving forward, resources or planned commitments to provide the team with the opportunity to attend conferences and visit other sites of best practice or similar would be valuable:

KS Participant 1: "Yes and wanting them to stay involved and interested and giving them... like conferences and reports, we need to be able to give that to them so that they can report to their peers so we need to make that happen and so they can feedback to other clinics and there is a big UK conference in the autumn and we certainly want them to be at that to present their data. Not me presenting it, but the outreach workers, that they do it because it's their data, their work, because it shows that you value them."

Ongoing capacity building is a core component of implementation. The exceptional capacity of the staff to respond to the existing needs of the service users and to respond to emerging trends was reported repeatedly in the interviews. The outreach staff worked above the call of duty in relation both to the hours put in and to the initiatives that they created and rolled out. This was recognised when the outreach team received a GALA award. GALAs were set up to honour LGBT+ people and organisations for their contributions to Irish society. The outreach team's achievement in winning the award was especially significant, because there were no fewer than 100 nominations for different online projects. The outreach workers operated in a range of

different locations including the GMHS clinics, social venues at special events and online. This highlighted both the complexity of the outreach programme and the extensive skill set that the workers possessed.

KS Participant 5: "I think we were very lucky with the team we had and I'm not sure if we didn't have that team that it would have been as effective."

A further key enabler was the suitability of the key workers to address the most vulnerable groups. The epidemiological research showed that a key at-risk group in terms of STIs and HIV was the Latin American community. Therefore, it was decided that one of the outreach workers would need to be fluent in Spanish and Portuguese. Sex workers also have an increased risk of contracting STIs and HIV, and the outreach worker had successfully managed to engage this group. This was recognised within the service as can be seen in the following quotes, which illustrate the success of the service in reaching vulnerable or harder-to-reach groups:

KS Participant 5: "One of the biggest things that we are very proud of is the interventions with the vulnerable population, especially with people who either work as sex workers or escorts who would not have otherwise linked into treatment."

KS Participant 7: "I think for us it's a way that [outreach worker] can reach, especially because [outreach worker] work with men who have sex with men. Because Ireland is a small place, [outreach worker] encounter loads of guys that are not open or they're afraid of going to the clinic because it's too open and they won't disclose any information and so for us to be able to reach this profile people was extremely important."

It is important to note also that building relationships with these vulnerable cohorts takes time, and that the "invisible scaffolding" that these relationships provide is essential to successful outreach and successful outcomes. This is illustrated by the following quote:

KS Participant 7: "The beginning was a slow process like they were kind of suspicious of what we were actually doing. But now they are going to the clinic and they come to us, like, and say 'I am a sex worker' and we suspect they are probably going to have an STI because the frequency of partners they have."

It was also reported that outreach work had helped a number of sex workers to resolve their addiction issues. This is illustrated by the following quote:

KS Participant 7: "[I]t's been brilliant so a number of them had addiction problems and they come to [outreach worker] asking for help and [outreach worker] referred them to addiction service and they are clean now (wow), Yeah (fabulous)."

These are very positive findings, however, the outreach service must be considered in terms of its sustainability and in terms of the expectations that it will face as it moves forward or has to operate within new contexts. Staff members have carried out their roles in an exemplary manner, repeatedly going beyond the call of duty. However, the numerous tasks involved within the outreach role may lead to staff burnout and to operator dependency. As the service moves forward, it is important to monitor and manage this risk by ensuring that that staff and service-delivery expectations and deliverables are in line and are appropriate to the level of resources invested and the administrative structures in place.

The evaluation of the outreach programme provided clear evidence of a willingness and ongoing commitment to learn from experience and from others. Monitoring and evaluation were also developed and reviewed through the online interaction forms, and through their ongoing improvement and development. Also important in this context was the production of an initial pilot report, which provided clear plans for future outreach work. One example of this was the identification of saunas and sex cinemas as areas in which outreach work would be needed. Evidence of follow-up on this aspect of the pilot report was later observed within the minutes of a team meeting. Documentary analysis provided evidence of good communication between outreach team members but it also highlighted a lack of ongoing meeting schedules, minutes or agendas. Although team meetings did appear to occur regularly and to allocate weekly outreach tasks, there was little documentary evidence of meetings in relation to ongoing governance, longer-term planning and sustainability. Improvements here could significantly enhance communication across the key-stakeholder group.

The shadowing data showed that communication within the outreach programme operations was excellent, though often very challenging. The following extract from the shadowing observation report shows how this communication process worked in practice and how essential it is for the service to have and retain staff members who are highly trained and who also have an opportunity for supervision:

"One day in May there were five Grindr interventions and one WhatsApp dialogue. Conversations can involve a service-user discourse over days and in some cases, weeks. Two such conversations were observed during the Tuesday and Thursday sessions mentioned above. Issues discussed had a broad range including coming out, sexual violence and mental health" (Shadowing/observation data)

The extent to which the outreach staff embraced and acted on the outreach programme's ethos of sex positivity, harm reduction and client-centred service was well evidenced within the sample online interactions. One such conversation is reproduced in the following table:

Table 18: Example of service ethos and codes of governance

Example of continual discourse on STI information	
Online query 1	<p>Question for you</p> <p>What are the risks of contracting HIV by giving oral</p> <p>I am so sorry I jumped straight in with my question</p>
Outreach Worker response 1	<p>Hi there, thanks for the message. That's exactly why we are here. Thanks for the question.</p> <p>HIV from oral sex is a very close to zero risk. It is extremely unlikely. Other STIs like Chlamydia and gonorrhoea are a lot more likely if you come into contact with someone who has it.</p>
Online query 1	Thank you
Online query 2	What are the symptoms of chlamydia or gonorrhoea
Outreach Worker response 2	<p>A lot of the time there are no symptoms of these STIs, particularly in the throat. However, some people experience burning when peeing, itching and discharge. There's a full explanation of all STIs on the Man2Man website at www.man2man.ie</p>
Online query 2	<p>Thanks for this</p> <p>Appreciate you taking the time.</p>

In terms of learning from experience and full implementation, particularly in terms of the potential to sustain or scale up the outreach programme, it will be important, as the outreach programme moves forward, to ensure that clearer guidelines for operational procedures and governance are in place. These guidelines need to take account of the possible outcomes that the service can expect. The development of a logic model would help to guide this. In the initial stages, there was a lack of clarity regarding what was expected of the outreach service. Further clarity would benefit the existing service. There is evidence of this need in the response to the following question, which was posed in the interviews:

When you set up outreach initially, were there outcomes that had to happen and do you think they did occur?

KS Participant 5: "We weren't sure, so for me the big thing was and for all of us was – would this work? There had been outreach attached to the GMHS service years ago and we needed to know if this would work and how it would work. We did hope to make links and interventions with vulnerable populations and we hoped to make links with sex-on-premises venues and with gay clubs, bars, nightclubs and, from a point of ticking boxes, all of that was done. Relationships were certainly built, but on saying that, the level of work that the lads put into building relationships, people would not realise that it might take six, seven or eight visits. So, we did tick boxes and we were productive but it's difficult to know how productive those interventions would be, I suppose, and also this was new."

The peer aspect of the outreach programme was repeatedly reported as being critical to the programme model, as was an awareness of emerging trends. Any logic model developed in the future might incorporate this insight regarding awareness.

Moving forward with the model, the design of a logic model will be important in order to identify and frame the rationale for determining what is effective and why, and what successful outcomes might look like.

4. Conclusions and Recommendations

In response to recent increases in the number of STI and HIV diagnoses among MSM nationally, the GMHS in partnership with the Gay Health Network (GHN) developed a pilot outreach programme to engage MSM in popular social venues and online. The objective is to offer sexual health information and resources while also providing referral support. The overarching aim of the outreach programme was to deliver a peer-led, sex-positive, information-and-resource service to the MSM community, with a view to engaging men in preventative services and accessing STI and HIV treatment and testing. The aim of this report was to evaluate this pilot outreach prevention programme in line with five evaluation objectives: programme achievement; stakeholder experience; programme delivery; enablers and barriers to implementation; and operations, resources and reporting. An implementation-science framework was used to situate the overarching findings within the context of these five objectives. It is also important to note that it is well recognised internationally that outreach work is inevitably challenging in nature. Moreover, because it is a preventative intervention its success tends to be difficult to measure. The question that arises is how to measure something that one has prevented from occurring. These challenges have been articulated and addressed on the website of Evaluation Support Scotland and in the work done by Emerson and Wilson (2017) in Belfast.

In terms of the eight outreach programme objectives, clear objective evidence was provided by the shadowing data, by the screen shots of online interactions that were observed and by the quantitative analysis of the online database over a one-year period. This evidence showed that the objective of promoting the use of condoms and lube as an effective form of protection from the spread of STI and HIV was being met. The evidence also demonstrated that the aim of making condoms and lube more freely available was being realised, as was the goal of increasing knowledge about the signs and symptoms of STI and HIV. It was also clear that the programme was fostering awareness of resources and relevant websites. The evidence base further showed that HIV prevention was being promoted and that the topic (especially in relation to in particular PEP and PrEP) was regularly explored and discussed with service users. Moreover, other relevant strategies were also being put in place. Stakeholder interviews with direct service providers provided evidence that effective connections with difficult to access groups were being made. Throughout all of the data sources accessed there was clear evidence that positive advice and language were being used to reduce STI and HIV-related stigma. Supports and practices that promoted respect, sexual consent and harm reduction were observed.

We have already seen above that the outreach programme was meeting objectives one, two and three, which were concerned, respectively, with programme achievement, stakeholder experience and programme delivery. In terms of service delivery and capacity, however, it was clear from the quantitative analysis of the online/phone and venue-based outreach database that almost half of the outreach work was done between 12.00 pm and 6.00 pm. A further fifth of the outreach work

was carried out between 6.00 pm and 9.00 pm. This also reflected what was found within the stakeholder interviews, which explained that, due to how the outreach staff were administratively employed, evening and late night work was considerably more expensive to the service. In order to maximise resourcing, the team may wish in the future to review its pattern of employment administration and the time-focus of the outreach programme. Extra flexibility may be needed if the service is rolled out to other locations (see recommendation 8).

Analysis of the databases also showed that over three-quarters of the online interactions were conducted on Grindr. Given that the focus of the pilot outreach programme was to engage MSM in popular social venues with a view to offering sexual health information, this would appear to be appropriate for the early stages of the programme. If the programme is to be rolled out to settings that are less urban, however, this may need to be reviewed. This focus may also need to be reviewed if the current programme is expanded or if the target group is widened to also include MSM who are less active on social media dating sites. A greater presence of the outreach programme on non-MSM sites, such as Facebook, may be more suited to those who access social media in the work place, in their homes or in other communal locations (See recommendation 6).

The evidence made it clear that the outreach programme were accessing its two overarching target groups: Latin American and Irish men. The shadowing data and the online database show that the service was also used by sex workers, PWID, men engaging in chemsex and men who do not identify as gay. Over one third of all outreach interactions were with Brazilian men. The overwhelming majority of those who interacted online with the outreach programme were resident in Dublin. Again, although the greater part of the outreach programme was conducted online, it is important to note that the nature of Grindr means that those involved in any given interaction on this platform will be located quite close to each other within a relatively small geographical area. This restriction may also be something to consider as the service expands or rolls out to other, less urban regions (See recommendation 8).

The evidence that resulted from the evaluation process also sheds light on the time invested in the outreach programme. A total of 902 online interactions were recorded in the 13-month (54-week) period from December 2016 to December 2017. When basic annual leave (eight weeks) for two staff members is taken into account for this period, this provided a crude average of approximately 902/46 or 20 interactions per week (one interaction per hour). Given that the team consists of two staff members who each work for only 20 hours a week, and that online outreach was only one aspect of the outreach workload (see recommendation 5), this would appear to be a very high level of output and an efficient use of manpower resources.

Among the main reasons for setting up the outreach programme was a desire to increase awareness of STIs and HIV and to improve levels of testing among MSM. The findings relating to the overarching topics addressed, together with online discussions with service users, provided clear evidence that the service was addressing these objectives. The programme's

potential reach could be seen as the online outreach sessions covered such central topics as HIV, sexual behaviour and sexuality, STIs, treatment and mental health, substance use and general information.

The individual topics that were most frequently advised on were PrEP and PEP. To provide additional data on measured impact, the pilot project would need to move into the next stage of mainstreaming and develop an anonymised system to track individuals who received outreach advice and subsequently presented at a clinic or elsewhere for screening and testing. Emerson and Wilson (2017) have developed a system of this kind in Belfast. While their focus was on testing their tracking of impact systems could be explored as a potential relevant model. Additionally, by setting up a service-user forum, it might be possible to assess impact in a less measured or documented way. Such a forum would enable those who use the service to provide ongoing input on how they receive the service and on how the service can continue to meet user needs on an ongoing basis (See recommendation 7).

The evidence acquired during the evaluation process also shed light on the extent to which objectives four and five of the evaluation –respectively, to identify enablers/barriers and to make recommendations for the provision of resources — were being achieved. When the process data was synthesised in line with the implementation-science framework, the result provided a good summary of enablers and barriers to the early and current stages of the outreach programme delivery. There was clear evidence of early support in terms of stakeholder consultation and buy-in, and in terms of programme leadership, resources and governance. Screen shots of conversations with service users provided clear evidence of MSM stakeholder buy-in. Stakeholder buy-in within venue settings was initially slow, and the outreach team spent significant time in developing relations and setting up appropriate administrative mechanisms to ensure that venues had ongoing relevant supplies. This was a key learning point for the possible development of additional services within other locations (See recommendation 8).

As the pilot programme developed, there was evidence of ongoing staff capacity-building building, clinical governance and management. While there was clear and committed leadership in the early stages, there was also evidence of a need for improved administrative structures, management and clear governance and ownership. As the service moves forward, greater clarity in the overall administration, management, funding and governance of the service would improve the process and implementation of the service (See recommendation 3). This will involve putting in place administrative structures and resources that will ensure efficient management of finances, effective planning and resourcing, provision of necessary staff training, planning for capacity building and preparation for ongoing management and governance. Clear leadership, administrative management and ownership of the service will be required to ensure that the work completed by the outreach team —and the structures and systems developed thereby — are captured, recorded and developed for sustainability, transferability and possible future mainstreaming and roll-out to other locations or for other future outbreak response needs. This was a key learning point from the evaluation (See recommendations 2, 3 and 4).

The findings documented above clearly indicate which aspects of the service are working exceptionally well, and which aspects need to be addressed. Information on how to address these latter aspects of the programme can be found in the international literature. Evaluation Support Scotland (ESS) works with third-sector organisations and funders so that they can measure and report on their impact. As part of this work, ESS provides guidance on evaluating prevention and articulates the challenges that arise when carrying out such an evaluation. As ESS observes, it is difficult to measure something that has not happened, particularly for earlier interventions. Because early interventions are often informal, it can be difficult to establish a baseline. Moreover, when a service is informal, it is inappropriate to record personal details. When funding is short-term, longer-term outcomes such as programme impact, savings and economic benefit can be difficult to capture and evaluate.

ESS recommends building a logic model that identifies the range of activities, participants and outcomes (short, medium and long term) for the prevention programme and its subsequent evaluation. This helps services to think through how their work links to long-term prevention or strategic outcomes. The model can be used to collate evidence, to self-evaluate and to evaluate the outcomes within the services control (short term). ESS recommends that services follow up a sample of service users to test the theory of change (particularly for medium-term outcomes) and use formal, published evidence and data to check assumptions about what works and what is the longer-term impact (See recommendation 1).

In light both of the findings from this evaluation and of the international literature on best practice, the key actions outlined below are recommended. Recommendations 1 and 2 specifically address improvements in the operational procedures relating to objective five of the evaluation, and the actions recommended will also enable the future identification of relevant success factors as required by objective four. Recommendation 3 addresses the issue of sustainability, and recommendations 4, 5, 6 and 9 — while recognising success as required by objective four of the evaluation — address the need for improved administrative and governance systems, and for ongoing monitoring and evaluation of the fit of the service to the context and setting. This is important if the model for the service is to be scaled up or rolled out to additional geographical locations and settings. Finally, in terms of objective five of the evaluation on resourcing and reporting, evidence was found that the service was highly efficient and effective, but there was a high risk that if staff left the service, there would be a significant loss in terms both of knowledge and of service capacity. The ongoing sustainability of the quality of the service was also found to be at risk due to issues relating to staffing contracts and structure. It was further noted that as the service expanded, there was a risk to data integrity and monitoring. Recommendations 6, 7, 8 and 9 address this risk.

The recommendations intended specifically for the outreach programme are those numbered 1, 2, 5 and 6. Recommendations for the wider governance are included within recommendations 3, 4, 7, 8 and 9.

1. A logic model for the outreach programme should be developed in order to provide a clear and well-defined description of the aims, objectives and scope of the programme.
2. Existing structures and processes should be clearly documented. Using the logic model, a living manual for the programme should be developed in order to ensure that the programme is measurable and accountable and can be both sustained and replicated with fidelity.
3. Given the pilot service has moved from initial start-up to later stages of implementation as an established and running service, it is essential that clear and appropriate governance of such a service be established so that these governance structures can be replicated as necessary in other geographical settings.
4. The administrative, management and resourcing structures of the programme should be clarified and documented. This would enable these structures to be mainstreamed beyond the pilot phase and to be replicated in additional settings.
5. To ensure that it remains fit for purpose, the daily timing of the service delivery should be reviewed. This may also necessitate a review of how outreach staff contracts are administrated.
6. The use of the current social media platform for the online delivery of the programme should be reviewed to ensure that it remains fit for purpose outside of urban populations and among MSM who may not be active on MSM websites.
7. If the pilot outreach programme is to be mainstreamed, it is recommended that a structure is put in place to measure follow-up presentations from the online programme to the clinic or other settings for STI and HIV treatment, advice or testing. This will require the filling of the original outreach-service manager post to ensure quality, integrity and fidelity to the programme model, administrative structures, governance and legal requirements. It is recommended that further details be obtained, or a collaboration initiated with the Belfast model of service or similar to ascertain how they developed their recording systems. Consideration should also be given to the establishment of a service-users forum to enable the ongoing assessment (as opposed to measurement) of impact from the perspective of the person using the services.
8. If the service is to be rolled out to other locations, it will be important to ensure that sufficient time is allocated to allow for venue-based stakeholder buy-in and for the provision of supplies. This will make it possible to put in place the “invisible scaffolding” that is needed to support the outreach programme on sites and at venues.

9. Finally, it is recommended that a protocol should be established for accurate database management and secure data storage. Should the service be duplicated in other settings, a common, secure database structure and management system will be required.

In conclusion, the findings from the evaluation demonstrated that a highly effective and efficient pilot outreach programme was in operation. The evidence also indicated that additional planning and resourcing in terms of governance, administrative structures, staffing and systems will be required to ensure the ongoing quality of the service experienced by both service users and staff.

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6. Appendices

Appendix 1: Interview Questions: GMHS Staff and Key Stakeholders

Introductory Question

Can you describe your role in the management and running of the outreach programme?

Tell me about the early stages of setting up the programme.

What were the things that helped and what were the challenges?

(Barriers and enablers at that time at the individual, service and system level)

What was a typical day like then?

Prompts

1. Stakeholder buy-in
2. Leadership
3. Resources
4. Implementation Teams
5. Implementation Plan
6. Staff capacity
7. Organisational Support
8. Supportive organisational culture
9. Communication
10. Monitoring and Evaluation
11. Learning from Experience

Thinking About How the Programme Has Developed:

Tell me about running the programme now.

What were the things that help and what are the challenges?

(Barriers and enablers now at the individual, service and system level)

Further Prompts

1. What are the positive aspects of the outreach programme?
2. What types of activities does the programme do well?
3. Why do you think this?
4. What are the “added value” aspects of the programme? (Prompts may include: STI trend spotting, reporting on emerging drug use trends, lining in with vulnerable groups, etc.)
5. What are the challenges now?

Thinking about Outreach Work:

6. How much of the outreach team's work is pure outreach? What about administrative tasks? Travel to outreach venues? Online activities, etc?
7. Where do you see the outreach programme in 12 months? In 3 years? In 5 years?
8. How does the programme address the diversity in the MSM community in Ireland?
9. How does the programme respond to new and emerging challenges to sexual health and wellbeing of MSM? (Prompts: chemsex, drug resistant gonorrhoea, enteric STI outbreaks, etc.)

Thinking about Expanding the Programme to Other Locations:

10. What key advice would you give to others starting up?
11. Which of your systems and procedures could be easily copied for another location?
12. How could the outreach programme be improved? What would be needed to support and sustain any potential improvements?

Prompts

- Capacity
- Need/ fit
- Resource availability
- Evidence
- Readiness

13. Do you have anything else you would like to say or add?

Appendix 2: Service-User Questionnaire

1. When, where and how did you become aware of the GMHS outreach programme?
2. How often would you come across the outreach programme?
Prompts
 - Online
 - In person
3. What are the positive aspects of the outreach programme?
4. What types of activities or things does the programme do well?
5. And not so well?
6. "What are your reasons for your response?"
7. Where else would you find information on issues that the programme addresses?
8. How does the outreach programme link you or your peers in with other services and supports?
9. How does it direct you and your peers/friends/partners/mates, etc. to other sources of information, services and supports?
10. Would you recommend the outreach programme to other peers/friends/partners/contacts etc?
11. How could the outreach programme be improved?
12. What else could the programme do?
13. Where else could it work or provide outreach (online and in person)?
14. Do you have anything else you would like to say or add?

Appendix 3: Observation Schedules for Non-Participant Observation in Public Venues

Evaluation fieldworkers (male and female) accompanied workers on visits to venues and afterwards recorded observations on structured schedules.

1. Type of venue
2. Numbers,
3. Ages
4. Ethnicity of men
5. Planning of the session
6. Engagement with men in the venue;
7. Topics addressed
8. Factors influencing delivery
9. Responses

Appendix 4a: Consent form – Stakeholders

PROJECT TITLE: Evaluation of the Gay Men's Health Service Sexual Health Outreach Programme

PRINCIPAL INVESTIGATORS: Prof Catherine Comiskey, Karen Galligan PhD Candidate, School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2

RESEARCHERS: Dave Mc Donagh, , School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2, Sioban O'Brien Green, Trinity Research in Childhood Centre, School of Social Work and Social Policy

BACKGROUND

The Gay Men's Health Service (GMHS) based in Dublin provides free sexually transmitted infection (STI) and HIV testing and treatment services to men who have sex with men (MSM). In response to recent increases in the number of STI and HIV diagnoses among MSM nationally, the GMHS in partnership with the Gay Health Network (GHN) developed a pilot outreach programme to engage MSM in popular social venues and online, with a view to offering sexual health information and resources and referral support.

The overarching aim of the outreach programme is to deliver a peer led, sex-positive, information and resource service to the MSM community, with a view to engaging men in preventative services and accessing STI and HIV treatment and testing.

The aim of this piece of research we are asking you to take part in, is to assess the ways in which the outreach programme is both received and delivered, by speaking with key people what works, what doesn't work, what we can do differently.

Participation will involve a one to- one interview with a researcher from Trinity who will explore the topics above. The interview will last 20- 30 minutes. The interview will take place in a private room at the HSE Gay Men sexual health building on days that the outreach team are not working to protect confidentiality.. The interview will be recorded, with your permission, using a digital recorder. All transcripts , audio and written, will be anonymised and securely stored for the duration of the research project. All views shared by contributors will be treated confidentially and all comments will be reported anonymously. Participants have access to relevant transcripts, on request, and any information deemed to be revealing about personal information or otherwise may be omitted. You have the right to ask for all of the data you provided to be withdrawn or destroyed. If you are uncomfortable with any question asked during interview, you do not have to answer. If you have trouble reading or understanding any information given, the researcher will explain it to you. Consent will not be taken if you do not understand any of the information given. At any point during this process, the participant or researcher has the right to terminate. Data will be kept in Trinity College for 5 years in a secure password protected computer folder and the information will not be used in future unrelated studies without further specific permission being obtained

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME:

CONTACT DETAILS:.....

PARTICIPANT'S SIGNATURE:.....

Date:.....

Statement of researchers responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

RESEARCHERS SIGNATURE:..... **Date:**.....

Appendix 4b: Consent form – Men Who Have Sex with Men

PROJECT TITLE: Evaluation of the Gay Men's Health Service Sexual Health Outreach Programme

PRINCIPAL INVESTIGATORS: Prof Catherine Comiskey, Karen Galligan PhD Candidate, School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2

RESEARCHERS: Dave Mc Donagh, School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2, Sioban O'Brien Green, Trinity Research in Childhood Centre, School of Social Work and Social Policy

BACKGROUND

The Gay Men's Health Service (GMHS) based in Dublin provides free sexually transmitted infection (STI) and HIV testing and treatment services to men who have sex with men (MSM). In response to recent increases in the number of HIV and STI diagnoses among MSM nationally, the GMHS in partnership with the Gay Health Network (GHN) developed a pilot outreach programme to engage MSM in popular social venues and online, with a view to offering sexual health information and resources and referral support.

The overarching aim of the outreach programme is to deliver a peer led, sex-positive, information and resource service to the MSM community, with a view to engaging men in preventative services and accessing STI/HIV treatment and testing.

The aim of this piece of research we are asking you to take part in, is to assess the ways in which the outreach programme is received by the target audience by speaking with people directly in one to one interviews about their experience of the service- what works, what doesn't work, what we can do differently. These interviews will provide the critical voice of the person the service is aimed at.

Participation will involve a one to one interview with a researcher from Trinity who will explore the questions above. The interview will last 20- 30 minutes. The interview will take place in a private room at the HSE Gay Men sexual health building on days that the outreach team are not working to protect confidentiality. The interview will be recorded, with your permission, using a digital recorder. All transcripts, audio and written, will be anonymised and securely stored for the duration of the research project. All views shared by contributors will be treated confidentially and all comments will be reported anonymously. Participants have access to relevant transcripts, on request, and any information deemed to be revealing about personal information or otherwise may be omitted. You have the right to ask for all of the data you provided to be withdrawn or destroyed. If you are uncomfortable with any question asked during interview, you do not have to answer. If you have trouble reading or understanding any information given, the researcher will explain it to you. Consent will not be taken if you do not understand any of the information given. At any point during this process, the participant or researcher has the right to terminate. Data will be kept in Trinity College for 5 years in a secure password protected computer folder and the information will not be used in future unrelated studies without further specific permission being obtained

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME:

CONTACT DETAILS:.....

PARTICIPANT'S SIGNATURE:.....

Date:.....

Statement of researchers responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

RESEARCHERS SIGNATURE:..... **Date:**.....

Appendix 5 Logic model – definitions and examples

<https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/logic-model-development/main>

What is a logic model?

A logic model presents a picture of how your effort or initiative is supposed to work. It explains why your strategy is a good solution to the problem at hand. Effective logic models make an explicit, often visual, statement of the activities that will bring about change and the results you expect to see for the community and its people. A logic model keeps participants in the effort moving in the same direction by providing a common language and point of reference. More than an observer's tool, logic models become part of the work itself. They energize and rally support for an initiative by declaring precisely what you're trying to accomplish and how. In this section, the term logic model is used as a generic label for the many ways of displaying how change unfolds. Some other names include:

- road map, conceptual map, /or pathways map
- mental model
- blueprint for change
- framework for action or programme framework
- programme theory or programme hypothesis
- theoretical underpinning or rationale
- causal chain or chain of causation
- theory of change or model of change

Each mapping or modelling technique uses a slightly different approach, but they all rest on a foundation of logic – specifically, the logic of how change happens. By whatever name you call it, a logic model supports the work of health promotion and community development by charting the course of community transformation as it evolves.

A word about logic

The word “logic” has many definitions. As a branch of philosophy, scholars devote entire careers to its practice. As a structured method of reasoning, mathematicians depend on it for proofs. In the world of machines, the only language a computer understands is the logic of its programmer.

There is, however, another meaning that lies closer to heart of community change: the logic of how things work. Consider, for example, the logic to the motion of rush-hour traffic. No one plans it. No

one controls it. Yet, through experience and awareness of recurrent patterns, we comprehend it, and, in many cases, can successfully avoid its problems (by carpooling, taking alternative routes, etc.).

Logic in this sense refers to “the relationship between elements and between an element and the whole.” All of us have a great capacity to see patterns in complex phenomena. We see systems at work and find within them an inner logic, a set of rules or relationships that govern behaviour. Working alone, we can usually discern the logic of a simple system. And by working in teams, persistently over time if necessary, there is hardly any system past or present whose logic we can’t decipher. On the flip side, we can also project logic into the future. With an understanding of context and knowledge about cause and effect, we can construct logical theories of change, hypotheses about how things will unfold either on their own or under the influence of planned interventions. Like all predictions, these hypotheses are only as good as their underlying logic. Magical assumptions, poor reasoning, and fuzzy thinking increase the chances that despite our efforts, the future will turn out differently than we expect or hope. On the other hand, some events that seem unexpected to the uninitiated will not be a surprise to long-time residents and careful observers.

The challenge for a logic modeller is to find and accurately represent the wisdom of those who know best how community change happens.

