EVIDENCE AS A RESOURCE OF CONTROL AND RESISTANCE IN 'ADVANCED LIBERAL' HEALTH SYSTEMS: THE CASE OF HIV PREVENTION IN THE UK

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A thesis presented to the University of London for the degree of Doctor of Philosophy

August 1999

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To Siwan, and to Mom, Dad & Nick.

ABSTRACT

This thesis suggests that, as the NHS is transformed from a directly-managed hierarchy into a devolved system, the production and use of 'evidence' are increasingly important elements in strategies of control and resistance. The power relations within which evidence is defined, produced and used, and the consequences of these processes, vary between the statutory and voluntary sectors, and amongst different professional and other groups. While these matters have been a topic of some previous conjecture, an empirical analysis, looking systematically at power, has not been published. This thesis develops such an analysis, in relation to HIV prevention. Two case studies, a genito-urinary medicine clinic and a voluntary agency, are examined.

The thesis concludes that evidence is implicated in health authority commissioners' 'hands-off' strategies of control, termed 'action at a distance', in relation to statutory providers; and their more interventionist strategies, termed 'steering at a distance', in relation to voluntary providers. However, it is also concluded that evidence often proves a problematic resource of control, and a valuable resource of resistance for providers.

The thesis develops and applies a novel view of power; which acknowledges the substantive value of 'governmentality', an analytic framework developed by Foucault, but which also recognises that, in order to render an adequate account of control and resistance, analysis must consider where interests are served, and where they are squashed. The analytical framework developed and used incorporates some elements from the work of Lukes.

CONTENTS

		Page
Front Piece		
Abstract		
Contents		
Acknowledgments		
Chapter 1	Evidence as a resource of control and resistance in 'advanced liberal' health systems	1
Chapter 2	Power and the production and use of knowledge	11
Chapter 3	NHS reform and a new focus on evidence in government policy	23
Chapter 4	Evidence and HIV prevention in advanced liberalism	45
Chapter 5	Research design	67
Chapter 6	Planning and delivery of HIV prevention in the case studies	95
Chapter 7	Evidence in the King George's Clinic case study	131
Chapter 8	Evidence in the Gay AIDS Action case study	172
Chapter 9	Discussion	225
Bibliography		265
Appendix 1	Interviewees	287
Appendix 2	Acronyms	289
Appendix 3	Structures of King George's Clinic & related organisations	291
Appendix 4	Structure of Gay AIDS Action	292

Acknowledgements

Thanks to the NHS Executive, for funding the study. Thanks to my supervisors, Ann Oakley and Sandy Oliver, for striking the right balance between providing support and guidance, and leaving me to get on with it. Thanks to my examiners, Graham Hart and Judith Green, for their extremely constructive criticism. Thanks to all those working in HIV prevention who were interviewed, or who otherwise gave help. All of you remain anonymous, but I'm in your debt. Thanks to John Vail, Steve Quilley, Tim Rhodes, Sir Michael Peckham, Gillian Hunter, Iain Chalmers, David Goldblatt, Rhodri Lloyd Hayward, Angela Harden, James Thomas, Amanda Nicholas and Matthew Hilton, for pointing me in the right direction or just listening. Thanks to my friends and family, for their very sensible lack of interest in evidence-based practice. Most of all, thanks to Siwan Lloyd Hayward for continuing to illuminate and distract.

CHAPTER ONE: EVIDENCE AS A RESOURCE OF CONTROL AND RESISTANCE IN 'ADVANCED LIBERAL' HEALTH SYSTEMS

This chapter explains the overall scope of the thesis, briefly discusses how the terms 'evidence' and 'evidence-based practice' (EBP) are defined within health services, and summarises the issues addressed in the other chapters.

Scope of thesis

This thesis draws on a body of literature which has argued that knowledge is central to the operation of power in modern societies. The thesis suggests that, as the National Health Service (NHS) is transformed from a directly-managed hierarchy into a devolved system linked by quasi-contractual relationships, evidence becomes an increasingly important element in strategies of controlling what is a potentially chaotic system. It is further suggested that, in terms of power relations, the conditions under which evidence is defined, produced and used, and the consequences of these processes will vary between the statutory and voluntary health sectors, and amongst different professional and other groups. The empirical component of the thesis sets out to explore the relevance of these suggestions for HIV prevention in the NHS.

HIV prevention has been chosen because: it involves a range of sectors and experts; the place of various forms of evidence is controversial; and conflict is obvious. It is not claimed that conclusions developed from examining HIV prevention will *necessarily* be applicable to other areas in the NHS. However, the thesis considers the possibility that some conclusions are more generally pertinent. The study focuses on both those involved professionally and as volunteers in HIV prevention. It does not attempt to examine the position of service users, though it is acknowledged that this is an important topic.

The questions which the study attempts to answer are as follows. In the planning and

provision of HIV prevention by NHS-funded agencies:

1. How are the definition, production and use of evidence determined by existing relations of control and resistance, between: 'central' and 'peripheral' agencies; commissioners and statutory/voluntary sector providers; and managers and clinical/non-clinical practitioners in statutory/voluntary sector providers?

2. Is evidence defined, produced and used in order to modify relations of control or resistance, particularly in the prioritisation of services?

3. Does the definition, production and use of evidence modify relations of control and resistance?

Some might find a political analysis of EBP uninteresting, and perhaps unduly cynical, seeing the rise of EBP as inevitably resulting from its unquestionable rational and ethical basis. Such a view is rejected for two reasons. Firstly, it ignores the fact that many of those central to the development of EBP have themselves referred to their own political, rather than purely technical, motivations in developing these technologies. Quotes which substantiate this argument are given in the next section. Secondly, the apolitical view implies a technological-determinist account of how technologies are applied, divorcing this process from the political and social realm. According to Webster (1995: 219) technological determinism:

> desocialises key elements of social change, persistently separating technology/technique from the social world (where beliefs and values are found), only to reinsert it by asserting that this autonomous force is the privileged mechanism for bringing about change.

A variety of social and political developments have made for a context conducive to the embrace of EBP, by the NHS and other health systems. EBP is, in turn, likely to have political ramifications, and these effects must be analysed with reference to their context.

This thesis makes an original contribution to sociological literature in that it empirically

examines the political conditions within which EBP is developed, and the consequences of these developments. While this has been a topic of some previous conjecture, among those involved in research and practice in HIV prevention (eg. Bhatt and Lee 1997), in health services generally (Cochrane 1989), and among health policy analysts (eg. Harrison 1998), an empirical analysis, looking systematically at power, has not previously been undertaken. Furthermore, the thesis develops and applies a novel view of power which acknowledges the substantive value of governmentality (Foucault 1991), but which also recognises that, in order to render an adequate account of control and resistance, analysis must consider where interests are served, and where they are squashed (Lukes 1974), something which governmentality fails to do.

'Evidence' in health services

According to Hacking (1975), the concept of 'empirical evidence' emerged in the latter part of the 17th century, associated with the development of causal logic and probabilistic thinking. Green (1997) distinguished between 'internal' (ie. empirical) evidence, and the formerly pre-eminent 'external' evidence, which was conceived as emanating from expert authority (eg. the sovereign), or from the associations of signs on the basis of relations of correspondence, rather than causality (eg. astrology). The medical profession rapidly adopted elements of the new scientific thinking in the 17th and 18th centuries (Foucault 1973). Despite this, medicine continued to be viewed as an art, as much as a science, and clinical judgment was often more significant than empirical evidence in the guiding of practice (Hoffenburg 1987). EBP has however recently aimed to challenge the authority of expert judgment, in medicine and other fields (Marshall 1997).

EBP is often viewed as the basing of practice on protocols (Haynes and Haines 1998) directly based on evidence, especially, but not exclusively, of effectiveness (Baker et al. 1997), and especially, but not exclusively, from prospective experimental studies with control groups (Muir-Gray 1997). The term, 'evidence-based medicine' (EBM) is sometimes used to refer to the specific case of using evidence in medical practice. A number of individuals are said to have been influential in the development of this view

of EBP. In the United States, Donabedian (1966) recommended a systematic approach to the evaluation of health care, in which interventions were viewed as comprising structure (what technologies were in place), process (how services were provided) and outcome (the impact on clients), all requiring evaluation. This followed on from previous work, for example by some American surgeons (Dent 1995), who had attempted to measure the outcomes of various operations. In the United Kingdom, Cochrane (1989) argued that, although there had been considerable research in basic science geared towards developing medical technologies, there had been insufficient evaluation of these and subsequent practices.

Clinical variation was one of the key factors which spurred an increasing focus on effectiveness. Bunker (1970), for example, highlighted the immense difference in rates of various surgical interventions between the US, and England and Wales. This could not be explained in terms of clinical need. As Cochrane and his supporters saw it, if doctors were practising in different ways, the aim should not simply be one of eliminating variation, but of determining which, amongst various practices, were, in fact, effective. This perspective was informed by an ethical position which saw medical practice as maximising good and minimising harm to patients. Cochrane also outlined a political rationale for determining the effectiveness of different services. He suggested that, in a situation where a population's demand for care outstrips the state's ability to fund care, there is an ethical duty on the NHS to provide what will bring about most benefit, and least harm, within the population:

> I believe... that the problem of evaluation is the first priority of the NHS... The main job of medical administrators is to make choices between alternatives. To enable them to make the correct choices, they must have accurate comparable data about the benefit and cost of the alternatives (Cochrane 1989:25)

Cochrane suggested that the individual autonomy of medical practitioners regarding standards of practice might become limited:

> I imagine that, if the research results are implemented, there will be a considerable limitation of [clinical] freedom. Indications for prescriptions, diagnostic tests, admission, length of stay in hospital etc. will get

more and more clinically defined, and a sort of 'par for the course', associated with each group of signs and symptoms, will be established, and those doctors with too many 'strokes' above or below 'par' will be asked to justify themselves before their peers... Some will undoubtedly object to this, but, if the evidence on which the 'par' is based is made clear, and the objective of being fair to all patients served by the NHS, is explained, I doubt if many will emigrate.

These arguments about service prioritisation and practitioner autonomy have been re-stated by more recent advocates of EBP (Muir-Gray 1997).

Cochrane championed the randomised controlled trial (RCT), a technique earlier applied in the fields of agriculture (Cochrane 1989) and education (Oakley 1998b), amongst others. RCTs are commonly said to have been first applied within medical science by Austin Bradford-Hill (Daniels and Hill 1952) to the evaluation of streptomycin, but were, in fact undertaken somewhat earlier than this (Oakley 1999). Cochrane developed a hierarchy of evidence; only those interventions showing immediate and obvious effect did not require formal evaluation and, of all forms of evaluation, the RCT was the most rigorous. This view, that the RCT is the best method of evaluating the effectiveness of interventions, has been repeated many times. In describing what is a wide consensus at least among some groups, Muir-Gray (1997:61) lists the following sources of evidence in order of preference: systematic reviews of multiple, well designed RCTs; one well designed RCT; well designed trials without randomisation; well designed non-experimental studies from more than one centre; opinion based on clinical evidence; and descriptive studies or reports of expert committees.

Davis and Howden-Chapman (1996) have suggested that EBM has been taken forward in the form of a social movement. Iain Chalmers (Chalmers et al. 1989) and David Sackett (Sackett et al. 1991) can be identified as key figures in this movement. Sackett's team at McMaster University coined the term 'evidence-based medicine'. In the UK, Chalmers founded the first Cochrane Centre, with funding from the NHS. An international Cochrane Collaboration has been established, comprising groups who produce systematic reviews of the effectiveness of a diversity of health care interventions. These ideas about EBP have now influenced policy in the NHS, discussed below and in

Chapter 3.

Other views about evidence, and how it can inform practice, have been expressed, some of which complement the above, and some of which contradict it. Some have asserted the importance of experience, as well as research, informing health care planning and practice (Smith 1996). Some have stressed that practice needs to be based on evidence of other aspects of services, as well as effectiveness (Black 1996). Some have questioned the feasibility, utility and epistemological appropriateness of trials for evaluating the effects of all, or some, interventions (Charlton 1995, Davies and MacDonald 1998).

The view of EBP described earlier, in which research informs the development of protocols which are used by practitioners to guide their decisions, implies a linear view of the implementation of research. Janowitz (1972), Weiss (1977) and Patton (1988) have argued that non-linear models better describe the effects of research on decision-making, than do linear ones. Although these authors focused on the decisions of policy-makers, rather than practitioners, the blurring of policy and practice decision-making in the NHS (Harrison et al. 1992) might imply the relevance of their ideas for the use of research in practice.

Thus, different views of EBP exist. Whilst not denying that questions as to the most appropriate and rigorous means of defining, producing and using evidence need to be addressed, this thesis does not attempt to do so. Instead, it examines how the context within which different organisations and professional and volunteer groups work affects how they define, produce and use evidence; and, in turn, what implications these processes have for their authority and autonomy.

Overview of other chapters

Chapter 2 develops a framework for empirically analysing power, based on Foucault's (1991) notion of 'governmentality', and Lukes' (1974) work on interests. The chapter explains that, according to Foucault (1991), with the advent of the liberal state in the

seventeenth century, government became tied to the collecting and use of knowledge about human conduct. The state did not, in the main, coerce or direct citizens, but rather, state institutions contributed, along with citizens themselves, to the articulation and development of various discourses (ie. frameworks for knowing and doing) which shaped citizens' wants, and affected their actions (Rose and Miller 1992). Experts thus became central to a form of power which Foucault termed 'governmentality'. According to Foucault (1991), as liberalism developed into advanced liberalism in Western societies after the Second World War, the collection and use of expert knowledge multiplied, and became increasingly devolved from central government agencies. Expertise, whilst still a necessary part of the apparatus of government, itself became scrutinised in terms of costs and effects.

Chapter 2 suggests that, while governmentality has substantive pertinence to an analysis of the context and consequences of EBP, it contains flaws which render it inadequate as a framework for informing the empirical component of this thesis. Lukes' (1974) work on power and interests is also reviewed, in order to develop a rigorous means of analysing the power relations within which evidence is defined, produced and used in the NHS. Referring to the work of Hughes and Griffiths (1999), two terms are developed, 'control via action at a distance' and 'control via steering at a distance', for analysing the use of evidence in the deployment of power.

Chapter 3 examines the 'advanced liberal' political context in which EBP has been embraced within the NHS. It reports that, in the course of the 1990s, the NHS has moved to a devolved mixed economy of provision, involving a diversity of groups from the statutory and voluntary sectors (Klein 1995; Kendall and Knapp 1996). After the publication of *Working for Patients* (DoH 1989), district health authorities (DHAs) became responsible for meeting the health needs of the local populations, via the commissioning of services from an array of semi-independent statutory, and fully independent voluntary, agencies. From 1996, DHAs merged with family health service authorities to form health authorities. The role of the central Department of Health (DoH) and NHS Executive (NHSE), in this new system are said to be increasingly ones

of setting the overall targets which influence local policy and practice, rather than of directing activities (Holliday 1995). According to Hoggett (1996), a new model has developed, in which the planning of activity is devolved, while control is centralised.

The NHSE has recently embraced EBP, and initiated a national Research and Development (R&D) Programme. Under its first Director of R&D, Professor Sir Michael Peckham (1991a), this programme is said to have embraced a form of EBP which prioritises an examination of effectiveness, the use of prospective experimental methods with control groups, and the application of evidence via protocols (Baker et al. 1997). Chapter 3 suggests that, although the development of EBP pre-dated the devolution of NHS planning, the recent embrace of EBP by the NHSE coincides uncannily with this development. It may be that evidence functions as a key resource in the new system. St Leger (1992) suggested that commissioners require a currency of quality, as well as of cost, by which to assess the services they commission. Effectiveness evidence could be used by commissioners as a means of informing their prioritisation and de-prioritisation of different forms of intervention in service planning. The NHS's first director of R&D indeed suggested the importance of research evidence in informing the prioritisation of services (Peckham 1991b). The explication and systematisation of practice in evidence-based protocols might also be used as a means of regulating the work of individual practitioners. EBP has been identified as a possible threat to medical and nursing clinical autonomy by Coles (1990) and Klein (1995), among others.

Chapter 3 also observes that EBP might be used by various organisations and groups as a means of resisting control. The possibilities that evidence could be used to resist the rationing of services (Franks 1996) and the curbing of practitioners' autonomy (Klein 1995) are considered. Chapter 3 raises a series of questions about EBP in the NHS in general, which later chapters attempt to answer with reference to one specific area, HIV prevention.

Chapter 4 examines the particularities of HIV prevention in the UK. This field is an interesting case study for the study of power-play and evidence, because of: the diversity

of statutory and voluntary agencies, and clinical and non-clinical groups involved (Berridge 1996); their apparently divergent views on what constitutes evidence (Bennett and Ferlie 1994); and the salience of control and resistance in an area of provision where health authorities have only recently become responsible for the planning of services (Bhatt and Lee 1997).

Chapter 4 considers Bennett and Ferlies' (1994) suggestion that different sectors and groups will have systematically different orientations to evidence. It assesses whether, for example, the statutory and voluntary sectors, and clinical and non-clinical groups will have different approaches to defining, producing and using evidence, which, in turn, have implications for the authority and autonomy of these groups. Chapter 4 hypothesises that 'control via *steering* at a distance' may be more likely in the management of the voluntary sector, and of non-clinical practitioners, while 'control via *action* at a distance' may be more likely in the management of the statutory sector, and of clinical practitioners. However, the chapter also raises the possibility that the boundaries between groups and sectors in devolved health care systems, such as the NHS, may be increasingly blurring (Marshall 1996), and so may not have a great bearing on actors' views and actions regarding evidence. Chapter 4 thus raises a number of additional questions, which the empirical component of this thesis attempts to answer.

Chapter 5 describes the research design employed in the empirical components of the thesis. The study involves a comparative case study design, in which two organisations involved in HIV prevention are examined. One of these is a voluntary agency, staffed largely by volunteers and administrative workers, while the other is a genito-urinary medicine (GUM) clinic based in a community NHS trust, and staffed by a variety of professional clinical and health promotion workers.

Chapters 6,7 and 8 present findings. Chapter 6 describes the groups and organisations involved, and the general authority and autonomy enjoyed by these. Chapters 7 and 8 report on the definition, production and use of evidence in each case study, and how these relate to the power relations between different organisations and groups.

Chapter 9 compares the findings from each case study, and, using the framework developed in earlier chapters, develops a sociological analysis. This analysis considers whether EBP is associated with strategies of control and resistance, and, if so, whether these can be characterised as 'control via action at a distance' or 'control via steering at a distance'. Chapter 9 considers whether EBP has different implications for the authority and autonomy of the statutory, compared to the voluntary, sector, and of clinical, compared to, non-clinical practitioners.

CHAPTER TWO: POWER AND THE PRODUCTION AND USE OF KNOWLEDGE

1. Introduction

This thesis considers EBP in terms of the power relations within which evidence is defined, produced, and used, as well as the consequences, intended or not, of these processes for the reproduction, and modification, of power relations. Although the topic itself is a novel one for such an analysis, the general approach taken is informed by a body of social theory, reviewed in this chapter, which has argued that the production and use of knowledge is implicated in the operation of power in modern Western societies.

Foucault (1991) suggested that, within 'liberal' societies, the knowledge-producing and -using activities of a diversity of experts have been centrally involved in the government of citizens' conduct. Furthermore, Foucault suggested that, as 'liberal' societies developed into 'advanced liberal' societies, in the West in the period after the Second World War, the activities of experts themselves became increasingly scrutinised, and regulated via technologies involving even more production and use of knowledge. In this chapter, Foucault's work is critically considered, both in terms of its substantive relevance to the concerns of this study, and its methodological relevance to an empirical examination of power.

2. Substantive relevance of Foucault's ideas

a. Foucault on 'liberalism' and 'governmentality'

According to Foucault (1991), 'liberal' societies first developed during the seventeenth century. Informed by Foucault's work, Rose (1993) argued that liberalism had a number of key features. Firstly, liberalism depended on citizens being active in their own government, rather than being subjugated by force, as had been the case in some earlier societies. Free citizens governed their own conduct in line with dominant discourses.

Secondly, in order to govern, liberalism sought to harness forms of authority outside central government. Expert practitioners were, for example, brought into the state apparatus, whilst retaining considerable autonomy in their practice (Johnson 1995). Thirdly, liberalism, for the first time, tied the process of government to the collecting and use of knowledge about human conduct.

Foucault (1977) developed the Panopticon as a metaphor for the surveillance and control of citizens. Developed as a model prison by Jeremy Bentham, the Panopticon comprised a central tower, with small windows all around, housing an observer. This tower was surrounded by a ring-shaped building, comprising a multitude of cells, each with a large window facing the tower, and each housing a single inmate. The structure enabled the central observer to scrutinise all inmates' actions. Foucault suggested that, as a result of the ever-present possibility of scrutiny, the inmates would modulate their actions in line with whatever regulations the institution determined. Foucault saw the observer as metaphorically representing the accumulation of knowledge about populations in modern society, and the rules as representing the discourses which populations co-articulate and employ to regulate their own conduct.

In what Foucault (1991) came to term 'governmentality', populations are influenced by a set of discourses determining acceptable behaviour, not as passive objects of power, but as active agents in its operation. Foucault's view on the workings of power within the modern state contrasts with that of other writers, such as Marx and Althusser, who emphasised the overt exercise of power by the macro-institutions of the state in the course of enabling the functioning of capitalism (Giddens 1971). Foucault even sought to problematise what is meant by 'the state'. According to Johnson (1995: 7):

Foucault's concept of government rejects the notion of the state as a coherent, calculating subject whose political power grows in concert with its interventions into civil society. Rather, the state is viewed as an ensemble of institutions, procedures, tactics, calculations, knowledges and technologies, which together comprise the particular form that government has taken; the outcome of governing.

Foucault repeatedly emphasised the special place of expertise in governmentality. As

Rose and Miller (1992: 175) argued:

> governmentality is intrinsically linked to the activities of expertise, whose role is not one of weaving an all-pervasive web of 'social control' but of enacting assorted attempts at the calculated administration of diverse aspects of conduct through countless, often competing, local tactics of education, persuasion, inducement, management, incitement, motivation and encouragement.

Governmentality is not a totalizing theory as to how government proceeds. The discourses associated with any form of governmentality are neither complete nor uncontested. Foucault recognised that actors take on board new rationalities and technologies, but use them according to local situations. His rule of the tactical polyvalency of discourses asserted that resistance is not ontologically distinct from the exercise of domination, but that the two are embedded within one another: where a discourse of domination operates, it will ineluctably open the way up for discourses of resistance. McNay (1994: 101-2) illustrates this potential with an example which Foucault himself used:

> on the one hand, the 'perverse implantation' of the nineteenth century - the massive proliferation of discourses on 'deviant' sexualities - served to reinforce social controls in the area of 'perversity' and to legitimise a notion of 'normal' heterosexuality. Yet on the other hand, this very multiplication of controlling discourses created a counter-vocabulary or 'reverse discourse', which could be used by those labelled deviant to establish their own identity and to demand certain rights.

Foucault (1991) acknowledged that the outcomes of any process of governmentality are contingent on local action. In processes of local action, diversity, and even paradoxes, are possible. In some locales, rationalities and technologies may come to subvert the system of government, as it is described above. Foucault's position on this has been questioned, however. Some have suggested that he tended to use governmentality to suggest a totalizing picture, in spite of his comments on its contingency. As McNay (1994: 102) says:

> Foucault tends to highlight disciplinary practices at the expense of a consideration of the various other practices that also constitute the social realm. Such activities might constitute the everyday activities of

individuals who resist, in a mundane and 'invisible' fashion, the normalizing pressures exerted over their lives.

b. Foucault on advanced liberalism and the government of expertise

Burchell (1993), elaborating Foucault's (1991) own ideas, suggested advanced liberalism differs from liberalism in three ways. Firstly, advanced liberalism involves a pluralisation of technologies. Welfare services, for example, have become reconfigured and detached from government institutional hierarchies. Welfare agencies are increasingly seen as semi-independent enterprising bodies. As the agencies of government gradually become more and more devolved, central control is maintained via contractualisation and related systems of accounting and monitoring. Secondly, a new relationship between expertise and the state has developed. Expertise and knowledge gathering are still a necessary part of the apparatus of government, but, rather than according unconditional respect and considerable autonomy to expertise, government seeks to scrutinise the actions of expertise, in terms of its cost and effects. As Bunton (1997:226) puts, and perhaps overstates, it:

> Calculative regimes and financial management have entered the relationship between the professional and the state. Audit and marketisation have rendered expertise governable by eradicating the uncertainty of truth claims.

This scrutiny and control occurs within the context of the contractual relations between devolved agencies described above. Thirdly, citizens become recast as 'consumers', in receipt of services from these devolved agencies.

c. The new NHS as an advanced liberal structure

What relevance, then, do Foucault's ideas have for Britain's NHS in the 1990s? While a more thorough and nuanced picture of developments in the NHS is presented in the next chapter, a number of elements within recent NHS reforms are highlighted here, to suggest that developments in the NHS do bear some resemblance to what Foucauldians

might describe as an 'advanced liberal' structure.

Many authors have suggested that the role of the state is increasingly becoming fragmented and limited, rather than coherent and comprehensive. Agencies concerned with health provision have become devolved to a local level, rather than being part of a national hierarchy (Klein 1995). Services can be provided by voluntary agencies as well as by semi-autonomous statutory agencies (Kendall and Knapp 1996). Government sets specific targets for its provider agencies to achieve, rather than directly managing them (Hoggett 1996). There has been increasing talk of rationing the work of these provider agencies using criteria of cost and health gain (Harrison and Pollitt 1994). The notion that citizens have a general right to comprehensive health provision appears to have been gradually eroded (Klein et al. 1996).

Health care provider agencies which were previously dominated by experts, such as doctors and other clinical professionals, have been encouraged to appoint general managers (Harrison et al. 1992). These managers often view their role as entrepreneurs, in seeking contracts within a competitive market for state and other funding. It has been suggested that managers seek to control the work of their expert practitioners in order to realise health gain and cost containment objectives (Harrison and Pollitt 1994). The users of services and the local populations in general have often come to be described as consumers rather than citizens (Pfeffer and Coote 1991).

d. EBP as expertise under scrutiny

As well as resonating with the general structural developments in the NHS, Foucault's ideas on governmentality in advanced liberal societies appear to have some specific bearing on the development of EBP within the NHS. From a Foucauldian perspective, EBP could be seen as reflecting an increasing expectation on the part of government that expert health practitioners justify what they do, both in terms of which services are prioritised, and how services are actually provided. Technologies associated with EBP could, within the new structure set out above, both politically legitimate and practically

enable: the regulation of peripheral provider agencies by central agencies; the local regulation of practitioners; the commodification of services in peripheral markets; and the local rationing of services. EBP could result in these outcomes, both as a result of intended strategies of control, or perhaps as unintended consequences of EBP being implemented for other reasons, not directly concerned with power-play, such as scientific interest.

Whether the definition, production and use of evidence result in the effects listed above is far from inevitable. In the course of implementing EBP, a number of tensions and paradoxes might arise. The implementation of a programme of evidence-based health services would require a proliferation of expertise. Many more individuals, from practitioner or other backgrounds, would need to be engaged in health services research. As this proliferation proceeded, it might well be that some forms of expertise come to run contrary to the view of evidence initially prioritised in the programme led by central agencies. Some of the implementors might simply reject some elements of the new programme, or perhaps retain a large degree of scepticism in implementing it. A critical view on provision, which the development of rhetoric and action on EBP is likely to encourage, might mean that a critical view is similarly applied to EBP itself. Questions such as 'is it feasible?', or 'is it cost-effective?' could be applied to the new programme. The new programme might encourage a questioning, eg. by practitioners and managers, of the evidence-basis of wider policy matters. As Foucault's rule of the tactical polyvalency of discourses suggests, it may be precisely at the points of most domination where resistance arises. These possibilities are further hypothesised in the next two chapters, and examined in the empirical case studies.

3. Methodological relevance

This thesis is a study of power. It aims to examine the processes by which evidence is defined, produced and used, in order to understand: how these are affected by the power relations between different groups; and how these, in turn, affect the power relations between these groups. The writings of Foucault have provided a stimulus to studying this

subject. The question addressed in this section is, can Foucault's writings provide a useful framework for empirically investigating power? His ideas are assessed and compared to those of Lukes (1974) and to Hughes and Griffiths (1999), in order to develop a framework for research.

a. Power examined bottom-up

Foucault (1986: 234-5) suggested that power is best explored bottom-up, rather than top-down. He wrote:

> the important thing is not to conduct some kind of deduction of power starting from its centre and aimed at the extent to which it permeates into the base, of the degree to which it reproduces itself down to, and including, the most molecular aspects of society. One must rather conduct an *ascending* analysis of power, starting, that is, from its infinitesimal mechanisms, which each have their own history, their own trajectory, their own techniques and tactics, and then see how these mechanisms of power have been - and continue to be - invested, colonized, utilized, involuted, transformed, displaced, extended, etc, by ever more general mechanisms and by forms of global domination.

This approach seems useful because, as suggested by Giddens (1984), it avoids the teleology inherent in studying the *functions* which power fulfills for the state, capitalism or any other structures. The consequences of power, intended or unintended, may indeed include the maintenance of the state, capitalism, or any other structural feature, but it does not follow that this should be the prime way in which they are understood. The state and capitalism are sociological abstractions which should result *from* analysis, and not form its *basis*. Instead, Foucault advocates a concrete examination of power in term of its *conditions* within which it operates and the *consequences* it has.

Thus, the empirical part of this thesis does not merely explore how those within central agencies, such as the DoH and NHSE, intend to deploy power, via the definition, production and use of evidence, and whether they succeed. Instead, it examines how evidence is defined, produced and used locally, and examines how power relations, including, but not restricted to, those involving central agencies, influence these activities, and are, in turn, themselves modified by them.

b. Operational and successful power

Foucault (1986: 233) urged that the analysis of power:

> should not concern itself with power at the level of conscious intention or decision; that it should not attempt to consider power from its internal point of view and that it should refrain from posing the labyrinthine and unanswerable question: 'Who then has power and what has he [sic] in mind? What is the aim of someone who possesses power?' Instead it is a case of studying power at the point where its intention, if it has one, is completely invested in its real and effective practices.

Lukes (1974) differed from Foucault in viewing both the intentioned, and the unintentioned, operations of power as legitimate objects of study. He differentiated between 'successful' and 'operational' power. 'Operational' power refers to an instance of a body affecting another body, regardless of intent. 'Successful' power refers to where the effects are intentionally brought about. Lukes considered all of these forms of power worthy of study. The question of whether intentioned strategies of control underlie the rise to popularity of EBP has earlier been identified as an interesting one to explore. This study therefore rejects Foucault's advice to ignore intentions, and follows Lukes' call to examine both 'successful' and 'operational' power (as well as intentioned, but unsuccessful, strategies).

c. Control and resistance

Foucault suggested that power is not, in fact, best conceptualised as the relationship of one individual or group having control over another individual or group, but rather as all those involved in a set of relations being active in the operation of power. He wrote:

> power... is not that which makes the difference between those who exclusively possess and retain it, and those who do not have it and submit to it. Power must be something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or a piece of wealth (1986: 233-4)

However, Foucault's caution against a view of power in which it is mechanistically

possessed by some and happens to others, can be heeded while still developing an analysis of power based on interests, as Lukes (1974) did. A non-mechanistic view of power, which considers interests, is developed and justified in the remainder of this chapter.

Lukes stated that power can be viewed in terms of the oppression of one individual or group by another individual or group. Lukes viewed power as the bringing about of actions in others which would not otherwise occur. He saw power as being exercised where individuals or groups are affected so that they act against their own wants or interests. Thus Lukes, much more clearly than Foucault, distinguishes between oppression and other relationships. Foucault's lack of interest in distinguishing between oppression and other relations through which power 'fluxes' might offer one explanation for Foucault's exaggeration of the pervasiveness of disciplinary practices suggested earlier.

Lukes' (1986) definition of interests is informed by that of Feinberg (1984: 34):

> taken as a miscellaneous collection, [interests] consist of all those things in which one has a stake, whereas one's interest in the singular, one's personal interest or self interest, consists in the harmonious advancement of all one's interests in the plural. These interests, or perhaps more accurately, the things these interests are *in,* are distinguishable components of a person's well being: he [sic] flourishes or languishes as they flourish or languish. What promotes them is to his advantage or *in his interest*; what thwarts them is to his detriment or *against his* [sic] *interest.*

Citizens can act for, or against, their interests, which are distinct from their wants. Lukes (1986), after Feinberg (1984: 37), distinguished between 'ulterior' interests and 'welfare' interests. The former refer to a person's or group's 'ultimate aims and ambitions', while the latter refer to 'conditions that are generalized means to a great variety of possible goals and whose joint realization is necessary for the achievement of more ultimate aims.' Lukes argued that, while ulterior interests, eg. the interest in developing wealth, will generally be guided by wants, welfare interests, eg. the interest in developing health, may very well be at odds with wants. Thus, Lukes suggested the possibility of false

consciousness, but recognised - unlike orthodox Marxists (Giddens 1984) - that all analyses of interests are themselves partial and essentially value laden, a point discussed below.

Lukes characterised his view of power as encompassing three dimensions. One dimension limits its view of power to instances where one individual or group, in explicit conflict over certain defined 'issues' with other individuals or groups, triumphs, and thus comes to influence the actions of the other individuals or groups (Dahl 1961). The second dimension also only focuses on conflict, but acknowledges this conflict may not occur so overtly around defined issues. Those who are dominated may not raise grievances they nonetheless possess, since there is little perceived chance of their triumphing in overt conflict with the dominant. Issues raised by the dominated may also be deflected by the dominant from discussion, and therefore overt conflict (Bachrach and Baratz 1962). Lukes' third dimension, in addition to encompassing the other two scenarios, includes, as the operation of power, instances where individuals or groups, without duress, come to act against their own interests, whilst failing to recognise this. In this case, wants and interests are in opposition. In viewing power as operating when it causes individuals or groups to act against their own interests, Lukes was thus stating that in being oppressed an individual or group can still express *agency* rather than being merely an *object* of power.

This third dimension of power seems most closely to resemble the form of power portrayed in governmentality. Power is not here exercised via direct subjugation, but by citizens controlling their own conduct. The difference between Foucault's (1991) and Lukes' (1974) frameworks are in the latter's, but not the former's, desire to explicate exactly where and when citizen's regulate their own conduct and so act against their own interests. Lukes' view thus avoids the mechanistic trap of seeing power as being *possessed* by some but of *happening* to others.

Hughes and Griffiths (1999) provide a different categorisation of power, distinguishing two different forms of control: 'action at a distance' and 'steering at a distance'. '*Action*

at a distance' describes a situation in which those who are controlled are active in this control, with little direct intervention from external forces. Hughes and Griffiths (1999) suggested this resembles the form of power implied in governmentality. They cite Rose and Miller (1992:174) who portray the form of power described in governmentality thus:

> Power is not so much a matter of imposing constraints on citizens, as of 'making up' citizens capable of bearing a kind of regulated freedom.

This form also bears a strong resemblance to Lukes' third dimension of power. '*Steering* at a distance', on the other hand, describes a situation in which control is exercised via the direct intervention of external agents of control. This resembles Lukes' (1974) first and second dimensions of power. Where Hughes' and Griffiths' framework differs, however, from Lukes', is in not considering interests and therefore, like Foucault (1991), not making a distinction between oppression and other forms of relationship between individuals and groups. Later chapters of this thesis use the terms 'control via *action* at a distance' and 'control via *steering* at a distance' in order to offer a distinctly Lukesian analysis of power, while retaining Hughes' and Griffiths' distinction between 'action' and 'steering'.

If a Lukesian approach is to be adopted, a key question is, how can interests be investigated in a rigorous way? Lukes argued that the challenge for researchers wishing to examine empirically the operation of power, especially in terms of its third dimension, is to develop conclusions about how the dominated would act in the absence of the exercise of power by the dominant, as well as developing conclusions about how the exercise of power by these dominant bodies actually affects what the dominated do. Polsby (1963) has argued that researchers who consider the interests, as opposed to the expressed preferences and wants, of research participants are, in effect, researching non-events; in that interests, unlike preferences and wants, are unexpressed. Lukes himself considered the researching of interests a legitimate, but difficult, task. In the empirical component of this thesis, interests are only considered where the consequences of action, or inaction, seem reasonably predictable. The focus is therefore on short-term, rather than long-term, interests.

Polsby argued that researchers will inevitably be selective in what non-expressed interests they choose as the focus of their attention. Lukes himself recognised - unlike orthodox Marxists (Giddens 1984) - that all analyses of interests are themselves partial, and essentially value laden:

> the notion of 'interests' is an irreducibly evaluative notion... In general, talk of interests provides a license for the making of normative judgments of a moral and political character. So it is not surprising that different conceptions of what interests *are* are associated with different moral and political positions. Extremely crudely one might say that the liberal takes men [sic] as they are and applies want-regarding principles to them, relating their interests to what they actually want or prefer, to their policy preferences as manifested by their political participation. The reformist, seeing and deploring that not all men's [sic] wants are given equal weight by the political system, also relates their interests to what they want or prefer, but allows that this may be revealed in more indirect and sub-political ways - in the forms of deflected, submerged or concealed wants and preferences. The radical... maintains that men's [sic] wants may themselves be a product of the system which works against their interests, and, in such cases, relates the latter to what they would want and prefer, were they able to make a choice (1974: 34)

It is accepted that this study of power, like any other, is influenced by the values of the researcher. These values are explicated where it is felt this is necessary. In Chapter 4, for example, some of my own beliefs regarding evaluation are touched on. In conclusion, the discussion presented in this chapter suggests that, while Foucault's work provides a great deal of substantive insight, and usefully calls for an ascending analysis of power, Lukes' work provides a more coherent, though nonetheless partial, framework for informing an empirical analysis of power.

CHAPTER THREE: NHS REFORM AND A NEW FOCUS ON EVIDENCE IN GOVERNMENT POLICY

1. Introduction

This chapter attempts to place the recent focus, in NHS policy, on the production and use of evidence, within a broader political context. It argues that changes in the structure and management of the NHS in the last decade or so can best be understood as reflecting the emergence of an 'advanced liberal' health system. The NHS, it is argued, has changed from being a directly-managed hierarchy into a structure in which the responsibility for planning and delivering services is devolved to local commissioning agencies and contracted providers. It then goes on to discuss how NHS policy has recently focused on audit and research, and suggests that these developments can be understood with reference to the increased scrutiny of expertise, within an advanced liberal system.

The chapter raises questions about: the conditions, in terms of the power relations between various groups working in the NHS, within which evidence is defined, produced and used; the central and local strategies which underlie the involvement of various groups in these processes; and the likely consequences of these processes for the power relations between these groups.

Developments in the NHS as a whole are considered, with a special focus on relations between central and peripheral agencies, and between general managers and various clinical practitioners, such as doctors and nurses. Although the terms 'central' and 'peripheral' are used in this thesis, care is taken to be specific about which agencies are being referred to. This is informed by Foucault's (1991) warning that the central state should not be reified as a coherent, calculating subject. The questions which are raised are explored in the empirical component of this thesis, in relation to one area of practice, HIV prevention. It is hoped that this exploration sheds some light on the broad issues discussed in this chapter. It is not assumed that HIV prevention is representative of other areas of NHS provision; the extent to which this might be so is discussed in Chapter 9.

Chapter 4 proceeds to focus specifically on EBP in HIV prevention undertaken within the NHS. It raises additional questions especially pertinent to this field, such as the role of the voluntary sector and of health promotion specialists (though this is not to deny their importance in some other areas of NHS provision).

Only policy developments prior to April 1997 are included in this chapter, because the empirical component of this thesis focuses on the financial year 1996/7. As a result, this chapter does not discuss developments after the election of the Labour government in May 1997.

2. Emergence of an advanced liberal structure

a. Conditions for change

From its foundation, the NHS was funded mainly by general taxation; funding coming centrally from the Treasury, via the then Ministry of Health. The administration of the service was intended to reflect this pattern of funding; the service being officially subject to central, rather than local, control. However, the NHS lacked explicit central objectives concerned with the health status of the population, though it did possess principles regarding the intended equitable and free-at-point-of-use nature of its services. Local policy was determined largely by the aggregated decision-making of highly autonomous medical practitioners working at the periphery (Harrison et al. 1992). The government found itself reliant on professional (largely medical) judgment as to how well the service was performing, and what was required from central policy. According to Klein (1995: 46):

> the complexity and heterogeneity of the NHS made it impossible to impose uniform national standards from the centre... the centre quite simply did not know best and indeed could not know best.

Discomfort with this lack of central management control of a centrally-funded service was one motivation for developing a new structure.

As well as specific anxiety regarding NHS policy being decided largely by medical practitioners at the periphery, successive Conservative governments in the 1980s were also said to profess general antipathy to professional monopolies, of which doctors were one such group. This view, informed by libertarian-right thinking, had it that professionals act to protect their own interests in their dealings both with the state and with their clients (Hayek 1986). Ideas flowing from this analysis included the suggestion that the state should act to protect the interests of individuals by encouraging more critical scrutiny of the work of professionals. This has its parallels in some forms of libertarian-left thought, but, whereas most left-wing thinkers (eg. Doyal with Pennell 1979) have advocated increased public participation within the systems of delivery as a means of overcoming professional dominance in encounters with clients, the right has tended to favour market-based solutions. Government subsequently proposed a number of reforms, which some have viewed as an attack on professionalism, such as general management (Griffiths 1983), and a rhetoric of consumer choice in the internal market (DoH 1989; DoH 1992b). These are discussed below.

A desire to devolve any responsibility for rationing was also said to provide a motivation for structural change. Previously, rationing of provision proceeded under a veil of 'clinical discretion'. In other words, the medical profession controlled the supply of health service provision by making decisions about what services individual users would receive, based on criteria of cost, as well as of need. Harrison and Pollitt (1994) have suggested that, despite some conflict regarding the level of funding of the service, this implicit rationing role was accepted by the medical profession, because of their increasing support for the state system and their expectation that, within a context of economic growth, the amount of resources directed into the NHS would continue to increase. In other words doctors viewed rationing merely as a temporary cost-containment exercise.

Pollitt (1993) argued that there was increasingly a need to move to a system in which the rationing of services proceeded explicitly, rather than implicitly, because implicit rationing was no longer sufficient. Whereas the immediate post-War years had seen sustained economic growth, the 1970s witnessed a period of 'stagflation' - low or nil

growth associated with high inflation levels. The Thatcher government's solution to this situation included significant cuts by the Treasury in public expenditure. During the period 1980-1989, the level of growth in NHS funding fell quite drastically. In addition, there were worries about an explosion in the demand for, and the costs of, health care. These came in response to forecasts of a 'greying' of the population (a rise in the number of older people, especially those over 85), as well as concerns about the costs of new technologies. It was thus felt by many that, with a 'bottomless-pit' diagnosis, implicit rationing would be insufficient.

Implicit rationing was also regarded as increasingly untenable, as a result of decreasing willingness on the part of the medical profession to co-operate in (Harrison and Pollitt 1994). There were frequent examples of 'shroud-waving', whereby clinicians sought publicity regarding under-funding in general, or regarding specific clinical cases, in an effort to gain further funds. In 1977, the BMA/Royal Colleges working party concluded:

> It is unreasonable to expect a profession to remain passive in the face of declining standards [and] inadequate resources (cited in Klein 1995:103)

Klein (1995) suggested that the 1948 concordat, with its implicit rationing, was only ever a temporary truce, rather than a final settlement, since both sides were uneasy with it; the government, because its own financial accountability made it unhappy with so many decisions being made by others; and many within the medical profession, because the concordat constrained the profession's activities within tight budgets determined at the centre. Structural reform would facilitate the increasing explication and devolution of rationing decisions.

b. A new NHS structure

The government white paper, *'Working for Patients'*, proposed major structural reform of the NHS (1989). The reforms were implemented in 1991, despite considerable opposition from professional and other groups. Local 'internal markets' in health service provision were set up: on one side, local providers; and, on the other, local

commissioners. DHAs and fund-holding general practices, were charged by the DoH with the responsibility for commissioning services to meet the assessed health needs of, respectively, their local population, and their registered patients. Commissioners thus acted as the centre's agents of planning at the periphery. Providers, encompassing NHS trusts, as well as voluntary and private sector agencies, were to compete to win contracts from these commissioners, though the realisation of competition has been questioned (Ham 1994). According to Hoggett (1996), the NHS reforms reflected an attempt to delegate responsibility for NHS provision, while centralising control over it.

The centre's role changed from one attempting to manage directly the periphery, to one setting targets for its agents at the periphery to implement (Holliday 1995). The Health of the Nation (Ham 1994) as well as the Patient's Charter, furnished the centre with possible frameworks for target setting. The only targets set prior to this were somewhat vague; the 1979 Royal Commission on the NHS, for example, identified the objectives of the NHS as being to secure improvement in the physical and mental health of the people, and the prevention, diagnosis and treatment of illness. In contrast, the Health of the Nation (DoH 1992a), set out 25 priority areas for the NHS, specifying health gain targets; the first time in its history that this had been attempted. Sexual health was among the topics identified as key areas. The Patient's Charter (DoH 1992b) set out a number of standards which users could expect from the NHS. If the service offered by NHS providers did not meet the required standard, then users were entitled to make a complaint to service managers. The standards focused on the administrative and domestic aspects of the service, such as: waiting list periods; waiting room times; and named nurses. Klein (1995) has suggested that the charter in fact functioned primarily as a rhetorical device, used by the government to defend itself against charges that increased NHS efficiency was being pursued at the expense of quality.

The new emphasis on targeting necessitated a greater flow of information from the periphery to the centre. Klein (1995: 124) wrote:

> The only echo of the language of rational planning [heard after 1982] was the insistence on the importance of developing tools of analysis and information systems designed to assess the quality and efficiency of the

services being provided.

This new emphasis on targeting and monitoring represented the culmination of gradual development during the previous decade of Conservative policy. At the beginning of the NHS, information flows reported on financial inputs, rather than performance outputs or outcomes. In 1983, the DoH developed a system of common measures of performance based on the aggregation of existing data, and which allowed comparison between districts and units. Indicators, of which there were initially 70, focused for example upon: manpower [sic]; support services; use of clinical facilities; and estate management. The new information flows, which the Health of the Nation and the Patient's Charter initiated, continued this trend; Health of the Nation data focused on outcomes rather than outputs for the first time.

Despite the rhetoric of central targeting and local management, direct central intervention did occur. Ham (1994) cited the DoH's (1993a) initiation of the London Implementation Zone, following the Tomlinson Report (1992), as an example of continuing intervention. The NHSE also directly managed certain key initiatives such as certain components of the R&D programme (Harrison 1998), which are discussed below.

As mentioned in Chapter 2, the new structure thus bore some resemblance to the 'advanced liberalism' rendered by Burchell (1993) and Bunton (1997), in that it involved: devolution of institutions; the development of enterprising bodies; an emphasis on contractual relationships; and the extended collection of information.

The new NHS structure, with its explication in contracts of what services would be delivered with what resources, offered the possibility of more explicit rationing of services (Harrison and Pollitt 1994); with DHAs as the obvious candidates for planning this rationing. Klein (1995: 140) suggests that one motivation behind moving to a delegated structure may have been to diffuse the political fall-out from explicit rationing:

While, in the post war era of economic growth, governments were anxious to centralise credit - to claim responsibility for the improvements made possible by increasing prosperity - the stress now is on diffusing

blame for the inevitable shortcomings in an era of economic crisis: to decentralise responsibility is also to diffuse blame.

This analysis again appears consistent with the Foucauldian view that, in advanced liberal societies, the state has a reduced commitment to providing comprehensive welfare and other provision. Exactly how rationing might occur, and whether it has in fact happened, is discussed in later sections of this chapter.

c. A new scrutiny of experts

In the NHS's early years, governments aimed to empower expert practitioners to function as they saw fit, and generally accepted their views as to proper priorities and approaches. A memo Bevan wrote to the Cabinet in October 1944 illustrates this:

> We can - and must - afford to bring the voice of the expert right into direct participation in the planning and running of the service (cited in Klein 1995:19)

The medical profession possessed a unique and broadly acknowledged status as the key experts within health care. Alford (1975) has characterised the medical profession as the generally 'dominant' interest group in health systems. The role of NHS administrators was seen very much as that of supporting front-line workers, and acting diplomatically to resolve local difficulties between different occupational groups, rather than being seen as one of initiating change (Ham 1985; Stewart et al. 1980). Administrators had neither the cultural authority, nor the managerial levers, to challenge experts' autonomy. Bevan was soon complaining to the Cabinet that:

> The doctors have secured too great a degree of control over hospital management committees and were pursuing a perfectionist policy without regard to financial limits which had necessarily to be imposed on this service as on any other public service (cited in Klein 1995: 33)

Though government quickly grew dissatisfied with the autonomy which experts enjoyed, this did not result in any concerted challenge until the 1980s. As mentioned earlier, dissatisfaction with medical autonomy provided a spur to the 1989 NHS reforms; and,

prior to this, the development of general management. Alford (1975) had earlier described managers as a 'challenging' interest group within health systems. From 1984, general managers were charged with: implementing policy at the periphery; directing funding; and monitoring the performance of practitioners. It has been widely concluded, however, that the introduction of general management was not, initially, successful in challenging doctors' clinical autonomy, since the clinical realm remained largely closed to managerial scrutiny (Harrison et al. 1992). General managers were accountable for the running of the service, but doctors still possessed immense cultural authority and clinical autonomy. Managers found that, just like the previous generation of administrators, they had few effective levers to influence doctors' clinical decision-making. Harrison et al. (1992) suggested that general managers may have had more success in challenging the authority of other groups, such as nurses.

Harrison et al. (1992: 113) argued, however, that the internal market set up a dynamic within which managers were in a far stronger position to breach what had until then been the purely clinical realm. They suggested that:

> if an organisation's external environment becomes more demanding than before, the influence of those responsible for managing the internal/external boundary (ie. managers) is enhanced.

Economic pressures might induce a dialogue between managers and practitioners, especially doctors. The purchaser-provider split might also reduce medical authority because it separates allocative and operational decision-making (Dent 1995).

It seems then that, in attempting to develop scrutiny and control over expert practitioners, the NHS reforms again resemble some features of 'advanced liberalism'. The next section considers how NHS policy has recently focused on audit and research, and suggests that these developments can also be understood with reference to the increased scrutiny of expertise in advanced liberalism. This section, and the one which follows it, raise questions which are, in later chapters, explored in relation to case studies in the field of HIV prevention.

3. Embrace of health service research technologies within an advanced liberal system

a. Development of health service research technologies

In the period after the second World War, there came to be an increasing focus on the health of populations and their experiences of health services (Armstrong 1983). A diversity of disciplines, of varying degrees of prior academic establishment and with some overlap, were involved in researching health services including: epidemiology (Petersen and Lupton 1996); medical sociology (Stacey 1991); health economics (Ashmore et al. 1989); and audit/quality (Shaw 1980).

There was a selectivity in the degree to which these new research technologies came to be taken up in NHS initiatives. It was suggested in Chapter 1 that the NHS has, predominantly, but not exclusively, favoured a model of EBP which prioritises evidence: of effectiveness; from prospective experimental studies; and implemented via protocols or guidelines. These elements have distinct origins, but according to Baker et al. (1997: 34-5):

> The advent of the R&D strategy has prompted consideration of the relationship between a number of hitherto diverse and previously apparently hermetically sealed elements of NHS endeavour and activity, namely: research and development; clinical audit; clinical effectiveness ...; and the consequent notion of evidence-based medicine

The two NHS policy initiatives most obviously concerned with the production and use of evidence; *Working for Patient's* sections on audit, and the NHS R&D programme, are considered here.

b. Audit in *'Working for Patients'*

Medical audit was developed in the US, originating, according to Dent (1995) with the American College of Surgeons' National Standardization Program in 1919, and

elaborated by Donabedian (1966) and others. Audit was widely adopted within the US Medicare and Medicaid programs in the 1960s and 70s, but had a low profile in the UK, until its inclusion within *Working for Patients* (DoH 1989).

Audit involves the development of agreed, measurable standards for specific areas of practice (Shaw 1980). The standards can be set out in the form of guidelines or protocols steering, or supporting, individual decisions about practice. Actual and ideal practice are compared, via the collection of information, either retrospectively or prospectively, on the work of practitioners. This comparison informs discussion of how actual practice can be improved. Audit is ideally then followed by re-audit, in order to assess if improvements in practice have actually been achieved. Thus, in a system of audit, individual practice is intended to be regulated by guidelines.

The audit literature suggests that standards can be developed based on research evidence, on consensus, or on expert opinion as to what constitutes sound practice (Shaw 1980). Audit can thus be viewed both as a means of producing evidence on the consistency of practice, and as a means of implementing evidence from research on the effectiveness, appropriateness or acceptability of services. The use of guidelines based on evidence from evaluations of effectiveness was specifically encouraged by the publication of *'Improving Clinical Effectiveness'* by the NHSME (1993).

Working for Patients (DoH 1989) made audit compulsory for doctors, whilst placing audit under the control of the medical profession, rather than managers. It did, however, grant managers the right to see aggregated data emerging from audit, and the right to commission external peer audit if they were not satisfied by the manner in which their own doctors were conducting it.

The medical profession had previously taken some steps to develop audit amongst doctors; the Royal Colleges, for example, developing a 'Quality of Care' initiative in 1985 (Calnan and Gabe 1991). In responding to *Working for Patients*, the profession was keen to ensure that their view, of medical audit as a tool of medical education not a

means of external scrutiny, prevailed. The BMA's 1989 Special Report on the Government's White Paper *Working for Patients* argued:

> It is inappropriate for the operation of medical audit to become a management function (cited in Coulter 1991: 13)

The Royal Colleges responded in similar manner, producing a set of guidelines which argued for: the medical ownership of audit; its principally educational rather than regulatory role; that non-participation should not be punishable; an emphasis on local standard-setting based on consensus; absolute confidentiality; and that shortfalls would be dealt with by peers, not management.

Nursing audit was not addressed in *Working for Patients*. However, nurses have developed a number of their own quality initiatives, sometimes under the rubric of clinical audit or research (Malby 1996), as well as using other specific quality tools, which tend to differ from clinical audit approaches in that they employ ready-made, rather rigid tools, often imported from the US. These tools place more emphasis on assessment by supervisors, rather than peers as is generally the case with medical audit (Harrison and Pollitt 1994).

c. NHS R&D Programme

In 1991, the NHS Management Executive (NHSME, later re-named the NHS Executive) appointed its first National Director of R&D, Professor Sir Michael Peckham. Peckham set out his aims in a lecture at the Royal College of Physicians in June 1991 (Peckham 1991b), before publishing Research for Health in June 1991 (Peckham 1991a). A Central Research and Development Committee (CRDC), comprising managers, academics, doctors and other health practitioners, and with an advisory rather than a steering function, was convened by the NHSME, as were a number of subsidiary advisory groups in various priority areas, which did not include sexual health.

The National R&D Director initiated a national priority setting exercise led by the

NHSME, on the board of which the R&D Director had a seat. This had the objective of identifying specific R&D priorities which could then be commissioned by the NHSME or its agents. In 1991, regional health authority (RHA) R&D directors were appointed, and regional committees convened or reconfigured. These again involved managers, academics, doctors and other health practitioners (DoH and NHSE 1991). The regional committees were intended to play a key part in the consultation process, giving their own views, and seeking the views of district commissioners and providers.

As the R&D programme developed, clinicians and academics appeared to involve themselves more than managers. St Leger (1992) suggested that the CRDC became dominated by academic, especially medical academic, interests. In 1995, the CRDC included nine medical academics, but only three health authority or trust managers. The regional directors were, without exception, doctors; generally with a background in medical research. Coulter (1995: 57) suggested that, although regional committees were generally more successful in eliciting the active participation of their managerial and other non-academic members than the CRDC, they were nevertheless dominated by academics:

> inevitably the keenest contributors tend to be those who hope to secure research funding once the priorities have been agreed.

James (1994) has also suggested a lack of commissioner interest in the consultation exercise undertaken to inform R&D priority setting.

There were some attempts to involve other groups in the R&D programme. The DoH launched a Strategy for Research in Nursing, Midwifery and Health Visiting (NHSE 1992). This aimed to develop further the research capability of these groups. No ring-fenced funding for nurses', or any other practitioners', research was provided, however.

In 1994, *'Supporting research and development in the NHS'* (Culyer 1994) was published. This addressed how the involvement of service staff could be ensured. It sought to increase commissioners' participation in the R&D programme, by making each

district's stake in the programme explicit to them. This was done by 'bottom-slicing', whereby each district would be given, as part of its allocation from the DoH, a nominal amount ring-fenced for R&D. This money was never actually distributed down to districts; instead it flowed directly into the central R&D budget. It was hoped that, by seeing that they were already significant investors in the R&D programme, districts would take a greater interest in it, and would contribute more energetically to the consultation exercise. By explicating to districts their investment, it was also hoped that pressure would be brought to bear on the central and regional managers of the R&D programme, to ensure that the programme addressed the needs of the districts, and thereby encouraged its future funding and survival. As Culyer wrote in 1995: 223:

> The levy symbolises the seriousness with which the voice of purchasers is taken and is also a signal to central R&D managers and to the research community in general that the task of creating a widespread research-orientated culture in the NHS has to command a high priority.

Culyer's report also addressed the management of the R&D programme. It recommended that, as well as RHAs playing a key role in the consultation exercises, they should manage most of the research programmes. In April 1996, however, RHAs were abolished (DoH 1993b) to be replaced by smaller regional outposts of the NHSE. These outposts took on responsibilities for R&D management, despite concerns that they would not possess the managerial 'critical mass' required to undertake this role effectively (Milner 1994).

The case studies discussed later in this thesis explore how, in this field of NHS provision, the definition, production and use of evidence in research, as well as audit, is determined by the existing relations within which these activities proceed.

4. Role of evidence in strategies of control and resistance

a. Audit

A number of commentators offer explanations for the embrace of audit. Klein (1995)

argued that audit enabled the government to refocus how it presented its policies on the NHS, stressing quality enhancement rather than cost constraint. Belkin (1997) suggested a role for audit in enabling services to be commodified in local markets. Commodification is discussed in detail in the next section. Others stressed the role that audit could play in legitimating and supporting regulation of practitioners (Coles 1990). According to Elston (1991: 69):

> Demands for greater 'value for money' have spawned a plethora of techniques for managerial evaluation and control over clinical activity. The new acronyms QA, PIs, DRGs, QALYs promise a new era in which the doctors' clinical freedom of action within the NHS might be progressively circumscribed through bureaucratic assessment.

From a Foucauldian perspective, audit could be seen as reflecting an increasing expectation, on the part of government, that expert health practitioners justify what they do. From this perspective, audit may have been embraced as part of an overall strategy by government to legitimate politically, and enable practically, the commodification of services in peripheral markets, and the local regulation of practitioners.

Audit also appears to have been seized by practitioner groups, and attempts made to use it in strategies of maintaining or increasing autonomy and authority. Harrison and Pollitt (1994: 107) suggested that the use of various audit and quality tools comprise one component of a strategy on the part of nurses to define more clearly the contents of nursing work and so maintain control over it:

> To some extent the development of systems for nursing quality assessment may be seen as yet another in a long line of defences constructed by nurses to strengthen their powers of resistance to ad hoc interference in nursing activities by the medical profession. Nurse managers can now point to apparently scientific ratings as justification for organising nursing in their way.

According to Salvage (1992), there are moves within nursing to create a new basis for the occupation, based on the notion that nursing work has its own therapeutic value, rather than being merely in support of doctors' work. This strategy is perhaps reflected in the fact that the tools often employ expert-derived standards based on theories of nursing

which prioritise nurses' advocacy and counselling roles, ie. the 'non-medical' elements of their work.

b. NHS R&D Programme

While many of those involved in the planning and implementation of the R&D programme undoubtedly have done so in order to develop what they would see as a rational basis for the NHS, other motivations concerned with the operation of power have been suggested. St Leger (1992) suggested the importance of producing evidence on effectiveness in enabling the commodification of health care services within markets. He argued that, without adequate measures of the quality and effectiveness of services, there was a considerable risk that competition between providers would be primarily on the basis of cost, and as a result the quality of services would deteriorate. Griffiths (1991:12) had previously identified the lack of evaluation in the NHS as impeding management:

> There was no attempt to establish objectives at the centre and no concentration on outcomes .. [the NHS] still lacks any real continuous evaluation of its performance... Rarely are precise management objectives set; there is little measurement of health outputs; clinical evaluation of particular practices is by no means common and economic evaluation of these practices extremely rare.

The possibility that the reformed NHS might facilitate the explicit rationing of services was raised earlier. Harrison (1998) has suggested that EBP potentially offers specification both of who is responsible for rationing (eg. practitioners) and the criteria to be used (eg. effectiveness). Weale (1998) distinguished between three forms of rationing: where services remain free and of high quality, but reduced in comprehensiveness; where services remain comprehensive and of high quality, but where means tests determine cost to the user; and where services remain free to all and comprehensive, but where the general quality of care is reduced. Weale suggested the production and use of evidence about the effectiveness or cost-effectiveness of services could facilitate the first of these. Klein et al. (1996) suggested that, to qualify as rationing, services must be excluded from provision on the basis of lesser effectiveness or cost-effectiveness, rather than complete ineffectiveness.

The production of evidence concerning effectiveness did indeed appear to be emphasised in the R&D programme (Ham et al. 1995). The R&D programme provided funding for both the UK Cochrane Centre and the NHS Centre for Reviews and Dissemination. Health technology assessment emerged as a priority area, and eventually became the only priority area to be managed by the central NHSE in a non-time limited manner (Kirk 1996).

In his introductory speech, Peckham (1991b: 367-9) emphasised that a systematic approach to researching health:

> is the only way of resisting the sometimes unreasonable and often unproven resource-consuming demands of lay, professional and industrial pressure groups... to create space for cost-effective practice and advances in medicine we must identify non-contributory practices that are in use and encourage their abandonment.

He suggested the exclusion of ineffective services might save the NHS £1 billion per year (Timmins 1996). Baker at al. (1997) suggest that the permanent status given to the health technology assessment reflected NHSE interest in curtailing expenditure on expensive new technologies. Peckham (1991b: 370) himself went as far as to say:

> Unless there are convincing arguments to the contrary, approaches new to the NHS should be used in the context of a trial and routine use should be discouraged... At an early stage of planning, the cost and organisation implications for the NHS should be examined in relation to existing methods.

However, it should be noted that the exclusion of ineffective services would not, according to Klein et als' (1996) criteria, count as rationing. Whether the R&D programme, and more generally, the development of EBP in the NHS, will contribute to the exclusion of ineffective or less effective services is considered in the next section.

Harrison et al. (1990) offer a different explanation for central government's interest in evaluation. They suggest that, rather than legitimating and enabling the rationing of services, a focus on evaluation may actually be used to legitimate continued state investment in the NHS. They argue that states are under increasing pressure to cut

welfare expenditure. According to Harrison et al. (1990:160) one means to justify continued expenditure is to demonstrate that resources, that are spent, are spent prudently:

> It might be possible to delay or avoid the crisis [of health spending] by purporting to increase the efficiency of the welfare state... if extended services can seem to be given without increases in expenditure both capitalists and the public will be happy.

From a Foucauldian perspective then, a new focus on EBP could be seen as reflecting an increasing expectation, on the part of government, that expert health practitioners demonstrate that what they do is effective, or have this scrutinised by others. EBP seems to have been embraced as part of an overall strategy by government to legitimate politically and enable practically: the control of the periphery; the commodification of services in peripheral markets; and the rationing of services, or, conversely, continued investment in services.

5. Consequences of EBP for power relations

This section considers the likelihood that the strategies suggested in the last section are successful. It also assesses what other possible consequences a focus on the production and use of evidence in audit and R&D might have for power relations between central and peripheral agencies, between commissioner and provider agencies, and between managers and practitioners working within providers.

a. Relations between central and peripheral agencies

EBP may serve as one resource within an overall strategy, by central agencies, of explicating the rationing of services, but delegating this rationing to peripheral agencies. The quotes given in the previous section suggest that the legitimation and enablement of rationing has contributed towards the DoH's and NHSE's interest in R&D. The production of authoritative research on effectiveness could allow local rationing to proceed according to centrally-endorsed criteria, thus allowing the possibility of action

at a distance. Commissioner or provider agencies could become key agents of delegated rationing.

There have indeed been some financial savings within the NHS as a result of eliminating wasteful investment in ineffective services. Research has suggested, for example, that: for some children, grommets are ineffective; and for whole populations, blood cholesterol screening is ineffective. Commissioners have developed agreements with providers to modify clinical activity accordingly (Muir-Gray 1997). However, it was concluded earlier that this elimination of ineffective interventions should not count as 'rationing'.

The R&D programme may fail to facilitate widespread rationing. Baker (1996) argued that the R&D priorities generated in consultation exercises may not coincide with the centre's rationing priorities. While managers are likely to prioritise the evaluation of existing interventions, in order to establish which ones may be de-funded on the basis of their ineffectiveness, academics and practitioners are perhaps more likely to favour the investigation of new technologies, impelled, suggests Baker, by personal interest. Kerridge et al. (1998) has bluntly put it that, since doctors are most influential in developing EBP, it is likely to serve primarily their own interests. This is, perhaps, most of all true of academic doctors, since these appear to be most heavily involved in central and regional R&D committees (Coulter 1995).

Where services are ear-marked for evaluation of effectiveness, Maynard and Sheldon (1997) have suggested that many of the experimental studies currently being undertaken fail to examine cost or effectiveness in terms of broad quality of life measures. This inhibits the comparison of different interventions, and therefore makes rationing on the basis of cost-effectiveness impossible.

Baker (1996) suggested that, regardless of which interventions are evaluated, practitioners may still not take up the findings of evaluation, because of their ignorance of, or lack of acceptance of, the evidence as a basis for rationing. The extent to which rationing according to criteria of cost and effectiveness is, in principle, accepted amongst

doctors is questioned by Harrison et al. (1992). They conclude that some sections of the medical profession have come to accept what they term a 'managerial' view regarding cost-effectiveness, while others have accepted the need to work within a managerialist ethos, without necessarily fully accepting its philosophical basis.

As predicted in Chapter 2, the widespread discussion of the R&D programme, and of EBP more generally, has prompted critical and subversive reactions. There have been a multitude of requests, apparently borne out of scepticism, for EBP itself to be evaluated in terms of effectiveness or cost-effectiveness (eg. Griffiths 1995). Others have applied ideas from EBP to central policy. Davis and Howden-Chapman (1996) drew attention to the lack of evidence underpinning the 1991 reforms. Coulter (1995) gave a number of examples of other central policies not being based on evidence, such as the 1990 GP contract including urine tests in routine health checks, and the government's refusal to ban tobacco advertising, despite the convincing evidence that this would have a positive impact on the nation's health.

The extent to which an emphasis on evaluation has actually acted to legitimate continued state investment in health services has not been discussed in the literature. Ham (1994) has suggested that experimental studies of effectiveness or cost-effectiveness are as likely to support the adoption of effective interventions, as to inhibit the adoption of ineffective interventions. Franks (1996: 10) argues that the embrace of R&D may be a:

> two edged weapon since .. evidence may, on the one hand support the reduction of [ineffective technologies], yet on the other, make it difficult to resist the introduction of effective but expensive new therapies.

b. Relations between commissioner and provider agencies

EBP has been used by commissioners in attempts to control the prioritisation of local services (Hope et al. 1998) and the way in which local providers deliver these services (Miles 1997). However, commissioners' attempts at using evidence to determine priorities have often been unsuccessful (Dixon et al. 1997), one reason being that

commissioners discover that the evidence which research produces does not necessarily answer the questions which commissioners have regarding comparative cost-effectiveness and appropriateness of services for local populations (Gray et al. 1997).

c. Managers and clinicians relations

This section firstly considers the implications of EBP for relations between managers and the medical profession, and then moves on to a similar consideration of the implication for relations between managers and other groups.

One possible outcome of activities concerned with the definition, production and use of evidence is the routinisation of medical practice, and the loss of individual practitioner autonomy. According to Sutherland and Dawson (1998), this has been a fear amongst doctors. According to Tannebaum (1994), doctors still place great faith in knowledge derived from personal experience, rather than from research, and in the concept of clinical judgment. Doctors involved in EBP appear to accept the importance of clinical judgment in the application of research. Haynes and Haines (1998) suggest, for example, that the use of guidelines will not result in 'cookbook' medicine, because of the centrality, to practice, of doctors' judgment and inter-personal skills. Muir-Gray (1997) suggested that the scope of algorithms for medical care is limited, because individuals' problems often do not slot into the options described, and because individual characteristics can make it difficult for an algorithm to prescribe exactly what care they should receive.

Furthermore, it may be that the basing of practice on guidelines means that individual doctors lose some of their autonomy, but that, as a group, doctors maintain their autonomy by ensuring that they, rather than others, such as general managers, lead on the development and auditing of guidelines. It has been suggested that a new model of professional regulation is emerging, wherein doctors' clinical activity is increasingly determined by guidelines collectively developed within the profession (Hoffenburg 1987;

Elston 1991). Klein (1995: 245) suggested:

> The monument to the 1991 reforms may turn out to be - somewhat unexpectedly - the medical profession's newfound enthusiasm for setting and monitoring its own standards.

Harrison (1998) speculated that the medical profession accepting their responsibility for basing their practice on evidence, but leading on the processes via this evidence was produced and used, might represent an accommodation between what Alford (1975) conceived as the dominant medical interest group and the challenging managerial interest group.

While managers are perhaps not able to exert thoroughgoing control over doctors' clinical activity, the balance of influence, however, may be more finely balanced than was previously the case, for a number of reasons: clinical guidelines are transparent - their contents open to managerial scrutiny; the aggregated results of audit based on guidelines are also open to managerial scrutiny; and managers have increased their influence as to which areas of practice are the focus of guideline development and audit (Klein 1995).

It remains to be seen exactly what form the balance of power between managers and the medical profession will take. As the internal market has developed, multi-disciplinary clinical audit, and managerial involvement in this, have increased. Service contracts between commissioners and providers have increasingly included specific clinical audit requirements. Failure to achieve standards can result in financial penalties for the organisation as well as approbation for the individual clinician. Thus, managerially dominated commissioning agencies have, in some districts at least, come to take a lead on clinical audit, indicating significant local shifts in practitioner-manager relations (Pollitt 1990).

However, the extent to which managers focus on R&D and audit may actually be quite limited. Caine and Kenrick (1997) reported that, within provider agencies, managers were rarely involved in facilitating EBP. Managers are said to have extremely limited access to research evidence, compared with doctors (Ferlie et al. 1998). These various

possibilities are explored in later empirical chapters.

EBP has similarly been viewed by nurses as a means by which they can resist managers curbing their autonomy (Salvage 1998). Estabrooks (1998) reported that nurses, like doctors, place great importance in knowledge derived from their personal experience, and on their clinical judgment. It may, however, be more difficult for non-medical practitioners, including nurses, to make a case that professional judgment is required to implement research evidence in the care of individual clients. Harrison and Pollitt (1994) argue that this reflects these other groups' lesser cultural authority in the eyes of both managers and the public at large.

Harrison and Pollitt (1994) suggest that, while nurses' strategy in developing audit and quality tools may well be to construct a recognised body of nursing expertise, the very rigidity of the tools and standards that are used may mean that the work of individual nurses becomes more easily directed by their managers. Harrison and Pollitt (1994: 110) conclude that the continued independence from routinisation of the medical profession compared with other groups:

> could be construed as the state tightening its grip on most groups of health care workers... whilst continuing to allow the medical elites just enough autonomy to ensure that they, and not the politicians, continue to carry out most of the responsibility for painful micro rationing decisions.

This chapter has identified a set of questions about the involvement of central and local statutory agencies, as well as clinical and managerial groups, in evidence production and use. The next chapter will consider the particular case of HIV prevention in the UK, and develop some further questions, both about the organisations and groups already discussed, and their involvement in HIV prevention, but also about voluntary organisations, and about health promoters and other staff working or volunteering in HIV prevention.

CHAPTER FOUR: EVIDENCE AND HIV PREVENTION IN ADVANCED LIBERALISM

1. Introduction

The last chapter concluded that the NHS has been transformed into an 'advanced liberal' health system. It argued that, within this system, expert practitioners are increasingly subject to scrutiny, both by managers, as well as by their peers. This chapter explores the extent to which HIV prevention has been incorporated into this advanced liberal system. It examines: whether HIV prevention practitioners are similarly under scrutiny; by whom; and with what aims. It considers the views of the various groups involved in HIV prevention on the production and use of evidence, suggests how these groups may become involved in EBP, and assesses what implications this might have for their authority and autonomy. These suggestions are then explored in the empirical chapters of this thesis.

While the chapter considers those involved in HIV prevention largely in terms of the professional and/or volunteer group to which they belong, care is taken not to reify the concept of 'group'. Patton (1990) suggests that the focus on discrete identities of 'expert', 'volunteer' and 'victim' is, itself, a product of the historically contingent bureaucratisation of AIDS. This point is accepted; it is acknowledged, for example, that, as well as many in the statutory sector having voluntary sector backgrounds, many doctors involved in HIV/AIDS, particularly in early responses, were themselves gay activists (Altman 1993). 'Group' is therefore employed as a heuristic device, rather than as an a priori empirical category.

2. HIV and its prevention

a. HIV

The first cases of what became known as AIDS were recorded in the US in the early

1980s (Gottlieb et al. 1981). Doctors noted an increasing frequency of rare cancers and opportunistic infections, particularly amongst gay men. This syndrome was initially termed 'Gay Related Immune Deficiency', before being re-termed 'Acquired Immune Deficiency Syndrome' (AIDS). The virus causing this syndrome was identified in 1983 by Montagnier in France, and Gallo in the US (Nye and Parkin 1994), and subsequently named Human Immunodefiency Virus. Two variants, HIV-1 and HIV-2, were identified, the former being more common and more infectious.

HIV is transmitted sexually, parenterally, and between mother and child. The virus infects various immune system cells, such as lymphocytes, monocytes and antigen presenting cells. At present, no vaccine is available. Initial infection with HIV is often accompanied by a short period of flu-like symptoms. There then follows an asymptomatic period of variable length, followed by the development of opportunistic infections, lymphadenopathy and neurological symptoms (Nye and Parkin 1994). These symptoms derive from the gradually increasing effects of HIV infection on the immune system. An antibody test was developed, and is used to diagnose HIV infection. This was introduced in the UK from 1984 (Garfield 1994). An AIDS diagnosis is made on the basis of clinical symptoms, and/or a fall in the CD4 (a type of lymphocyte) count of an individual below a certain level. Individuals infected with HIV can be treated using what have become known as combination therapies. There is, however, at present no cure.

By January 1996, there was an estimated cumulative world-wide total of 30.6 million infections with HIV, and an estimated cumulative total of 10.4 million cases of AIDS (Mann and Tarantola 1996). Approximately 93% of HIV infections, and 94% of AIDS cases, have occurred in developing countries. By July 1998, a total of 32,242 HIV infections and 15,565 AIDS cases had been reported in the UK. Of UK AIDS cases, 72% are known, or presumed, to have died. Sixty per cent of those diagnosed with HIV infection in the UK probably acquired the virus during sex between men (PHLS 1998).

b. HIV prevention

In the absence of a cure or a vaccine, prevention via social interventions is viewed as important (Mann and Tarantola 1996). Primary prevention attempts to eliminate the possibility of getting a disease (Jones 1997a). Primary HIV prevention, which aims to prevent transmission of HIV from infected to uninfected persons (Hickson 1998) has been underway in the UK since the early 1980s.

HIV prevention can be attempted via the use of health promotion (Hickson 1998). Health promotion is a broad set of ideas developed by a diversity of groups involved in a variety of activities, of which HIV prevention is one. The definition of health promotion developed by the World Health Organisation (WHO) is as follows:

> Any combination of health education and related organizational, political and economic intervention designed to facilitate behavioural and environmental adaptions which will improve or protect health. (Anderson 1983: 11)

Health promotion literature often stresses the importance of defining health broadly and positively, rather than merely as the absence of disease (Tannahill 1992). It also often stresses that health is determined by a breadth of factors, including, but not limited to, clinical interventions (Lalonde 1974). Other determinants of health are said to include individual lifestyle, as well as socio-economic and environmental factors. Health promotion literature also often emphasises the importance of public participation as a benefit, per se (WHO 1986).

Health promotion is sometimes said, by its supporters, to provide a different framework for action than the medical model (Jones 1997a). The latter has been defined, for example by Jones (1994), to include: health defined as absence of disease; health services orientated towards treating disease in institutional settings; and an understanding of health and illness based on a biological model of disease and illness. Health promotion literature often refers to social science critiques of medicine, for example of: its negative view of health (Antonovsky 1993); and its prioritising doctors' definitions of health and

illness over those of lay people (Tuckett 1976). However, it should be acknowledged that the medical model is not, itself, rigid or static. Not all doctors hold the views indicated as 'medical', above (Calnan and Gabe 1991). There has also been some reformulation of medical thinking, partly as a result of social science critique (Nettleton 1995).

Some of those involved in HIV prevention may not describe what they are doing as health promotion (eg. Scott 1997). Some may describe their activities as health promotion, but may omit from their practice some or all of the principles listed above (Davison and Davey-Smith 1995). The organisation of 'health promoters' as a professional group within the NHS is discussed later in this chapter.

3. HIV prevention in the NHS

a. Gradual inclusion within an 'advanced liberal' NHS

By the 1990s, HIV prevention was brought into what was described in Chapter 2 as an 'advanced liberal' NHS. In contrast, the period from 1982 to 1986 was characterised by the virtual absence of any statutory involvement in HIV prevention (Weeks 1989; King 1993); and the period from 1986 to 1989 was characterised by central government involvement in the planning of HIV prevention so direct (Berridge 1996), as to distinguish it from the general moves to local delegation typifying advanced liberalism.

This mainstreaming of HIV prevention into the more general management of the NHS was associated with its down-grading as a political issue: from national emergency to normalised problem. The Day Report (PHLS 1993) revised estimates of future HIV incidence and prevalence down from those produced by the Cox Report (DoH 1988). There was less talk of a general catastrophic epidemic (Berridge 1996) and an increasing view that HIV infection was largely restricted to certain population groups, including gay men, some African communities, and drug-users. Elements within the Conservative government had always been uncomfortable with the special status given to HIV/AIDS. As predictions of future incidence were reduced, the then Secretary of State for Health,

Virginia Bottomley, could more easily reduce central government's involvement in planning. Berridge (1996: 10) concluded:

> AIDS revived a type of 'welfare state ethos', which most assumed was absent in Britain of the 1980s. The role of the state assumed a new importance. But history does not repeat itself, and what seemed to be emerging by the end of the [1980s], in part because of more general policy changes in health services and the local authorities, were new forms of relationship between traditions of voluntarism and of state activity.

Within an advanced liberal system, HIV prevention was increasingly characterised by: a target-setting centre; delegation of planning to local commissioners; a plurality of 'expert' providers; and the scrutiny of expertise.

b. Target-setting centre

A number of initiatives furnished the centre with a framework for the setting of HIV prevention targets, which those working in local agencies were to achieve. Although the government's Green Paper on the Health of the Nation left out HIV/AIDS altogether, the subsequent White Paper (DoH 1992a) included it. Targets for reductions in gonorrhoea, rather than HIV, incidence were set, these being viewed as valid markers for reduced sexual risk-taking, both in populations with low and high incidences of HIV. The NHSME required DHAs to report on the achievement of these targets in their district.

The AIDS Control Act was enacted from a Labour MP's private member's bill in 1987. As a result, the NHSME required, from each DHA, the publication of an annual report on AIDS cases and relevant services across sectors. In practice, these reports tended to focus on NHS, rather than voluntary sector or local authority, actions (Berridge 1996).

As well as these targets, the government continued to allocate 'ring-fenced' funding for HIV prevention as a means of encouraging its local prioritisation. This was despite ring-fencing being removed in 1994 from HIV treatment and care funding (Garfield 1994).

c. Delegation of planning to local commissioners

RHAs funded some HIV prevention from 1987 (Berridge 1996). Health authorities in each district became responsible for the commissioning of all HIV prevention services, with the abolition of RHAs, in 1996 (DoH 1993b).

Some of those undertaking HIV commissioning were career general managers, who had worked in other areas of NHS commissioning or provider management; while others were HIV specialists, with previous experience of HIV services, either within the NHS or in the voluntary sector (Bennett and Ferlie 1994). Few were from public health medicine backgrounds (Berridge 1996).

Although commissioners still had to allocate funding according to central ring-fences and targeting directives, they had considerable leeway as to their commissioning decisions. Ring-fences were, in fact, sometimes interpreted loosely; resources being directed, for example, towards drug treatment and young people's sex education services (Berridge 1996).

d. Plurality of expert providers

In reviewing the groups involved in HIV prevention below, the term 'expert' is used to denote the specialist practitioner roles of the groups concerned, rather than to denote any evaluation, positive or negative, of these groups' skills or knowledge. The question of whether these groups are regarded by others as expert, and with what implications, is considered, however, in the empirical component of this thesis.

Voluntary sector agencies

Self-help groups developed during the initial period of state neglect (Kobasa 1991; Day and Klein 1989). Gay men in the UK formed the Terry Higgins Trust in 1982, re-constituted as the Terrence Higgins Trust in 1983, to provide care and education. Prior

to this, a great deal of education had been undertaken by Gay Switchboard, a telephone advice line for lesbians and gay men, as well as informally, amongst networks of friends and sexual partners, and in the gay media (King 1993).

The emergent HIV voluntary sector was extremely diverse (Weeks et al. 1994). A minority of agencies were run solely by volunteers, while some did not even recruit volunteers. Volunteering is defined by Sheard (1996) as unpaid, freely chosen work oriented towards people (other than oneself or one's immediate circle of friends and family), or towards the environment. Some organisations did not even term themselves a 'voluntary agency', preferring alternatives such as 'AIDS Service Organisation', 'Non-Governmental Organisation' or 'Community Based Organisation'. Altman (1993) argued the choice of terminology was often a political one; the term 'community', for example, suggesting a social proximity to those with, or at risk of, HIV infection. Some organisations saw themselves as 'activist' organisations, lobbying for wider change, some as service provision agencies, and some as both (Schram-Evans 1990).

Statutory funding was provided to voluntary sector organisations from 1985 onwards, via grants from: local authority AIDS Support Grant allocations; and from central government *Section 64* funding. Statutory funding was provided via RHAs from 1987. With time, and especially after the advent of the NHS internal market, the HIV voluntary sector was increasingly funded via service level agreements (commonly termed 'contracts'), rather than grants. One survey found that nearly 80% of HIV voluntary sector funding came from statutory sources (Sharma et al. 1992), most of this being in the form of contracts. A similar trend was simultaneously observed in the rest of Britain's voluntary sector (NCVO 1993).

This tendency for the state to fund specified work by voluntary agencies reflects, according to Kendall and Knapp (1996), an era of 'welfare pluralism'. Marshall (1996) suggested that the increasing devolution of, and conferring of semi-independent status on, state agencies, and the state funding of voluntary agencies, blurred the distinctions between the voluntary and statutory sectors. Schram-Evans (1990) described an

increasing institutionalisation, and retreat from radicalism, of the HIV voluntary sector, associated with increasing statutory funding. However, Schram-Evans did not explicate exactly what she meant by these terms. Berridge (1996) and Weeks et al. (1994) offer some clues, however, in reporting that, with the increasing statutory funding of the HIV voluntary sector, campaigning often gave way to a greater emphasis on service provision.

There is considerable diversity amongst those working or volunteering in the HIV voluntary sector (Weeks et al. 1994). Though many workers began as volunteers without formal skills, some have developed formal expertise, via training in health education and related disciplines (Berridge 1996). Some stress the importance of those gay men without formal training in health promotion involving themselves in the planning and provision of HIV prevention (Scott 1997). Conflict has sometimes developed within HIV voluntary agencies between volunteers and salaried managers (Altman 1993; NAT 1992; Berridge 1996). Butler and Wilson (1990) suggest that voluntary sector leaders may come to resemble general managers in the statutory sector. Statutory contract funding may have increased the authority, within voluntary agencies, of what has been described as a salaried 'AIDS elite' (Freeman 1992).

Statutory sector agencies

Some statutory agencies have provided HIV prevention from the beginning of the epidemic, though this was initially often un-planned, and lacking in central government support (Berridge 1996). UK GUM clinics have traditions, both of undertaking sexually transmitted disease (STD) prevention, and of providing open access, confidential, and non-judgmental care, including for gay men (Berridge 1996). These traditions were applied by some, but not all, clinics in the development of HIV prevention (Bennett and Ferlie 1994). HIV/AIDS became defined as an STD in the UK, largely as a result of the involvement of certain GUM physicians in developing early HIV/AIDS services, and advising government on policy. In contrast, in the US, most HIV work was undertaken by chest physicians, and HIV/AIDS was not, there, conceived primarily as an STD.

The status of GUM clinics rose in the course of the 1980s, partly as a result of their importance in providing services for those either with, or vulnerable to, infection with HIV, and other viral STDs (Berridge 1996). The recommendations of the Monks Report (DHSS 1988), including that GUM clinics should focus more on sexual health promotion (SHP) and should receive more funding, were accepted by government. These developments were said to enhance GUM clinics' capability of providing HIV prevention services (Bennett and Ferlie 1994).

Various professional groups are involved in HIV prevention within GUM clinics, including: doctors; nurses; health advisers; and clinical psychologists (CPs). The extent to which these groups are interested, and involved, in HIV prevention, and the approaches they favour, is uncertain. Stott et al. (1994) suggest that health promotion is not a central concern for most doctors. Given the reported tradition of STD prevention in GUM clinics, however, it is possible that GUM doctors are more interested than most. Jones and Cribb (1997) suggest that, in general, doctors are likely to view health promotion largely in terms of disease prevention and clinical treatments. The health promotion component of nursing practice has been emphasised in a number of training and policy documents (UKCC 1986; RCN 1989; ENB 1991). Latter (1994) reports that, in general, hospital nurses, like doctors, have an individualistic and disease-orientated notion of health promotion. Whether GUM doctors and nurses share these more general orientations is unknown.

In response to the Monks report, there was an increased recruitment of health advisers in some GUM clinics, a large part of whose work was concerned with: partner notification; pre- and post-test counselling; and health promotion work. These practitioners often undertook a great deal of clinics' HIV prevention work (Berridge 1996). Health advisers require no formal qualification, though many have backgrounds in nursing or social work (Berridge 1996). CPs were already increasingly involved in GUM clinic-based provision prior to AIDS; this trend accelerated in the course of the epidemic

As well as GUM clinics, statutory health promotion units also became involved in HIV

prevention. Health promotion units undertook a range of HIV prevention-related activities including direct provision, as well as facilitating provision by other organisations, such as: voluntary agencies; NHS trusts; and general practices. This facilitative role has come to predominate (Bennett and Ferlie 1994).

Health education units, as they were originally termed, were initially sited in local government, entering the NHS after the 1974 reorganisation (Sutherland 1987). These units were based firstly in area health authorities, and, from 1982, in DHAs. Health education officers increasingly came to be retitled health promotion officers or health promotion specialists, though some remain as health education officers (Rawson and Grigg 1988). *Working for Patients* did not specify the position of health promotion units in the internal market (Adams 1996). Jones (1997b) reports that 60% of health promotion units were, by 1997, located within providers, rather than in DHAs.

According to Nettleton and Burrows (1997), health promoters have been neglected in sociological analysis. Health promoters come from a diversity in the backgrounds, with various amounts and forms of training (Lussier 1984). Specialist health promoters, as Ewles (1996) terms them in order to distinguish them from other practitioners carrying out some health promotion as part of their broader activities, have been described by Davison and Davey-Smith (1995:92) as a 'rather amorphous professional grouping'. There is no statutory obligation for training or a license to practice. Post-graduate diplomas have developed from the early 1970s, but are not standardised in terms of content. A professional association, the Society of Health Education and Promotion Specialists, exists, but membership is not compulsory.

e. Scrutiny of expertise

This section considers both the scrutiny of providers by commissioners, and the scrutiny of practitioners by their managers, as well as by commissioners.

Commissioners appear keen to scrutinise, and indeed impose control on, the providers

from whom they commission HIV services. Berridge (1996) and Small (1994) describe an increasing emphasis from commissioners on 'rationalising' a system which they view as having developed haphazardly. Bennett and Ferlie (1994: 8) described the difficulties DHA managers faced in this earlier period of development:

> The level of uncertainty was such that it was difficult to set and monitor unambiguous objectives but rather it was important to learn how best to respond... The climate was not rationalistic but rather tinged by waves of panic, guilt and denial.

Commissioners appear be more active in the specification and monitoring of the work of some providers than others. In a study of sexual health alliances in various English districts, the service specifications and monitoring requirements appeared stricter for voluntary agencies than for statutory agencies, perhaps reflecting a lack of trust between commissioners and voluntary agencies (Ingham et al. 1997). Billis and Harris (1996) suggest that, in general, contract-funding of the voluntary sector by statutory funders has tended to bring with it increased requirements for the specification and monitoring of services. Regarding statutory providers, however, Evans et al. (1994) report a minimal impact, to date, of commissioning on the development of GUM-based HIV prevention. Weatherburn et al. (1997) found that HIV prevention in GUM clinics was rarely even specified in contracts.

A need to prioritise services is commonly talked of by commissioners (eg. Ridley and Jones 1996), despite increasing HIV prevention allocations to many health authorities. Commissioners of HIV prevention appear to see 'value for money' as the chief criterion guiding their decisions to invest or disinvest in services (Weeks et al. 1994; Bhatt and Lee 1997). Van Teijlingen and Huby (1998) reported that commissioners seek evidence from evaluations in developing a picture of benefit and/or value for money. Van Teijlingen and Huby do not specify what form of evaluations are favoured by commissioners. This question is explored in the case studies reported in later chapters of this thesis.

Both RHA and DHA commissioners have often, in fact, funded evaluations (Berridge

1996). The evaluation of HIV prevention has also received some funding from the NHS R&D programme (NHPIS 1998) , although HIV prevention and sexual health are not, as reported in Chapter 3, themselves priority areas. The total amount of funding actually provided for the evaluation of HIV prevention, either by the R&D programme or by commissioners, is not recorded. However, it is reported that, despite evaluation not apparently being prioritised by commissioners at the initiation of the internal market (Bennett and Pettigrew 1991), by 1994 it was increasingly becoming prioritised (Small 1994).

As discussed in Chapter 3, as well as providing information to enable technically the rationing of services, evaluation may enable the political legitimation of such activities. The extent however to which the rationing of HIV prevention actually requires this legitimation is uncertain. Health promotion funding in general has often been short-term, and projects have been de-funded with an absence of the furore which greets the closure of acute hospital wards (Leichter 1991). Parish (1995) argues that, because the benefits that health promotion is intended to bring are long, rather than short, term, this means that political support is often less forthcoming. Klein (quoted in Leichter 1991:92) suggested that this position also arises because the benefits of health promotion are sometimes more abstract than tangible:

> Those who will benefit cannot be identified; moreover the benefit itself is uncertain. For prevention is about the reduction of statistical risk, not about the delivery of certain benefits to specific individuals.

Whether these arguments apply to HIV prevention services is uncertain. It may be that evaluation serves to legitimate continuing investment in, rather than (or as well as) the rationing of, HIV prevention. Van Teijlingen and Huby (1998) argue that evaluation has become more important in HIV/AIDS than elsewhere because the area is a stigmatised one, and because of political pressure to prove that money has not been wasted. They also suggest there is a greater need to prove cost-effectiveness in the face of scepticism and jealousy from those working in other less generously funded areas. It may also be that the visibility of ring-fenced funding inputs may cause funders to focus more closely on HIV prevention services' outputs and outcomes. This literature does not specify what

form of evaluation is being discussed.

As well as provider agencies being scrutinised by commissioners, the work of individual practitioners is scrutinised; by their own managers, by commissioners, by their peers; or by a combination of these. Monitoring, audit and evaluation might all serve as resources in strategies of scrutinising or controlling the activities of practitioners. The possible role of clinical audit particularly in strategies of controlling clinical practice was discussed in the last chapter. Audit does not appear to have received great attention in the HIV prevention literature. Weatherburn et al. (1997) report that GUM clinic staff often resented and resisted any involvement of commissioners in the development and auditing of clinical protocols. This research focused, however, on protocols for clinical, rather than HIV prevention, services. No literature on audit in the HIV voluntary sector was found. In the voluntary sector more generally, what little evidence exists suggests that contract specifications rarely include guidelines for the activities of individual workers (Richardson 1995) or volunteers (Hedley and Davis Smith 1994).

4. Diversity of views on evidence

The views of many involved in HIV prevention diverge from those described in Chapter 3 as at the centre both of the NHS R&D programme (Peckham 1991a), and of *Working for Patient's* sections on audit (DoH 1989). Numerous illustrations of this divergence are given in this section. This supports the view offered in Chapters 2 and 3 that, when there is a multitude of individuals or groups engaged in doing or using research in the NHS, there is every likelihood that many will hold views on research which are different from or critical of those which are established as mainstream. Some have argued that sector and occupational group membership act as predictors for orientations to particular forms of evidence. Bennett and Ferlie (1994), for example, remarked that different groups involved in HIV planning base their actions (in terms of practice and research) on different models. They suggested that: clinical doctors use a biomedical model; public health doctors use a community/population model; health educators use a social/educational model; and the voluntary sector uses an experiential model. Bennett

and Ferlie did not however explain what these models actually comprise.

Postulating these kinds of associations can imply both an unduly simplistic view of group identity, contrary to Patton's earlier warning, and an excessively determinative effect of group membership on orientations to evidence. It need not be the case, for example, that individuals who consider themselves activists reject scientific evidence (eg. Altman 1993). The apparent blurring of distinctions between the statutory and voluntary sectors in general (Marshall 1996) suggests that care should be taken in suggesting stark contrasts between the two regarding evidence preferences. However, what may turn out to be stereotypes may nonetheless suggest possibilities which can be explored in case studies. The orientations of different groups to different forms of evidence, and different ways of applying evidence to practice, are therefore considered in this section.

a. Prioritisation of personal experience by the voluntary sector?

Bennett and Ferlie (1994: 34) suggest that a focus on using personal experience is a key feature of what they term 'social movements'. They state (1994: 69):

> There have... been profound epistemological questions raised in debate, such as whether scientific knowledge has a privileged status in relation to experiential knowledge. Theorists coming out of social movements indeed emphasise the primacy of lived experience as a source of knowledge.

Though not all within the HIV voluntary sector are likely to perceive themselves as being involved in social movements, many certainly would (Altman 1993). Many describing themselves as HIV activists have asserted the importance of using experience from within affected communities instead of, or in addition to, some research evidence (Watney 1994; Altman 1993). Altman (1993: 3) writes:

> Central to the contribution the community sector has made to the politics of AIDS is the claim that it has expertise on HIV/AIDS equivalent to that of virologists and epidemiologists. This assertion is essentially a political one, for it derives from a view of knowledge not as a set of objective data waiting out there to be discovered, but rather as a process involving the interaction of human practices and institutions ... one which argues that knowledge grows as much out of lived experience as out of the application of scientific

methodology... What the gay community contributes to an understanding of the epidemic is a kind of self-reflexive knowledge: thinking about your place in society enables you to make sense of epidemiological and survey data through a process of reflection and metaphor which brings a richness of interpretation not readily available to positivist 'science'.

These claims seem qualitatively different from the claims of some clinical practitioners, aired in Chapters 1 and 2, that judgment and experience is needed in applying scientific knowledge and/or research evidence, in the course of practice; in that experience is given a central, rather than an auxiliary, position. Irwin (1995) distinguished between 'citizen knowledge' and 'expert science', on the basis that the former is local and contextual, and produced by lay people, while the latter is formalised and generalisable, and produced by experts. Judging by the quote from Altman above, the experiential knowledge promoted by some HIV activists certainly appears to come under the heading of citizen knowledge. However, some expert practitioners, including doctors, have also stressed the importance of experience informing practice (Smith 1996).

Irwin acknowledged that some attempts have been made to bridge the gap between citizen knowledge and expert science, referring to what Davison et al. (1992) term 'lay epidemiology'. Here, local and contextual knowledge is said to be combined with formal and generalisable knowledge. Williams and Popay (1994) have suggested that lay epidemiology has been used by community activists in making their case to wider policy communities. There are, indeed, examples of research projects being undertaken with the involvement of HIV prevention voluntary agencies (eg. Hickson et al. 1994), which suggest that at least some of the HIV voluntary sector is prepared to embrace approaches to the production of knowledge which involve elements of formalisation and generalisation.

The importance of formal research, where it is conducted, being 'owned' by the communities in question is often asserted (Mukasa 1997; Watney 1994). Watney (1994) suggested that much of the best research in HIV prevention has been done by activists, though no evidence was offered to support this assertion. Activists have criticised the quality and political acceptability of research being undertaken by others, and have

accused some academic researchers of placing career imperatives before practical utility (eg. Watney 1994.)

b. Antipathy to quantification on the part of health promoters?

On the part of some professional health promoters, there is an antipathy to the use of quantification in research. Smithies and Adams (1993:60) argued that many health promoters see the use of quantitative studies as rooted in an 'uncritical subservience to the mystiques of conventional evaluation methods'. Health promoters have argued that the emphasis, within health promotion, on client, rather than medical, definitions of health militates against using quantitative measures of health and illness (Naidoo and Willis 1994). However, without embarking upon a detailed methodological review, it should be pointed out that quantitative measures can be constructed so as to encompass client perspectives, and consider positive and broad definitions of health and illness (Bowling 1997).

Oakley (1998a) has argued that the distinction between quantitative and qualitative research is socially constructed, and that one motivation for some health promoters' criticism of quantitative research is a desire to distance their own group's approach to research from what is viewed, mistakenly so argues Oakley, as a medical one. This point is considered further in relation to health promoters' views on experimentation, discussed below.

In contrast to health promoters, DHA commissioners have, according to one study by Ingham et al. (1997), a clear preference for quantitative evidence, though the reasons behind this are not reported.

c. Reluctance to evaluate effectiveness on the part of health promoters and the voluntary sector?

What has been termed an 'effectiveness movement' has developed within HIV

prevention, as in other areas of clinical care and health promotion (Oakley et al. 1995; Hart 1996). Aggleton and Moody (1992) categorised evaluations as to whether they focus on outcome and/or process, and whether they aim to provide formative and/or summative evaluation. Hart (1996) has suggested that much early evaluation in HIV prevention was process- and formative-focused, rather than outcome- and summative-focused, and so did not produce evidence on the effectiveness of services.

As mentioned in Chapter 1, some have stressed the importance of examining other aspects of services as well as effectiveness (eg. Black 1996). There appears a particular reluctance on the part of some, among health promoters and within the HIV voluntary sector, to evaluate the effectiveness of services. Ewles (1996) suggested that prioritising the evaluation of effectiveness is generally regarded by professional health promoters as an outside agenda imposed upon them, rather than something which health promoters have themselves pressed for. Smithies and Adams (1993:65) asserted that, in health promotion in general, evaluation of effectiveness is sometimes regarded sceptically by practitioners, because of its rationing connotations:

> It is widely recognised and documented that community development workers have tended to view evaluation as a funder's tool, usually employing both personnel and methodology that are unsympathetic or inappropriate... Indeed it sometimes seems to have been the case that the evaluation that was likely to be least sympathetic to community development was deployed and then produced results to justify closing down projects on the grounds that they were engaged in radical and political work.

It may indeed be that these attitudes are entrenched, because, historically, health promotion has perceived itself to have been subject to explicit rationing, much more than have clinical services (Smithies and Adams 1993).

Bennett and Ferlie (1994: 99) suggested that HIV voluntary organisations may be unenthusiastic about focusing on effectiveness because they have often based their work on values, which are firmly held, but empirically untested. Bhatt and Lee (1997: 215) argued that fierce competition between HIV voluntary providers has inhibited them from

critically scrutinising the effectiveness of their own services:

The market mechanisms... have created a situation in which embattled organisations are compelled to work against each other rather than work with each other. Part of this process has entailed the flourishing of absolutist claims involving efficacy, moral, political and ethical authority, leadership, representation and ownership, as well as the creation of immense expectations that would be difficult for any organization to meet or sustain in practice in the longer term.

There may be particular ethical difficulties for voluntary organisations in becoming involved in what they perceive as rationing-related evaluation. These organisations might see themselves as having a prime responsibility to their members, or to specific communities, rather than to the population as a whole, and hence might understandably be anxious about being involved in cost-effectiveness studies which might result in the transfer of funds away from services for their own members or communities.

d. Antipathy to experimental designs on the part of health promoters?

As mentioned above, an antipathy is notable amongst some health promotion personnel to the evaluation of services using prospective experimental studies with control groups (Oakley 1998a). Such designs have been asserted by Oakley et al. (1995), among others, as the best means of providing reliable evidence on the effectiveness of HIV prevention and other interventions. Oakley (1998a) suggested that many health promotion texts do not refer to experimental designs, such as the randomised controlled trial (RCT), or are dismissive of them. Health promoters have criticised experimental designs for a variety of reasons. Davies and MacDonald (1998: 209), for example, argued:

The biomedical model perceives health in an individualistic, reductionist way as an absence of illness, and regards health promotion or health education as a tool of preventive medicine, concentrating on behavioural risk factors. Effectiveness is based on predictability through repeatable, empiricist results. Using the credibility of the medico-scientific paradigm it perceives effectiveness and quality only in positivist and empiricist terms; its gold standard being the RCT. Its underlying ideology is expert driven, authoritarian and disempowering; seeking evidence through narrow clinically based methods and short term quantitative outcome measures.

In the quote, the RCT is equated with the medico-scientific paradigm, which is said to embrace a positivist and empiricist epistemology. RCTs are also associated with an authoritarian and disempowering political stance. Health promotion is implied as standing against this paradigm and this stance, and so the RCT is viewed as philosophically and ideologically inappropriate for the evaluation of health promotion. Though this view is arguably somewhat simplistic (see eg. Bonell 1999), this section seeks not to engage with, but merely to describe, these views. Others have discussed practical, as opposed to philosophical and political, difficulties in applying experimental designs to the evaluation of some health interventions (eg. Charlton 1995), including HIV prevention (eg. Webb 1997).

Oakley (1998a) suggested that some health promoters wish to distance themselves from experimental designs, partly because these designs are regarded as being encompassed within the 'medical model'. She argued that this distancing might comprise one element by which health promoters aim to construct a professional identity distinct from medicine. MacDonald (1997) previously made similar arguments in relation to social workers' attitudes to experimental evaluation designs.

Others have suggested that health promoters object to experimental designs because they are threatened by scrutiny of their work (Sheldon et al. 1998). According to Stone (1996: 29):

> The hiring of inexperienced and semi-skilled youngsters to spread tendentious health promotion messages to a bemused and sceptical public will soon be a thing of the past. Professional journals are already loudly trumpeting the virtues of evidence-based practice and the concept will cause some soul searching within the newly established, and still precarious, health promotion empires up and down the land.

Similar criticism of experimental designs is not found in literature on, or of, the HIV voluntary sector. Bhatt and Lee (1997) actually argue that voluntary sector providers of HIV prevention are actively drawn to experimental evaluation of their services, driven by a desire to relieve their considerable anxiety about the impact their work has.

e. Confusion about audit among health promoters and the voluntary sector?

As mentioned earlier, there is little discussion of audit within the HIV prevention literature. Bonell (1996) reports that individuals from HIV voluntary agencies, as well as statutory sector health promotion specialists, often knew little about audit. Billis and Harris (1996) suggested the voluntary sector in general has struggled with developing an understanding of quality, and applying this to their services. Weatherburn et al. (1997) reported that many GUM clinic staff were actively engaged in audit, though of clinical more than of HIV prevention activities. No assertion was found in HIV prevention literature that guidelines are an inappropriate means of implementing the results of research.

5. Leadership of EBP and consequences for power relations

Chapter 3 concluded that EBP may have implications for relations between: central and peripheral agencies; commissioners and providers; and managers and practitioners. EBP may serve as one resource within an overall strategy, by central agencies, of explicating the rationing of services, but delegating this rationing to peripheral agencies, to be undertaken by commissioners or by practitioners themselves. The chapter listed a number of factors which might, however, impede the use of EBP in rationing services. Conversely, EBP may function as a means of legitimating continued state investment in the NHS. Chapter 3 suggested that EBP may be used by commissioners to control the prioritisation of local services and the work of local providers. EBP may also be used by managers, within providers, to regulate the work of practitioners. Chapter 3 argued that, while doctors are likely to succeed in regulating their own practice, via controlling EBP, managers are more likely to control the work of non-medical practitioners. This section considers which groups are likely to lead on EBP within HIV prevention, and what consequences are likely, for power relations between different agencies and groups.

The views of some within the voluntary sector, and some professional health promoters, appear, according to the admittedly rather sparse evidence reported in the last section, to

diverge somewhat from those views that, according to Chapter 3, are currently institutionalised within NHS policy on R&D. Furthermore, they also appear to diverge from those held by commissioners, who according to Berridge (1996) are also funding HIV prevention research. In contrast, GUM clinic staff are likely to hold views on EBP which converge more with those embraced by NHS central policy makers, and by commissioners, though again the evidence presented is sparse.

It is possible therefore that, while GUM clinic staff become actively involved in the production and use of evidence, funded by the NHS R&D programme and/or by local commissioners, HIV voluntary sector and statutory health promotion unit staff do not. It is also possible that these latter groups already do, or in the future will, find that approaches to the definition, production and/or use of evidence which do not coincide with their own views are imposed on them by local commissioners, or perhaps by their own managers.

EBP may come to function as a resource within HIV commissioners' and central government agencies' strategies of control. As a result of the differential involvement described above, these strategies might involve: 'control via *action* at a distance', in the case of GUM clinics; and 'control via *steering* at a distance', in the case of voluntary agencies and statutory health promotion units. In order to promote EBP in line with the central orthodoxy exemplified in the R&D strategy, it is possible that commissioners and/or the managers of voluntary agencies or statutory health promotion units may steer, at a distance, those practitioners within their organisations who are, themselves, unwilling to initiate EBP in line with the central orthodoxy. Commissioners and GUM clinic managers may find that they do not need to intervene so directly to initiate EBP amongst clinical practitioners who are already themselves initiating EBP in line with 'official' models.

Chapter 3 suggested that those practitioners, notably doctors, who collectively themselves manage the development of EBP, may preserve their group, and perhaps their individual practitioner, autonomy. Voluntary and statutory health promotion staff, not themselves

managing the production and policing of EBP, but having these activities imposed on them by commissioners or provider management, may have both their individual and group autonomy severely circumscribed.

However, in line with Foucault (1991), the strategies of control described above may be resisted. Those agencies or groups who might be expected to undertake certain forms of EBP may actually reject these models. Chapter 3 described widespread scepticism about EBP (Griffiths 1995), and a tendency to use EBP, somewhat subversively, to undermine other elements of central government policy (Coulter 1995). Agencies and groups advocating other ways of defining, producing or using evidence, or refusing to become in any way involved in EBP, may succeed in obtaining local support, and possibly funding to take forward their alternative approaches. Challenges may not necessarily only come from practitioners, but also from commissioners and managers, who according to Chapter 3 have sometimes found that research evidence has not necessarily met their needs (Gray et al. 1997). The consequences outlined above, then, are possibilities that are explored in the empirical components of this thesis, rather than inevitabilities which can be concluded as a result of the literature already reviewed. The next chapter describes the research design underlying the thesis' empirical component.

CHAPTER FIVE: RESEARCH DESIGN

1. Defining research topics and questions

In order to develop a set of research questions to inform empirical investigation, it is necessary to move from the broad set of concerns discussed in Chapters 1 to 4, to a more precise idea of the topic to be examined, and the questions to be asked of it. Lofland and Lofland (1995) stated that a research topic comprises 'units' and 'aspects'. This study takes as its 'unit', the processes of definition, production and use of evidence within certain case studies. The study focuses on evidence used in informing practice and policy decisions. It assumes that no hard and fast distinction can be made between these two activities (see Lipsky 1980). As its 'aspect', the study takes the meanings of evidence and EBP, and the relations of control and resistance which affect, and are themselves affected by, processes of evidence definition, production and use.

Lofland and Lofland also provide a typology of questions to be asked of research topics. These include: type (what is a topic); structure (what comprises a topic); magnitudes (how big is a topic); frequencies (how common is a topic); process (how does a topic develop); causes (what determines process); consequences (what are the results of process); agency (the volitional determination of process). These questions are used to inform the phrasing of the present study's overall research questions, which are as follows:

In the planning and provision of HIV prevention by NHS-funded agencies:

1. How are the definition, production and use of evidence determined by existing relations of control and resistance, between: centre and periphery; commissioners and statutory/voluntary sector providers; and managers and clinical/non-clinical practitioners in statutory/voluntary sector providers?

2. Is evidence defined, produced and used in order to modify relations of control or

resistance, particularly in the prioritisation of services?

3. Does the definition, production and use of evidence modify relations of control and resistance?

These overall research questions are answered with reference to the study findings in Chapter 9. As well as these overall research questions a number of operational research questions are also developed to inform data collection:

1. What organisations and groups are involved in the planning and provision of HIV prevention?

2. How and why do different organisations and groups define evidence?

3. How and why do different organisations and groups produce evidence?

4. How and why do different organisations and groups use evidence?

These operational research questions inform the structure of Chapters 6 to 8.

2. Case study design

a. Definition and remit

Research design is distinct from research method (Bryman 1989) . The former refers to the overall approach to the collection and analysis of data, and includes eg. the experiment, the survey and the case study. The latter refers to the means by which data are collected, and includes eg. the questionnaire, and the semi-structured interview.

Yin (1994: 13) defines a case study as:

> an empirical enquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident.

Bryman (1989) defines case studies as involving five sites or fewer. Case studies are often the most appropriate method to examine 'what' and especially 'how' and 'why' questions. Case study research is appropriate to investigating the current study's research questions, both because the definition, production and use of evidence are not neatly delineated processes, and because the study aims, both, to describe, and to explain events.

b. Generalisation from case studies

The study aims to examine particular cases in order to develop theory which is potentially generalisable to other sites. Case study research does not attempt to develop statistically generalisable findings; the extent to which the phenomena under study arise in standard or similar form elsewhere is unclear (Yin 1994). Any generalisation from case study research must be on the basis of an analytic assessment, on a case-by-case basis, of what other sites the theory applies to, and how the theory needs to be modified in each case. This study does not itself aim to test the generalisability of any theory produced, since this would require extensive multi-site research.

c. A comparative approach

According to C. Wright Mills (1959: 214):

> The hardest thing in the world is to study one object; when you try to contrast objects, you get a better grip on the materials and you can then sort out the dimensions in terms of which the comparisons are made.

A comparative case study provides the best means of exploring the inter-relation of power, and processes of evidence definition, production and use. In order to address the current study's research questions, the research design involves comparison between two

organisations: one, a statutory organisation, mainly involving doctors and other clinical workers, as well as managers; and the other, a voluntary organisation, involving volunteers, non-clinical workers as well as managers. The cases are described in a later section.

Fieldwork was undertaken in 1997 and 1998 and focused mainly on events occurring in the 1996/7 financial year, though events prior to, and after, this were also examined where this seemed necessary to understanding what was going on. It was hoped that, by looking at the experiences of both organisations in the same period, this would promote comparison. A prospective observational study was considered unfeasible for a number of reasons: undertaking two observational studies simultaneously would be impractical; organisations would not allow unfettered participant or non-participant observation; the sites in which evidence would be defined, produced and used would be difficult to predict and therefore observe; and many relevant documents would not have been produced while fieldwork was underway, thus hampering comparison between observations and official records.

d. Qualitative data

Case studies can utilise both 'quantitative' and 'qualitative' data (Yin 1994). Lofland and Lofland (1995: 18) suggest that quantitative research:

> seeks to determine the frequency of pre-conceived kinds of things.

Qualitative approaches, in contrast:

> find out what kind of things exist in the first place.

Because this study seeks to explore the meaning of evidence and the nature of power relations in evidence definition, production and use - topics which are very far from being pre-conceived sociologically - the study set out to use qualitative data to develop a sociological understanding. However, an epistemological distinction between

quantitative and qualitative approaches to research is rejected, a point discussed later in this chapter.

3. The cases

a. Defining and identifying cases

It is difficult to study processes of evidence definition, production and use in their entirety. Weiss with Bucuvalas (1980: 27) have previously concluded that:

> To systematically study the gamut of activities from the formulation of research to its application in decision-making - and all the failings distractions, and countervailing influences that can affect those activities - is beyond the resources of a single project.

In their research, Weiss and Bucuvalas focused on multiple cases of policy makers' receipt of a research report. The current study elected, instead, to focus on the entire process of evidence production and use, but, in order to make the research feasible, in relation to two cases only.

In order to enable the current research questions to be answered, the organisations chosen as cases needed to be similar in some respects, and to differ in others. Both must receive NHS funds and undertake primary HIV prevention. Both needed to be involved in evidence production and use. Cases needed to differ in one belonging in the statutory sector, and one belonging in the voluntary sector. The organisations identified did not, however, need to be representative of other similar organisations in terms of evidence production and use; the research sought to examine what happens, in terms of power and meaning, when organisations do engage with evidence production and use, rather than examining whether all or most organisations are involved in evidence production and use.

The study necessarily focuses, not only on each organisation, but also their relations with other organisations, including commissioners, other providers and relevant central agencies. Chapters 3 and 4 consider, in some detail, the role of central agencies, such as

the DoH and NHSE, in HIV prevention and in promoting EBP. Some of this information is used, alongside information collected in fieldwork, to inform discussion in Chapter 9. This proved important because central agencies had little direct involvement in the case studies.

Suitable organisations were identified using my own knowledge of the field. I had previously worked as a researcher in an HIV voluntary agency, as well as a commissioner of primary care research in a health authority. I have some knowledge of, and contacts with, local HIV prevention agencies and health authorities. I also referred to the National HIV Prevention Information Service, based at the Health Education Authority, and to the National AIDS Manual, a reference book on HIV/AIDS matters, to identify possible cases. King George's Clinic (KGC) was chosen as the statutory case study. Gay AIDS Action (GAA) was chosen as the voluntary agency. These, together with almost all other names used to report findings, are pseudonyms. This matter is discussed in a later section. The organisations met the criteria for inclusion listed above. Both received most of their funding for services from the NHS and both were engaged in primary HIV prevention. KGC was situated within an NHS community trust, while GAA was a private, not-for-profit company, with a volunteer membership and elected board. Two other factors, though not criteria for the selection of cases, opportunistically made for an interesting comparison. Both KGC and GAA focused primarily on HIV prevention with gay men, and both were attempting what were regarded as experimental evaluations of one of their HIV prevention interventions. KGC undertook clinical as well as HIV prevention activities, while GAA focused solely on the latter. Rather than hampering comparison, this disparity was used as a topic to be explored.

b. Description of organisations involved in cases

King George's Clinic

KGC is a GUM and HIV treatment clinic, based in an NHS community trust in London, and formed from the merger, in 1994, of two previous clinics. The clinic has no explicit

aims and objectives. HIV prevention activity within the case study was heavily influenced by a series of documents produced by the district HIV prevention strategy group, and the clinic Sexual Health Promotion Group (SHPG). These documents are discussed in Chapter 6 and 7. The composition of the SHPG is discussed below.

The trust within which KGC is sited provides various services, including mental health and family planning, as well as GUM and HIV services. The trust has a Chief Executive, various directors, and a non-executive board, appointed by the Secretary of State for Health.

The clinic's modern premises, located in central London, house a men's clinic, a women's clinic, and an HIV treatment clinic, as well as an academic department, which is discussed below. In terms of 'whole time equivalents', at the time of fieldwork the clinic employed 4 consultant doctors, 7 specialist registrars, 4 senior house officers, 13 clinical assistants, plus a number of academics undertaking clinical sessions. The clinic also employed 21 nurses, 8 health advisers, and 5.5 clinical psychologists (CPs).

The Clinic Director is a GUM consultant, accountable to the Trust Medical Director, who is also a GUM consultant. The Clinic Director officially manages the other GUM consultants. Junior doctors are accountable to supervisors, who may be consultants, or academic doctors with honorary NHS contracts. Two academic doctors act as Clinical Co-ordinators, one leading on GUM services, and one on HIV treatment services. Nurses are accountable to the Clinical Services Manager, who is, in turn, accountable to a senior nurse in the trust. Health advisers are accountable to a Health Adviser-Manager, in turn accountable to the clinic's Business Manager and GUM Clinical Co-ordinator. One former health adviser is employed as Liaison Worker, working between the clinic and King George's HIV Prevention Unit (discussed below). The Liaison Worker is managed by this unit's manager, and also receives supervision from the GUM Clinical Co-ordinator. The Liaison Worker is responsible for managing the GUM Development Worker, vacant at the time of fieldwork. The clinic's management structure is summarised in Appendix 3.

The clinic has a Management Executive Group, which includes the Business Manager, the Clinical Co-ordinator, as well as practitioner-managers in medicine, nursing, health advice and clinical psychology, and the director of the academic department. It is chaired by the Clinic Director. A 'house meeting', involving slightly less senior staff, focuses on operational issues. A general clinic meeting is also held, preceded by occupation-specific meetings. The SHPG includes the various practitioner-managers, the Business Manager, the Regional Audit Facilitator, and a representative from the HIV prevention unit. This was initially chaired by the Clinic Director before being passed to the Liaison Worker. The work of this group is discussed in Chapter 6 and 7.

The clinic is commissioned by Aldbridge Health Authority to provide GUM and HIV treatment services, receiving around £4 million annually. The main business in the men and women's clinic is the diagnosis and treatment of STDs, HIV testing, pre- and post-test counselling, STD and HIV partner notification, counselling for those with HIV and other sexual health issues, and sexual health promotion (SHP), including HIV prevention.

The clinic receives many thousands of attenders annually, with over a thousand being diagnosed with HIV infection per year. Gay men make up approximately 40% of clients in the men's and the HIV clinic. There are relatively few clients from other groups viewed as vulnerable to HIV infection.

The clinic is open access. Clients report to reception, and then wait for an appointment. In the young gay men's clinic (run weekly in the men's clinic), clients, first of all, see a health adviser, reflecting the fact that the majority of consultations in this clinic are not prompted by symptom expression. In all other clinics, clients, first of all, see a doctor, who takes their sexual history, and assesses what further action is required. Doctors engage in diagnosis, treatment and health promotion, and can also refer the client to other staff for specific activities: to nurses for various tests; to health advisers for education and counselling; and to CPs where specific psychological problems are suspected. Consultations with doctors average 10 minutes while health advisers see clients for up to around 25 minutes, and nurses on average for around 5 minutes.

In terms of HIV prevention and other SHP: doctors focus on assessment and opportunistic provision; nurses largely on condom provision and training and on SHP regarding herpes; health advisers on more in-depth education and counselling, especially but not exclusively in pre- and post-HIV test counselling; and CPs in cases where psychological factors are affecting risk-taking behaviour. As well as this standard management there a number of specific interventions, which are discussed in Chapters 6 and 7.

Organisations linked to KGC

King George's NHS Trust houses another GUM clinic, the culture of which, in terms of both clients and staff, is said to be very different from KGC. The clinic was not included in this study.

KGC's offices also house the London University Department of Sexual Health (LUSH). The department includes a variety of researchers, many, but not all, of whom are medically-qualified. The department engages in basic, clinical and epidemiological research. LUSH's director is a medical scientist, other senior figures include a clinical researcher and an epidemiologist. LUSH received a total of around £2.7 million annually, most of this for basic and clinical research. Specific incomes for epidemiological, behavioural and social research were not available.

Formally, the department is managed by an Academic Management Group, which includes the senior figures mentioned above, plus other senior academics. An R&D Group meets bimonthly to discuss strategic issues. This group comprises senior academics, as well as KGC's various practitioner-managers, including the Clinic Director. There is also a Staff Groups Representative Meeting, where more junior academic staff meet to promote communication within the department.

The trust which houses the clinic also includes King George's HIV Prevention Unit (KGHU), mentioned above. This unit undertakes HIV prevention and SHP work, some

working with the clinic, and some working with other agencies and directly in the community. KGHU is funded to the level of approximately £500,000, of which around £130,000 is allocated for developing SHP in the trust's GUM clinic. KGHU provide support to KGC in the development of policies, training, and in condom and materials provision.

This unit is managed by the KGC's Business Manager. Prior to this, KGHU was managed within the trust's Health Promotion Department. KGHU comprises a number of teams in areas such as: gay men; NHS services; and African communities. The clinic Liaison Worker is managed within the NHS services team, as is the vacant GUM Development Worker post.

Gay AIDS Action (GAA)

GAA was founded in June 1992, as an organisation run by gay men for gay men. It has a number of aims: minimising the scale of the AIDS epidemic among gay men; minimising the harmful effects of HIV infection among gay men; minimising other harmful effects of the epidemic upon gay men, such as AIDS-related homophobia and discrimination. GAA's major programme of work is entitled the London HIV Campaign (LHC). This is discussed below.

GAA's principles are: that gay men should be equal citizens and entitled to the same rights and respect as other members of society; that HIV continues to affect gay men more than any other group in society; prevention and care should be designed and resourced in a way that accurately reflects the epidemiology of HIV rather than inappropriate models of equal opportunities; that gay men are best placed to plan, implement and evaluate HIV prevention for gay men; that, in the absence of a vaccine, safer sex is the best way of preventing HIV transmission; that HIV prevention work should enable gay men to choose safer sex strategies independently of moral or political considerations; that supportive and positive models of gay identity are essential for HIV prevention; and that the diversity of gay men and their consensual sexual choices should

be respected. In 1996, GAA changed one of these principles from: ordinary gay men are best placed to develop HIV prevention; to: ordinary gay men 'properly trained and supported' are best placed to develop HIV prevention.

GAA is constituted as a private limited company, with a board of directors elected by its volunteer members. Its small set of offices is located in a business centre in London. According to various documents, 100 volunteers were recruited in 1992/3, and 185 in 1993/4. By 1995, GAA had approximately 150 active volunteers. Volunteers' characteristics are discussed in Chapter 6.

After training, volunteers work in one or more of a number of groups which focus on the following aspects of provision: information and public relations; safer sex education; training; research; and work with HIV-infected men. These groups sub-divide into cells to work on specific projects. Volunteers gain membership and voting rights after having volunteered for the organisation for some time. Each volunteer group has a co-ordinator, who is a volunteer elected by members. Co-ordinators sit on a co-ordinators' committee. GAA is said to be 'volunteer-led', in that volunteers, in cells, determine what projects occur; and volunteers, on the co-ordinators' committee and the board, determine broader policy. In this, volunteers are said to be supported by staff.

GAA's General Manager manages an LHC Operational Manager, as well as some workers, including a Research Assistant. The General Manager himself is accountable to Directors, and is managed by the Chair. The LHC Operational Manager manages the Volunteer Support Worker plus all administrative support workers, serving each volunteer group. As well as being line-managed by the General Manager, the LHC Operational Manager is accountable to the co-ordinators committee. GAA's structure is summarised in Appendix 4.

At the time of fieldwork, the organisation received around £200,000 annually, almost all from statutory sources. There are no membership fees. Its largest source of funding has been two consecutive contracts for the London HIV Campaign. LHC1 lasted from April

1993 to March 1996, and was funded by a number of RHAs, plus several health authorities, including Aldbridge, Burkington and Cherrington, (discussed below). The LHC1 contract was subsequently taken on by a consortium of inner and outer London health authorities (with management co-ordinated by Cherrington), upon the demise of RHAs in April 1995. LHC1's objectives were: to assess risk activities amongst gay and bisexual men; to assess appropriate risk reduction techniques; to develop appropriate methods to convey accurate and constructive HIV prevention information; to evolve frameworks for working with diverse groups of men to empower them in making decisions about HIV prevention; and to develop appropriate evaluation techniques.

Funding for LHC2 was provided by a consortium of inner and outer London health authorities, again including Aldbridge, Burkington and Cherrington. LHC2 ran from April 1996 to March 1998. Cherrington was responsible for the development of the LHC2 contract between October 1995 and February 1996, which was then passed to Burkington to manage. In addition to LHC, GAA was separately funded by various health authorities to undertake HIV prevention at various locations in London, as well as various smaller projects around the UK.

GAA has adopted an overall model termed 'community mobilisation'. This is described in Chapter 6. The organisation engages in a variety of different activities, said to be informed by community mobilisation, including: face to face communication in outreach, workshops and group-work; the development of written materials, such as leaflets and a newsletter; and the development of various mass media campaigns.

Aldbridge, Burkington and Cherrington Health Authorities are discussed below. Various other organisations were involved in the GAA case study, and are discussed in Chapters 6 and 8.

Aldbridge, Burkington and Cherrington Health Authorities

Aldbridge commissions services from KGC, while Aldbridge, Burkington and

Cherrington were among the consortium of health authorities commissioning services from GAA.

Health authorities are NHS agencies given authority by the Secretary of State for Health to commission health services for their local populations. Their non-executive boards are selected by the Secretary, while their executive directors are salaried staff directing the work of the other staff, and themselves accountable to the board. Health authorities issue commissioning intentions in the autumn of one year, as a basis for the negotiation of contracts with providers for work commencing the following April.

At the time of fieldwork, each health authority had an HIV commissioner, usually accountable to a director. Commissioners titles varied between health authorities. Burkington and Cherrington, but not Aldbridge, also employed assistant commissioners to undertake mainly administrative duties in support of the commissioner. Health authorities also employ public health staff, some, but not all, of whom are medically-qualified. In addition, at the time of fieldwork, a consortium of inner London health authorities, including Aldbridge, Burkington and Cherrington, employed two HIV voluntary sector commissioning advisers. These advised health authorities on developing a co-ordinated approach to the commissioning of voluntary sector services. One focused on north London, and the other on south London.

4. Field procedures

a. Access

Access was negotiated in meetings with individuals identified as key 'gatekeepers' ie. commissioners, provider managers, and senior practitioners. Access was facilitated by my prior relationship with some of these gatekeepers, and by referring to mutual contacts when making contact with gate keepers whom I did not know. Referring to my own past experience in a health authority, and in the HIV voluntary sector, seemed to prove useful in securing access.

I stressed the small time commitment that would be required from participating individuals and organisations. I indicated that organisations and individuals would be formally anonymised in findings, and that I would strive to prevent individuals being harmed as a result of their involvement with the study. These matters are further discussed in this chapter's section on ethics. I also indicated my willingness to consider the organisation's own needs whilst undertaking the study, but indicated the study would not be fully collaborative, and I would not produce a specific report for the organisation. I did, however, promise to provide informal feedback to the organisations. I also indicated that participating organisations would have no right to veto or alter data or analyses.

Weinberg and Williams (1972) suggest that, in fieldwork, especially at the beginning, there is a risk of becoming identified with one faction, to the detriment of access to other factions. Because I had only previously worked for eighteen months in the HIV field, and was not, as far as I was aware deeply involved in any disputes, I hoped that I was not already identified as belonging to any one faction. I also hoped that, because the study did not involve prolonged engagement with an organisation, as a participant or non-participant observer, I would not become associated with any one faction in the course of fieldwork. Although factions became clearer in the course of fieldwork, prior knowledge of the field provided some guidance, and I used this in avoiding unbalanced contact with some factions, rather than others, in the course of fieldwork. However, identification with one faction, by others, could not be ruled out. Since access was negotiated via senior managers, I might have become identified with these (Bryman 1989). This was addressed by stressing to other participants that the research was not management-led, and was not being used in an evaluative manner.

b. Sampling documents

Documents were sampled, not on their representiveness of an organisation's general documentation, but, purposively, on their relevance to addressing the research questions. In meetings with gatekeepers, I indicated my particular interest in documents relating to

strategy and contracting, internal management, and the definition, production and use of evidence. These indications were put in more 'everyday' terms than this, however. I also indicated my broad research interests to these key gatekeepers, and took their advice as to which documents would be of interest. Other documents were identified in the course of subsequent interviews; these represented a minority of documents collected. I was aware that, in discussing my research interests with gatekeepers, this might affect the contents of their accounts in subsequent interviews. However, in making my interests known, I did avoid discussing matters such as power relations and meanings; this probably minimised any direct effect on interviews.

c. Sampling interviewees

The sampling of individuals to be interviewed was, again, not intended to be representative of all individuals within an organisation. Sampling was purposive in addressing analytic concerns. Guided by this purposive approach, I attempted to include all relevant groups present within an organisation, as well as to include senior and junior members of a group.

Individuals were identified via snowballing from multiple starting points, including gatekeepers and individuals identified in documents. In asking initial contacts about others suitable for interview, I stressed that dissenters and opponents, as well as consenters and allies were sought. This was in order to avoid a systematic bias of samples towards alliances, rather than oppositions. Participants seemed happy with this approach, and dissenters and opponents were indeed suggested. However, it appeared to be the case that individuals enthusiastic about activities such as the production and use of evidence were more willing to take part. A GAA co-ordinator, for example, said to be sceptical about EBP did not return my calls asking if he would like to be interviewed. All those interviewed are listed in Appendix 1. The GAA sample involved few volunteers who did not have specific positions, such as director or co-ordinator, within the organisation. Despite repeated requests, GAA management did not provide a list of 'grassroots' volunteers to approach. Instead, I explored the position of these volunteers

by examining documents, and by asking other interviewees, including some ex-GAA volunteers, about the views of this group.

5. Interviews as a method of data collection

Informed verbal consent was sought from potential interviewees. Interviewees were told something of the aims of the study. The provision of full information to participants, gatekeepers and interviewees alike, was, to some extent, limited because, at the beginning of fieldwork, it was difficult to predict which direction the study would take. These limitations to the information which can be given to participants when negotiating access have been acknowledged by Roth (1977).

Interviews were semi-structured, using interview guides. The development of these guides was informed by the operational research questions. The guides were adapted to each individual. All guides retained a core section, which addressed, for example, the interviewee's training and qualifications, their views on the organisation, and their views on what was meant by the term evidence. Guides also included points particular to each individual, which had been suggested in documents or other interviews.

Moyser (1988) advises of the need, when studying elite groups, for familiarity with terminology, significant events and dates. This, he suggests, enables the development of rapport, as well as the framing of useful questions, and the avoiding of being 'fobbed off' with standardised or superficial answers. Some of those interviewed in the current study, for example senior practitioners and managers, could be viewed as members of elite groups. The situation was complicated by my own participation in the field under study. Participation in the field made me particularly anxious to demonstrate a knowledge of certain key issues in HIV prevention because, I assumed, this would be expected by interviewees. This knowledge, some of which I possessed prior to fieldwork, and some of which I acquired in the course of fieldwork, did appear to be useful in gaining more than superficial information.

It has been suggested that an effective style of presentation within an interview is one of being 'non-threatening' and 'acceptably incompetent' (Lofland and Lofland 1995). This involves avoiding challenging participants and freely admitting ignorance. An acceptable level of incompetence was somewhat difficult to adopt in the present study, because of the need for, as well as the assumed presence on the part of interviewees of, some level of competence. A style which was regarded as 'knowing incompetence' was sometimes adopted instead. At points in some interviews, I made clear that I wanted to ask seemingly obvious questions in order to get to the root of participants' experiences. Phrases, such as 'this may sound like a silly question, but I want to hear what *you* think about it', were used. Participants appeared to understand this, occasionally laughing in recognition of the interviewer's ambiguous position, and, at times, using phrases like 'well you know, really, don't you?'. A non-knowing incompetence was adopted in discussion of areas where I felt I could admit to ignorance, without damaging my legitimacy in interviewees' eyes. I felt I could, for example, acknowledge ignorance of the specific approaches to HIV prevention adopted within a particular organisation.

As recommended in most social research textbooks (eg. Lofland and Lofland 1995), I did not immediately address issues central to the research such as, in this case, the meaning of evidence or power relations. Instead, I allowed the interviewee to talk more generally. This enabled me to see whether the interviewee would raise the issues without prompting. If the interviewee did not raise these issues, then I would eventually ask more focused questions. I used a biographical style of questioning, with early questions about the interviewee's previous experiences and education serving to break the ice and provide context. I aimed to move on to other areas only later in the interview, when the interviewee was relaxed. I was aware, however, that even these icebreaker questions might address sensitive issues for some interviewees. For example, a number of interviewees answered questions relating to how they became involved in HIV work, by discussing their experiences of their own or other's HIV infection.

I strove to avoid leading questions. I did, however, sometimes feel a desire to set out my own views on various matters. This particularly arose when interviewing people whom

I already knew, and when I was keen to test out emergent ideas. Though, in rare instances, this form of exchange might have been appropriate, it was generally guarded against. The presence of other social researchers amongst those interviewed provided a regular and useful discipline. I tried to refine questions in the course of undertaking successive interviews; questions did change, but only slightly. I judged this had only very minor effects on the consistency of data collection, and the comparability of cases.

The order as set out in interview guides was rarely kept to, as interviewees were encouraged to speak freely as they saw fit. Interviews contained a certain amount of checking of facts which were recorded in documents. While this sometimes felt labourious, it was continued because of its value in cross-checking the facticity of accounts. Reference to documents was made when interviewees had difficult recalling events. Some questions were repeated in the course of the interview in re-phrased form, where it was considered that some checking of the internal consistency of an interviewee's accounts might be useful. Care was taken to ensure that, by the end of the interview, all relevant matters in the guide, and any arising in the course of the interview, had been fully discussed. Time constraints sometimes prevented this, however.

At the end of the interview, interviewees were asked what they thought of the interview. Points raised here were often pertinent to the research questions and, with the interviewee's permission, were recorded and included in analysis. It was sometimes slightly embarrassing and stressful asking for feedback, especially from other social researchers.

Interviews were tape-recorded and transcribed. Transcripts were not sent to interviewees for verification. My supervisors and I felt that respondent verification (Buchanan et al. 1988) might, in this particular study, lead to participants reassessing what they said in interviews and withholding, or seeking to change, some of their comments. This was considered particularly likely, given the perceptible speed with which ideas about evidence and EBP developed in HIV prevention.

6. Methods of analysis

a. Approach to analysis

Analysis focused on the ideas that were put across in interviews and documents rather than on how conversations or documents were framed. Thus, it might be termed 'content', rather than 'conversation' or 'discourse', analysis. However, use of the term 'content- analysis' does not imply that analysis merely set out to count the frequency of use of certain terms, according to a pre-set scheme of meaning . Rather, the analysis sought to develop an understanding of meaning, by constant comparison between the research questions, the theories which informed these, and the data.

The mode of analysis, informed by the work of Lofland and Lofland (1995) and described below, shares, with grounded theory, an interest in developing a sociological account from a pre-existing world of social meaning, rather than examining the world in terms of the operationalisation of already-held theory. The analysis was, unlike some accounts of grounded theory (Pidgeon 1996), informed by pre-existing theories, particularly regarding power, as discussed earlier. These theories were used to interpret data, but were themselves reassessed in the light of emergent data. This is discussed in Chapter 9.

b. Process of analysis

The process of coding documents began prior to interviews commencing. Document-coding threw up ideas, which were addressed further within interviews. While the analysis of documents was useful in developing an understanding of process and relations, interviews were more useful in exploring motivations and values. The process of analysing documents was completed alongside the coding and analysis of data from interviews. This fuller analysis of document and interview data occurred after fieldwork had been completed. The two case studies were analysed at around the same time to promote comparison.

Documents and interview transcripts were coded. Text which was judged as pertinent to research questions was highlighted. Short code words were then applied to items of data. Lofland and Lofland (1995: 186) suggest that researchers should consider the following questions when applying codes:

Of what *topic*, unit or aspect is this an instance? What *question* about a topic does this item of data suggest? What sort of an *answer* to a question about a topic does this item of data suggest?

Memos were then developed which explained further what codes meant. The documents and transcripts were reviewed again in the light of these memos, adding new codes and developing new memos where necessary. Lofland and Lofland distinguish between 'initial' and 'focused' codes. They suggest that the former become topics for the latter, in a cyclical process of selecting and elaborating the most useful codes, and applying these to more data.

Answers to the operational research questions were then drafted, from the array of memos already developed. The accuracy of the emergent analysis was judged via a third review of the data. Analysis and codes were redrafted accordingly. Then, the data were reviewed again and particularly useful quotes were pasted into the analysis. The analysis was then reviewed in the light of the added quotes, and re-written where necessary. The analysis was then edited to comprise Chapter 6 to 8.

Some additional fieldwork, comprising three new interviews and one re-interview, plus several short re-interviews by telephone, was undertaken where there were gaps in the information required to answer questions. These data were scrutinised in terms of the previous codes, memos and analysis, and any necessary amendments were made.

c. Accuracy of data

Neither documents nor interviews provided a straightforward account of what happened. Documents and interviews are frequently used to put across a particular line or version of events, and may obscure alternative views (Gottschalk et al. 1945). The same terms

may have different meanings in different documents and accounts (Bryman 1989).

While recognising that accounts did not unproblematically represent the truth, the truth was sought. What the term 'the truth' can actually mean within social research is addressed in this chapter's epistemology section. In terms of practical procedures for assessing the accuracy of representations in documents and interviews, Lofland and Lofland provide a number of criteria: the directness of report; the likely effect of social location on the skewing of reported opinion; own social location; previous plain errors in account; internal consistency in account; and external consistency with other accounts, frequently termed 'triangulation' (Bryman 1989). These criteria were used to assess data. Furthermore, I assessed the accuracy of references to research by reading the research myself. Those statements judged as factually questionable were viewed nonetheless as potentially of value in providing insights into participants' own systems of meaning and strategies.

d. Validity and reliability of emergent analysis

According to Yin (1994), the validity of emergent analyses can be assessed using a number of criteria. 'Construct' validity refers to how well the data have been organised conceptually. 'Internal' validity refers to the utility of the analysis developed in explaining the data. 'External' validity refers to the generalisability of the analysis to other contexts. The former two, but not the last, criteria can be used in assessing the validity of the findings emerging in this research. These criteria were employed in the drafting and re-drafting of analysis described above. It is hoped that the inclusion of a considerable number of quotes and references to what was said and written in case studies should allow the reader to make some assessment as to whether the analysis is coherent and comprehensive. One technique used in analysing data was the identifying of data which did not fit the emergent analysis and so required some re-formulation of this analysis. Several examples of this are identified in Chapters 6 to 9, such as consideration of the commissioning of GAA's group-work intervention. Consideration of external validity was not undertaken since this would require a systematic exploration

of additional cases. The theoretical potential for generalising the findings to other contexts is considered in Chapter 9.

The reliability of the analysis developed in this study could be assessed by examining whether, if the study was repeated by another researcher, the same findings and conclusions would be generated. In the social sciences, while exact replication is impossible, approximate replication at other similar sites is feasible. It is hoped that the detailed description, in this chapter, of the design and methods used would enable such an assessment of reliability.

7. Epistemological issues

a. Interpretivist approach

This study embraces an interpretivist approach to the relationship between the accounts which comprise data, and the accounts which comprise sociological analysis. Giddens (1974:79) suggests that the roots of *interpretivism* lie in the belief that different approaches are required in the social sciences, compared with the natural sciences:

> The difference between the social and the natural world is that the latter does not constitute itself as 'meaningful': the meanings it has are produced by men [sic] in the course of their practical life, and as a consequence of their endeavours to understand or explain it for themselves. Social life - of which these endeavours are a part - on the other hand, is *produced* by its component actors precisely in terms of their active constitution and reconstitution of frames of meaning whereby they organise their experiences.

The social world is one which has been given meaning by its constituent actors. Therefore, in order to analyse this world, it is necessary to draw from the concepts which actors themselves use. A hermeneutic process is required for actors' meanings to inform sociological accounts. What 'hermeneutic' means in this context is the re-interpretation from one framework of meanings, those of participants, into another, that of the sociologist (Giddens 1984). The hermeneutic process involved in the collection and analysis of fieldwork data requires what has been described as a 'merging of horizons'

between investigator and participants.

Social proximity between researcher and actors can be both useful and dangerous within a hermeneutic approach. Davis (1973) discussed the 'Martian' versus the 'convert' stances required of researchers. Researchers need to get close enough to their objects so that they can develop real understanding of their views and concerns. However, researchers also need to stand back, in order to appreciate the particularity of actors' views and concerns, and how they relate to the research questions. Lofland and Lofland (1995) suggests that social researchers need to adopt both stances simultaneously.

How one balances the need to strive for proximity and distance depends on one's starting point. In the current study, there were various sources of social proximity and distance between actors and myself. As an HIV prevention researcher, I was likely to have at least some proximity with all those in the case studies, particularly with other researchers. I had, at various times, also been a medical student, an employee of the HIV voluntary sector, and a commissioner. I therefore was likely to have at least some social proximity with doctors, voluntary sector workers and health authority employees in the case studies. The research itself also brought me into some proximity with those involved in the cases, though not as much as would have been so if the research involved observation.

However, the fact that I am no longer actively working in HIV prevention or in a health authority, am not a doctor or other practitioner, and the fact that I am not a gay man, meant that I was simultaneously also likely to have at least some social distance from many in the case study. I also maintained some distance from the practical concerns of those in the case studies, by attempting to think sociologically, in order to problematise phenomena which might otherwise have seemed commonsensical to me. My continuing to read sociological material in the course of fieldwork was useful here.

As well as a hermeneutic process underlying the development of a sociological account from lay accounts, sociological accounts can similarly come to influence actors' own accounts, via what has been termed the 'double hermeneutic' (Giddens 1984). In the

study, it seemed that sociological ideas had already invested some actors' thinking. This included, but was not restricted to, researchers or those who had some sociological training. The HIV prevention field itself sometimes seemed awash with sociological ideas. Sociological ideas developed in the course of the current study might influence thinking in the case studies, either via actors picking up ideas in the course of interviews or conversations, or as a result of feedback or actors eventually reading reports of the research.

b. Status of sociological accounts

The sociological account is not merely a means by which voice can be given to lay accounts; it is distinctive from actors' own accounts in being informed by a set of questions which are unlikely to be raised by the actors themselves. The sociological account is not simply one of a number of accounts, all with equal validity or invalidity. It should be distinctive in that it is the result of systematic enquiry involving explicit and transparent methods. The sociological account should strive to be open to scrutiny by other sociologists, as well as by others, including those who have participated in the research. Lay accounts rarely strive for such transparency, or are subject to such systematic critical scrutiny.

This does not mean that the sociological account is 'objective fact'. On the contrary, it is an artefact of social practices, and embodies a variety of unempirical assumptions. Some of these, such as the theories discussed in the course of this and earlier chapters, can be made explicit. Others may not be explicit, and their existence may not even occur to researcher, research participants or audience. Thus, a sociological account strives for facticity but does not achieve it, and cannot be regarded as 'objective', in being derived only from empirical observation.

It must be recognised that the qualitative case study approach employed in the study cannot be used to develop definitive information on causation. The research will not, for example, be able to conclude definitively that 'a certain form of evidence was used

because a certain form of occupational structure existed within a particular case'. Instead, the research, by considering the association of phenomena, and the processes which appear to link them, will develop theories about causation, and indicate what factors affect the degree of certainty involved in these theories.

In order to develop more definitive information, a number of cases would need to be examined, which showed variation in what could be termed a dependent variable (eg. from use to non-use of certain form of evidence) and in which the effects of the proposed explanatory variable (eg. form of occupational structure) could be disentangled from other potentially explanatory variables (eg. such as form of funding arrangements). This would require a large number of cases, where presence and absence of all variables across different cases would allow differential effects to be unpicked; such a study is unfeasible.

Human beings possess agency, and their behaviour is not open to prediction in any mechanical sense. However, certain regularities in social relations do occur and social science, rightfully, attempts to examine these, and produce conclusions that have some applicability beyond the time and space in which research was conducted. Any such generalisability must carefully consider the contextual factors which promote and inhibit this generalisation. The possibility of generalising the conclusions generated in the current study to other contexts is considered in Chapter 9.

8. Ethical issues

As mentioned earlier, almost all names used to report case studies are pseudonyms, used to anonymise findings. One organisation, the EPI Centre, was not anonymised. It was concluded, by my supervisors and myself, that this would have been absurd, given that the EPI Centre is housed within the research unit that I, myself, work, and given the frequent reference to the work of the EPI Centre (eg. Oakley et al. 1995) in Chapters 1 and 4. After some thought, it was concluded that naming this organisation would be unlikely to increase the extent to which other organisations in the case studies could be identified.

It was concluded, prior to fieldwork, that the identity of the participating organisations, and even some individuals, would be obvious to some readers. Confidentiality being a matter of degree rather than absolutes, particularly in research involving groups of stable membership, is well documented (eg. Vidich and Bensman 1968). All participants were informed of this point, and of the additional measures which would be taken to protect those participating in the research, which are discussed below.

Despite the difficulty of protecting the anonymity of participants, this procedure was retained, both in order to maintain anonymity in the eyes of those readers who are not able to penetrate it, and in order to prevent the findings being used to single out the organisations involved for explicit criticism by the press, in the unlikely event that this thesis is read by journalists.

It was decided that, in addition to anonymity, 'harm to participants' would be used as an ethical criterion. If reporting on data, even in anonymised form, was judged as likely to cause harm to an individual, additional means were considered to prevent data being linked to that person. If this proved impossible, then the data were simply withheld from the final findings. The possibility that harm might arise was judged both by me, by my supervisors, and by participants themselves. Interviewees and those providing documents were informed about this strategy of preventing harm, and were asked to indicate items of information which might cause harm. A small number of items were thus identified.

9. Fieldwork experiences

a. Participants' attitudes and actions

Most participants seemed extremely open. Most seemed, and some stated, that they felt unthreatened by the research. In many cases, this reflected an appreciation that the study did not aim to evaluate organisations' practice. Some were more circumspect, and did appear to see the study as an evaluation. Some, indeed, stated that they hoped the study would demonstrate their organisation's worth. Some participants from GAA were

nervous about my association with the EPI Centre, since this organisation was perceived as holding a particular view on the value of RCTs, which was not shared by many within GAA. I stressed, however, that I was not working within this centre myself, and was not interesting in establishing the right-ness of any one view of evidence, but in exploring how others defined evidence. Only one participant, from the Public Policy Research Unit (see Chapter 6), explicitly stated that he could not be completely open in his account of events. Others may not have told the whole story, or may have been careful to tell a particular version. Participants' views might have been tailored to what they thought I wanted to hear, or to what would best represent them, their group or their organisation.

Some participants reported that their interviews made them reflect on the issues discussed. Some were keen to discover my views. Some even appeared keen to recruit me as ally, in disputes about evidence. While this felt distinctly uncomfortable to me, it was also somewhat flattering, and made me feel that my research might actually be read by some of those taking part in the study.

Some participants criticised the scope of the study. One researcher thought I should look at the evidence-basis of HIV prevention, rather than explore the 'politics' of it. A former GAA Chair said I should not focus on GAA's use of evidence, but, rather, on the commissioners' lack of use. In these cases, I attempted to defend the study, without entering a prolonged discussion of my ideas or interests, and so perhaps biassing the interview.

b. Own attitudes and actions

I worried a great deal about whether my fieldwork focused too much on the background context of structures and relations, rather than more substantially on questions of evidence. In the course of analysis, I felt the decision to focus heavily on context was vindicated, in that the background data did appear essential in addressing the research questions.

I sometimes felt that I tended to think more like a participant in the HIV prevention field, than as an external observer. I could easily drift into focusing more on my own judgments about an organisation's production or use of evidence, rather than on how their evidence production and use were affected by, and in turn affected, power relations. Although this developing of proximity with participants concerns could be a useful tool in analysis, I also had constantly to strive to maintain focus on the research questions at hand.

The passivity required in fieldwork occasionally made me feel uncomfortable. I sometimes felt compromised by not being able to challenge views with which I disagreed. I had envisaged that managing criticism of people I was friends or colleagues with would be a difficult issue in fieldwork. However, this turned out to be less of a problem than expected, at least in the more formal context of an interview. This issue was sometimes more difficult in the more informal setting of the conversations which preceded or followed on from interviews, or which occurred in other settings such as conferences.

I sometimes felt that my interviews with those I knew well, particularly with individuals whom I liked, were less searching than those undertaken with others. I tended to explore, rather than assume meanings, more thoroughly in interviews with people whom I did not previously know well.

At times, the high expectations of participants caused me to become dispirited, because I wondered what the research would actually contribute to HIV prevention efforts. I also worried about the harm that might befall organisations as a result of their involvement in the study. Because EBP has become such an important criteria for commissioners and others to judge a provider's worth, I worried that my study would be inappropriately used to assess performance, when this was not one of the aims behind the design. Overall, however, fieldwork proved interesting and enjoyable. Despite my own misgivings, I was delighted with the enthusiasm and seriousness with which participants approached the study. I hope my findings prove of some value, and do not cause too much upset, amongst those who gave so much help.

CHAPTER SIX: PLANNING AND DELIVERY OF HIV PREVENTION IN THE CASE STUDIES

1. Introduction

This chapter addresses the first of the thesis' operational research questions, in relation to each of the two case studies: 'What organisations and groups are involved in the planning and provision of HIV prevention?' As well as KGC and GAA, several other organisations, whose work affects HIV prevention in these case studies, are examined. Only those aspects of their work which have a bearing on either KGC or GAA are considered. As discussed in Chapter 5, fieldwork focused mainly on 'peripheral' agencies. This chapter does not include specific sections on 'central' agencies. However, fieldwork did include some interviews with staff from central agencies, as well as some analysis of central documents other than those discussed in Chapters 3 and 4. These interviews and other documents are referred to, where pertinent, in this and the next two chapters.

2. Organisations involved in the KGC case study

a. King George's Clinic (KGC)

The clinic's 'statutory' status was not questioned by interviewees, despite it: involving some volunteers in its young gay men's clinic; employing some staff who also volunteer for voluntary agencies; and co-operating closely with some voluntary agencies in the development of certain services. Several interviewees suggested the clinic had a culture typical of the statutory sector, but had some difficulty pinpointing what this meant. Some suggested it involved emphasising 'checks and balances' being imposed by senior managers and practitioners over the clinic's activity.

None of those interviewed questioned KGC's status as a 'provider of HIV prevention services'. A number of points were raised however which indicated a complexity, not

indicated in this phrase. The term 'sexual health promotion' was more frequently used than 'HIV prevention'. Interviewees suggested that this did not reflect a de-prioritisation of the prevention of HIV, in relation to other STDs, but, rather, a view that HIV prevention was integrated into attempts to prevent other STDs, as well as into the promotion of more positive notions of sexual health.

As mentioned in Chapter 5, a Sexual Health Promotion Group (SHPG) was convened, and prepared two reports, in 1993 and 1996, which aimed to develop practice in this area. The group used the term 'sexual health promotion' to refer to social, rather than clinical, interventions such as HIV testing, or treatment of STDs, the latter nonetheless being viewed as important in HIV prevention and SHP. Throughout its course, this chapter reports on the actual terms used in interviewees' accounts and in documents.

SHP was provided both within clinic consultations, as well as within specific SHP interventions. It encompassed: face to face work with individuals and groups; the provision of written materials; and the provision of condoms and lubricants. Documents and staff accounts stressed the importance of empowering individual to develop their own sexual health strategies. Casual remarks made, especially, by doctors and academics often suggested, however, that discussion between practitioners and clients was sometimes more geared towards determining the behaviour of clients, rather than empowering them to make choices. Sue, the Health Adviser-Manager commented:

I think any medical setting is always very much driven to behavioural change.

But acknowledged that not all doctors had a determinative approach.

Although SHP at the clinic, unsurprisingly, did not encompass attempted change at the societal level, it did acknowledge the social context within which HIV transmission occurs. The first SHPG report, for example, acknowledged the importance of economic, and other, factors affecting sexual practice.

Health promotion literature was generally regarded as a useful guide to the development

of services in the clinic. The Ottawa Charter and various specific books were cited as examples. The clinic's focus on social context and empowerment, reported above, was said to have been influenced by thinking within health promotion. Criticisms raised were that health promotion comprised eclectic approaches which lacked an overall framework, and sometimes focused on factors beyond service providers' remits. Jenny, a former KGHU manager, commented:

> you're getting smatterings of health promotion theory, you're getting smatterings of research methods, you're getting sociology, and you're getting medicine. You've got all these little smatterings of things, and they're not pulled together particularly... well.

Very few staff had received formal training in health promotion, a matter discussed in later sections.

Although all those interviewed acknowledged the clinic was a provider of SHP, interviewees varied as to how central this was seen to the clinic's role. Some saw the diagnosis and treatment of STDs, including HIV, as being more central. Kate, a nurse working as the Clinical Services Manager, commented:

> I think some people would see it as more marginal... Certainly quite a lot of the medics would, because they're very treatment-orientated, whereas the nurses and health advisors, I think,... see it much more as an integral... and a very important part of the their job.

It was suggested that, in the recent past, some doctors had not been keen to undertake HIV prevention, seeing it as not within the clinic's treatment remit. Most staff indicated that the clinic now saw SHP and HIV prevention as an important part of KGC's work, and that the clinic focused on these activities more than many other clinics. This was said to be in response to the needs of a clientele viewed as being particularly at risk of HIV infection, including large numbers of gay men. In their accounts, some interviewees continually blurred the distinction between diagnosis/treatment and prevention activities. This suggests they saw the two as closely integrated.

The clinic was viewed as an expert provider, in that practitioners held specific, formally-learnt skills which enabled them to undertake their role. Although some suggested that experts needed to learn new skills and develop new approaches, in order to provide appropriate SHP, there was no suggestion that users needed to involve themselves in the planning or provision of services. Users' views were not explored.

The clinic's service level agreements with its local commissioner, Burkington Health Authority, did not include specification of what SHP should be provided, although clinical services were specified. The commissioner's reasons for this omission are discussed below. This non-specification allowed KGC considerable autonomy in the planning and delivery of SHP. This autonomy was both a source of satisfaction, and a source of irritation, within KGC. To some, it allowed KGC staff to use their skills and knowledge to develop innovative services, without what was regarded as interference from commissioners. The lack of specific SHP funding also appeared to remove, from the minds of some within the clinic, the threat of 'de-funding'. However, some staff, particularly doctors, resented what was perceived as a lack of health authority pro-activity and proper funding, regarding SHP.

SHP at the clinic was influenced by national policy. KGHU and KGC staff suggested that the district's first HIV prevention strategy had been set up directly in response to a circular from the NHSME requiring the development of local HIV prevention strategies. Unlike the case of many other neighbouring districts, KGHU and KGC staff, together with others in the district, had responded energetically to this circular, partly because it was in line with their own interest in developing what was hoped would be a rational array of HIV prevention services. KGC's relationship with central agencies was, however, ambiguous. Other central directives were said to have been less whole-heartedly addressed. The SHPG's decision not to use Health of the Nation targets as local measures of progress is discussed in Chapter 7.

The extent to which the clinic could be considered an organisation distinct from those organisations with which it had links, eg. London University Department of Sexual

Health (LUSH) and King George's HIV Prevention Unit (KGHU), is considered in the sections on those organisations. The different occupational groups working within KGC are considered in a specific section later in this chapter.

b. King George's HIV Prevention Unit

This service, housed in the same NHS community trust as the clinic, was engaged in HIV prevention and SHP, some, but not all of it, in association with the clinic. Like the clinic, KGHU's statutory sector status was unquestioned.

Much of the work undertaken elsewhere specifically addressed the prevention of HIV, while most of its work with the clinic was termed SHP, and was said to encompass the prevention of other STDs and the promotion of positive sexual health. KGHU performed a facilitative, rather than a direct provision, role in its work for the clinic. This included: the development of written materials, the distribution of condoms and lubricants; staff training; and input into clinic SHP policy. KGHU staff had led on the development of the first district HIV prevention strategy, as well as being closely involved with the clinic in the development of the SHPG reports.

KGHU participants viewed it as having considerable autonomy from its main funder, the health authority. Although its services were specified in its contract with the health authority, it was said that the majority of this specification was written by KGHU managers and then agreed, with only minor amendments, by commissioners. The commissioner, in interview, agreed with these points, but stressed that he held a view as to what services were required, and was prepared to intervene more when needed. No KGHU staff complained about the commissioner's lack of pro-activity. Relations were viewed on both sides as productive. The health authority was said to have valued the KGHU's work on the first HIV prevention strategy and the SHPG reports. The health authority had invited a representative from KGHU onto the group leading on the second district HIV prevention strategy, now convened by the health authority. The commissioner himself had, formerly, been employed within the trust. This appeared to

have encouraged a mutual respect regarding each others' skills.

The KGHU had, until 1996, been managed within the Trust Health Promotion Service, but was now managed within the clinic. KGHU's Manager was now accountable to KGC's Business Manager. This relationship was characterised as formal line-management, with regular meetings involving review of plans and activities. Both managers reported, however, that KGHU staff's specialist skills were recognised by the Business Manager, who focused his own attention on contracting, and on co-ordinating KGHU's activities with other parts of the department. Despite their managerial integration, KGHU and KGC were viewed, internally and externally, as distinct organisations.

While relations between KGHU and the clinic were generally said to be close and productive, it appeared that they were not so close as they had been in the recent past. Some newer KGHU staff did not appear to have quite as much individual authority within the clinic, as had some past staff. Several former KGHU staff reported that developing working relationships with clinic staff had taken some time. Doctors, in particular, were said initially to have been suspicious of KGHU staff, and to have judged individuals in terms of their personal skills and abilities, rather than in terms of their identification as HIV prevention workers. Jenny, a former KGHU manager, commented:

> Talk about sort of suspicious, 'Who are you?'... It's the old, 'What's your profession?' stuff... [a senior registrar] gave me a very hard time. 'What exactly do you know about GUM? How can you come in here and, .. .oh we've heard these health promotion people before, they're all mouth and no trousers!'.

KGHU was also said to have a generally productive, though sometimes tense, relationship with LUSH. Relations between the two, in the production and use of evidence, are discussed in Chapter 7.

KGHU staff working with the clinic included James, the clinic/KGHU Liaison Worker, engaged largely in policy and planning. James had formerly been a health adviser, but suggested that he increasingly saw himself as an HIV prevention worker, rather than a

health adviser, and, towards the end of the period of fieldwork, actually left the trust to take up an HIV prevention post in a voluntary agency. His views are largely considered as those of a KGHU worker, but will be referred to in some discussion of health advisers also. There also existed a Development Worker post (vacant at the time of fieldwork), with a training remit, managed by the Liaison Worker. KGHU's Manager and other posts were also closely involved in SHP at the clinic. Whereas several former KGHU staff had received diplomas and master's degrees in health promotion, no current workers had done so. This was said to result from an increasing difficulty in arranging for staff to take study leave, and a view from trust management that employing a diversity of people with a range of skills and identities was more important than formal training. KGHU's transfer from the Health Promotion department to KGC had further distanced it from those with formal health promotion training. Most staff working in KGHU described themselves as HIV prevention workers, rather than health promotion specialists. This was ascribed to their lack of formal training in health promoting, rather than because of any negative views on health promotion, which all saw as a useful basis for HIV prevention. Most staff also lacked any formal training in research methods, though the service's manager suggested some had developed skills in the course of certain projects, which are discussed below.

Line-management within KGHU itself was said to involve regular meetings involving the setting and review of targets for work. Management was said to be highly directive, with the manager pushing staff to ensure targets were met.

c. London University Department of Sexual Health

The department's status as an academic research organisation was seen as somewhat complicated by its extremely close links with the clinic. Some participants questioned the reality of any distinction between the two. George, an academic doctor, commented:

It's close knit, and I think, to some extent, the division sometimes feels artificial.

Trevor, a non-medical academic commented:

> It's part of the clinical environment - a lot of the academics run clinics... There's a very fluid relationship between the academic side of the work and the clinical side.

Some academic doctors undertook one or two clinic sessions per week, in addition to their academic activities. Others had a substantial managerial role in the clinic. Two acted as Clinical Co-ordinators: one for GUM services, and one for HIV services. These roles were intended to lead the development of strategic planning in each of these two areas. The GUM Co-ordinator however suggested that, for both co-ordinators, operational planning had, unintentionally and unfortunately, come to dominate the role. A number of academic posts, including these co-ordinators, were funded by the health authority. The rationale of the health authority and of the trust, in developing this arrangement, was that these posts would stimulate more research activity, which would, in turn, allow the trust to gain Research Support Funding from the NHSE's R&D Programme. LUSH and the clinic also convened a number of joint meetings about both practice and research. A medical academic also held an advisory position within KGHU.

Thus, LUSH and the clinic in many ways worked as a single organisation, and were certainly treated as a single organisation in the accounts of others, for example the commissioner. There were certain areas where the distinction was more clear; the clinic was not involved at all in some LUSH projects (see Chapter 7). There were also some tensions in the relationship between the clinic and LUSH. Some of these arose from differences in expectations. LUSH's staff were viewed as sometimes somewhat removed from the 'front-line' of provision and less pressurised in terms of time. Their prime aim was characterised as the production and publication of research. The clinic's culture, it was suggested, was more geared to the practicalities of service delivery, and was extremely time-pressured. Its prime aim was portrayed as the development of services meeting clients' needs. Differences and tensions were, unsurprisingly raised more often by individuals internal, rather than external, to the two institutions.

The department was widely regarded as being predominantly a medical one, in a number

of senses. It was housed within the pathology division of a medical school. While the department was staffed by individuals from a wide variety of backgrounds, the majority of those in senior positions, or on secure long-term contract, including all three sub-department heads, were medically qualified. Only one non-medical doctor, a sociologist, was on a long-term, core-funded contract. Contractual status was seen by some as directly affecting an individual's standing within the department, since those with secure employment had more opportunity to develop a portfolio of research, and recruit and manage other researchers. Some of those interviewed suggested that the department was 'medical' in the kinds of research it undertook, while others disagreed. This point is considered further in Chapter 7. One non-medical academic questioned whether the department was medically dominated. He argued that, while most of those in senior position were medically qualified, this fact was often incidental to their approach to LUSH's work.

The department appeared to have considerable expert authority. Several of its senior figures were widely viewed as pivotal in the development of local GUM and HIV services. The local health authority commissioner indicated his respect for the academic expertise possessed by the department. Several medical and non-medical academics were invited by the health authority onto the group developing the second district HIV prevention strategy. LUSH was said to have considerable autonomy. Though the health authority funded a number of posts, these were not tied to any service contracts. The individual employment contracts did require the approval of the health authority, but these did not include the specification of what academic activities the post-holder would undertake. LUSH's being funded from a number of sources also meant the authority any one funder had over it was limited.

Within the clinic, it was said that a small number of senior figures, though prepared to consider the views of juniors, heavily influenced the direction of projects. A new management structure, introduced after 1996/7, was said to have made for more transparent decision-making in which those in more junior positions could have more say. Relations between senior figures and the staff accountable to them were said not to be

best described as line-management, but rather were characterised as informal and focusing on support and intellectual development, rather than direction of activities.

d. Burkington Health Authority

As mentioned earlier, Burkington did not explicitly commission HIV prevention, or other SHP services, from the clinic, though KGHU activities within the clinic were specified in contracts. However, Roger, the commissioner, reported in interview that it was his assumption that, in commissioning clinical services from any trust, appropriate health promotion activities would also be included. Thus, the commissioner considered that he was implicitly commissioning SHP from the clinic. It appeared that the commissioner did not feel the need to commission SHP explicitly from KGC, because he was satisfied with existing provision. Matthew, a KGHU manager, commented:

> I think it's because they have confidence... the service is going to deliver... a product, at the end of the day, which is of benefit, and to a high standard.

The commissioner himself echoed this. His lack of anxiety reflected his perception that KGC was competent in its delivery of SHP, and his own need to focus instead on the treatment and care aspects of KGC, since this involved a much greater spend. The very tangibility of the clinical aspects of provision within KGC, measured, for example, via patient episodes, may have lessened the commissioner's anxiety in commissioning what he acknowledged was the somewhat less tangible SHP aspects of the clinic's work.

The commissioner had no formal training in commissioning, though had received some training in social research. He had worked in health promotion within the trust, though had no formal training in this area. Public health doctors within Burkington were said by Roger not to be greatly involved in the commissioning of HIV prevention services. Their skills were not seen as lying predominantly in this area. Public health doctors were, however, central to the planning of needs assessment and evaluations in other aspects of the health authority's work, however. This point is returned to in Chapter 7.

The amount of time the commissioner could devote to considering HIV prevention and SHP matters was limited. Until September 1997, Roger had undertaken HIV commissioning with minimal support from other staff. He had, until recently, also been responsible for commissioning general health promotion. Furthermore, repeated re-structures in the health authority had added to his work-load difficulties.

There were indications that Burkington Health Authority sought to be more pro-active in influencing the provision of HIV prevention and SHP services in the district, including within KGC. The second HIV prevention strategy group, unlike the first, was convened and managed by Burkington Health Authority. The Director of Public Health had initially been chair, this being transferred to Roger, the HIV commissioner, upon the resignation of the Director of Public Health. Roger himself emphasised his desire to influence the agenda within which local providers worked.

3. Occupational and volunteer groups involved in KGC

a. Doctors

All doctors shared a common basic training and certification, and many, including some academics, had undergone or were undergoing specialised training in GUM and/or HIV medicine. No doctors had any substantial training in the theory and methods of HIV prevention or health promotion. Most doctors working in the clinic, or LUSH, had at least some training in research. Laura, an academic doctor commented:

The NHS consultants are very research-orientated NHS consultants.

Medical identification appeared to transcend division into academic and service doctors. Many doctors were involved in both spheres. All academic and service doctors stressed their professional identity when discussing their background and role. Jane, a medical academic, commented:

I think of myself primarily as a medical epidemiologist. I have a background in medicine, and I'm now a

professor of epidemiology, but with a training in public health medicine.

Doctors possessed considerable authority in the planning and provision of SHP services, as well as treatment and care services. Certain doctors were said to have exercised considerable authority in the development of SHP in the clinic, via their involvement in the SHPG. It was suggested that doctors often possessed particular authority on multi-disciplinary groups. Discussing another multi-disciplinary group, Richard, a Senior Health Adviser, reported:

My experience of attending..., because [the Health Adviser-Manager] couldn't go, was that it felt very hierarchical, and that, with the best will in the world, a lot of the conversation is going on between three of the senior clinicians... and [the Business Manager] ... It didn't feel like we were there on an equal footing, my position is not the same as the senior clinicians...or...[the Business Manager].

Other practitioners said they had accepted the need for doctors to take a leading role in the SHPG, because of a perception that, in order to make SHP an important part of service provision, doctors would have to feel some ownership of it. The importance of medical participation was seen to result from their being most patients' first point of contact, giving them control over subsequent referral. In order for a client to receive appropriate SHP, doctors would need to believe in the importance of SHP, and possess basic skills in determining sexual health needs, and assessing where these could best be met. Thus, doctors' authority in the planning of SHP arose indirectly, from their authority in the provision of the clinic's services in general.

Doctors also exercised some authority in the planning of SHP via the role played by the GUM and HIV Co-ordinators in service planning. Although Angela, the GUM Co-ordinator, emphasised the important contribution of others, most other staff highlighted her particular authority in influencing treatment and SHP policy. Angela held direct authority over health advisers via her co-supervision (along with KGC's Business Manager) of the Health Adviser-Manager.

Doctors' authority in the planning of SHP is interesting, given their acknowledged lack

of formal training in this area. The GUM Co-ordinator, and those doctors involved in the SHPG, emphasised that their role was to work closely with other groups with more formal skills in SHP, in order to co-ordinate SHP with the rest of the clinic's work.

As a group, doctors possessed a high degree of autonomy. Doctors were managerially not accountable to other groups. Doctors also possessed considerable individual authority. Junior doctors were supervised by senior doctors, although this was relationship was described as rather unstructured training supervision, rather than structured task-setting and monitoring. Simon, a junior doctor commented:

There's not a clear management line... I suppose the person that I am, in theory, managed by, I have a tutor, so I guess they would be the person... who would call me if I was apparently doing something wrong... There are very clear management structures for the other staff groups, you know, there's a definite line-manager for everyone, and, I suppose, we do have a line-manager, because we have our tutor, but it's not really quite the same.

Senior doctors were officially line-managed by Jonathan, the Clinic Director. Consultants were required to meet annually with the director, in order to review their duties, and agree their professional development priorities. The director suggested, however, that, reflecting the entrenched tradition within medicine of consultants being autonomous, his actual authority was limited. Jonathan commented:

The line-management, really, amongst consultants, is rather an odd creature in that... consultants really do have an extraordinary degree of autonomy, and, when consultants decide to do something which... the line-manager might disagree with,... it is... amazingly difficult to... change that.

The lack of line-management among consultants, compared to other staff groups, was echoed by several practitioner-managers and the Business Manager. The director had however been successful in making some consultants attend training in SHP, against their wishes. However, it being a matter of professional development rather than practice, this example may not typify relations. The Clinic Director himself was accountable to the Trust Medical Director. Only at the level of the Medical Director being accountable to the Chief Executive, were doctors accountable to trust management.

b. Nurses

Nurses also formed a distinct group within KGC, having a common training and certification. Most had some training in SHP. Few nurses had research as a part of their nurse training, although some had attended research training provided by LUSH. Some of those working in LUSH had a nursing background, thought these did not appear to have significant links with clinic nurses. None of the KGC nurses had honorary appointments with LUSH.

Certain nurses appeared to have considerable authority within the clinic. The Clinical Services Manager, whose role included that of nurse-manager, appeared well respected amongst all staff groups, and influential in clinic planning. She had been involved in the SHPG. Nurses as a whole, however, were not central to the development, or to the delivery, of SHP, despite the inclusion of health promotion in their own training. Nurses had not developed a clearly-defined role in SHP, their role as set out in the SHPG reports being to provide opportunistic advice, focus on Herpes Simplex Virus prevention, and supply condoms. Nurses' marginal role appeared to result from KGC, like most GUM clinics, employing health advisers, who specialised in counselling and partner notification, roles which might otherwise have been performed by nurses.

Some nurses appeared anxious about this lack of involvement and authority in SHP, suggesting nurses needed to define their role more clearly to other groups. One nurse commented, for example, on the fact that the KGHU had consulted KGC doctors, but not nurses, in the writing of a SHP booklet. Other nurses appeared content to accept their marginalised role in SHP, focusing instead on other areas, for example, developing nurse-led care in the women's clinic.

Nurses, like doctors, possessed within-group line-management. Junior nurses were line-managed by a number of charge nurses, who reported to the Clinical Services Manager, as mentioned above, herself a nurse, and, in turn, accountable to a senior nurse within the trust. Line-management was said to involve the setting and assessment of tasks. John,

the Business Manager, among others, suggested:

> There's much less individual autonomy for nurses [than doctors], there's quite a rigid nursing hierarchy.

Nurses interviewed suggested that GUM nurses had more individual autonomy than those working in many other specialities.

c. Health advisers

Health advisers did not have common certification, training or skills. While most came from a social work or nursing background, some did not; one, for example, had previously worked in the HIV voluntary sector. Though all possessed some form of counselling certification, this varied, as did the specific counselling methods which health advisers favoured. Only one, the Health Adviser-Manager, had any formal training in health promotion, a master's degree in health promotion, which also included some training in research. This manager had an honorary appointment with LUSH. No other health advisers had been trained in research, or had honorary appointments. All health advisers belonged to a professional organisation. Health advisers suggested that it was difficult for them to define their identity, and role, to others within the clinic. Richard, a health adviser, commented:

> There is a problem in health advisory work. We don't have a professional training structure... I think we suffer from a bit of an identity crisis... Medics, and psychologists, and nurses have a very clear professional training; and, working within a clinic, everybody knows what their training involves. I come from a real hotch-potch of a background - I have counselling qualifications ..., I don't have...the sort of qualifications that would fit normally into a medical context, and I think... often doctors and nurses are a bit unsure about what we do.

Health advisers perceived that other groups judged health advisers in individual terms rather than granting an expert authority to the group. They expressed resentment regarding instances where other practitioners impinged on their area of practice, or

questioned their input. Sue, the Health Adviser-Manager, commented:

There was a [doctor] at a conference going on about... provider referral versus index referral for chlamydia... babbling on ..., and I thought, 'why are you presenting this? You're not a health advisor, why don't you go and do a bit of research in your own field... and leave us to do our own work?'

Other groups reported that they viewed health advisers as possessing particular expertise in SHP. Whether health advisers had authority in the planning of SHP in the clinic is uncertain. Health advisers had been involved in the first HIV prevention strategy group and the SHPG. The first SHPG report suggested health advisers' authority in developing the practice of other groups:

Health advisers play a key role in disseminating information on prevention and establishing good practice in health promotion across the whole staff team.

Health advisers had been active in the provision of training to other staff groups during the implementation of the first SHPG report. The KGHU/KGC Liaison Worker had now taken over the chairing of the SHPG from the doctor who had originally been Chair. Sue, the Health Adviser-Manager sat on the SHPG, as well as on a number of other management groups. She suggested that health advisers had some authority in the development of services:

If you go to... one of the doctors here and say, 'I thought I'd do this, what do you think?', you get a good idea, ...'Have you thought of 'x'? Have you thought of 'y'? What would you need? Who would help you?'. You don't get, 'Well, you're a health advisor, what would you know?'

However, health advisers' participation in the planning of SHP was, perhaps, not as authoritative as these points might suggest. Although involved in the SHPG, health advisers had not initiated this, a doctor and a KGHU worker having taken this responsibility. In spite of delivering training to other groups, the doctor and the KGHU worker appeared more important in pressing for this training. Despite both the KGHU/KGC Liaison Worker (and the Health Adviser-Manager) being well respected in the clinic, it seems that the Liaison Worker's chairing of the SHPG has coincided with

it occupying a less central place within the clinic, and research groups becoming more active in developing innovation in SHP (discussed in more detail in Chapter 7). Health advisers in general, and their manager and Liaison Worker in particular, appeared to act primarily as expert advisers to those doctors who possessed greater overall authority in the planning of SHP, rather than themselves leading policy.

Health advisers were keen to develop the cohesion and status of their group. Their professional organisation had developed a number of statements of ethical principles. These, as well as the attempted development of common training and certification, were viewed as important in their achieving greater status.

Health advisers had only partial within-group management. Juniors were managed by a Senior Health Adviser who was, in turn, managed by the Health Adviser-Manager. This manager was, however, accountable to the GUM Co-ordinator, as well as to KGC's Business Manager. The Liaison Worker was managed by the KGHU Manager, rather than by the Health Adviser-Manager. Line-management was said to be quite structured, involving the setting and assessment of tasks, sometimes in the face of opposition from individuals. Sue, the Health Adviser-Manager commented:

> I mean, [the health advisers] get on with things, and report to me and,... occasionally, I'll say, 'Well no, you need to be doing that'... And they're [thinking], 'Oh god,...why's she going on about that?... Some of the things that we have to do, or we're bringing in, are probably not hugely popular within the team, but we've got to do them.

Their being able to choose a variety of methods suggests a certain amount of autonomy was possible. The Health Adviser-Manager's own management, by the GUM Co-ordinator and Business Manager, was said to be fairly loose, allowing her a measure of autonomy.

d. Clinical psychologists (CPs)

CPs possessed a common training and qualification. They were said to have a variable,

but small, element of health promotion in their training. All were members of a professional organisation. Some CPs had honorary appointments with academic departments, the former CP-Manager with LUSH, and the acting CP-Manager with another department. CPs did not have an especially close relationship with research psychologists employed in LUSH or elsewhere, these being seen as a separate group.

CPs had, of late, began to press for a greater role in SHP. Previously, their role in SHP had been relatively minor, involving the assessment and treatment of clients whose psychological morbidity affected their sexual risk-taking. CPs' attempts to develop a greater SHP role appear to have mostly been favourably received by others in the clinic, as a result of their perceived expertise in psychological theories that were increasingly viewed as useful in informing SHP. The second SHPG report, which CPs became involved in writing, acknowledged this.

CPs had begun to meet with health advisers to give supervision regarding elements of health advisers' work judged to be 'psychological' in nature, including referral criteria to CPs. Some CPs questioned the expert authority of other groups, notably KGHU staff, in developing SHP. The acting CP-Manager, Greg, commented:

> The way in which health promotion is conducted [at KGHU]; well my experience of it, is largely at a 'face-validity', 'common-sense' provision of information, education model of health promotion, which is...essential, but not sufficient, in bringing about behaviour change.

There was some reaction against this growing interest in SHP by CPs. A KGHU manager viewed CPs as 'difficult', and lacking in experience in SHP. Several health advisers acknowledged some tensions existed between CPs and themselves, as a result of perceived overlaps in their role. One health adviser commented that health advisers sometimes resented what was perceived as CPs' greater authority and status. Health advisers had been alarmed by another trust making its health advisers redundant, and, instead, having CPs lead on SHP.

CPs did have within-group line-management. This was said by Joanne, a CP, to focus

on support, rather than direction. CPs were accountable to the acting GUM CP-Manager who was, in turn, accountable to the Trust Head of CPs. Individual CPs were said to possess considerable autonomy in their practice, for example, choosing which areas of practice to specialise in.

e. Managers

Managers did not form a distinct group in the clinic. A number of individuals had managerial duties, all except one of these identified primarily in terms of their practitioner role, such as doctor, nurse, health adviser or CP. The clinic was said by several interviewees as being unusual in the number of practitioners keen to become involved in management. John, the Business Manager, who was not from a practitioner background, did identify as a general manager, but did not consider himself part of a distinct occupational group, feeling he had little in common with most other general managers working in the NHS. This individual had some formal training in management from short courses, but no formal qualification in this area.

The Business Manager had some line-management authority; managing the Health Adviser-Manager and the KGHU Manager, amongst the staff focused on in this case study. John was widely respected and regarded as influential. This influence appears to have been mainly in the realm of administration, rather than SHP or clinical matters. The individual's authority was viewed as reflecting his having a unique perspective on health authority commissioners' and other funders' views, and on his being aware of developments in other similar providers.

f. Volunteers

The clinic involved young gay men as volunteers in operating its young gay men's clinic. These volunteers performed 'meet and greet' duties, but had little say in the policy or practice of the clinic. No volunteers were interviewed since they had no discernible role in decision-making regarding the production or use of evidence.

4. Organisations involved in the GAA case study

a. GAA

All interviewees saw GAA as a voluntary-sector organisation, pointing to its volunteers and its 'volunteer leadership' ethos (discussed below) in support of this. At the time of fieldwork, the organisation had around 350 volunteers, of whom about 150 were thought to be active. Some acknowledged that GAA was largely dependent on statutory funding, but did not see this as particularly unusual or detracting from its voluntary sector status, although implications for autonomy were noted (discussed below). As mentioned in Chapter 5, most of GAA's funding came from its contracts to provide a programme of work known as the London HIV Campaign (LHC), a pan-London HIV prevention project for gay men. The first programme, LHC1, was undertaken between 1993 and 1996 and initially funded by RHAs before being taken up by a consortium of health authorities in 1995. The second programme, LHC2, was undertaken between 1996 and 1998, funded by a consortium of health authorities.

Some suggested that 'community', rather than 'voluntary', organisation was the appropriate term to describe GAA, because, it was argued, the important thing about the organisation was that it was comprised of gay men working for the benefit of their own community, rather than being comprised of people volunteering for a cause not immediate to their own community or identity. Others queried this, seeing GAA as unrepresentative of the gay men's community, or questioning what was meant by the term 'gay men's community'. The profile of volunteers is discussed in a later section.

Some research participants viewed GAA as belonging to a wider array of HIV prevention or gay voluntary organisations, pointing, for example, to GAA's membership of an HIV voluntary agency alliance, concerned with sharing knowledge and representing members' interests. Several others suggested that, in spite of this membership, GAA had been, and continued to be, characterised by a tendency to stand apart from other providers, of whom

it was often very critical. Previous research looking at GAA had suggested:

> [GAA's] original strategies tended towards separatism, rather than collaboration with other agencies... GAA members recognise that initially the organisation was known for its critical, challenging and even aggressive voice.

One interviewee, who was not directly involved in GAA's work, questioned whether HIV prevention was its prime raison d'etre, suggesting that gay rights was sometimes a stronger focus. However, most research participants saw GAA as being involved in HIV prevention, and some suggested that a rights agenda was a valid part of this work.

GAA was involved in what was described as the 're-gaying of AIDS' movement. This comprised assertion of a need to: prioritise funding for gay men's HIV prevention, reflecting this group having the highest incidence of infection; enable ordinary gay men to lead HIV prevention; and encourage an approach to HIV prevention which embraces a positive view of gay sex and sexuality.

Community mobilisation was viewed as GAA's modus operandi, though many had difficulty in explaining what this meant. It was not officially defined by GAA, but could be summarised as: 'ordinary' gay men becoming active in GAA; leading on the development of projects; developing knowledge of HIV prevention via this work; and passing this knowledge on to their friends and sexual partners in the course of their everyday lives. Participants' accounts differed: some stressed community mobilisation as a means of peer education or the diffusion of HIV prevention messages, while others saw it as a means of allowing ordinary gay men, volunteering for GAA, to use their experience to develop a variety of HIV prevention projects. Participants suggested that GAA provided a variety of HIV prevention services using face to face work, printed materials and mass media events.

There was some disagreement between research participants as to the approaches which underlay these methods. Some suggested that GAA focused primarily on empowering gay men to make informed decisions about their risk-taking, while others suggested the

agency tended towards a more directive approach. Most participants suggested GAA focused primarily on interventions aimed at individual gay men or gay male communities, rather than addressing wider social determinants of risk. Some suggested that GAA was modifying this focus, to embrace campaigns aimed at these broader factors. Some participants suggested GAA tended to focus on HIV prevention rather than on gay men's broader health or social concerns, in part as a reaction against the focus of earlier 'Men who have Sex with Men: Action in the Community' (MESMAC) projects, co-ordinated by the Health Education Authority. These were projects described as community development, which aimed to address sexual health issues identified by behaviourally homosexual men. Others pointed to GAA's combining of HIV prevention messages with other information, in projects focusing, for example, on bondage and cruising.

The question of whether GAA was influenced by ideas from health promotion literature was a contested one. Many research participants stated that GAA had, at its foundation, been critical of what was seen as 'mainstream' health promotion's neglect of gay men's work, and its preference for methods inappropriate to gay men. Health promotion was viewed by some as being led largely by heterosexual experts, rather than by gay men.

Health promotion was associated with the work of statutory health promotion units, as well as with the MESMAC projects. MESMAC was particularly unpopular, because of its perceived tendency to target men having sex with men, and not identifying as gay, rather than those who did identify as gay. Robbie, a GAA worker and founder commented:

I think it was anti- the MESMAC project, that whole 'finding the hardest-to-reach' philosophy. And I think there was this thing, that if these theories had led to this happening, then they weren't worth very much.

'Professional health promotion' was often positioned in opposition to 'ordinary gay men' helping themselves. William, a health authority commissioner commented:

I have heard [a GAA founder] say, 'You know, it's ordinary gay men who best know about safer sex. Back to the origins of the epidemic, how did gay men find out about safer sex? They found out from each other,

and not from a health promotion leaflet.'

Many GAA participants appeared to have only a very vague notion of what health promotion was; several acknowledged that they had read little health promotion literature. Some, from within and outside GAA, suggested that criticism of health promotion was largely rhetoric, employed in order to support the development of the 're-gaying' agenda (specifically the need for ordinary gay men to lead HIV prevention), and to differentiate GAA from previous projects. It was suggested that GAA actually did use health promotion ideas in the development of its work. These interviewees cited community mobilisation itself as being informed by community development ideas, developed in mainstream health promotion. Others suggested the dismissal of health promotion went beyond rhetoric, and had resulted in a lack of use of ideas from health promotion in GAA projects. These individuals saw community mobilisation, for example, as being a *reaction against* community development. GAA's decision to employ administrative support workers, rather than workers with specific health promotion skills, suggests that the agency did indeed question the value of health promotion at more than a rhetorical level.

However, at the time of fieldwork, GAA was referring, increasingly frequently and positively, to health promotion. In a newsletter article in May 1996, Graham, GAA's General Manager wrote:

HIV workers have posed for a decade... as the movers and shakers of promotion, so it is hard to admit that in many ways generic health promotion has been rather good. Perhaps even considerably better.

Again, this embracing appears to involve more than rhetoric. A number of GAA workers have undergone some training in health promotion. GAA has also explicitly referred to health promotion theory in the development of some newer projects, for example, a group-work intervention. There was still some negativity about health promotion, however. Brian, a GAA worker, for example, commented:

'Health promotion professional' is a dirty word around here, and is used as a dirty word, around GAA, by

volunteers.

All research participants clearly indicated that GAA strove to maintain some autonomy from health authority commissioners in the realm of developing priorities, and services. GAA saw themselves as the originators of re-gaying, and were fearful that interference from outsiders could derail the re-gaying movement. GAA volunteers, in particular, were portrayed as seeking to avoid being directed by commissioners. Brian commented:

> There's this idea from the volunteers, particularly at the moment 'cos we're going through this re-funding thing,... that we don't want to do work that the funders want us to do ..., volunteers don't want to... be funder-led.

A few GAA workers and volunteers were not wholly resistant to some direction from commissioners, however.

Several interviewees, including commissioners, as well GAA staff, suggested that GAA's being largely funded from a small number of statutory sources made any desire for autonomy difficult to realise. GAA was said, by some, to possess a number of resources which it could use to protect its autonomy, and to assert its authority in influencing commissioners' and others' actions. One of these was its status as an expert in gay men's HIV prevention. Some GAA participants said that, during the early years of LHC1, RHA funders had acknowledged GAA's expertise, and had sought education from GAA in the area of gay men's HIV prevention. Although health authority commissioners were said to show less respect for this authority than regional funders had, the situation was somewhat ambiguous. Commissioners did comment on the lack of expertise within providers, one suggesting:

> There is a less accepted body of theory... I think there is an understanding of what goes on [in clinical services] that is fully accepted; with HIV prevention, it's not, it's not clear what's going on. There isn't an accepted body you can work with.

GAA's General Manager did, however, suggest that commissioners sometimes accorded GAA some expert status in developing the details of provision.

A number of GAA participants suggested that GAA's status as a 'community' organisation also provided some protection from what was seen as interference from commissioners. The large volunteer force was viewed as group which was extremely resistant to commissioner direction, and that commissioners were unwilling to confront. Commissioners derided this idea, suggesting that GAA's membership did not represent a constituency whom commissioners must consult or placate. Alex, a commissioner argued:

I think they've got a much weaker base beyond individuals who are just involved in the organisation. So, it's an organisational lobby, which is very different from having widespread support across the sector, or service users or whatever... Whereas, you can't deny that, if 50 people with HIV write into the authority complaining about something, saying we've been using these services and they've gone away, [that's a more powerful lobby].

A GAA manager suggested that, while the volunteer membership did not directly protect the organisation's autonomy, it created an organisational culture where management was very clear of its responsibility to maintain GAA's autonomy.

Other resources were identified. Several pointed to GAA's connections with the gay media, and suggested that GAA often used these, at times of conflict, to press home its perspectives and to criticise its opponents. Others identified GAA managers' involvement in HIV policy circles as allowing them to lobby commissioners. Some commissioners had been involved, alongside some current GAA managers and directors, in the foundation of GAA, and saw themselves as still being involved in the re-gaying movement. Some commissioners and GAA staff and volunteers did indeed regularly meet to discuss these wider issues in informal, as well as formal, settings. However, GAA's voluntary sector status was viewed, by one commissioner, as detracting from its ability to undertake inter-organisational lobbying. He suggested that, because GAA, unlike statutory sector HIV prevention providers, lacked a government-nominated board and Chief Executive, it lacked figures who would have considerable authority in negotiations with similar figures within health authorities.

b. Health authorities

Several health authorities commissioned services from GAA. Three, in particular, Aldbridge, Burkington and Cherrington, were seen as leading the commissioning of LHC2.

Each of these health authorities employed a commissioner. Some of these also had other service areas, such as drugs services or general health promotion, within their remit. During 1996/7, the Aldbridge and Cherrington commissioners had assistants to support their work, while the Burkington commissioner did not. In addition, during 1996/7, two pan-London HIV voluntary sector commissioning advisers were also involved in planning commissioning. One of these, Mark, was based at CHA and the other, Anthony, at another health authority. Both were interviewed.

No research participants disputed that health authorities were statutory sector organisations engaged in commissioning HIV prevention and other services. Some did suggest however that, in addition to their role as NHS commissioners, some of those employed by health authorities had other roles. Two of the commissioners funding GAA had previously volunteered for GAA, and one had been a founder. Both had now ceased any volunteering, but were said to retain links with some still involved in GAA.

As mentioned above, health authority commissioners were explicit in their desire to influence or direct GAA activities. Mark commented:

> We probably don't want them to be independent, actually. We're looking for a voluntary sector which works in a way which we... want them to work.

No commissioners made similar points about statutory providers. This was something of a departure from regional funders, who had reportedly been willing to give GAA considerable autonomy. Regional staff were reported as being more focused on facilitating the development of the organisation, whereas health authority commissioners suggested they now wanted to see 'results' in terms of service outputs.

It seemed that health authority commissioners were motivated by a sense of anxiety, engendered by a number of factors. Firstly, there was an ambivalence to funding GAA because of its ambiguous position in commissioners' thoughts. Commissioners often questioned GAA's competence, and worried that a negative perception of the work of GAA could threaten their broader aim to re-direct resources to fund more HIV prevention for gay men. However, these commissioners also saw GAA as a symbol of the success of re-gaying, and so were extremely unwilling to de-fund the organisation.

Secondly, there was a nervousness about funding HIV prevention at GAA because of what was perceived as its intangibility, relative to other services. Alex, a commissioner commented:

> It's much more tangible what happens in the acute setting. You know, you've got sensible units, or, not necessarily sensible units, but you've got units of activity - what are the various inputs, and what are you trying to achieve? Whereas, when you've got, 'Oh, we've got this really fantastic volunteer stuff, and it's doing really great work', it's actually quite difficult to cut through some of that crap.

Commissioners had a desire to know what 'return' they were getting on their investments. They repeatedly referred to value for money as their key investment criterion. How they sought to assess this is considered in Chapter 8.

Commissioners had some formal authority in that they acted as the purchaser of services in a market which involved a variety of providers, and so could de-fund organisations. Some within GAA even suggested that commissioners had developed a multitude of providers, in order to boost this source of authority. Although commissioners denied this, they did view their position as funders as a resource of authority, and frequently referred to their ability to threaten or enact de-funding.

As well as formal means of asserting their authority, commissioners also possessed some more informal resources. Some commissioners portrayed themselves, and to a much lesser extent were seen within GAA, as experts in HIV prevention. Some commissioners acknowledged their limited skills and knowledge, and cited the breadth of their

responsibilities, lack of time and lack of training in explanation. Anthony, a former voluntary sector commissioning adviser, commented:

> I think, largely, commissioners are under-skilled for what they do. And that's not a reflection on them, that's a reflection on how much training and support they get... It's learning on the job, but if you're learning about terminations of pregnancy, you're learning about how to manage an acute contract, contract variations, if you're learning about a huge range of things, the amount of time you can spend, in detail, learning is very limited.

Commissioners did have access to some advice from public health staff, medical and non-medical, within their health authorities. Public health staff's skills in HIV prevention were sometimes questioned, however. Commissioners sometimes used specialist advisers from outside their health authorities. This is discussed further in Chapter 8.

5. Occupational and volunteer groups involved within GAA

a. Volunteers

Documents produced in GAA's early years stressed the importance of GAA being led by 'ordinary' gay men, rather than by experts. Experts were viewed as those who had worked professionally in de-gayed HIV prevention services, and who had employed methods and approaches of HIV prevention which were inappropriate to gay men. Some within GAA stressed that the founders' emphasis on ordinariness was intended primarily to motivate the recruitment of a body of volunteers to enable the CM methods developed by GAA's founders to be implemented. Graham, founder and General Manager, commented:

> I think it was really important... to us, that our volunteers believed - no, knew - that they were in control; that this wasn't token; that... we weren't lending them power. What's the famous quote, 'People can never be given power, they can only take power'. And that they weren't being given power; we, collectively, were taking power.

A commissioner emphasised that founders were themselves experts. Other interviewees

went further, arguing that the recruitment of ordinary gay men was only ever intended, by some founders, to give legitimacy to, and allow the implementation of, founders' own views. These participants suggested that the empowerment of ordinary gay men was never viewed as anything other than rhetoric. William, a commissioner and former volunteer, commented:

> It was an organisation created, managed, and funded by the elite, for the delivery of specific objectives.

The veracity of GAA's claim to seek to involve and empower 'ordinary' gay men to lead the organisation was an issue of debate. Some questioned whether GAA volunteers were representative of gay men's 'community'. Tom, a GAA director, commented thus, describing a style of dress worn by 'scene' gay men:

> It is a certain type of gay man; it's your 'army trousers and vest'.

Others both within and outside GAA echoed this. Brian, a worker, however disagreed:

> It's always been completely, and utterly, diverse.

According to one survey, most volunteers fell into the 26 to 35 age range. The vast majority of volunteers were white, most of these being UK-born, with some from other European nations. Seven per cent were Black, Asian or of mixed race. More volunteers resided within inner, than outer, London boroughs. Sixteen per cent knew themselves, and 2% assumed themselves, to be infected with HIV. No information on social class was available. GAA did recruit gay men who had not previously been employed in HIV prevention services, although information on what proportion these were of the total volunteer force was not available.

In the course of their initiation into the organisation, recruits were trained in a number of areas, including: knowledge about HIV transmission and the HIV epidemic; project planning; and evaluation and needs assessment. This training was widely recognised to be of variable quality. The question of whether volunteers emerged from this training as

'expert' or 'ordinary' is unclear.

Volunteers' authority and autonomy in the organisation was a topic of discussion within and outside the organisation. As mentioned above, some research participants viewed GAA's founders as seeking to involve volunteers, but not genuinely to empower them to lead GAA. These individuals viewed GAA as actually being led by an elite of volunteer directors and paid staff, most of whom had been involved in GAA's foundation. Neil, a former co-ordinator, commented:

> It is actively used as a way of getting your own way in an agency. Basically, it's quite clever. I don't think it's a conscious ploy, but it has been used as a way in which a small group of people can actually control, much more tightly, an agency, than they could, otherwise.

The point that GAA encompassed an elite group which comprised some, but not all, paid staff and some directors and co-ordinators was also made by those who did not hold such critical views as the above. Many accounts appeared to describe GAA participants according to whether they belonged to this elite, or to the rank and file of volunteers, or of paid staff. It may be that this categorisation, rather than that based on participants' formal titles provides a useful description. This is considered more in this chapter and in Chapter 8.

Other accounts emphasised the autonomy of volunteer groups. A report on the LHC1 programme suggested that GAA operations develop from the activity of groups:

> Each group was said to define their own objectives... Individual group strategies were in turn brought together under a more operational annual strategy [which] represented the consolidation of the various group strategies.

Some participants suggested that, while GAA founders wished to balance volunteer leadership with their own continuing influence, in the course of time, ordinary volunteers had become more and more authoritative within the organisation. These research participants suggested that, at the level of activity of volunteer groups and cells, the rank

and file had become more and more autonomous, and paid staff and directors had little influence over them.

Most interviewees suggested that volunteer groups currently had considerable autonomy, at the level of developing individual projects, though not in wider policy. Volunteers, working in cells and groups, were not managed by the administrative support workers, but rather these workers were accountable to volunteers (as well as to their own line-managers). While volunteer co-ordinators provided some direction for volunteers in cells within their group, these co-ordinators were said to be, with a few exceptions, themselves very much of the rank and file.

As mentioned earlier, GAA had recently changed one of its key principles from: ordinary gay men are best placed to develop HIV prevention; to: ordinary gay men properly trained and supported are best placed to develop HIV prevention. Some participants suggested that this change, initiated by the Chair, was beginning to change these relations. Volunteers were said to be expected to take more note of the views of workers in developing projects. The extent to which this happened is considered in this and Chapter 8.

b. Workers

Most of GAA's salaried workers were employed as administrative support workers, rather than as health promotion or HIV prevention specialist workers. No GAA workers identified as health promotion specialists. Job specifications did not require candidates to possess specialist knowledge, skills or experience relating to HIV prevention. This employment of non-specialists was instituted some time into LHC1, workers previously being employed as HIV prevention specialists. This decision was said to have been taken by directors to prevent GAA developing into a 'professionalised' organisation where workers' concerns became remote from those of ordinary gay men. This was seen as occurring in some other organisations viewed as de-gayed. The decision to employ administrative workers was taken by some research participants as indicating that GAA

was serious about empowering ordinary gay men, and prioritising their experience in the development of HIV prevention. Nonetheless, some of the administrative workers did have what were regarded internally as specialist skills in HIV prevention, developed either through previous experience, or through formal training. Although none of the workers had received formal training in health promotion, some had been trained in, for example, research methods and health care management.

There was a lingering suspicion of professionalism and expertise. Brian, a worker, commented:

> The biggest insult you can get is, 'Oh, you're being a professional!',... because it's used as [meaning] you've lost touch... with what it's like to be a gay men.

As well as administrative support workers, several newer workers with specialist skills had been appointed, including a Research Assistant. This latter post required applicants to demonstrate specialist qualifications and experience.

Although workers were identified by other research participants primarily in terms of their paid post, several workers also volunteered for GAA, including one who had been a founder of GAA. This again points to a complexity in identification within the organisation, not indicated by formal titles.

Workers' formal authority over the work of volunteers was limited, but was said to have somewhat increased with the redefinition of volunteer leadership. Graham, the General Manager, commented:

> [The Chair] has been trying to develop a notion of volunteer leadership, which is much more about a partnership of equals between workers and volunteers, where workers, because they were committed to volunteer leadership, encouraged volunteers to come up with the ideas, but also be supportive of volunteers, give volunteers access to evidence. People shouldn't over-rule volunteers, but they might try and persuade volunteers that they're mistaken.

Workers' informal authority over volunteers varied, dependent on a number of factors.

Workers who had a long attachment to the organisation, especially as founders or volunteers, were seen as more authoritative, and were listened to by volunteers. Once more, this suggests that individuals' formal roles are not necessarily the key to understanding how GAA operates. Some workers opted to volunteer for the organisation so that they could initiate projects, within a volunteer role, that they could not within a worker role. Some maintained a strict separation between their volunteering and working, while others did not. Workers' expertise was not itself referred to as a source of authority over volunteers.

Administrative support workers' split accountability to volunteers and to their line-managers was a source of some autonomy. These workers' performance could not be judged, by their managers, on the basis of the activities of the group, since this was beyond any worker's control, and so workers' performance was judged, instead, on the basis of the support they provided to their volunteers. Other workers were accountable solely to their line-managers, making for more rigid line-management of specialist, compared to administrative, workers.

c. Managers

GAA's General Manager was a founder of GAA, who had been employed soon after it first received statutory funding. The LHC Operational Manager was not a founder, but had volunteered for GAA prior to his employment. The General Manager worked in close partnership with the then Chair as well as with an ex- Chair. Both managers were also volunteer-members of the organisation. Distinctions between salaried management and volunteer directors, and other elite members, appeared somewhat blurred.

Both managers had themselves previously been directly involved in the practice of HIV prevention as well as its management: the General Manager in a salaried post in a health promotion unit; the LHC Operational Manager as a GAA volunteer. Both felt they had considerable expertise in HIV prevention, the former informally acquired, and the latter through experience as well as formal training in health promotion and research. Neither,

however, regarded himself as a health promotion professional, feeling their skills to lie in other areas, such as management and facilitation.

At the level of developing project work, neither manager possessed considerable formal leadership authority, for the reasons already described. As in the case of workers, in order to initiate HIV prevention projects, managers had to propose them in their role as volunteers. Their ability to do this was resented by some within GAA. At other levels within the organisation, managers could initiate action more straightforwardly, for example setting up seminar series and organisational reviews in their capacity as managers. They were still accountable to volunteers in this work. Keith, the LHC Operational Manager, commented:

> It's difficult; because I have the title Operational Manager, it doesn't mean I have the power which would normally go with that title... I'll come up with ideas, and they'll be run past co-ordinators committee, 'cos I work to co-ordinators committee ..., and if it's taken up with that committee, then I can run with it.

Managers could also direct the work of the specialist workers, since these had no accountability to volunteers.

The General Manager was said to be directed by the Chair, as well as being influenced by certain other members of GAA's elite, and an ex-Chair in particular. The LHC Operational Manager was said to be closely managed by the General Manager. Both managers stressed their accountability to volunteers. The General Manager expressed some irritation at the accountability demanded by one group co-ordinator. Interestingly, the General Manager appeared to use his lack of individual autonomy arising from volunteer leadership as a means of resisting moves by commissioners to direct the organisation's activities. William, a commissioner, commented:

> I think [the General Manager] pandered, played up, to it. [His] position in the negotiation would always be, 'The volunteers won't like that, you know'.

At a more informal level, managers possessed considerable informal authority; especially

the General Manager, as a result of his long involvement with the organisation. Keith, LHC Operational Manager, also commented:

> People respect the fact that I was a volunteer.

One worker pointed out, however, that many newer volunteers had never met the General Manager, a fact which placed some limit on the reach of this informal authority.

6. Conclusion

A number of key conclusions can be derived from the findings presented in this chapter. The first of these concerns the possibility that the terms commonly used to describe the organisations and those working within them are not necessarily the most descriptive. In the GUM clinic, the distinction between academic and clinic doctors could easily mask the overlap in the roles and identities of these groups. In the voluntary agency, the distinction between staff and volunteers does not indicate the fact that the organisation possesses an elite, which includes both staff and volunteers, as well as a rank and file of other volunteers and workers.

The second conclusion to make is that the two case studies explored in this chapter include, within them, organisations which differ markedly in respects which may have considerable influence on how evidence is defined, produced and used within each. The GUM clinic is a statutory agency which employs staff who consider themselves experts, have little problem with this status, and are widely considered, including by funders, as authoritative. Although considered important by many of those employed in the clinic, SHP is not the only service provided by the clinic, and indeed is not explicitly funded. The commissioner who supplies most of the clinic's funding intervenes very little in specifying what SHP occurs in the clinic, in large part because he is satisfied with how this is undertaken by the provider.

In contrast, the voluntary agency appears to combine something of an anti-expert ideology, with a firm belief in its own authority in planning HIV prevention, and a

combative approach to some other agencies. HIV prevention is at the centre of the organisation's remit, and is explicitly funded by commissioners. Commissioners themselves appear somewhat dissatisfied with the work of the provider, and express increasingly directive ambitions.

It is suggested these differences will have implications for the place of evidence within wider relations of control and resistance for these two case studies. Chapters 7 and 8 examine how the relations involved in each case study affect the definition, production and use of evidence, and, in turn, how evidence definition, production and use reproduces and/or modifies these relations.

CHAPTER SEVEN: EVIDENCE IN THE KGC CASE STUDY

This chapter, and the next, aim to answer the remainder of the operational research questions: how, and why, do different organisations and groups define evidence?; how, and why, do different organisations and groups produce evidence?; and how, and why, do different organisations and groups use evidence? This chapter reports findings from the GUM clinic case study, while Chapter 8 reports findings from the voluntary agency. These findings inform the overall discussion presented in Chapter 9.

1. Processes of evidence definition

a. The traditional centrality of evidence derived from research in the clinic and LUSH

Amongst most KGC, as well as all LUSH, staff, research was viewed as a process for generating evidence involving formalised, pre-planned processes of investigation, into the biological or the social realm. One clinic doctor suggested:

> Research describes its own method, so others can repeat it.

This was viewed by most as the only means of generating evidence. Participants associated the terms 'evidence' and 'research' with the terms 'rigour' and 'peer review'. The term 'evidence' seemed to be used to denote information produced through processes whose rigour could be judged because of their formality. One academic doctor commented:

> The thing... about research is that it is transparent, it's not necessarily always sound, but at least... you can judge if it is, or not.... There's peer review.

Experience was defined by all those questioned on this matter as information which people develop as a result of informal reflection on their own or others' lives. There appeared to be little blurring of research and experience. Only a few interviewees, a

nurse, a health adviser and a CP, counted experience as a form of evidence comparable to that from research. Many interviewees nonetheless considered that experience, as well as intuition and anecdote, could sometimes be of more use than research. Kate, the Clinical Services Manager, commented:

> Not everything about delivering nursing care to a person is about science, you know. A lot of it is about communication style, a lot of it is about getting them on board.

But many also suggested that experiential forms of information, though often useful, could be unreliable and should preferably be supported by evidence from research. The phrase 'anecdotal evidence' as a description of information derived via informal reflection, did occasionally crop up in documents. For example, in discussing gay male attenders' use of drugs, the second SHPG report stated:

> Anecdotal evidence indicates that a named contact, possibly a member of staff involved in satellite clinics or in outreach, may facilitate initial access to mainstream service.

But note the tentative phrasing employed. The report also refers to evidence from research in discussing the issue at hand.

Other interviewees suggested that research could itself examine people's experiences but considered that this process was different to individuals' own informal reflections. Research could offer what was a mediated view of experience, and this could be counted as evidence.

Participants suggested that research could focus on a number of topics. Evaluations represented one form of research which focused on various aspects of service provision. Some evaluations could focus on a service's impact on clients, ie. its effectiveness, while others could look at other aspects of services.

Research was viewed as providing answers to questions in order to develop generalisable knowledge, whereas audit was viewed as the comparing of local practice to various

standards of practice, some of which were informed by research and some of which were opinion-based. A distinction was made between 'quantitative' and 'qualitative' research; this is discussed in a later section.

At the time of fieldwork, research was seen as a necessary activity which required the leadership, or at least the support, of research specialists. There was no debate about the priority of externally, or internally, conducted research, nor about the distinction between research and unmediated experience.

The emphasis on the importance of evidence from research appeared to be motivated by a widely held sceptical mind set. Several academic, as well as some clinic, staff repeatedly emphasised the importance of questioning assumptions and past research, as part of an effort to develop a more accurate view of social or biological phenomena. Laura, an academic doctor, exemplified this by questioning others' assumptions about, for example, the effects of school-based sex education, and the feasibility of undertaking partner notification with gay men and black women. This scepticism, it was suggested, was unsurprising in an organisation dominated by those trained scientifically. One academic described the clinic having a leaning towards what he termed 'hard science', which he equated, in the case of the clinic, with the biological sciences. Academic and clinic doctors, many other academics, nurses, CPs and others had all been trained, to differing extents, in various biological sciences.

Many also held what might be called a 'rationalising' ethic concerning research. Staff placed great emphasis on using research to improve, as they saw it, the rational basis of practice. Many saw it as part of their occupational identity to inform practice using research. One CP suggested CPs saw themselves as 'scientist-practitioners'. Although no other groups used this term, many clinic practitioners emphasised that their group engaged with research to develop practice.

Some within LUSH as well as outside, suggested the department had a distinctly 'medical' orientation to research. They had, however, great difficulty in explaining

exactly what they meant by this. Others disagreed. Trevor, a non-medical academic, commented:

> [LUSH] is within the medical school, so it will have a strong leaning towards 'hard science'. But, in terms of the methods used, I think it's very eclectic... We have a head of department who's a [medical scientist], but, at the same time, he's keenly aware of, and supportive of, the social and behavioural side. It would be an over simplification to talk of it as a medically-based department.

The value attached to research among practitioner groups seems to have been bolstered by the wide perception of the importance of becoming involved in research in advancing both individual careers and the status of occupational groups. George, an academic doctor, commented:

> I'm sure it's because of changes within the NHS itself... The research agenda has been brought, more and more, into NHS practice, clinical practice. And I think it now behoves clinical practitioners to know more research methods and methodology.

In KGHU, research was less of a focus of attention. Nevertheless, participants defined research and experience in similar terms as in the clinic, and did not blur the distinction between the two. Interviewees suggested that experience could be extremely important. However there was again a clear awareness of its limitations.

Managers had become increasingly supportive of research, particularly since the advent of Research Support Grants being awarded to trusts by the NHSE on a competitive basis. These were intended to provide for the service costs of providers being involved in research. Managers also valued the presence of certain researchers as bringing prestige to the clinic.

The health authority commissioner, Roger, held views broadly in line with those of the majority of clinic staff. He stressed his need to use evidence from research in informing his work as commissioner of HIV prevention for the district. He did not indicate his need to use evidence from his own or from others' experiences. When asked, he distinguished between research and experience in terms of the former being conducted using systematic

and more rigorous means. Roger indicated that he saw staff based at KGC and LUSH very much as the experts in the production of research evidence, and was keen to involve them in the second district HIV prevention strategy being convened by the health authority.

b. An effectiveness/evidence-based practice movement

Views on effectiveness

Several people within the clinic and LUSH were involved in what they termed an 'effectiveness' and/or 'evidence-based practice' (EBP) movement, these terms being used with considerable overlap. This movement aimed to stress the particular importance of evaluating the effectiveness of interventions, using particular research methods, discussed below. The term 'evidence' was often used by interviewees, seeing themselves in this movement, to refer specifically to evidence of effectiveness. Interviewees using the term evidence did, however, recognise that evidence could, and should, also refer to other topics, such as the need for, and acceptability of, services.

These individuals identified themselves as belonging to an international movement which was asserting the importance of, and developing mechanisms for, the production and use of evidence on the effectiveness of health and social interventions. This movement included, but was not limited to, individuals involved in the international Cochrane Collaboration, discussed in Chapter 1. Several LUSH medical and non-medical academics were involved, within this Collaboration, in the review of evidence on the effectiveness of clinical interventions for STDs.

It was suggested, by several interviewees from the clinic and LUSH, that, internationally, concern and interest had been growing for several years about the extent to which HIV prevention and SHP interventions were based on evidence of effectiveness. Several identified key developments in this process, such as: calls by a US epidemiologist and sociologist for more evaluation of HIV prevention; several studies undertaken in the US

which aimed to evaluate the effectiveness of HIV prevention projects; and reviews by the Evaluation of Health Promotion and Social Interventions ('EPI') Centre, a team based at the Institute of Education, University of London, on studies aiming to evaluate the effectiveness of various forms of HIV prevention intervention. Some KGC and LUSH staff were said to have been keenly interested in these developments, as well as in the NHSE's increasing emphasis on evidence of effectiveness. According to Justin, a non-medical academic:

> I think there was also, you know, a push, maybe from central government about evaluation, more effective evaluation of..., not just HIV prevention, but of all medical care, and .. with the NHS centre in York, and things like that. So...I think... it is becoming more and more a culture of... the NHS.

Two individuals, Laura, an academic epidemiologist, and Jonathan, the Clinic Director, were particularly central to the growing interest in effectiveness and EBP within the clinic. Many interviewees described Laura's role as a 'product champion', in developing processes of evidence definition, production and use, in both SHP and clinical services. Jonathan developed an interest, specifically, in evidence of the effectiveness of SHP. He had chaired the SHPG, and saw a focus on effectiveness and EBP as a logical continuation of this work.

Both of these doctors said their interest in evidence of the effectiveness of SHP developed partly as a result of attending an international conference, where a US academic presented the results of his study of the effectiveness of an HIV prevention intervention targeting gay men (Kelly et al. 1991). This study employed a design which compared cities where a new intervention was delivered, with cities where no new intervention was delivered. Jonathan and Laura had also both read a number of reviews published by the EPI Centre, mentioned earlier. The first of these reviews was, itself, actually commissioned by a group in which a LUSH medical academic was involved.

Laura's and Jonathan's focus on effectiveness could be understood as an extension of their sceptical mind set and their rationalist ethic. They stressed the intellectual basis of their interest in producing and using evidence of effectiveness, questioning assumptions

about the positive and negative effects of SHP interventions. Both also emphasised that rigorous evidence on effectiveness should inform the development, as well as the ethical rationing, of services. Laura commented:

Laura-I think we have a responsibility, actually, to use the resources, that we've got, as effectively as possible... You have to prove that you're doing more good than harm. And I think you also, in a cash monitored NHS,... have to think about what it costs for that improvement, and decide whether that's worth it ...
Interviewer-So it is linked to rationing, really?
Laura-Yes.

In 1994, the two doctors presented, to colleagues, their ideas on the importance of evidence of effectiveness, and their suggestions for an RCT of a SHP intervention. Many, but not all, academic and service colleagues were initially said to have been resistant, largely on the basis of judging their suggestions impractical. There was also a view, on the part of some, that SHP did not require rigorous evaluation because it, undoubtedly, was effective. Laura commented:

Laura-I have to say, it was met with a fair degree of resistance.
Interviewer-Why?
Laura-Just because....it seemed like... it would be a difficult study to undertake, and it would be difficult to measure outcomes effectively... And whether it was appropriate to... [People thought], 'Surely, everybody knows it's good to talk to gay men about... so, you know, why do you need to do it?

Kate, the Clinical Services Manager, commented:

Kate- I can remember being absolutely horrified, when they first mooted it.
Interviewer-Why?
Kate-Because I was thinking, 'Oh my god, I can't believe... that they think that we can do this, that they think that we can randomise messages to patients'. And when it was first suggested, it was suggested in such a crude way, it was like, 'On Monday, we'll tell them the truth, and, on Tuesday, we'll tell them something else'.

It seemed that the ideas gradually passed into acceptance within LUSH. This was

supported by changes in staffing. An individual with an interest in evaluation of effectiveness was recruited, and an existing medical academic, with a similar interest, returned from maternity leave.

Enthusiasm about effectiveness and EBP appeared to have spread in the clinic. Angela, an academic doctor and the GUM Co-ordinator, commented:

And now...I would say the drive is equally between the two. I mean, I... was delighted,[that] not long ago, I sent out an e-mail to a bunch of people about something I was looking at doing,... the dropping of [the] standard examination that we do and... two of them immediately sent back to me, 'Oh, we're going to change this. It must be evidence-based, and we must look at it.' And I just thought,'Yes,...they're all thinking on the same line'.

The term 'evidence-based *medicine*' (EBM) was used in some documents, for example those discussing the NHSE-funded 'Evidence-Based Medicine Frontline Site' project (see below). Some doctors also used the term 'evidence-based medicine' apparently as a synonym for evidence-based practice, in their accounts. Other doctors reported that this term had initially been more widely used by doctors, but that the term 'evidence-based practice' was replacing it. Several non-doctors within the clinic, especially nurses, stressed the importance of using the term 'evidence-based practice' rather than medicine, on the grounds of its greater inclusivity.

Simon, a junior doctor, and Angela suggested these ideas had been taken up both by doctors and nurses, while Laura was less certain. The uptake of these ideas by other groups was even less certain. One health adviser used the term 'evidence-based research' when appearing to refer to EBP. This possible confusion might reflect an only superficial penetration of EBP ideas into some realms. Some individuals, notably a health adviser, were less sceptical about the effectiveness of the clinic's services than others, and so were not greatly interested in, though were not totally dismissive of, the effectiveness movement.

Some CPs and nurses, though accepting that the current discussion about effectiveness

and EBP originated largely from doctors, were keen to stress their own group's involvement in the development of these ideas. Greg, acting CP-Manager, commented:

It was all part of our training... Now, we didn't call them systematic reviews then, we called them 'meta-analyses'... It was never questioned that your work had to be empirical-based, evidence-based ..., although we didn't actually sit there and talk about [it], in terms of systematic reviews and evidence-based practices. I guess, during our training, it became obvious that we were a little bit more obsessed about, evidence-based practice, and doing systematic reviews, as now they are called, than, for instance, our medical colleagues... It was... with some bemusement and relief ..., when the medical profession seemed to have, of late, taken on board evidence-based medicine and systematic reviews. It's welcome, it's very much welcomed, and I guess we tried not to make too many, 'Yes, well, of course, that's what we've been doing for years' type noises.

Christine, a nurse, suggested that EBP was a logical continuation of the 'nursing process', an approach to nursing developed in the US several decades ago:

You see, the thing is, a lot of what we did in nursing is evidence-based. We just don't call it that. And, you know, good-old 'nursing process', which I was trained in, was about doing away with ritual...and approaching care along the way of assessment, implementation, evaluation. That was the process, and I've always argued that we've allowed medics, in a way, to kind of monopolise the evidence-based agenda, when, actually, we're the only ones that were actually trained in that kind of process - but we don't call it that, and that's why I think it's a real shame, that nurses haven't actually taken a lead.

A number of reasons were suggested for the growing influence of the effectiveness/EBP movement within the clinic and LUSH. One was the championing activities of the two doctors already cited, especially Laura. Another was the receptive culture, with its pre-existing focus on research, and commonly held sceptical mind set and rationalist ethic. Angela commented:

I think that it's... landed extremely well in the culture of, particularly LUSH [which] has always been to... question our practice, and, 'Why do we do that?' and, 'Who said it's a good way of doing it?'. So, it fell into fertile ground, as it were. And I think that's true of wider than LUSH. I think the NHS department here, as well, has largely been staffed by people who are happy to question what we're doing, and not just say, 'Oh ..., that's the way it's done'.

Effectiveness and EBP were viewed as innovations, and were embraced within an academic department and clinic possessing a culture which sought to innovate. George, an academic doctor commented:

> Because of this drive to be a centre of excellence, I think we've constantly pushed the margins, in terms of looking at what is new, and what is good practice.

It was also suggested that the effectiveness/EBP agenda were not seen as threatening within the clinic and LUSH. There was no perception that funding would be threatened as a result of evaluations. In the case of SHP, this is perhaps unsurprising given that SHP was not explicitly commissioned. Roger, the commissioner, commented:

> They don't get anything, separate.... so we can't take money away from them, no I mean it's not a threat.

The Clinic Director also alluded to this. In fact, most staff associated undertaking evaluation with increasing income potential, a view borne out by events described in a later section.

In KGHU, there appeared to be much less discussion of effectiveness or EBP and the two were not so closely associated. James, the Liaison Worker, suggested that, while some evidence was used, the phrase 'evidence-based practice' had not been widely adopted. The KGHU Manager did not use the phrase without prompting. While there was some interest in focusing on effectiveness, and some effort to produce and use evidence on effectiveness (discussed later in this chapter), this did not have the status of a movement within KGHU.

KGHU's relative lack of focus on effectiveness, and its more recent uptake of the term 'evidence-based practice' could be ascribed to its lack of connection to the networks within which these ideas were communicated within the clinic and LUSH, as well as to the lack of a pre-existing 'scientific' culture emphasising the centrality of research evidence and scepticism. KGHU staff seemed to vary within their accounts as to how sceptical they were, at some points acknowledging the general lack of evaluation and the

great uncertainty they had regarding what might be effective in minimising HIV infections, while at other times identifying, as exemplars of effective HIV prevention, certain projects which had not, in fact, been evaluated. This may have reflected an only partial penetration of ideas about the importance of evidence of effectiveness within KGHU.

Commissioners appeared interested in effectiveness and in EBP, and described their need to use evidence of effectiveness in their own commissioning decisions. LUSH and KGC participants suggested that, after initially being uninterested in evaluation and seeing the priority simply as getting more resources into HIV prevention, commissioners had become increasingly focused on questions of effectiveness, exemplified by their increasing focus on effectiveness at meetings of the second district HIV prevention strategy group.

Views on 'trials'

For Laura the academic doctor, and Jonathan, the Clinic Director, the effectiveness agenda, as well as concerning the basing of practice on evidence of effectiveness, also necessitated embracing experimental methods and systematic reviews as the best means, respectively, of producing and reviewing evidence of effectiveness. Experimental methods were seen as involving studies in which baseline and outcome measures from a group receiving an intervention were compared to those from another group, either receiving no intervention, or a different intervention. In order to ensure that the groups closely resemble each other, except in terms of their exposure or non-exposure to the intervention under evaluation, group members are allocated randomly to each group (in randomised controlled trials or RCTs), or the groups are matched in terms of what are regarded as key characteristics (in matched controlled trials). The term 'trial' was often used as a short-hand for these experimental methods. Systematic reviews referred to a process whereby evaluation studies are included or excluded within an overall analysis on the basis of a structured assessment of their rigour.

Trials were a subject of controversy within the clinic and LUSH, while systematic reviews were not generally controversial. Laura was a continued firm advocate of the centrality of evidence from trials, whereas Jonathan reported that his position had 'softened'. He suggested that, although he still favoured these methods, he recognised that these were sometimes unfeasible or inappropriate in the SHP field, and that other methods were also useful. The views of other staff on experimental methods varied. There was an active debate about the utility, feasibility and ethics of trials. Anne, a former KGHU manager, suggested that people's views could be classified as follows:

> There are people who really believe in it... And then, there are a lot of sort of 'middle-of-the-roaders', who are pragmatic, and would say, 'Just choose the method that makes sense, for what you want to get out,... and you might use more than one method',... And then, there are people who feel very uncomfortable around, the scientism, the scientificity of it all, who don't understand it, and feel it's very mystifying.

Most interviewees were indeed not easily categorised as strong proponents or strong opponents. The majority were enthusiastic about trials, but also recognised difficulties. Two staff from LUSH wrote a journal article in which they categorised opposition to trials:

> Debate about randomised controlled trials generally takes one of two forms. If it is accepted that the [RCT] is the method of choice for estimating the efficacy of interventions, then debate is confined to the conditions which permit the trial on ethical and practical grounds and make the findings useful beyond the trial itself... The second form of debate involves more fundamental opposition to [RCTs]. In the behavioural and psychosocial field, ethical objections have been raised about withholding interventions that are believed or assumed to be beneficial. In addition, it is argued that randomised controlled trials are not applicable in this field because they ignore the importance of external influences, participant choice, qualitative research methods and the complexity of behavioural and psychosocial interventions.

Most critical points made about trials in the clinic and LUSH could be viewed as sitting within the first form of debate in the quote above. Some interviewees were generally sceptical about the feasibility of evaluating SHP interventions using experimental methods, or of generalising the findings to other sites. A former KGHU manager and a CP fell into this camp. Others were only sceptical about the feasibility of evaluating

certain specific SHP interventions using experimental methods. Simon, a junior doctor, for example commented:

I think, to have a randomised controlled study, you need to be able to have a very clearly-defined outcome, and a very clearly-defined intervention. And so, as soon as you lose that clearly-defined intervention, then it starts becoming quite hard to have a randomised controlled study. So, for instance, the health promotion team, recently, they've been doing it a long time, going out into cruising areas. I think it would be very difficult to, you couldn't do a randomised controlled study of what the effect of them going in and doing was, because you can't get hold of the people who have been in the intervention.

The key distinction appeared to be between individuals who were determined to use experimental methods, regardless of the difficulties involved, and individuals who were not opposed to using experimental evaluations, but who would turn readily to non-experimental methods if experimental evaluation looked unfeasible. Angela, an academic doctor, commented:

I do realise that there are some interventions that are probably impossible to trial ..., I suppose some behavioural interventions. Which is quite difficult. And... I mean,... my prejudice is that you probably can find a way to trial most things.

A minority of interviewees did voice criticism of trials which appeared to be of a more 'philosophical', rather than 'practical', nature. For example, Christine, a nurse, indicated her discomfort with what she termed the 'empiricism' of experimental methods:

Empiricism's very, very attractive [but], you know, something makes me uncomfortable about it... I don't know why, I just think ..., especially in the field of sexual health,... sometimes we... ignore the context in which people get STDs... The world is not objective and, you know, it's an arena of competing interests... And I'm not sure that, always, the quantitative measures capture that.

None of these individuals were, however, actively opposed to the development of experimental methods within LUSH and KGC. These individuals were not in communication with each other about these views, and showed little inclination to develop a discussion within the clinic or LUSH on these matters.

Some suggested that, despite having some concerns about the validity of trials, the only way to convince many others within the NHS of the effectiveness of an intervention was by using a trial. Richard, a health adviser, commented thus on one study undertaken with LUSH (discussed later):

Richard-I think, for the purposes of it being taken seriously, I don't see how else they could have done it...
Interviewer-When you said they had to do that..to be taken seriously, taken by seriously by whom?
Richard-By the people who would fund it; by those who would publish the work; by those who would be evaluating the work in terms of its research value.

Several participants were extremely reluctant to appear negative or critical. Sue, the Health Adviser-Manager, after commenting on the limitations of RCTs, did jokingly say:

I hope you're not going to quote me on any of it - I like RCTs!

Christine complained that sometimes people's position could be stereotyped, so that those raising difficulties with trials could be viewed as not in the EBP 'camp'.

It was also suggested that HIV staff, and doctors in particular, were receptive to the possibility of undertaking trials of SHP partly because of the generally accepted importance of trials of the effectiveness of HIV therapies. Medical and nursing staff, it was argued, had accepted the need to evaluate effectiveness in clinical aspects of the speciality, and the need to use experimental methods to do this, and were largely comfortable with transferring these ideas into SHP aspects of the speciality. Kate, Clinical Services Manager, commented:

One of the things that I really like about working in GUM and HIV is that - and I think this is mainly because of...the impact of HIV - is that, because it's very new, and all the treatments are new, there's very much a culture of trying to assess what we are doing and trying to look at what works well.

The commissioner stressed his enthusiasm for evidence from experimental evaluation, seeing the RCT as the gold standard of evaluation. There was some discussion in the second district HIV prevention strategy group about the feasibility and utility of different

evaluation methods. According to minutes from the group, KGC's Clinic Director, and staff from LUSH, all expressed the view that RCTs could provide useful information, but that their feasibility was somewhat limited in the area of SHP. The commissioner was said to have increasingly come to acknowledge the limitations, as well as the value, of experimental methods as a result of these discussions. He did not raise this in his own interview, however.

c. An embracing of qualitative research

As well as an increased focus on evidence of effectiveness and on experimental methods, the existing research status quo was also gradually modified, but not fundamentally challenged, by another process: the embracing of qualitative research as a complement to quantitative research. Many within LUSH and the clinic, including senior figures, stressed the value which they ascribed to qualitative research. Trevor, a sociologist, was said to have influenced thinking within LUSH so that qualitative research was more often considered as a possible component of research. He described it as his mission to popularise these methods within the department.

What was meant by the term 'qualitative' appeared to be research referring to textual accounts from interviews and other sites of discussion. Most research participants did not refer to qualitative research having a different philosophical basis to quantitative research. Interviewees saw qualitative research as of use in complementing quantitative research. Angela, a medical academic, mentioned the importance of qualitative research in developing interventions. Other uses for qualitative research listed included: informing the development of quantitative measures; assessing users' needs; and investigating the generalisability of interventions. Angela suggested that both quantitative and qualitative approaches were used as appropriate:

> Unless, it is, that I'm blind to it, because I'm part of the department, I'm not aware of [any preference for qualitative or quantitative]. I think we're fairly eclectic; arguments rage over quantitative versus qualitative research, and, I think, most of us have sat here, rather bemused, thinking, 'Well, time and place for both, isn't there?' And the two complement one another, and we've often done work that involves a bit of both.

I mean polarisations, like that, I think we tend to ignore.

Her account suggests a lack of acceptance of any fast distinction between quantitative and qualitative research.

Roger, the commissioner, also recognised the value of qualitative, as well as quantitative, research. He suggested, however, that commissioners often had a particular need for relatively clear-cut and concise quantitative evidence, for example on service users' needs and interventions' effectiveness, which commissioners could use in their decisions about which services to commission.

2. Processes of evidence production

The study primarily focused on activities in the 1996/7 financial year but, as discussed in Chapter 5, some events prior to, and after, 1996/7 were examined. In order to promote an exploration of developments over time, the analysis presented here, and the corresponding sections of Chapter 8, divide activities into those occurring before 1996/7, and those occurring during and after 1996/7. Evidence production is also categorised, here, according to whether it focused on KGC services or on other sites or issues, and whether it was viewed as research or audit. The production of evidence via activities other than research, such as experience, is not discussed here since any processes were informal, indistinct, and undocumented.

a. Pre 1996/7

i. KGC-focused research

Gay Group evaluation

An HIV prevention group-work intervention, entitled 'Gay Group' (GG), was developed and evaluated by a CP and some health advisers. The intervention was said to be informed by a range of social psychological and other theories. It aimed to empower gay

men to modify their sexual behaviour so that they would be happy with their level of risk-taking. The intervention provided information, and addressed clients' self esteem, sense of control, and ease with their sexuality. It involved two day-long, and two evening-long sessions.

The evaluation included what was regarded as a summative component which used quantitative baseline and outcome measures, focusing on a variety of what were termed 'psychological' factors. These measures were not validated prior to the evaluation. Behaviour was assessed via a questionnaire item seeking clients' own views as to whether their behaviour had changed. The design involved no control group. The evaluation also included what was termed a process evaluation, which explored clients' views on the process, using qualitative methods. Neither the intervention nor the evaluation were additionally funded. The summative evaluation concluded that the intervention was effective in improving attitudes. The process evaluation concluded that, in order adequately to address behavioural issues, group-work required more than one day.

Most of those interviewees discussing the project were positive about it. Peter, a non-medical academic, suggested, however, that the design was limited by its non-validated measures, and its lack of a control group. Gay Group continued to be provided after the evaluation, running parallel to the Group-work Behavioural Intervention for Gay men (GBG), the newer group-work intervention (discussed below). The evaluation was viewed as influencing both the development of GBG and similar projects elsewhere. The project may also have encouraged the view that CPs had a key role to play in the development of SHP in the clinic.

Evaluation of District HIV Prevention Strategies and SHPG reports

Those developing the district HIV prevention strategies and SHPG reports planned to evaluate the implementation of programmes informed by these documents. The first HIV prevention strategy placed great emphasis on monitoring the progress of the overall

programme, according to pre-set objectives:

The intangible nature of prevention work, with its uncertain outcomes and long term programmes suggest a... reason for a prevention strategy. It will give a sense of purpose and direction to those involved, through setting objectives, indicators and outcomes which are both realistic and challenging.

It was suggested that the district HIV prevention strategy group should lead on the evaluation of the overall programme of work, focusing on key outcome measures, whilst those engaged in the delivery of specific elements in the overall programme should lead on process evaluations of their work. A paper by a researcher employed by the trust suggested:

The monitoring and evaluation has to take place on a population level... and therefore recognise the need to address final outcome measures. The process measures of particular projects or programmes will not be investigated by this sub-group; they are the concern of the particular services undertaking the projects.

Both overall outcome evaluation of the district programme, and process evaluation of its individual components was said not to have satisfactorily developed. Jenny, a former KGHU manager, commented:

I have to say the evaluation side... was pretty poor.

Although the work of the SHPG was initiated by the overall district strategy and comprised one element of the implementation of the overall programme, the SHPG did plan to monitor progress within the clinic in terms of outcomes, as well as in terms of process. There was again considerable emphasis on tangible progress. Anne, a former KGHU manager, commented that clinic staff were keen to evaluate SHP training for doctors because of its tangibility.

The SHPG considered a number of overall targets which could be used to monitor overall progress. Interviewees reported that the group chose not to use the DoH's Health of the Nation targets, comprising reductions in rates of gonorrhoea and teenage pregnancies,

since these were considered poorly thought-through and irrelevant. According to the second SHPG report:

> after reflection within the SHPG, the GUM service and the Quality Department, it was decided that it was not possible to set meaningful targets, in terms of behavioural and disease indicators for the implementation of SHPG recommendations. This was due to the uncertain relationship between behavioural and disease indicators and any prevention activity within an open access service.

Although other targets were set, these were not, in the event, used to monitor progress. Jonathan commented thus:

> There were targets... set, but I'm not sure how valid they were. I can't even think of what targets there were, though. I'm sure in the second report, nobody went back to the first report, to look at the attainment of targets.

The only evaluation which did occur took place under the rubric of audit, and is discussed in a later section.

Some within the clinics commented negatively on KGHU's progress in evaluating work initiated as a result of the first HIV prevention strategy. Their evaluation was, in general, said to be limited. Peter, a non-medical academic, commented:

> They get some really brilliant things up there. And their evaluation sucks; if there is any at all, it's bad.

Partner notification research

Various KGC doctors and health advisers, as well as some LUSH medical academics, were involved in a national group set up in 1992 to develop research on HIV partner notification. The group was said to have been initiated in response to DoH interest in this issue. Various English GUM clinics, among them KGC, were involved in a number of projects; policies on partner notification were developed and progress in implementing these was monitored, as was the number of HIV infected individuals subsequently identified, and the acceptability of these processes to the users involved.

ii. Research on other issues/sites

Since 1988, LUSH, working with other centres, has been the site of an externally funded centre for co-ordinating HIV/AIDS research. The clinic undertakes unlinked anonymous HIV testing of clinic attenders. Evidence of the continuing rise in infections, particularly amongst certain vulnerable groups, is said to have informed the development of specific SHP interventions.

As well as research on infections, a great deal of research focused on sexual behaviour. LUSH, together with other agencies, was funded by to undertake a large survey of sexual behaviour and belief. LUSH also undertook research on the sexual behaviour of gay men. This work was proposed by LUSH, and subsequently received funding from Aldbridge Health Authority. Funding has been renewed annually, in order to repeat the surveys. This research was undertaken in collaboration with a number of HIV voluntary agencies. As well as being viewed as providing valuable information on risk-taking behaviour and need for HIV prevention, the surveys have been viewed, by some, as having a role in assessing the impact of the overall array of gay men's HIV prevention services. It was recognised however that precise attribution of changes in behaviour to the effects of services was not possible. Commissioners themselves said they valued the research but could give no account of how they have used the research to inform their work.

iii. Audit

Management of audit

KGC undertook a considerable amount of multi-disciplinary clinical audit, some of which focused on SHP issues. As well as multi-disciplinary audit, staff groups also undertook a certain amount of within-discipline audit. According to contracts between KGC and the health authority, commissioners had the right to determine what topics were audited by KGC staff. However, in practice, commissioners did not exercise this right. Audit within KGC, and at another GUM clinic within the same trust, was led by a committee

with no health authority representatives. The committee was chaired by a consultant, with representation from doctors, nurses, health advisers and CPs. Clinic doctors appeared most involved in setting multi-disciplinary audit priorities, although medical academics also appeared to influence both multi and single-disciplinary audit agendas, exemplified by the prioritisation of a number of topics prior to, and during, 1996/7 (see below).

Trust managers were happy for practitioners to lead on audit. The development and auditing of guidelines by practitioners themselves was viewed by senior managers as the best means of ensuring consistent and appropriate provision, though still with some allowance for individual practitioners to exercise judgment where appropriate. This was favoured over more explicitly authoritarian line-management, which was viewed as incompatible with the pre-existing culture of practitioners having some discretion in how they practice.

Although groups other than doctors had some autonomy in developing and auditing their own guidelines, the scope of these was defined, in effect, by the areas in which the medically dominated audit group did not lead. Kate, Clinical Services Manager, commented:

> I think, in terms of... clinical... protocol, yes, the medics are more in charge than anybody else. Having said that, each staff group will devise its own protocols for its own area of care delivery:... whatever... sort of patient management issues fall into their lap.

Staff undertaking audits had a number of sources of support available to them. The trust audit team was committed to providing a certain amount of audit assistant time to the clinic. A Regional Audit Worker was also based at the clinic, and managed by the Clinic Director, in his additional role as Regional Audit Lead. Academics were also said to offer informal support to clinic workers in undertaking some audit projects.

Most staff groups appeared to find having their practice scrutinised within audit acceptable. Doctors were said to have initially resisted such moves, but had found the

process increasingly acceptable. This was said to result largely from their having considerable say in determining how audit was conducted, as well as their recognition of the value of audit in doctor's education. It was suggested by one individual that this acceptance was not typical of all branches of the medical profession; some specialities, such as surgery, being more resistant, because of a more entrenched culture of individualism and autonomy. Other practitioner groups within the clinic also appeared to find audit of their practice acceptable and useful. Health advisers were said to have initially been extremely uncomfortable with other staff being involved in the assessment of their service in the course of the implementation of the first SHPG report. This is discussed below. However, this group now appeared enthusiastic about both multi and single-disciplinary audit.

KGC staff recognised that audit produced a form of evidence, but distinguished between audit and research as described earlier. Some projects blurred the borders between audit and research. Examples of these are given in the section on audit in and after 1996/7.

Themes in audits

A number of different themes recurred in audits prior to 1996/7. Some audit focused on assessing client satisfaction. Emphasis on this topic was said to have been influenced by a desire to assess the success with which the recommendations of the SHPG had been implemented. After some consideration, experimental methods, and the use of behavioural outcomes, in the evaluation of routine SHP provision were judged unfeasible and inappropriate by academics and service staff. Client satisfaction was viewed as a practical way of evaluating the provision of SHP within routine appointments. A standard for what patients should expect in terms of SHP had been developed:

To ensure that every patient attending the GUM service is provided with;- an opportunity during the medical consultation to discuss their individual strategy for sexual health and given appropriate support, advice and referral as required. - accurate and relevant information... on the prevention of specific STDs as appropriate to their needs - access to a supply of free condoms and lubricant... supplies should be accompanied by education about condom use as appropriate.

A number of satisfaction surveys had been undertaken, using questionnaires and interviews. Support for these audits had been provided both by trust, and by regional, audit staff. Academics had not been involved in these surveys. Many staff suggested that these surveys had been conducted somewhat half-heartedly, and of limited help. Jenny, a former KGHU worker, commented:

> We tried to do some sort of patient satisfaction work with the quality people... in the trust... And we did do interviews, but it wasn't very satisfactory. I felt that we could have done a lot better on that; it just didn't get any very interesting findings around what people thought of the service.

Dissatisfaction with how these surveys had progressed had informed moves within LUSH and the clinic to develop more rigorous evaluations of non-routine SHP provision within the clinic, which eventually resulted in the GBG evaluation. This is discussed later.

Other audits had focused on the amount of time which different staff groups spent on SHP. One of these audits had been initiated by the SHPG, whose members wished to obtain some indication as to whether staff groups were involving themselves in SHP, as a result of the SHPG report. The SHPG appeared anxious to develop a consistent approach to SHP within KGC, because of the clinic's complex referral system. Their view was that, unless all staff had a clearly defined SHP role which was actually performed properly, then clients might miss out on SHP, or might be put off returning as a result of inappropriate or excessive provision. The SHPG reports included the requirement that guidelines be produced for the development of SHP by each practitioner group. The reports also required that SHP activities undertaken by all groups be documented.

The SHPG's interest in target-setting and monitoring appears informed both by the widespread acceptance of this approach elsewhere in the NHS, as well as their own anxiety regarding the intangibility and controversy of HIV prevention. The group sought to ensure progress in this area was efficient and viewed as uncontroversial, and sought to retain some top-down control in the auditing, if not in the developing, of specific guidelines.

Jenny, a former KGHU manager closely involved in the SHPG, reported that, as mentioned earlier, health advisers were, more than most groups, reluctant to have outsiders scrutinise their practice:

> Probably, the most important thing about [implementing SHPG report] was how much resistance we got from health advisers... I think it was... feeling threatened as a profession, and not wanting to be open about their practice. And they really,... put up a lot of resistance. We were not allowed anywhere close to what health advisers were doing really... And it was the bizarrest thing, because they were ever so friendly and nice, but, when it came to actually looking at their work, no way.

James, the Liaison Worker, suggested this reluctance reflected health advisers' insecurity:

> They really feel that, somehow, they're going to be told they're not needed, and their job is going to be done by other people... But it is very hard, because it is very difficult to define our job exactly,... lots of nurses, lots of doctors aren't quite sure exactly what health advisers do.

Other health advisers suggested that their reluctance resulted instead from their unwillingness to breach the privacy of their consultations.

Another audit was initiated by the Clinic Director and an academic. This audit aimed to assess the extent to which different practitioners were involving themselves in SHP. According to some interviewees, including the Clinic Director himself, the audit had the implicit aim of encouraging the health authority commissioner to provide specific funding for SHP. As mentioned already, a number of clinic and academic staff were disappointed with the absence of explicit resources for clinic SHP services. They hoped that, by emphasising the large amount of SHP underway in the clinic, this might encourage the health authority to re-consider the possibility of ear-marked funding for SHP. According to John, the Business Manager:

> Part of that was... almost trying to assess the proportion of, say, nurses' time; how much of that is about prevention.? You know, like giving out a condom: is that prevention? Some of that area is quite grey. Now, we were doing some of that work partly for funding reasons ..., to argue that the treatment service should have access to HIV prevention [funding. I]... , as the manager, was kind of pushing that agenda.

At the time of fieldwork, some considerable time after the audit's initiation, it had not however been completed. It also appeared unlikely that the audit would convince commissioners of their need to fund SHP. Commissioners were already quite aware of the considerable amount of SHP underway in the clinic. They ascribed their unwillingness to provide extra funding for KGC SHP services, not to a lack of awareness of the extent of existing provision at the clinic, but to other factors which the audit could not address: their view that the clinic, like any other clinical service, had a responsibility to provide health promotion services as a corollary to clinical services; and the view that the health authority would not reduce funding for other HIV prevention, or generic health promotion, in order to provide more funding for clinic SHP.

A number of single-disciplinary audits also contributed to an assessment of the SHPG report implementation. Some focused on the process of referral within the clinic. Health advisers, for example, audited the appropriateness of other staff groups' referrals to them. The SHPG report had set out referral criteria for SHP:

Guidelines on which patients should be referred to health advisers aim to ensure that those with particular issues around prevention receive in-depth counselling and support.

Doctors also audited their documentation of SHP work in 1994, again as recommended by the SHPG report. The SHPG report reads:

It is recommended that the existing guidelines for doctors on pretest discussions be amended to state that all offers of referral to health advisers, whether accepted or not, should be documented... It is recommended that a standardised format for sexual history taking be introduced throughout the service in order to achieve consistently accurate risk assessment.

There was also a multi-disciplinary audit of the young gay men's clinic. This focused on attendances and referrals, as well as a social, behavioural and medical profile of its clients. Patient satisfaction was also examined. Health advisers audited their partner notification regarding clients diagnosed as having STDs. This was done in 1991, 1993 and 1995.

As well as formal audit, clinical coding enabled an informal auditing of doctors' practice. As cases were resolved, or otherwise completed, patient notes were reviewed by senior doctors, so that clinical activity could be coded and recorded. As well as serving an administrative function, this process was used as a means of peer review, with doctors being notified where their practice did not meet the standards set out in the Clinic Guide (the clinic's handbook of guidelines for various conditions) and other guidelines. Interviewees suggested that this process of peer review was largely restricted to clinical, rather than SHP, practice.

b. 1996/7 and after

i. KGC-focused research

Group-work Behavioural intervention for Gay men (GBG) evaluation

Laura and Jonathan, as well as other individuals from a number of different staff groups, including health advisers and CPs, bid to the local NHSE regional office for funding for an RCT of an HIV prevention group-work intervention for gay men. In contrast to the earlier evaluation, medical academics, rather than the CPs or health advisers, took the lead in developing the study. There was some disagreement among interviewees about the extent to which other staff groups were actually involved, prior to funding being awarded. Some suggested that individuals such as James, the KGHU-clinic Liaison Worker, had been closely involved in the early planning of the bid. James himself commented:

> [My involvement] was quite a bit before funding... was actually given. I lose track of time, it was probably about a year and a half before funding was acquired. But, I remember being asked, by Laura, being asked to cobble together a description of what the intervention could be like ..., and presenting this at an academic meeting... It was a good example of tying in with an intervention, you know, from the beginning with the research.

Others suggested that these individuals had hurriedly become involved in order to

develop an intervention mostly only after funding had been awarded. According to the majority of accounts, the intervention was put together hurriedly and in order to facilitate the undertaking of an RCT. Jenny, a former KGHU manager, commented:

Jenny-They didn't consult at all. They put in this proposal, and then, when they got the money, it was like, 'Ah...what are we going to do?... They're health promotion sessions, aren't they? Gosh, so they are. Well, we know about that, now don't we?...Do we?'... And it was like..., you know, there was a lot of anger around it...

Interviewer-Who was angry, just to be clear?

Jenny-The health advisers were angry, the health promotion people were angry;... it was very badly managed.

Matthew, KGHU Manager, and Greg, acting CP-Manager, echoed these views. Non-doctors certainly seemed involved not so much in framing central questions, as in advising on the practical aspects of developing the intervention. The development of GBG exemplified an SHP intervention being put together by a group of people focused on developing research, rather than by the SHPG, the group formally charged with developing SHP in the clinic. Jenny suggested that doctors had increasingly come to assert dominance over SHP since they now perceived it as lying within the realm of research, which was their own, rather than other groups', domain of expertise:

I think they were over the moon that this idea had come up, and that, you know, suddenly it was in their realm. And so there was no surprise that they didn't consult with the people who, if anyone, had some expertise about the actual health promotion interventions.

Sue suggested that research was increasingly coming to lead the agenda in SHP, especially in a context of lessening activity on the part of the SHPG. She suggested that

I think [the SHPG] had a sort of major thrust in... 1992 or 3, something like that, and then it underwent a period of, you know, a new Chair then no Chair... It did lose its impetus.

Commissioners had not been asked to involve themselves in the planning of the bid. This was not required by the NHSE.

In funding GBG, the NHS regional office appeared to act as a responsive grant-funder, rather than a commissioner. Although some priorities and criteria were indicated, these were extremely broad. Several of the investigators recalled that the regional office had specifically requested RCTs. Several other interviewees suggested that bidders were motivated to include an RCT design partly as a result of pressure from funders. However, in documents, and in an NHSE manager's account, it was clear that the regional office had not prioritised experimental evaluations. David, an NHSE regional office manager, commented:

There's not a belief within the R&D directorate, that all we should fund is RCTs.

Funding documents stressed only that submitted projects must be in line with the NHS R&D programme definition of research, as involving systematic enquiry and producing generalisable findings. Sexual health research funding was awarded to several non-evaluative projects. Evaluative projects that were funded included experimental and non-experimental designs.

The regional office did not appear to have a view as to what, if anything, it would do with the evidence produced by the research it funded. This might have reflected the preponderance, on the committee awarding funding, of academic doctors and other academics, rather than health authority or trust staff. Regional staff reported great difficulty in involving NHS staff in its work. David commented:

We do try and involve people in the service... and, ideally, the people from the service will have a bit of research knowledge. But, those people aren't always easy to find.

The R&D Directorate was also said to be somewhat marginalised from the rest of the regional office's performance management and finance functions, further resulting, perhaps in an academic, rather than service, focus.

While some from within, and outside, LUSH suggested that the department's work was partly determined by what funders would finance, insiders stressed that the department's

status, and specifically the involvement of some of its staff on national bodies, allowed it to influence, as well as respond to, funders' agendas. This latter view was supported by a regional R&D manager.

The GBG project was awarded funding of £170,000, and initiated in June 1995, set to report in November 1997. King George's NHS Trust provided an additional £11,000 worth of health adviser time for the project.

The project aimed to recruit gay men who, it was judged, might benefit from an HIV prevention group-work intervention, on the basis of their attendance at the clinic with an STI or with concerns about sexual risk-taking. Those who gave consent to become involved were randomised to an intervention group, involving group-work, or to a control group, in which they received standard management, ie. consultations with various staff in the clinic, with routine one-to-one SHP provision. The study included a broad range of baseline and outcome measures on knowledge, attitudes, behaviours, as well as some biological markers. Process and cost information was also collected as also were, at the suggestion of the social scientist recruited to manage the study, some qualitative data.

The intervention, like GG, its predecessor, was based on a range of social psychological models. The originators of the trial had originally wanted to trial an intervention very similar to GG. Laura commented:

> We thought, 'Wouldn't it be great to do something in the clinic'. And... we came up with the idea of trying to trial GG.

In the course of the development of the GBG intervention, however, the investigators decided to reduce the length of the intervention to one day, in order to facilitate the recruitment and retention of participants, and so make using an RCT design practically feasible. This reduction in the intervention's length occurred despite the conclusion from the evaluation of GG, reported earlier, that, in order to address adequately clients' behavioural issues, group-work required more than one day. The research referees, which the regional office asked to comment on the research proposal, had voiced concerns about

whether a short intervention could properly apply social psychological models:

> it is questionable whether one single session of intervention, even if it lasts seven hours, would be expected to enable participants to acquire more than superficial understanding of the principles of cognitive behavioural intervention. As the intervention is already being given by non-cognitive behavioural therapists (essentially by health advisers) it is difficult to know what degree of cognitive behavioural therapy remains to the intervention.

The investigators had, however, undertaken some initial research on client acceptability, and had concluded that gay men would prefer a one day course. James, the Liaison Worker involved in the study, remained unconvinced:

> We did have to tailor the intervention to some extent. And that isn't really what I think should happen with sexual health; we should be finding research, means of research, that fit in with the intervention as well.

James implied that GBG was not real group-work, by referring to another group-work intervention:

> GBG's a one day workshop, [another study] is real group-work.

Thus, in effect, the use of a prospective experimental design was prioritised over the retention of the intervention originally conceived as the focus of the study. Investigators' prime interest appeared to be in the implementation of the RCT as a technology. Peter, the GBG researcher, commented on how the intervention itself was regarded by those developing the study:

> It was a prime, kind of, bit of activity that could be evaluated.

The main interest of the investigators did not appear to have been to produce evidence which could be used to prioritise existing forms of SHP in the clinic. The evaluation would provide evidence on the effectiveness of a new intervention. It would not provide any evidence on the effectiveness of the group-work which the clinic already provided. Most KGC and LUSH staff who discussed the matter in interviews recognised that the

study would not provide evidence which could unambiguously tell the clinic what interventions should be prioritised at the end of the study.

Staff working on the study experienced some difficulties with recruitment and attrition. They succeeded, however in maintaining a large sample size and continuing to randomise between groups. The study over-ran, necessitating the investigators seeking approximately £30,000 additional funding from Aldbridge Health Authority. The health authority, as mentioned earlier, though not previously involved, was keen to fund completion of the study. The commissioner commented on his general interest in encouraging trials of SHP. He also hoped that the GBG study would provide him with evidence on the effectiveness, or otherwise, of group-work interventions, which he could use in commissioning services from other providers. The evidence would not inform his commissioning of KGC, however, because specific funding for SHP was not allocated. Furthermore, the fact that the intervention at the centre of the GBG study was untypical of group-work developed in other providers meant that evidence from GBG would probably be of limited use in this broader role.

In spite of certain misgivings about the intervention cited above, most within the clinic, including those who were uncertain about the utility and feasibility of applying RCTs to SHP in general, appeared supportive of, and enthusiastic about, the study. Several suggested their enthusiasm for effectiveness, trials and EBP had increased as a result of the perceived success of the study.

KGC staff also collaborated with Gay AIDS Action in developing and providing the latter's own group-work intervention. This intervention was in fact actually at times undertaken on KGC premises. The Clinic Director was happy for this collaboration, although a GBG investigator was uncomfortable with support for what he saw as an unnecessary and inferior evaluation.

Other KGC-focused research

Some research was undertaken without formal funding. Academics, doctors and health advisers co-operated on research examining patterns of testing in the men's clinic and in the young gay men's clinic. This was done in order to try to understand why some men sought HIV testing and some men did not, and how this related to their risk of HIV infection. It seemed that many practitioners were interested in undertaking research, motivated both by an interest in improving practice, but also in developing their own skills and careers, as suggested earlier.

Collaboration between academic and service staff in undertaking audits and research was generally regarded as successful. However, some tensions were evident. Some interviewees suggested that the interests of academics and practitioners often differed, with academics needing to complete and publish research, while practitioners had more interest in applying research to their immediate practice. These tensions could sometimes lead to disagreements. It was also suggested by some non-medical practitioners, that academics could sometimes be overly critical of practitioners' ideas for research.

ii. Research on other topics/sites

LUSH continued to undertake epidemiological and behavioural surveys. The survey of gay men's sexual risk-taking was expanded, sampling now occurring in sites across London. What was regarded as a small additional amount of funding required for this was provided by Aldbridge Health Authority, despite the now pan-London remit.

CPs in the clinic successfully bid to a charitable body to conduct a study of the attitudes, knowledge and behaviour of individuals from certain African communities, in relation to HIV prevention and risk-taking. It was hoped that this study would inform the development of appropriate SHP provision for these groups, in GUM clinics and other sites.

LUSH developed an RCT evaluation of school-based sex education in collaboration with another university team of researchers. This evaluation is not within the remit of the case study, however, because it did not focus on GUM practice. KGHU staff, together with another university, were involved in a study evaluating an HIV prevention intervention for gay men using gymnasia. The study employed an experimental design involving intervention and control sites. Again, this study is not within the remit of this case study, because it did not focus on GUM practice.

At the time of fieldwork, London HIV commissioners were planning a programme of evaluation of various methods of gay men's HIV prevention. This was informed by the prior work of the second HIV prevention strategy group. Commissioners did not specify any research designs, experimental or otherwise, as requirements for evaluation proposals. There was no suggestion that KGC's or other GUM clinic's services would be prioritised in such an evaluation programme. The perceived lack of interest amongst commissioners in the effectiveness of KGC SHP provision was a matter of complaint by the Clinic Director in his interview.

iii. Audit

Jonathan, the Clinic Director suggested that audit had come to fulfill a different function within KGC than had originally been envisaged. Initially, he suggested, it was hoped that audit could be used to assess the extent to which practice achieved the standards set out in policies, such as those listed in the SHPG, and in specific guidelines. It was now recognised that the huge volume, and diversity, of activities ongoing within KGC meant that audit could not assess even a small fraction of this. Therefore, audit was increasingly being used as a means of addressing topics which practitioners recognised as particularly problematic. Jonathan commented:

Jonathan-Where audit fits in is difficult. I mean, if you think that we have maybe three or four half days of audit each year, and we've got this massive, incredibly diverse service with... far in excess of 100,000 people attending, plus all the other bits and bobs that happen within the service ..., the chances of audit being... a useful exercise in... actually looking at how the service develops is really gone.

Interviewer-It used to be a hope?

Jonathan-Yeah, I think so but... the audit structure has been set up, and we're obliged to undertake audit in our contract... We usually use it as stock taking, and looking at difficult areas.

For example, in the period in, and immediately after, 1996/7, audit was used to agree and assess practice on advising clients about the risks of HIV infection via oral sex, and about genital wart prevention.

A multi-disciplinary audit focused once more on the young gay men's clinic. Some single-disciplinary audits continued to focus on previous themes. Doctors re-audited their documentation of SHP in 1997. Health advisers audited client satisfaction with counselling. CPs and health advisers audited the appropriateness of other groups' referrals to them.

3. Processes of evidence use

a. Pre 1996/7

i. Evidence-based guidelines

Most practitioners, of all groups, appeared keen to become involved in the production and use of evidence-based guidelines. This was viewed as: benefiting the quality of practice; a way for individuals to develop skills useful for their career: and enabling groups to develop attributes viewed as valuable in increasing group's authority. Sue, the Health-Adviser Manager, commented:

We are very conscious, you know, when we stand up and talk about our work, doctors will say, 'What evidence do you have?... Have you done an RCT on that?'... How can you argue your own professional standing if someone says, 'Well..., could you show me why one-to-one health education is useful?' ...[if you can only reply] 'Well we did a little audit'...you know?

The Clinic Guide, the SHPG reports, regional guidelines and various specific guidelines all included some guidance for SHP practice. These documents were produced mainly

by doctors. As noted previously, the SHPG recommendations for practice were developed by a multi-disciplinary group, with a senior clinic doctor and a KGHU manager most closely involved. All were said to be based on a mixture of evidence and expert opinion, but none were referenced. Angela, a medical academic, commented:

> We...write our [guidelines] from what we know of the literature, and circulate them to everyone we can think of, to see if anyone has a different opinion. And, once we've finally got what we think is the best,... that's what our Clinic Guide is.

In general, the guidance for SHP was thought to have some basis in evidence, but less so than was the case for clinical guidelines. George, a medical academic, commented:

> They're constantly updated and reviewed... In terms of advice that you give I don't think it's necessarily based on evidence as much [as]... common sense. Well, actually, that's not true... I can think of things like herpes simplex and wart infections [where]... yes, it is based on evidence, and what we know of epidemiological transmission of infections. So, yes..., to some extent, it is based on evidence.

The guidelines included in the SHPG report were based on a consensus amongst those on the SHPG, and among staff of the clinic more generally, as to what was required, rather than on any systematic review of evidence of what was effective or appropriate. It was suggested that it was very difficult to provide detailed evidence-based guidelines on SHP practice, because the evidence base on effective GUM based interventions was low. Angela commented:

> If you were only to base your health promotion on evidence-based health promotion, you probably wouldn't do very much health promotion. That's one of the difficulties.

Most practitioner groups reported use of guidelines in SHP and other aspects of their work. CPs reported that their work was not greatly influenced by protocols, guidelines or standards, evidence-based or otherwise. Greg, the acting CP-Manager, commented that several were, however, in development.

Many interviewees stressed that practitioners could diverge from the practice set out in

the guidelines if this could be justified. Simon, a junior doctor, commented:

> If you want to break a guideline; [you can] as long as you can give a valid reason for why you've done it. So, I mean, I don't have a problem with them at all... , as long as I can write in the notes and say, 'Well, I haven't followed the guidelines because of this.'

Laura commented on this with regard to HIV prevention guidelines:

> We know this is what we should be doing with every client. And it either happens, or it doesn't, according to time and other pressures, you know. Because, obviously sometimes it won't be appropriate, and a medical problem will be overwhelming.

Individuals from other clinical practitioner groups also commented that judgment was required in applying evidence in any form in the treatment of individuals. It was not, however, necessarily the case that all guidelines left room for such individual discretion. This point is taken up in a later discussion of the work of nurses in the nurse-led women's clinic in 1996/7.

ii. Evidence-Based Medicine Front-line Site

Laura was, as discussed previously, instrumental in developing various processes for the reviewing and using of evidence, mostly in the area of clinical practice, but also SHP. She successfully bid to the regional NHSE office for funding to develop KGC as a so-called Evidence-Based Medicine Frontline Site. Funding enabled doctors to receive training in evidence-based medicine techniques, as well as to search for evidence on a newly installed Medline terminal in the registrars' room in the clinic. This project was viewed as being hindered by various problems which were said by KGC staff to result from poor management at the regional office. Most interviewees, other than clinic and academic doctors, seemed unaware of the project.

Laura also convened a monthly EBM meeting for junior doctors. This largely focused on clinical matters, and on systematic reviews of RCT evidence. Although Laura was sometimes discouraged by the poor attendance of senior doctors, at this meeting, she also

saw the forum as important in developing a critical mass of enthusiasm among junior doctors for EBP. She commented:

I felt very despondent about it for a while. But we have actually changed the culture, so that nobody says anything without knowing what the evidence was... I do actually think the thing that has changed the culture is just getting a critical mass of us trained up...And so...there was me saying evidence-based medicine every other word for a period of time until I moved onto something else, 'cos I got a bit dull. And then... there were kind of 4 or 5 senior people, other than me, who got trained in it. And then ..., by the time ten junior staff had been, actually, there were enough of us who were getting involved with it, that it changed the culture.

iii. Evidence-based interventions

The evidence-base of general SHP was discussed earlier. Some specific SHP interventions were said to be based on evidence. The GG intervention, developed by health advisers and CPs, was said to be based on a certain amount of evidence, from studies of the effectiveness and appropriateness of the models used in other contexts, such as drug and alcohol programmes.

b. During and after 1996/7

i. Evidence-based guidelines

New guidelines for GUM-based practice were being developed by a sub-group within the Medical Society for the Prevention of Venereal Disease, an international medical society. These would provide guidance for clinical practice, with some reference to SHP. Laura was involved in this sub-group. She reported that these guidelines would be explicitly based on, and would cite, research evidence, and would be adopted by the clinic. Guidelines for partner notification produced in 1996 by the Society of Health Advisers in Sexually Transmitted Diseases do not appear to be based on evidence, but rather were based on a consensus of opinion within the society.

A nurse-led service was developed in the women's clinic, encompassing SHP and clinical

activity. Practice was said to be determined by strict guidelines, some of which were based on evidence. Doctors had been heavily involved in the development of these. Jonathan commented:

> We're now..., for the first time, employing nurse practitioners..... I hope what will be happening soon will be that, when you come into the clinic, you'll be seen, evaluated, managed chiefly by nurses, and never see a doctor. That is a... very straightforward situation, following clinical algorithms and so on.., that's going to happen more and more.

John, the Business Manager suggested the protocols used were rigid, leaving little room for inconsistency in practice. This appears to contrast with the general view on medical guidelines, which emphasised room for individual discretion.

ii. Reviews of evidence

A number of reviews of evidence in the area of SHP were conducted by staff at KGC. One review was by a registrar, training in public health medicine, with a placement in LUSH. This project was discussed at the district strategy meeting, and received the approval of the district Director of Public Health. The registrar was being supervised in undertaking the review by the KGC Clinic Director, and by the head of LUSH's epidemiology sub-department. The review used systematic criteria for assessing evidence of the effectiveness of various forms of HIV prevention. The review then went on to compare its conclusions, as to what interventions were effective, with the services that were currently provided at KGC. Both supervisors acknowledged that one motivation behind the project was to emphasise to commissioners that the array of SHP provided at the clinic appeared to reflect what has been identified as most effective so far. This review was not, however, completed.

The second district HIV prevention strategy led by the health authority, but written largely by providers, also included a review of research. This did not use any explicit criteria by which studies were included. It included a variety of research on need, process and other matters, as well as on the effectiveness of interventions. This review did not

appear to have influenced SHP in the clinic.

The commissioner had also undertaken several in-house reviews of HIV prevention research literature, much of this research actually having been commissioned by Burkington or other inner London health authorities. These reviews included research on a variety of topics including, but not limited to, effectiveness, and did not use explicit selection criteria. Roger, the commissioner, said he was comfortable undertaking such reviews, because of his own training in social research. Public health staff were said not to have been involved in producing these reviews. Since the commissioner did not commission SHP in KGC, it is unlikely that these reviews influenced the clinic's provision.

iii. Evidence-based interventions

Several interviewees emphasised that most SHP provided in the clinic was not based on any evidence. John, the Business Manager, commented:

> What isn't so well developed, is [that] our health promotion strategies are lacking in evidence. And, partly, that's because it's hard to evaluate anyway... It's much more fuzzy... And our treatment clinicians are worried about that... We're getting much more into that now, and some of the work that's going on in LUSH is looking much more at that.

This was widely recognised by clinic and academic staff. The commissioner did not address this question directly, limiting his discussion to his belief in KGC's general 'competence' and its commitment to develop evidence on the effectiveness of SHP.

Some interviewees stressed the lack of use of evidence by KGHU in their collaborative work with KGC and more generally. George commented:

> There is still a sort of opinion, or a view, that a lot of health promotion is not based on any evidence at all, and it's based on bright ideas, creativity... I think one of the tensions, historically, between public health and health promotion, is the fact that public health has always been driving the effectiveness agenda; perhaps sometimes with a view to cost-cutting; and health promotion is saying, 'This intervention is

wonderful, this is ground breaking'. But we say, 'Yes, but we need to know if it works, either to support it or to throw it out.' So, there has always been a tension between the two.

KGC possessed some processes for the collation and application of research. Most practitioners said they regularly read journals, this appearing more common among doctors and CPs, and less common among nurses, health advisers and KGHU staff. Specific articles were often circulated within the clinic. Practitioners could attend journal clubs held by LUSH, but few actually did

The GBG intervention was said to be based on a certain amount of prior evidence, including from the GG evaluation. Greg, acting CP-Manager, questioned, however, whether the choice of the intervention was evidence-based:

The selection for that particular item in the first place, that particular package, was not particularly evidence-based. It was based on a relapse prevention model, that works well with changing difficult behaviour in drug and alcohol settings and...[other] risk behaviour settings, but has not actually been worked ..., as far as I'm aware, in terms of sexual health and sexual behaviour... The successes or failures of the GBG project will depend on the fact that ..., good luck really, whether they've chosen the right intervention.

This point was made by others, including a senior medical academic at LUSH.

4. Conclusion

In summary, the GUM clinic and the academic department worked closely together in producing and using research evidence. Many of those involved in the work were influenced by, and were themselves involved in, an international movement asserting the importance of, and developing techniques for, producing and using evidence of effectiveness in particular. There appeared to be a great interest amongst some academic, as well as some clinic, staff in developing the RCT as a technology of evaluating SHP. Some differed from these positions, though mostly this amounted to hesitation about the feasibility of applying experimental designs to the evaluation of some SHP interventions, rather than any more wholesale rejection of RCTs.

There was a wide acknowledgment that, currently, many SHP services in the clinic are not evidence-based, though commissioners did not make this point. The commissioner, though he provided no explicit funding for SHP in the clinic, appeared strongly approving of the SHP and research activities of clinic and academic staff, and accepted their authority in determining these activities. The commissioner appeared to believe that KGC and LUSH were advancing the health authority's interests in undertaking, for example, the GBG evaluation. The data suggests, however, that this was not necessarily the case.

Within the clinic, service and academic doctors appeared mostly to lead processes by which evidence was produced and used. Other practitioners were also involved in these processes, but apparently with less authority. Doctors and other practitioners appeared strongly motivated by ethical and scientific concerns, but also by career and professional advancement imperatives. Managers tended to support, but not lead, these evidence-producing and -using activities. Chapter 9 examines these activities, in terms of the power conditions within which they unfold, and their implications for various interests.

CHAPTER EIGHT: EVIDENCE IN THE GAA CASE STUDY

This chapter, like the last, aims to provide answers to all but the first operational research questions: how, and why, do different organisations and groups define evidence?; how, and why, do different organisations and groups produce evidence?; and how, and why, do different organisations and groups use evidence? This chapter reports findings from the voluntary agency case study. Findings from this, and Chapter 7 inform the overall discussion presented in Chapter 9.

1. Processes of evidence definition

a. The information preferences of the re-gaying movement prior to 1996/7

This section describes how, in developing and implementing community mobilisation, as a model of HIV prevention, and volunteer leadership, as an organisational model, GAA needed to address difficult questions regarding its views on what constituted evidence.

i. The reconciling of research and experience

GAA founders stated that they wished to use both gay men's experiences and research in informing GAA's work. These terms were not explicitly defined in early GAA documentation. According to interviewees, what was meant by 'experience' was an expression, from gay men themselves, as to what HIV prevention needed to do, based on knowledge and skills gained in the course of their everyday lives. Research, on the other hand, was viewed as the product of formal enquiry. Tony, a worker, commented thus on research:

> There's the evidence provided by researchers, who've gone out and asked specific questions, and tailor-made them in a certain way, from which you can get specific answers.

Research was not, however, equated with activity undertaken by academics or other

outsiders, since GAA had itself, from its inception, undertaken activities which it termed research.

Some GAA founders reported that they did not seek to prioritise either experience or research. They considered that, in de-gayed HIV prevention services, research was being used a great deal, and gay men's experiences were being used minimally. They argued that they sought to give special emphasis to experience to act as a corrective to this perceived imbalance. Andrew, a founder and former Chair, commented:

> [Using experience] wasn't meant to be applied as a dogmatic thing; it was meant to be a way of swinging the pendulum the other way, so you emphasise the other end of the pendulum. So, that doesn't mean that the pendulum won't end up settling somewhere in the middle... Everyone else is way at the extreme, of not using the resources of gay men from all walks of life to formulate planning, whereas, obviously, what you need is a mixture of the two.

As well as correcting an imbalance, another rationale behind asserting the centrality of experience was to encourage community mobilisation. It was hoped that this would indicate to gay men that their views would be taken seriously within the organisation.

Some within GAA said they did not make any distinction and saw no real differences between research and experience. Colin, a founder and former Chair, commented:

> If you take a holistic notion of what research can be, research is about observing your environment, and interpreting and analysing what you've discovered through your observations.

Some, for example Robbie and Brian, both workers, saw such differences as being only in terms of the quantity of collected information, rather than the quality. In the period prior to 1996/7, certain processes operating within GAA blurred the distinction between research and experience. New volunteers were encouraged to see the information they possessed through being gay men, such as information on the behaviour and views of their social contacts, as being a sort of research in miniature. GAA founders wrote that the organisation should engage in 'guerilla' research which differed from academic research in being done 'quick and dirty' in an informal manner. GAA volunteers were

also encouraged to assess research conducted outside the organisation in terms of their own experiences. This view was still influential. Keith, LHC Operational Manager, commented:

> What I like about the way GAA takes research, is that when they're presented with a piece of research, they'll look at it, but they won't necessarily take it on face-value, they'll take it, and see whether or not the research reflects their own experiences.

Commissioners recognised GAA's interest in using experience, but were sceptical of its value. William, a commissioner, commented:

> They don't seem to refer to any [evidence], except, you know, their own personal experience. Maybe interesting, but, you know, not very valid.

Commissioners commented that, while experience might provide some useful information for use within providers, they themselves were interested in information collected through formalised monitoring and research. All commissioners reserved the term 'evidence' for this meaning.

ii. The prioritisation of qualitative research in discussion

Although GAA founders embraced the value of both experience and research, some favoured, at least at the level of discussion, certain forms of research over others. A GAA document on research written by a number of founders suggested:

> What styles or methods should we use?... Qualitative methods where possible since the key issues of safer sex are often not easily quantifiable.

Several founders had a background in social science or cultural studies. To these individuals, qualitative research seemed to involve a distinctive way of thinking, which sought to engage with the experiences of research participants, and saw its aims as the presentation of a multitude of points of view. Quantitative research, in contrast, was

viewed as seeking to understand the world in terms of categories developed by the enquirer, and to develop a single authoritative understanding. Quantitative research was associated with a medical view of the world. Neil, a former Research Group Co-ordinator, commented:

> There was an argument that quantitative research was reductionist, reduced gay men's lives into figures... There was some kind of an idea that, through this work, you were hiding, or masking, a real epidemic, somehow... I can remember [one founder] was really heavily into this, that this was a way that medical researchers used to... inoculate themselves, or keep themselves away, from the reality of gay life, and that this was the outsider's way of doing research, was to collect figures.

As well as attempting to distance themselves from the 'sites of suffering' in the HIV epidemic, quantitative researchers were sometimes seen as being implicated in attempts to control the behaviour of those living in the epidemic. Qualitative researchers, in contrast, were often viewed as seeking to close down gaps between researchers and the researched, and empower the latter.

Because these criteria of judgment refer to a consideration of what view of the world research embraces, they are henceforth referred to as philosophical. Another term, pragmatic, is used to refer to those criteria of judgment which address, instead, the feasibility and utility of different forms of research. It is appreciated that these criteria do overlap somewhat, in that judgments of utility will be informed by judgments, for example, of philosophical validity. However, these terms are intended to provide a heuristic to describe participants' views on evidence.

Some research participants suggested that GAA, and others influential in HIV prevention, did not actually have a coherent position on qualitative and quantitative work. Steven, a researcher who has worked with GAA, commented:

> It's my own opinion that a lot of the people, who are key players in HIV prevention in this country, are very inconsistent in their theoretical-ethical... positions when they argue about things. I don't think it's intentional, but... most people, imperceptibly to them and to others, shift between different theoretical groundings.

Steven suggested that, in many cases, GAA founders deployed arguments for and against certain approaches to research, opportunistically, in specific inter-agency conflicts.

Later in GAA's development, those individuals who had framed the early discussion of qualitative and quantitative research had left the organisation, appeared to have changed their views, or both. Newer staff and volunteers, usually from backgrounds other than cultural studies or social sciences, framed the debate in less philosophical terms. In documents, such as a draft guide to research, as well as in interviewees' accounts, qualitative research was viewed simply as research about what people said, or wrote, usually involving relatively small sample sizes, while quantitative research was viewed as research analysing responses to questionnaires, or other simple numerical information, usually involving larger sample sizes. According to Joe, a worker, there was little discussion of research philosophies:

Anything with -ist on the end of, people aren't interested in.

It seems that, as GAA developed, volunteers and workers were often actually suspicious of qualitative data, because of anxieties about possible bias and lack of representiveness of findings. The co-ordinator of GAA's Research Group, himself from a market research, rather than social science, background, sought to overcome this suspicion of qualitative research by stressing its practical utility.

Commissioners suggested that, while they recognised the value of both quantitative and qualitative research, they often did not have the time to read through lengthy qualitative research reports. They argued that what was most useful to them was clear and concise evidence on the needs of their population, and the effectiveness of services in order to inform their investment and dis-investment decisions. It was suggested that this evidence was usually quantitative.

iii. The prioritisation of internal research in discussion

As mentioned above, GAA founders considered that the organisation should engage in

research. This was often termed 'guerilla' or 'quick and dirty' research. Just as qualitative research was initially prioritised in discussion over quantitative research, internal research often became prioritised over external research, sometimes for similar reasons. Neil argued that there was a view that research which distanced itself from gay men arose because the groups who controlled it were not, themselves, gay men:

> So, therefore, if we worked with gay men, and if gay men did the research, all of these silly discourses would be gone; we'd sweep them aside ... We'd all be speaking the same language, and... this was going to facilitate us to do marvellous research work, very quickly.

External research seems to have come to be viewed as the province of academics who, driven by motivations other than preventing HIV transmission, undertake largely irrelevant work. Andrew, a founder and former Chair, wrote in the newsletter:

> Our research is led by volunteers, and so we need only to be guided by what is most urgent... By contrast professional research organisations often have to compromise with what the 'research market' will fund... We're nobody's poodle when it comes to research... Over the last 14 years the majority of HIV research projects have been framed with little or no involvement from community activists. Thus the questions asked have often been academic in the worst sense of the word.

This prioritisation of internal research, by some within GAA, was also motivated by a desire to encourage volunteers to conduct their own research, and so develop their skills. Some interviewees also viewed GAA antipathy to external research as reflecting GAA's general critical, and competitive, stance in relation to other organisations involved in UK HIV prevention. Alex, a commissioner, caricatured the GAA view:

> 'We are GAA, we are the be-all, and end-all, of all knowledge, and experience, and all wonderfulness about gay men.'

Some of these individuals argued that GAA was traditionally much more critical of UK research, than research from countries such as the US and Australia.

Some GAA insiders suggested that some within GAA were actually suspicious of all

research because of its tendency to objectify gay men. Gordon, the Research Group Co-ordinator, commented:

> Some see it as... something which is not appropriate to that, kind of, 'activist' mode, because it's putting people in a test-tube, and that's not what activists do, you don't understand people by doing that.

How these discursive processes affected the production and use of various forms of evidence in the early years of GAA will be considered in later sections.

b. An effectiveness movement in 1996/7

The last chapter discussed the existence of an international effectiveness movement, both in relation to health and social services in general, and in relation to SHP and HIV prevention services. Developments which can be said to have arisen as a result of this movement, such as the US study evaluating gay men's HIV prevention, and the EPI Centre review of the effectiveness of HIV prevention, were also cited by interviewees from the GAA case study as influential, though often in ways which differed from those in KGC.

An effectiveness 'movement' was apparent within GAA. This comprised a number of different individuals with a diversity of concerns and purposes, united in their desire to stress the importance of GAA and other HIV prevention organisations evaluating the effectiveness of their services, in terms of their impact on the risk-taking behaviour of gay men.

Some of those involved in these processes were founders or other 'elite' staff or volunteers at GAA. They stressed a new emphasis on effectiveness to be a continuation of earlier re-gaying efforts. It was suggested that, whereas earlier campaigns had been directed at ensuring that gay men had their fair share of properly funded HIV prevention services, newer campaigns should be directed at ensuring that gay men had their fair

share of effective HIV prevention services. One founder wrote in the newsletter in 1995:

It's all very well demanding more money for gay men's work, but as I pointed out in [a previous article] more money doesn't necessarily equal fewer infections. It may just be money down the drain... Until recently the success of prevention work has been judged according to the number of people it reached and whether people liked it or thought its message relevant to them... All prevention projects, not just GAA, need to be looking at their effects on behaviour.

Thus, calls for a focus on effectiveness were phrased in the same 'rights' framework as the earlier calls for re-gaying had been. The effectiveness movement appeared to have been propagated within GAA by its elite. Tom, a director, suggested in answer to the following question:

Interviewer: Has GAA become more focused on what works?
Tom: I think it definitely has, top-down it has. I'm not sure about bottom-up. Graham and some of the Directors, some of the co-ordinators, and some of the staff.

However, there were, according to some accounts, signs that the arguments, for and against, were to some extent being taken up by GAA's rank and file volunteers and by workers. With one or two exceptions, most workers and volunteers seemed aware of the debate and could, for example, give sophisticated descriptions of RCT methods.

A number of commissioners called for a new focus on effectiveness. Some of these couched their arguments in similar terms to those described above. This may have reflected the fact that these individuals did not merely operate as commissioners, but also as 'pundits' within HIV policy circles; they wrote articles in the gay press and were involved in informal, as well as formal, discussions with GAA members and others. Mark, a commissioning adviser, suggested the effectiveness agenda was an extension of re-gaying:

I would like to see stuff which is more than re-gaying, which is more about... trying to rationalise some of the work which has been done around gay men... Getting some rigorous evaluation, so it's not just throwing money at a bid or at a target group, but you have something which is worth throwing money at.

Arguments from commissioners were sometimes also framed in other ways, depending on context. Within health authority internal documents, they were often couched in terms of: the need to achieve most health gain from health authority spend; the need to get value for money on investments; or the need to inform future rationing of HIV prevention provision. Commissioners saw their role as ultimately being one concerned with prioritising services on the basis of effectiveness and cost. Graham, the General Manager, commented:

> Commissioners have a need for evidence which is quantifiable, and which will tell them what to spend more on, and what to spend less on, what works, and, if we want to prevent 'x' units of HIV, what must we buy... The best intentioned of them have a view, that evidence will tell you what works, and what doesn't, and you should fund more of what works, and less of what doesn't.

Commissioners acknowledged they needed evidence on other topics, as well as effectiveness, but saw effectiveness evidence as particularly important, given their role as investors. Mark acknowledged that, currently, HIV prevention was relatively well funded, but that this might not always be so:

> It's looking ahead, so that, in future, we'll be able to say, 'Well, actually, we do need to spend this money and we've done our utmost to get this kind of evaluation, this is how far we've got'; which is probably more than other sorts of health promotion, we're trying to be in there first.

Commissioners suggested that they needed, at least, to attempt to evaluate the effectiveness of HIV prevention. Thus, commissioners were influenced by the rationing debates occurring more generally within health services.

GAA personnel and commissioners appeared to differ as to their scepticism about the effectiveness of GAA services. Commissioners frequently expressed considerable scepticism, whereas those within GAA less frequently did so. Some GAA staff and volunteers called for evaluations of effectiveness, whilst still expressing an assumption that services were effective. Mark suggested it was hard for GAA to be sceptical because of its ideological belief that activities developed in the gay community were, per se,

effective:

These people, who work within GAA, are coming up from within the community, they are all community activists, so what they're doing must by definition be right... You can't criticise it, because, if you do, you are being intrinsically homophobic.

Other rationales appeared to be implicit in some participants' enthusiasm for a focus on effectiveness. Some commissioners appeared to seek to emphasise evidence of effectiveness because they sought to distinguish their approach as health authority commissioners from the regional funders, who had often been their predecessors, and who had reportedly been much more focused on examining the process rather than the outcomes of HIV prevention.

Some participants suggested that commissioners' interest in evidence of effectiveness was actually more superficial than some of these points might suggest. Neil replied thus to the following question:

Interviewer: What do commissioners want, in terms of evidence?

Neil: To cover their backs.

Interviewer: Against what?

Neil: Against the criticism that they're funding any old rope... Commissioners want any evidence they can get their hands on, and it doesn't matter, and it really is almost like a tick-box.

None of those who asserted the importance of producing and using evidence of effectiveness restricted their definition of evidence to that relating to effectiveness. All appeared to believe that evidence could, and should, also focus on other facets of a service, such as its quality, acceptability and appropriateness.

There were some signs of a reaction against the effectiveness movement or movements. Some within GAA did not seek to place special emphasis on evidence of effectiveness. These individuals tended not to be sceptical about the effectiveness of GAA's services.

Keith commented:

I think we're comfortable with the idea that it's effective.

Some were suspicious of the motivations behind calls for investigation of GAA's effectiveness, seeing it as a means for commissioners to de-fund GAA or achieve a negotiating advantage over GAA. Keith commented:

I'd say, from my experience, that you have to know how evaluation is being used, and whether, or not, it's going to be used as a way to improve your work, or to get you over a barrel in funding rounds.

William, however, thought that insecurity about funding sometimes functioned as an excuse:

There's not been a single cut in gay men's funding for the last 4 years. It's been a growth area. So, to what extent is there competition? It's a load of old tosh, and I think some of the providers hide behind the fear and rhetoric of the market.

There was conflict and uncertainty as to the methods which were required to produce evidence on effectiveness. Disagreement often centred on the pros and cons of the RCT. Within this case study, the term 'RCT' appeared to be used to refer both to experimental designs involving randomisation, as well as to those involving matching. Other terms, such as 'prospective study with control group', 'experimental evaluation' and 'controlled intervention' were also occasionally used.

Some commissioners stressed that attempts, at least, must be made to evaluate HIV prevention using RCTs. It was suggested that the public health staff employed in health authorities viewed these as the most rigorous forms of evaluations, and that, if the long-term security of health authority investment in HIV prevention was to be assured, it needed to be evaluated to the standard that public health staff required. Some commissioners shared this view, and considered that evidence of effectiveness could only reliably be gathered via the use of RCTs. Others, though asserting the value of the RCT,

also acknowledged that sometimes this method was not feasible, and that, in these cases, other methods should be used. Some commissioners appeared to have repeatedly changed their minds on this issue, initially being critical of RCTs, then endorsing them enthusiastically, and then viewing them as only one of a number of useful methods. Others, especially within GAA, did not consider that evidence on effectiveness could only be produced via the use of RCTs, and believed that a variety of methods could be used, such as single group longitudinal studies, or qualitative studies.

Some commissioners appeared to view RCTs as a symbol of rigour, and providers' anxiety about, or opposition to, them as a sign of lack of rigour. Graham suggested commissioners' views on RCTs could sometimes take on a symbolic quality:

> The presence of a control group became almost like a talisman; if there was no control group, then the evaluation could not be sound. The simple existence of any kind of control group, anything, would transform it from being unacceptable to acceptable.

A magazine article by, William, a commissioner, did appear to suggest RCTs as a symbol of rigour, and provider mis-givings about them as a sign of lack of rigour:

> The very mention of the words evaluation, methodology, random, control or trial can reduce the most dedicated HIV prevention worker to a whingeing mass of indifference and excuses.

c. An evidence-based practice movement in 1996/7

This was a movement, again both from within GAA and outside, highlighting the importance of basing practice on evidence from research. Those involved tended to distinguish between evidence from research and information from other sources. In some ways, it ran in opposition to the earlier concern with reconciling research and experience, not because it sought to de-prioritise experience per se, but because it sought to make a distinction between experience and research. Gordon, the Research Group Co-ordinator,

writing on the importance of undertaking pre-testing, exemplified this distinction:

> Many of our assumptions are based on our own experiences as gay men, or are more often based on what we 'feel' to be true - these feelings aren't always wrong but equally they aren't always right.

This was seen by some as a another attempt to redress a difficult balancing act between using experience and research. In the accounts of those asserting the need to base practice on evidence, the term 'evidence' was not restricted to that of effectiveness, nor was it restricted to evidence from experimental studies. Calls for EBP included, for example, using evidence of appropriateness and acceptability from pre-testing, in the development of educational leaflets.

A number of factors were important in providing a context for the development of this movement within GAA. One of these was the re-definition of volunteer leadership. Many individuals in GAA, most noticeably managers and directors, had become dissatisfied with how volunteer leadership had developed, particularly with volunteers basing projects on their own views and experiences, with little reference to research, or to the knowledge and skills possessed by GAA workers. Calls for EBP were often linked to calls for a modification of how volunteer leadership worked.

The movement to encourage EBP also fell within more general moves within GAA to use new forms of language. GAA directors and managers stressed that the organisation's funding was dependent on creating an impression of competence and professionalism with commissioners. Language was seen as an important tool in these attempts. In the period leading up to the end of the LCH2 contract, the term 'evidence-based practice' began to pepper almost every document produced within GAA.

GAA workers and volunteers also acknowledged that another influence on the rise of discussion of EBP was pressure and persuasion from commissioners. Commissioners, like GAA's own elite, appeared to be acting in response to concern with how volunteer leadership was developing. Commissioners were also prompted to action by their desire to expect the same of the providers with whom they contracted as might their colleagues

in other areas of commissioning. Commissioners also appeared to see EBP as symbolic of a rigorous approach to the provision of services, and so sought to encourage this within a provider they saw as lacking in rigour. Alex acknowledged that commissioners often used the term as a rhetorical tool, when attempting to exert their authority. Commissioners, like GAA's own elite, appeared, in their calls for EBP, to view evidence as referring to evidence from research, and, similarly, did not appear to see the term as referring only to evidence of effectiveness, or from experimental studies.

Many within GAA welcomed calls from commissioners for EBP. For some, commissioners appeared to be the leading advocates of EBP. This made one GAA director question his assumptions about the need for GAA to resist being steered by health authorities.

Others dismissed the idea that EBP was a new movement within GAA, arguing that using evidence had always been part of GAA's philosophy and practice. Some continuity was apparent in GAA discussion. A document produced by the organisation in 1995 had, for example, stated:

A key feature of LHC is the extent of linkage within the project between prevention and research.

Colin, a founder and former Chair, even suggested (wrongly) that the phrase might have been first coined within GAA:

I think it sounds suspiciously like a Graham-ism, evidence-based practice.

Use of the term 'Graham-ism' here suggested that the General Manager might have been the originator of the phrase 'evidence-based practice.'

2. Processes of evidence production

a. Production prior to 1996/7

Evidence production in this period can be considered according to a number of categories, with some overlap between them. Before setting these out, the general development of the Research Group is described.

i. Research Group

The Research Group was instituted by the founders of GAA, along with the other groups, listed in Chapter 5. Several of the original members of the group, as mentioned earlier, had a background in cultural studies or social science. The first co-ordinator was a professional social researcher, based at a university and undertaking HIV prevention research. Subsequently, a small number of other volunteers became involved, including one other professional social researcher. As well as the co-ordinator, others influential in the group were: GAA's first Chair; a founder who worked as an academic; and a founder who worked as a journalist, with a particular interest in the epidemiology of HIV. Neil, the first co-ordinator suggested there was not, initially, an over-abundance of research skills and experience within the group.

Neil reported that the group was beset by tensions from early on, with, as he perceived it, some members seeking to use research as a resource in campaigning, with little regard for rigorous methods or open enquiry. Others argued that tensions arose mainly between group-members who advocated what was regarded as 'academic' methods of enquiry, and those who favoured 'quick' and 'pragmatic' research. These interviewees used the term academic to refer to unnecessarily formal, jargonistic and not readily useful research.

Research Group failed to attract interest from the great body of new volunteers, few became regular participants, and those who helped in specific projects often found the work dull. The first co-ordinator resigned after about eighteen months, to be replaced by

a volunteer, with no previous experience of research. The group collapsed soon after this point, as involvement fell to virtually nothing.

The group was re-instituted in 1995. Several of the founders, as well as some newer directors, were involved. A new co-ordinator, Gordon, with a background in market research, and only three months' involvement with GAA, was appointed. A worker, Tim, was shared with Training Group. New projects were initiated, a prime aim being to mobilise the interest of volunteers. These projects are discussed later.

ii. Monitoring

The LHC1 contract, which formed the basis for most of GAA's work from April 1993 until March 1996, included a monitoring section, said to have been drafted largely by the provider. The collection of information on audiences reached, and methods used, was limited, with very little setting of targets. However, this contrasted with the lack of any monitoring required by commissioners of King George's Clinic's HIV prevention activities.

iii. Re-gaying research

A number of research projects aimed to contribute towards campaigning about re-gaying. Some of these projects demonstrated inequities in the funding of HIV prevention services for gay men compared to other groups (1992/3). Others sought to highlight a lack of rigour in the planning and provision of gay men's HIV prevention by other agencies. One study, for example, criticised the way in which various statutory agencies undertook needs assessment (1995), and another study criticised the standard of practice in GUM clinics (1993/4). Another study demonstrated the difficulty gay men had in obtaining strong condoms from a variety of NHS and commercial sources (1993/4). These studies were not explicitly labelled as campaigning projects. However, most of those interviewed were in no doubt as to their place within GAA's early campaigns for a re-orientation of funding towards gay men's HIV prevention, and for a re-assessment as to

how gay men's HIV prevention should be planned and provided. A GAA internal document, of the time, suggested that one of the purposes of research was to 'put issues on the agenda'. Some also viewed these projects as attempting to create a sense of anger that would 'mobilise' gay men, who were involved in doing the research or who read about it in the gay press. This was, again, not an explicit aim. Anthony, a commissioner, commented:

> I think the point about what benefit does the research have,... 50% of it was about politicisation and mobilisation of the communities who were out there doing the research.

The projects were led by a small number of founders, in collaboration with a small number of workers and volunteers. Some of the projects were done in association with other agencies. This reflected a view, reported in interviews, that, especially in its early years, GAA had to make contacts with wider HIV policy networks, in order to lobby for change.

Despite the priority given to qualitative research in discussion, these projects employed a range of different forms of evidence. This included numerical data, for example on patterns of funding and availability of condoms, as well as verbal account-based data, for example on the development of gay men's HIV prevention needs assessments by health authorities. These forms of evidence were viewed, respectively, as quantitative and qualitative. The apparent comfort that GAA had in using quantitative evidence, in addition to qualitative evidence, its avowed favourite, might reflect the fact that these studies did not generally focus on gay men's lives, but rather on funding streams and the work of professionals. This might have meant GAA was less worried about using methods which were regarded, as discussed earlier, as having a propensity to distance the researcher from the researched. However, GAA's use of quantitative evidence might also have resulted from a pragmatism regarding the use of information in campaigning, which ran against, and surmounted, any 'philosophical' preferences.

Some GAA insiders suggested that some within GAA undertook research to validate their existing views and inform existing campaigns. Tom, a director, commented thus about

one GAA founder:

Tom: He knows exactly what he wants to show. And so many other people must have said this, it's shocking. But what he wants to show is usually right, but it's politically motivated, not research motivated. And then he makes it look like research, so it's politically acceptable.
Interviewer: Does that mean he cuts corners?
Tom: Yes, well, he makes things up as he goes along, basically. I'll give you an example. This is in a more recent questionnaire I developed with him, working on a couple of needs assessments... The questions would be things like, 'Where do you get most of your support?', and the choices would be: 'Gay friends; gay colleagues; gay bars; gay cat on the corner; stuff like that'. So the conclusion would be: 'Gay men get lots of support from other gay people'.

Similar suggestions were made in several other interviews.

Some of the 're-gaying' studies appeared to contribute to increasing the prominence of debates about re-gaying. A study of the funding of gay men's HIV prevention by different authorities appeared particularly successful in this regard. Some, from outside GAA as well as within, concluded that this research had been important in influencing health authority resource re-orientation, as well as DoH policy on targeting. Andrew, a founder and former Chair, wrote in the GAA newsletter:

When de-gaying was at its height and neglect of gay men was greatest, our most powerful tool for changing the agenda was counting and comparing numbers.

The study of condom availability was said by some research participants to have significantly contributed to campaigning for the free distribution of strong condoms to gay men. Projects were also said to have been important in influencing the RHAs' approaches to funding gay men's HIV prevention. Other projects were said to have only provoked irritation on the part of other agencies. The research on GUM clinics, undertaken using covert participant observation, without the co-operation of GUM clinics, was cited by a large number of those interviewed as a case in point. The extent to which these projects mobilised gay men to volunteer for GAA is not clear, although it is unlikely that they inspired many gay men to become involved in research, given

Research Group's small volunteer base.

iv. Research on risk-taking behaviour

GAA undertook, collaboratively or alone, a number of studies of risk-taking behaviour. These examined behaviour amongst: gay men involved in the sado-masochistic 'scene' (1993/4), gay men attending an annual lesbian and gay festival (1993/4); men cruising and socialising on a heath in inner London (annually from 1993/4); and UK gay men holidaying in European resorts (1995/6). These projects involved GAA founders and others, involved in Research Group.

A number of factors appeared to prompt these projects. One motivation behind the research was to identify which sub-groups of gay men were most in need of HIV prevention, and to inform the development of appropriate services. Furthermore, the research could be used to demonstrate the need for the services that GAA provided to funders and potential funders. It was also suggested by some interviewees that some of these studies were partly motivated by a desire to validate existing preconceptions. It was argued by one participant that, in involving itself in the survey conducted at the lesbian and gay festival, GAA sought to demonstrate that the sexual behaviour of young gay men was more risky than that of older gay men. GAA reportedly hoped to use evidence from the survey in lobbying for sex education for gay teenagers. Another interviewee suggested that the study of gay men involved in sado-masochistic sex was intended to demonstrate, and celebrate, this group's success in minimising its risk-taking.

Neil, the former Research Group Co-ordinator, suggested that GAA engaged in so much of this behavioural research because of a perception that very little of this research had already been conducted. This individual commented that, towards the end of his involvement with GAA, he began reading a great many journal articles, and making contacts with other researchers, and realised how much high quality behavioural research already existed.

Despite the prioritisation given to qualitative research in discussion, these studies again used largely quantitative data, namely analysis of numerical information drawn from responses to fixed response questionnaire components. It was suggested that this reflected, once again, a pragmatic view that this form of research would be more feasible and useful.

The impact of the research on service development is difficult to gauge. Those interviewed suggested that the research on the heath had been useful in developing work at this site. A voluntary sector commissioning adviser suggested that the RHAs had been impressed by these studies, their serving to legitimate GAA's expert authority.

v. Internal evaluation

GAA undertook a number of internal evaluations of its services prior to 1996/7. These included evaluation of: a sado-masochistic workshop; a bondage skills course; a recruitment campaign; and a cruising skills workshops. These evaluations were conducted using formal methods, in that evaluators followed some kind of written protocol. They mostly involved assessment of participants' views on the acceptability and appropriateness of the services, and were viewed as process evaluations. Both quantitative and qualitative methods were used. None of these evaluations involved control groups. The evaluations were undertaken mainly by the workers supporting these projects. Although the volunteers supported these evaluations, workers reported that they were less interested in evaluation than the workers, and minimally involved in undertaking the evaluations.

Some projects were subject to informal (ie. lacking in any written protocols) evaluation. This involved discussion of the success or failure of projects involving GAA staff, volunteers, and friends on the gay scene. Written materials and media campaigns, as well as of GAA's volunteer induction programme, were subject to informal evaluation. Various managers and workers commented on the value of informal evaluation.

As mentioned earlier, there was a lack of scepticism about the effectiveness of GAA projects amongst many GAA workers and volunteers. Rather than evaluation examining *whether* a service was effective, some GAA participants emphasised that evaluations were a means: to show that services did work; to discover which elements worked better than others; or to explore why projects were effective. It was suggested that negative evaluation findings demotivated volunteers more than would be the case with a salaried workforce. Tony, a worker, commented:

> You need results, and a sense of achievement. And when people stop feeling that, they feel demotivated, especially since they're giving their free time. It's alright if you've got a wage... if you've got people coming in to volunteer, they need something quick, so they can say, 'I'm achieving something, I'm affecting the epidemic',... to retain their interest and involvement in the organisation.

The evaluations were generally viewed as contributing to the ongoing development of projects, rather than as a means of identifying which services would be repeated and which would be abandoned. A few GAA staff and volunteers used the terms formative and summative, respectively, to describe these two forms of evaluation. No services were actually discontinued as a result of poor evaluation findings. William, a commissioner, commented critically upon this:

> They tend to do research, but they're not prepared to look critically at what happens, or what they do, so you would never get a piece of research which said, 'God, this was complete crap, and why are we doing it?'

vi. External evaluation

As well as these internal evaluations, GAA was subject to an external evaluation of the LHC1 project. This was a condition of Region funding the work. Initially, GAA founders pressed for an outcome evaluation of this work, suggesting that LHC1 be judged in terms of its success in reducing the incidence of HIV amongst gay men in London. This was judged unfeasible by all the researchers tendering for the project, who offered process evaluations and some assessment of non-behavioural outcomes.

The Public Policy Research Unit (PPRU), based in a university, was commissioned to undertake the evaluation. One researcher working at PPRU was involved in GAA's Research Group, and reduced his involvement in the organisation, as a result of concerns that this involvement would be perceived as compromising his role as an external evaluator. PPRU developed an evaluation approach focusing mainly on process, which regional commissioners, it was suggested, did not greatly influence, but with which they were satisfied. Participants did not indicate any role for GAA in the development of evaluation methods. After initial tensions, it was said that PPRU and GAA developed close working relations.

An evaluation report, which focused on a number of specific interventions, on volunteer recruitment, and on staff's and volunteers' overall views of GAA, was produced in 1996. By this time, the funding of LHC1, and its evaluation, had been devolved to health authority commissioners. These were said to be unenthusiastic about the report, particularly its great volume and its focus on process. Commissioners said the report did not influence their activity.

A PPRU researcher suggested that these health authority commissioners were, unlike their regional predecessors, uninterested in process and in developing GAA, and more interested in outcomes and in judging whether GAA was effective. Some of these commissioners, in interview, suggested that process was largely the concern of providers, while outcomes were more properly in commissioners' realm.

Within GAA, some directors and co-ordinators did not read the report, but said they had been influenced by findings reported back to them in the course of the evaluation. GAA managers suggested the evaluation had been useful. One area which was said to have been modified as a result of the evaluation was the recruitment of volunteers. The report was also used to defend GAA against accusations, from a national newspaper, of mis-spending public funds. Robbie, a worker, commented:

[The newspaper] said, 'Some groups have been accused of running workshops to help gay men have a better sex life, rather than to prevent AIDS'... Our very kind of boring rebuttal [was] this is what we do,

here's the evidence. We used evidence in there, quoted... the PPRU evaluation ..., completely paraphrasing that, 'Workshops that are either community-based, or something else, are best placed to deliver skills and bla, bla, bla.'

b. Production in 1996/7

i. Growth of the Research Group

Research Group developed in the course of 1996/7, from a group which involved the co-ordinator and a half-time worker, to one which involved a small but relatively active group of volunteers. Its co-ordinator invested considerable time in the group, while experiencing a period without salaried employment. A number of studies and other projects raised the profile of Research Group within GAA.

Tom, one of those involved in the group, produced a report assessing the problems GAA encountered in undertaking research. This report concluded that: projects frequently were left incomplete due to a dissipation of volunteer interest; many projects were completed, but were not written up, because volunteers and workers saw their utility as being limited to their own cell, rather than more generally; and volunteers had more problems completing interview-based, as opposed to questionnaire-based, studies, because of the greater mass of data and difficulty of analysis of the former. Tom also produced a guide for volunteers engaged in research. This guide was never actually published, reportedly because of other projects taking priority.

ii. Monitoring

The LHC2 contract included more detailed monitoring requirements than had LHC1. William, a commissioner, commented thus about the detailed targets in the LHC2 contract:

It was, quite definitely, part of an continuum to move from,... 'Here, have half a million love, and, as long as you do something nice, that will be lovely',... through to something that was actually fairly descriptive

as to what they were supposed to do, had volumes and dates attached... It would mean that they would have contractual outputs, that they would have to deliver.

Commissioners were especially keen to ensure the new contract included the setting and the monitoring of targets regarding the age, ethnicity, and HIV status of service users, since commissioners feared that those gay men whom GAA involved, or otherwise contacted, were not representative of gay men overall.

The monitoring requirements, like the rest of the LHC2 contract, were said, by commissioners and GAA staff, to have been developed consensually. GAA interviewees also suggested the contract had generally been left vague enough to give GAA some autonomy in the detailed planning and delivery of services. Commissioners, however, said they occasionally used some of the targets specified in contracts to enforce GAA activity. William commented:

To do anything outside of central London, they always had to be contractually forced. So, we were always saying, 'You have to do one in each health authority', and they would always whinge about it.

iii. Continuation of prior trends in research

Commissioners suggested they were not generally impressed with GAA research. However, they continued to fund GAA to do research because the LHC1 contract had included research, and commissioners did not wish to enter into conflict on this issue. Research was also seen as useful in developing the skills of volunteers. The new LHC2 contract attempted, however, to provide some specification of what research GAA should do, including: small in-year 'reflective' (ie. informal) evaluations; four written evaluations; two needs assessments; an anonymous volunteer survey; the distribution of contact monitoring cards; and an audit of volunteers to be done internally by GAA. The topics chosen and methods used were otherwise left to GAA, largely being decided by the Research Group.

GAA continued to undertake projects aiming to criticise what they regarded as 'de-gayed'

services, and to campaign for 're-gayed' services. One project aimed to highlight the inadequacy of HIV prevention for gay men in prisons. This research, planned in collaboration with an academic department, was, however, aborted just prior to sending out questionnaires, when it was discovered that it replicated work already done by another agency. Another project was intended to survey the anti-homophobia policies of other HIV/AIDS provider agencies. This had, however, stalled and was being re-launched.

GAA also continued to undertake research on risk behaviour amongst gay men. As well as further studies being conducted on the heath, GAA initiated a larger study examining the views and activities of gay men in London, and another city in southern England, regarding HIV risks. This research was initiated by the Research Group worker, because he did not accept the view, commonly expressed in HIV policy circles, that gay men have a well developed knowledge of the riskiness of different forms of behaviour, but require further support in acting on this knowledge. Although the research was initially only intended to focus on knowledge amongst gay men in London, its remit grew to encompass both behaviour and a sample of gay men in the other city. This expansion, it was suggested by the worker, was only partially planned and reflected a common pattern within GAA, whereby the enthusiasm of volunteers and workers sets projects off in a variety of directions. Tom commented on the frequent un-planned nature of projects:

> With many of the groups, it was just, 'Well, let's do a questionnaire on 50 people, and OK, so what do you want to find out? Er, well, I'm not really sure.'

The project differed from some earlier pieces of GAA research, in reviewing existing literature prior to data collection. The research was said to be proceeding slowly, as a result of a lull in volunteer interest. Other research on risk-taking included: a study on gay men's experience of unsafe sex, using unstructured interviews; and a project which aimed to recruit sexually active gay men to interview their partners on sexual behaviour and risk-taking.

GAA continued to undertake internal evaluations. These were largely initiated by staff

and volunteers, belonging to the rank and file, rather than the elite of the organisation. One evaluation focused on cards that GAA distributed in bars, and that men could use to note the telephone numbers of potential sexual partners, and which bore HIV prevention information. Another focused on a workshop in which gay men could discuss relationships and HIV prevention. Both of these, like earlier internal evaluations, focused mainly on process, and were intended primarily to inform project development, rather than project prioritisation. Both evaluations did, however, also make some attempt to assess the impact of the interventions on gay men. The card evaluation employed a questionnaire asking gay men whether the card had prompted them to initiate negotiation of safer sex with prospective partners. The relationships workshop used interviews to assess whether the sessions had affected communication within men's relationships. Thus, once again GAA research utilised a mixture of quantitative and qualitative data. This utilisation now occurred within a context, wherein prioritising qualitative data, even at the level of discussion, was absent.

The card evaluation concluded that, while these resources were viewed as acceptable and appropriate to gay men, they had no apparent effect on the initiation of safer sex. There was some talk, within GAA, of censoring this finding. Eventually, however, it was included in the evaluation report, but given much less prominence than the more positive conclusions. GAA participants concluded that a card alone was unlikely to have any impact on risk-taking behaviour, and so largely dismissed the negative finding. This conclusion appears to beg the question of why a question about impact on behaviour was included at all. As well as these predominantly process evaluations, GAA undertook an outcome evaluation of a group-work intervention. This is discussed in a separate section, since it represented a departure from prior trends.

A number of new trends emerged in research in 1996/7.

iv. Pre-testing

Prior to 1996/7, the acceptability and appropriateness of only a few materials, such as the

cards mentioned earlier, had been pre-tested on gay men not involved in GAA. Although a guide to project-planning, produced by GAA's founders, mentioned pre-testing, volunteers were not required to follow this guide. The amount of pre-testing appeared to increase following the Research Group Co-ordinator writing in the newsletter about the importance of this activity (discussed earlier). Some projects were not pre-tested, and some were pre-tested on gay men involved in GAA. Robbie, a founder and worker, commented:

We do tend to pre-test on other volunteers who are not involved in the project, to see what they say.

Commissioners continued to express concerns about the lack of pre-testing. The minutes of a contract monitoring meeting in 1997 stated:

Commissioners generally expressed concerns on the lack of piloting, and directed GAA that this is an area that they wish to see strengthened - particularly piloting using 'real' gay men.

v. Research on the structure of gay men's communities

Two projects sought to construct a picture of gay men's communities in terms of residence, socialising and 'sexual mixing'. One, conducted between 1994 and 1996, looked at gay men's mobility within London. The other aimed to undertake a systematic census of gay men in the UK, investigating demographic, social and behavioural characteristics. Both projects were initiated by a founder and former Chair of GAA who continued to volunteer within the Research and other groups. Both projects were taken forward by others within GAA, the mobility study by a volunteer who went on to become a GAA worker, and the Census by the Research Group Co-ordinator and worker.

A considerable motivation for both projects was to instill, amongst volunteers, an interest in doing research and in joining Research Group. Gordon, the co-ordinator, stressed in a newsletter article, and in his interview, the lack of research done on gay men's communities, compared to the heterosexual population, and the fascination that doing this

research should hold for gay men:

One of the most exciting things about research into gay men is that so little basic information currently exists - until a few years ago very little was known about us, even by ourselves.

The mobility project appeared to have been more successful than the census project in stimulating volunteers.

As well as mobilising volunteers, both projects had other rationales. The project on mobility was said to have been informed by a desire to demonstrate the irrationality of commissioning gay men's HIV prevention on a district, rather than a pan-London, basis. Since gay men were so mobile in terms of residence and socialising, it was argued, HIV prevention should be co-ordinated across London districts. Robbie commented:

Robbie: I think [that project] was done to prove a point... It was done to be of use to GAA, for our funding battles.
Interviewer: It was that explicit?
Robbie: No, no it wasn't that explicit, but that's definitely what it was for.

The results were indeed used to criticise the existing funding arrangements. Thus, as well as exemplifying a new interest in examining gay men's communities, the research also exemplified a continued commitment to using research in campaigning. The Census project was hoped to provide data which would inform national targeting of gay men's HIV prevention, and develop appropriate services.

The mobility project did involve, and the Census project aimed to involve, mainly quantitative research. Quantitative research, it was suggested both by GAA members and others, was chosen because it was seen as appropriate to the projects in question, but also because it was actually viewed as easier to collect and analyse, than was qualitative data. As mentioned above, GAA had encountered more problems completing interview-based projects than questionnaire-based projects.

While the Census project had progressed only to the stage of seeking external funding, the mobility study was completed and published. This study was regarded, within GAA, as a triumph in that volunteers' involvement was maintained, data were collected and analysed, and positive feedback from commissioners and external researchers was received. Commissioners, however, suggested, in interviews, that the research would not encourage them to develop more pan-London commissioning. Although commissioners were impressed with the presentation and contents of the report, they were generally sceptical about the quality of provider research. Commissioners also suspected GAA tended to seek to produce the data which supported its beliefs and aims. Anthony, a commissioner, commented:

> Now, this could just be me, but I distrust research done by a provider agency. I have to confess, I distrust that, because of the clear organisational interests involved.

Commissioners also pointed out that their failure to maintain and develop pan-London commissioning did not result from their lack of awareness of gay men's mobility, but rather from the organisational difficulties which hampered inter-district collaboration, and which were not addressed by the research. William commented:

> The pan-London thing... It seems to be utterly rational and straightforward that one has to commission things on a city-wide basis for a population as mobile as gay men... I don't see why we have to have reports coming out of our arse to demonstrate that to some commissioner... Providers, in their wildest fantasies, they will never realise what a nightmare it is working with 7 or 12 commissioners, all of whom have got opinions of their own, local views of their own, chief executives who don't support them.

vi. Internal outcome evaluation

In 1996/7, GAA developed what was intended to be an RCT evaluation of a group-work intervention. The General Manager initiated the project, in his role as a volunteer. This aroused the irritation of some within GAA, both because of their disapproval of his using his volunteer membership as a means of prioritising a favoured project, but also because of certain specific objections to the project which are discussed below. Joe, a worker,

commented:

I do sometimes think that [the General Manager] can be a bit pushy about getting his pet projects. Like, [the group-work] wouldn't have happened... all the workers know that, if you put a volunteer hat on, you can get things done, and that's what [the General Manager's] done with it, you know, and it's a bit fishy.

The manager sought to initiate the project as a response to the heated debate, ongoing in HIV policy circles at this time, on the feasibility, utility and ethical acceptability of RCTs, which is discussed above. The manager sought to develop an RCT to break what he perceived as a dead-lock, concerning their merits. Graham himself commented:

G: It seemed, to me, the debate was a bit, 'Oh no we won't, oh yes you will, oh no we won't, oh yes you will', kind of... So, partly, I thought we could break up that log jam a bit, and, also, do some interesting work on the way, if you see what I mean. Let's take a chance, and start a dialogue, and go at this in partnership, bearing in mind that this is the intervention which is best suited to this kind of evaluation, we see how it goes from here ...
C: Was one of the points of the RCT, to show the limitations of controlled trials?
G: Yeah, yeah, erm but partly to discover for ourselves as well.

Though the interviewer's question here seems somewhat leading, this topic had already been raised by Graham prior to the interview. Graham's aim appeared to be to demonstrate that GAA was willing to attempt an RCT, and that any objections GAA had to RCTs were based on a pragmatic and empirical consideration of utility and feasibility, rather than more outright hostility to RCTs.

GAA interviewees were divided on their views of the study. Some shared the manager's interest in exploring the feasibility and utility of RCTs. Some did so, but were convinced that RCTs' feasibility and utility were extremely limited. Several of these suspected the manager's prime motivation was to demonstrate this to commissioners. Keith, the LHC Operational Manager, commented:

It's Graham's baby, and I spoke to him beforehand about it, and I was going, 'You can't do this, you can't do this, it just won't work'. But I think he understood that, he understood what the problems were before. So, knowing what the problems were but doing it anyway, I can't say that he was doing it on purpose, you

know, but it wouldn't be a complete surprise.

Funding for the intervention came from a national HIV prevention project and from a gay magazine. GAA sought funding from Cherrington Health Authority for the evaluation. GAA initially requested £31,250, but increased its request to £56,640 after commissioners asked for the evaluation to involve larger numbers of gay men. This increased cost was rejected by commissioners, and so the original samples were retained. Commissioners indicated, in internal correspondence, that they were keen to fund the project as a means of developing GAA's capability to produce and use evidence. A commissioner also stated that the project would contribute towards GAA's 'maturation' as an organisation. Commissioners seemed to see the proposed evaluation as sign that GAA's views on RCTs were beginning to converge with their own. However, from remarks made by GAA staff made above, this did not appear to be the case. Neither party, however, discussed these deeper rationales with the other.

A Research Assistant, Gavin, was employed to undertake the evaluation, and two facilitators who had developed and delivered group-work (in KGC) were sub-contracted to provide the intervention. Group-work was said to be informed by cognitive-behavioural, and other social psychological, models. Some of the sessions were delivered in gay venues, and some in King George's Clinic. The evaluation involved potential participants being interviewed by the Research Assistant to assess whether the intervention might be appropriate for them. Participants were then to be randomised, to receive group-work or to enter a control group and go on to a waiting list to receive group-work at a later date. Both the intervention and control groups were to have baseline and two sets of outcome assessments.

Difficulties regarding the recruitment and retention of participants arose early in the project, and a number of steps were taken to address this. While initially using only press advertisements, recruitment now also occurred via GUM clinics and via outreach in gay venues. A decision was also made to slot in new recruits, non-randomly, into the intervention and control groups, in order to balance the numbers involved in these, in the face of men dropping out. This resulted in the trial ceasing to be a *randomised* controlled

trial. This was not, apparently, viewed as significant by those involved in the study, who generally continued to refer to it as an RCT.

Gavin reported some concern that his initial meeting with potential participants often involved the provision of education and support, and so amounted to an intervention in itself. It was concluded, within GAA, that this might be of value to participants. Although it was recognised that this might hamper the RCT evaluation of the intervention, it was concluded that 'the evaluation cart should not lead the HIV prevention horse'. Thus, the initial in-depth interview was retained, but was reported as a limitation in the evaluation design.

When the RCT was reported at a conference in 1998, the limitations of the RCT design to the evaluation of HIV prevention, and the inappropriateness of commissioners using the RCT as a gold standard, were emphasised. The poster read:

> [The RCT design] compromises validity by limiting scope for interventions [and] compromises generalisability because of highly select nature of participants. Random allocation fails to acknowledge individual preferences and needs ... Evidence-based commissioning and health promotion have been dominated in recent years by the elevation of Control Trials as the 'Gold Standard' of evaluations. Despite our best efforts we found it difficult to answer the commissioners' question; 'Just tell me what works'... The evaluation was commissioned to inform commissioning and yet the decisions on commissioning were made 6 months before reporting and without reference to the evaluation.

The report also concluded that there was no statistically significant difference in outcomes between the intervention and control groups. It was suggested that this resulted from the effects of the initial interview, as well as reflecting the small sample sizes used.

vii. External outcome evaluation

Although both the LHC2 project and its evaluation were to be funded by a consortium of inner and outer London commissioners, a small sub-set of inner London commissioners, all of them gay men, and two of them former GAA volunteers, led the commissioning. These commissioners had an ambiguous relationship with GAA. They

saw GAA as symbolic of what they regarded as the wider effort to re-orientate HIV prevention spending to those groups most at risk, and, in the case of those who had previously been volunteers, had some residual loyalty to the organisation. However, they viewed GAA as frequently incompetent, and were nervous about commissioning services from an organisation viewed as difficult to control.

These commissioners' first concern appears to have been to protect their re-orientation of HIV spending. As a result, commissioners were reluctant to de-fund GAA, or to otherwise draw attention to what they saw as the organisation's limitations. However, they were also concerned to make GAA a more rigorous organisation. As mentioned earlier, they wished to have considerable influence over GAA's activities, using a combination of target-setting and monitoring, as well as more direct managerial intervention. As part of these efforts, commissioners sought to use evidence from an evaluation to specify, in subsequent contracts, which services GAA should continue to deliver, and which services should be discontinued. Commissioners were quite clear that they wished to prioritise GAA's services on the basis of relative effectiveness, and not merely eliminate those services judged to be totally ineffective. These aims were not shared with GAA until near the end of the LHC2 evaluation. Alex, a commissioner, commented:

> I think we dress up what we want to achieve, because we don't want to show our hand too much to the provider who might be being evaluated.

An external evaluation of LHC2 was commissioned in 1996. Commissioners recognised that they possessed few research skills, and sought to engage advice from researchers in commissioning their evaluation. They chose not to use in-house public health advice, since this was considered not particularly expert in the evaluation of HIV prevention, and instead engaged the services of the EPI Centre. This team, which had published systematic reviews of the effectiveness of HIV prevention, was viewed positively because of its advocacy of the value of trials in determining effectiveness (Oakley et al. 1995).

Edward, a GAA founder and commissioner, described commissioners' desire from the

outset to commission an RCT evaluation of LHC2:

You know, we're putting in... all this money, actually this is an opportunity to get a controlled trial done, actually we wanted them to do one.

Lynne, an EPI researcher confirmed that commissioners came to them already favouring an RCT.

The EPI Centre commented on commissioners' first draft specification of the LHC2 evaluation. This initially requested tenders for an evaluation of the cost-effectiveness of LHC2 as a whole, and of specific component interventions. The EPI Centre suggested that commissioners should instead specify an evaluation of the effectiveness of specific components of LHC2, as well as some analysis of costs; they considered an evaluation of the cost-effectiveness of LHC2 as a whole unfeasible. Furthermore, the EPI Centre recommended that commissioners assess tenders in terms of whether prospective experimental methods, with control groups, were proposed. The commissioners accepted these suggestions, and a revised specification was issued. Lynne confirmed that what commissioners wanted was evidence which would allow them to prioritise GAA's services:

They said... they wanted to look at whether they could replace some of the services they were providing by others that were more effective.

Commissioners initially intended to produce a specification which indicated commissioners' general needs, but that was not prescriptive regarding methods. In the event however, the specification did include direction on methods. This was, according to Anthony, a commissioner, because of their lack of faith in researchers offering the methods which commissioners sought:

Anthony: [There was a sense] of despair, partly distrust as well.

Interviewer: Distrust of researchers?

Anthony: Yeah, I think there was an element of ..., that, if you don't define closely enough, then what you do is you end up getting [them] going off in one direction and out of control.

By July, a number of bids were received. Some suggested the unfeasibility of undertaking trials, and were rejected by commissioners. PPRU's bid offered to undertake a mixed method evaluation, wherein trial methods would be used 'where feasible', a phrase used repeatedly in the tender. In suggesting this approach, PPRU was aware that GAA was contemplating developing a group-work intervention, which might be amenable to trial evaluation. Ben, a PPRU researcher, commented:

I'd been speaking with Graham, and I already had a sense, when I was doing the proposal, that there was [an intervention]... which Graham was thinking about as something which could be done very much in an experimental style of evaluation erm, and so... that's why I put it in the proposal.

The PPRU tender did, however, also tentatively suggest limitations to the feasibility and utility of RCTs. The tender also undertook to provide some analysis of costs.

It appears that, despite PPRU's reservation about RCTs, and its tender being couched in language which did not make any firm commitment, its offer to explore the feasibility of applying trial methods within the LHC2 evaluation was genuine. An EPI Centre researcher was convinced of this, because PPRU had approached the EPI Centre about the possibility of developing a joint bid, with the EPI centre leading on the trial elements.

Despite commissioners' suspicion about PPRU's commitment to RCTs, their dissatisfaction with the LHC1 evaluation, and their irritation with what was regarded as the excessive use of social science 'jargon' in PPRU's bid, PPRU, along with one other research team, was short-listed for interview. In the subsequent interviews, commissioners focused on the teams' commitment and ability to undertake an RCT evaluation of LHC2. Both teams were asked to make a presentation on which LHC2 components might be subject to a trial, and how this would be done, which PPRU did. Edward, a commissioner, commented:

Oh, they were very circumspect, but we had to pin them down, we made then come up with one.

PPRU's understanding of RCTs was judged by commissioners, and their EPI Centre

advisers, to be the more developed of the two short-listed applicants. Commissioners again complained of PPRU's use of what was considered jargon. Commissioners awarded the contract to PPRU, despite lingering doubts about its commitment to trials. The EPI Centre researcher concluded that PPRU was awarded the bid largely because commissioners' were very worried that the LHC2 evaluation would be dogged by a lack of co-operation from GAA, and believed that PPRU would be able to work more easily with GAA, given its previous experience with them. While the EPI Centre was an 'outsider', having very little contact with GAA, PPRU was seen very much as an 'insider'.

The initiation of the LHC2 evaluation was delayed for a number of reasons. During this time, commissioners stressed that PPRU must strive to implement some form of trial. A letter from Edward to PPRU in August 1996 stated:

> The panel appreciates your caution when considering what may be learnt from controlled trials in this area... However... [commissioners] would like the research team to remain open to the possibility of the evaluation including a controlled trial.

The commissioners insisted that a steering group, rather than an advisory group, be set up. While PPRU preferred the advisory group option, it accepted that commissioners had the formal authority to determine the nature of the group. This group included the commissioners, PPRU and GAA representatives, and two outside advisers, a researcher from another university, nominated by PPRU, and Lynne, an EPI Centre researcher, nominated by the commissioners.

As the evaluation commenced, Lynne noted the reluctance of the commissioners to become actively involved in managing the project. She commented:

> I always had the impression that the commissioners were... extremely busy. They had commissioned this thing... and I don't think they were keen on having a big involvement in it, or... critically looking at it, or steering it, or whatever... Edward, who, to me, was supposed to be in charge of the whole thing,... he was only there for one or two of the meetings that I was there for. So, he was either too busy, or off sick.

Edward himself acknowledged that his frustration with the project caused his management of the project to be less energetic than it might have been:

We've had terrible problems, and they frustrated me so much, I used to try and get other people to do it, because they'd drive me so nuts, I'd want to scream at them. So, [my commissioning assistant] used to have to liaise with PPRU much more... We were, probably, a bit at fault with that, because... it was just too unbearable to call.

The lead commissioner's reluctance to intervene may also have been related to his lack of interest in what he termed 'process-management'. This was used to refer to managing the detail of operations, rather than overall strategy. Other commissioners said they avoided involvement in the project where possible, for similar reasons.

PPRU attempted, without success, to include trial methods within the LHC2 evaluation. The group-work intervention, which was originally viewed as a candidate for trialing, became the subject of an internal evaluation funded by extra resources, and so could not be included in the LHC2 evaluation. A comparison of various methods of volunteer mentoring was identified as a possibility for an RCT by PPRU. GAA volunteers and workers successfully argued, however, that mentoring should not be subject to a trial, because, they considered, it was unlikely to be ineffective, so rendering a control unethical in their view, and because randomisation would prevent GAA from providing volunteers with the form of mentoring which they judged most appropriate for individual's needs. Tom, a GAA director, reported that the GAA volunteer support worker complained thus:

'It's the first time we've tried it in groups, and the whole point is, you can have a feeling... who would be best with who, but now I've got to assign them randomly, so that's fucking everything up.'

PPRU accepted these arguments. However, an outcome evaluation, lacking in comparison or control groups, which PPRU eventually undertook, concluded that the volunteer mentoring was actually ineffective in achieving its aims.

In February 1997, PPRU wrote to commissioners setting out their view that RCTs should not be especially prioritised:

evaluations with control/comparison groups are costly to set up (in terms of time and resources) and... the evidence from them - as I am sure you are already aware from recent debates - may often be no better than evidence from other forms of evaluation (provided they are rigorously conducted).

Commissioners were becoming increasingly alarmed that the evaluation was proceeding slowly, did not yet include any trials, and focused on specific projects rather than LHC2 as a whole. This last concern arose despite the fact that the evaluation contract specified only evaluations of specific projects, and not of LHC2 overall. Commissioners wrote to PPRU, expressing their concerns, and threatening to withdraw funding unless these were addressed. Their letter, of May 1997, read:

As the lead Authority for this contract, we have to inform you that we are very concerned with progress to date, and wish to draw your attention to the terms of your contract with [the health authority] at this point.

It proceeded to list specific concerns:

Failure to keep to programme of evaluation that was outlined in your bid... Perception that the evaluation is a continuation of that conducted under LHC1... We were, you will recall, concerned at awarding PPRU the contract for this work precisely because of a fear that you might continue to use exactly the same ways of working on this project. The LHC2 evaluation's main aim is to look at how and why community mobilisation works and its role in reducing HIV prevention [sic] in London. Thus far into the evaluation the Authorities have seen little evidence that this is what you are doing.

Edward emphasised that PPRU's failure to undertake an RCT was the major source of concern for commissioners:

There were some aspects of LHC2, as we understood it at the time,... that could well have been applicable to controlled trials, possibly some training things or SOMETHING, and we were sure that it could be done... we wanted just one, just one... They failed singularly.

A meeting was held, to which commissioners and PPRU, but not the external advisors

or GAA, were invited. PPRU brought one of its senior academic to this meeting. This individual led on developing a compromise, whereby the possibility of implementing trials would be abandoned, but PPRU would endeavour to conduct an overall evaluation of the effects of the LHC2 programme. This would survey gay men's views on their awareness of GAA/LHC, and of the effects this had on their behaviour. This meeting was the first occasion that commissioners shared, with PPRU, their desire to use the results of the LHC2 evaluation to decide which GAA services should be de-funded. Commissioners subsequently informed GAA of these plans, thereby greatly angering them.

While commissioners expressed enthusiasm about the new plan within the meeting, upon production by PPRU of a written summary of the methods to be used, commissioners expressed doubts as to the proposed method's validity. PPRU researchers suggested this change in commissioners' views might have reflected their being initially impressed by the academic authority of a senior PPRU figure, which then dissipated in subsequent private reflection, and in meetings where no senior academics were present. Ben, a PPRU researcher, acknowledged that PPRU had fielded a senior academic in the meeting, partly in order to impress commissioners:

> You can sometimes use that in a way ..., you know, the way that [one of our professors] looks ... He can be seen as a quote 'heterosexual professor', with his beard. So, he presents a particular image which can be quite useful to play on, and my impression is that, yeah, when [another of our professors], particularly, was there, there would be nodding and agreement, 'Oh yes, that's right, that's good', and yet, when the programme evaluation paper was written, which is what was based on what [that professor] said, then that was rubbished ..., and I don't think that would have been the case if [he] had been in the room.

The programme evaluation was, however, accepted with minor amendments. The EPI Centre researcher strongly opposed this decision, and subsequently resigned from the group, perceiving her inclusion in the advisory group as tokenistic.

An evaluation report was eventually produced, sometime after commissioners had made their decision as to which GAA services should be re- and de-commissioned.

Commissioners reported that some feedback during the course of the evaluation had proved useful, and the report would prove useful in later commissioning decisions. Commissioners also acknowledged that the evaluation did not deliver all the information for which they had hoped.

The evaluation was thus directed by no single group. GAA succeeded in resisting a trial evaluation of an intervention where it viewed this as inappropriate and unethical. This was despite GAA not being involved in the development of the evaluation specification, or in the selection of a research team. PPRU succeeded in not being forced to implement a trial where it considered this inappropriate, despite pressure from commissioners that a trial or trials should be undertaken. Commissioners succeeded in re-orientating the evaluation from that initially planned by PPRU, but failed to secure all their demands. Commissioners themselves recognised that they had failed to direct PPRU to implement trials in the LHC2 evaluation. Edward commented thus:

Edward: I think we were faced with PPRU deciding that they'd do whatever they liked, regardless of anything we'd requested... They were determined, and that's what they've done, with a bit of tweaking... And we've had absolutely no power to stop that.
Interviewer: Why, as commissioners, haven't you?
Edward: Oh, do commissioners ever have power?

They suggested a number of reasons for this. Commissioning research was regarded as more difficult than commissioning other services, because the progress of the former was not easy to set targets for, or to monitor. Edward commented:

Edward: You agree something with them, and then it just becomes something else... By the time you realise, it's too late to change it.
Interviewer: Is it different when you commission a service?
Edward: Yes well, a service, you realize much quicker, and they don't bamboozle you constantly... With a service ..., you are monitoring, you directly yourself, outcomes of some nature, they're probably outputs, but you're monitoring something. You are also getting feedback from the users of the service, and you've got a mechanism for both of those things coming back to you... You can pitch up and do a visit, or whatever, and we do all those things. You know what's going on with a service. With this evaluation, you know, it all happens behind closed doors somewhere.

Commissioners also commented on the difficulty of negotiating with researchers who used language which was inaccessible to most commissioners, and acknowledged their own limited research skills. Mark commented:

> It's like... going to the dentist, or having your plumbing done, you are completely in the hands of this expert.

Edward commented that he did spend some time trying to develop his knowledge and skills, so that he could assert, in researchers' own terms, what was required. He reported, however, that this became too much:

> It actually took me a lot of work for every meeting, to be able to back them down. And I haven't got the time to do it. So, we didn't bank on the time we'd need ..., so we let them get away with some things, because we didn't have the time.

The lack of success, by commissioners, in securing an experimental component to the evaluation of LHC2 might also have reflected commissioners' superficial commitment to developing an RCT. If more committed, commissioners might, for example, have embarked on a longer-term project to work with GAA in developing interventions ready for, and amenable, to RCT evaluation. There was also some perceptions that commissioners' preference for RCTs was dimming. Graham, GAA's General Manager, commented:

> [1]They have this view, this 'Oakley-esque' view of what constitutes evidence; and after 2 years of everyone saying to them, 'That's too narrow',... they've now accepted that there might be other, additional approaches, at least some did.

Some commissioners reported that the LHC2 evaluation had made them more doubtful as to the feasibility of RCTs. In a subsequent call for evaluation of gay men's HIV prevention services, which included those provided by GAA, commissioners did not

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1* It should be noted that Oakley et al. (1995) do not cite RCTs as the only means of evaluating HIV prevention interventions.

insist on bids including trials.

Other consequences of the evaluation include an even greater deterioration in trust between commissioners and GAA, as a result of commissioners' lack of disclosure of their desire to use evidence from the evaluation to determine which of GAA's services health authorities would commission in future. Keith, the LHC Operational Manager, commented:

When the LHC2 evaluation was being commissioned, we were trying to get a sense from the commissioners about how they were going to use the evaluation. And we were told, quite clearly, that they weren't going to use that to either fund or de-fund us... And then... at a meeting we were told that... they were going to use the results of the evaluation [to] decide whether to fund it or not. I mean, it's that whole thing, about not believing what's being said at meetings, that I find really frustrating.

PPRU were also cynical by the end of the evaluation. Ben was suspicious that the evaluation had been viewed by commissioners as a tool with which to control providers:

In terms of GAA, you know, there's this rowdy group of people, who you're never quite sure what direction they're heading off in, which you could see as a strength. But I know that, if I was a commissioner, I would be very wary of that, because questions might get asked about, 'What, exactly, have you commissioned? What are these people doing, disrupting, causing scandals in the media?'. Things like that, how do you respond to it?... What we were doing, as evaluators,... was really a form a surveillance, with an overall emphasis on controlling things, and keeping things so they don't sort of explode, and become too politically sensitive.

As well as the LHC2 evaluation, Aldbridge Health Authority commissioned a process evaluation of GAA's work on a heath in inner London. This was done by a medical school-based research team led by a social scientist. Although the commissioner initially asked for an evaluation of the effectiveness of the project in reducing gay men's risks of HIV infection, he was persuaded by the researchers that this was unfeasible, given the amount of time and resources available to undertake the project. The commissioners' acceptance of this view may have reflected the academic deparment in question having considerable academic authority. Whereas PPRU's diffidence with regard to the

evaluation of effectiveness was regarded with suspicion by commissioners, the medical school team's was accepted as pragmatic. GAA were said by the researchers to appreciate keenly the importance of external evaluation in maintaining funding, and were happy to co-operate. The study's findings were said to have been important in the health authority's decision to expand the project's remit, from the summer months to all year round.

3. Processes of evidence use

a. Use prior to 1996/7

i. Justification for community mobilisation

A number of GAA's founders used a certain amount of external research evidence in justifying their proposals for how GAA should be organised, and what activities it should engage in. This evidence was referred to in various reports and funding proposals, as well as in a series of meetings which sought to drum up interest in GAA. According to one GAA report:

> LHC is unusual, if not unique, because it was specifically constructed in response to the findings of the best available international research.

This research was said to include the US experimental study of the effectiveness of gay men's HIV prevention cited earlier (Kelly et al. 1991). This compared a number of mid-Western cities, where no intervention was delivered, with a number of similar cities, where an intervention was developed. The intervention, though planned by academics, was delivered by gay men identified by researchers as popular figures from the gay scene. These were trained as peer-educators, and provided support and information to other gay men. Cross-sectional surveys of gay men's risk-taking behaviour were done prior to delivery of the intervention, and some time after. Another study referred to in GAA literature was conducted in California, and used a similar design, but, instead of the intervention being planned by academics, the gay men who became involved in the

project themselves developed the interventions (Kegeles et al. 1996). Other projects referred to by GAA included descriptive studies from Australia.

Additionally, GAA founders referred to the changing incidence of HIV amongst gay men in the UK in support of the methods and organisational models which GAA was adopting. It was argued that, in the mid-1980s, in the absence of any statutory provision of relevant HIV prevention, UK gay men engaged in informal self-education, and, as a result of this, the incidence of HIV in these years remained remarkably low. It was suggested that this informal self-education fell off in the later 1980s, as a result of a perception amongst gay men that statutory agencies were now delivering relevant HIV prevention. However, so GAA's argument went, the statutory response failed to target gay men, or use methods appropriate for gay men. As a result of this, infections amongst gay men started to rise once more. GAA argued that what was required in the early 1990s was a re-invigoration of self-education by ordinary gay men, supported by statutory funding.

The description of the UK epidemic, and the role of informal peer-education within it, is based on an analysis which uses epidemiological data on HIV infection, as well as anecdotal information on the level of informal peer education amongst gay men. It thus provides another example of GAA blurring the distinction between research and experiential evidence. It also exemplifies GAA's use of forms of information such as quantitative evidence, which ran against some of its early rhetorical positions. Overall then, GAA presented a range of different forms of evidence in support of their proposals for HIV prevention, including evidence from experimental evaluations, as well as epidemiological and anecdotal information.

These arguments appeared to have been successful, in that GAA had been awarded statutory funding. Commissioners did however express some uncertainty, and even some suspicion, as to whether the evidence in question did support the plans which GAA presented. One commissioner questioned the relevance of the studies to the current UK

epidemic. William commented:

I think there were serious transferability issues... London is a massive urban conurbation... and, it seemed to me, [US researchers cited by GAA] were working in predominantly... quite closed communities, where the gay scene was relatively homogenous... where, perhaps, there were only one or two bars, or seven or eight bars, and, if you went into that bar, so-and-so would always be there, and they were well known as a person in their peer group... I think that that is fundamentally difficult to envisage in a city like London, where you've got this never-ending flow... of people... Secondly, the epidemic is probably... now, and probably was then, at a different stage in London to when the [US] project was done... The researchers in America, they were talking about communities that were very glad to get a safer sex intervention... But, it would be difficult to argue that most gay men in London didn't know what safer sex was, so I think, in terms of stages of knowledge, attitude, if not behaviours, things were slightly different in London.

Some of this evidence was also questioned internally. One founder wrote thus in the newsletter:

The downturn in infections in the mid-1980s could simply be due to the natural containment of new infections within a highly sexually active group of gay men. Once this group changed its behaviour (between 1983 and 1985), the behaviour of most other gay men could have been irrelevant to the dynamics of the epidemic. Thus the uptake of safer sex amongst a much wider group of gay men may have been of only marginal significance, leading us to overestimate the power of long-term community based prevention work today.

ii. Use of evidence in operations

The work of volunteers was not guided by protocols, although some GAA documents, such as the project planning guide mentioned earlier, were intended to provide some guidance for volunteers working on projects. No evidence-based guidelines were used. Most participants agreed that, prior to 1996/7, GAA generally used very little evidence, from external research, in developing its services. Tom, a director, commented:

No-one ever referred to journals or discussed journals.

Experience appeared to be a more important source of information. According to the

1995 LHC refunding proposal:

Volunteers'... actions are informed from the everyday experience of their lives. This tends to lead to 'no nonsense' policies. Volunteers work with the gay scene rather than on the gay scene. They see and know what gay men are already doing and try to fit into that pattern, acting as safer sex spin doctors.

According to an LHC1 report, volunteers' experiences, anecdotes and common sense assumptions formed the basis of the organisation's ongoing needs assessment.

Volunteers were trained to use both experience and research in the planning of projects, but the former was emphasised more than the latter. Research Group's Co-ordinator, Gordon, illustrated this with reference to one exercise from his initial training, in which new volunteers try to describe what another new volunteer was like, on the basis of their appearance. About 50% of these guesses were said to be correct, which was said to demonstrate the value of using gay men's experience as a form of information.

It was suggested that many volunteers prioritised their own experiences, because of a belief in the importance of asserting the centrality of ordinary gay men's lives. Robbie, a founder and worker, commented:

Well, it was set up by experts, but with the intention of involving and mobilising ordinary gay men. And I think that it's like, with a lot of things, when you pass on a message, and drum it in, I think the message that was drummed in loudest was that your experiences as ordinary gay men is really valuable, and that's what makes you a good volunteer, and you know what needs to be done. Whereas, at the same time, what got lost a bit was that... there are other places we can learn.

Others suggested that many workers and volunteers found research personally intimidating. Brian, a worker, commented:

My experience of research from outside this organisation is that research is used as a weapon against... your intelligence... Because of the research-speak, you have to learn how to speak research before you can understand it, and it makes it unfriendly to gay men who are using it.

It was said that very few volunteers engaged in projects reviewed research evidence. Indeed the lack of literature reviews, even as a preliminary to GAA's own research projects, was notable. Where research evidence did filter into the work of cells, this was often from articles, in the gay press, summarising research. Some research was referred to in the GAA newsletter, but this was rarely in reference to the development of specific projects. Cells were said to have used evidence emanating from internal research in the development of some projects. The surveys conducted as part of GAA's work on the heath were highlighted as providing evidence which was used in the refinement of this work.

b. Use during 1996/7

i. Justification for community mobilisation and various methods

GAA managers and directors continued to refer to research evidence to justify their use of community mobilisation. As well as reference to the studies described above, they referred to evidence from the systematic reviews conducted by the EPI Centre. GAA managers also used evidence from trials and from systematic reviews of trials to justify their adoption of group-work methods. Graham, the General Manager, wrote thus in the newsletter:

> And this shit works? Oh yes. Proved by gold standard-copper-bottomed-man-in-white-coat-randomised-control-trial evaluations. Indeed it is one of only two approaches that have been proven to work. That's why funders like it so much. Evidence-based, see?

Despite GAA managers' frequent criticism of the limited utility of evidence from trials, evidence originating from such studies was employed to justify GAA's activities. It does not necessarily imply a contradiction however: although these managers did not especially value trial evidence, neither did they totally dismiss it. These managers were also unapologetic in employing the evidence that they viewed commissioners as most likely to be convinced by.

Commissioners were, in the course of 1996/7, formulating their plans for commissioning gay men's HIV prevention after the end of the LHC2 contract. Commissioners indicated to GAA that, while some funding would be available, DHAs wished to commission group-work from agencies other than GAA, and did not wish to commission another community mobilisation project like LHC2. GAA managers argued that commissioners' views were not in line with the evidence which commissioners themselves hailed as most rigorous. In one letter to a commissioner, Graham wrote:

> You and I are both deeply committed to evidence-based promotion but differ a little on the question of what constitutes evidence. I think you broadly take Prof Oakley's 'Gold Standard' line while I have broader criteria which include RCTs only as one of a range of evidences. In this letter, however, I refer only to RCT evidence.

The letter goes on to argue that commissioners should heed the conclusions emanating from trial studies, namely that what was termed 'community-based peer-education' and 'group-work interventions informed by cognitive-behavioural models', were amongst the most effective interventions in gay men's HIV prevention. The letter cited various original studies, as well as reviews by the EPI Centre. The letter concluded:

> On the one hand you want us to do evidence-based work, on the other hand it seems you don't want to commission us to do the only work for which there is evidence of effectiveness and in which we are leading providers. You may have additional evidence... and I would be very grateful if you could let me have the references.

GAA thus attempted to employ commissioners' own standards of evidence to argue against health authority commissioning decisions. Several, both from inside GAA and outside, suggested that, while commissioners' rhetoric emphasised their use of evidence, much of their work was not based on evidence. Keith commented:

> I think a lot of the decisions are based on personal feeling more than evidence... And I think a lot of commissioners talk about using evidence. There was a hell of a lot of talk before this round of commissioning, that they were going to commission on the basis of evidence. So show me. I would love to see what evidence they've used to make the decisions they've made. If commissioners have used evidence, then presumably I could go round to them and say, 'Show me... what evidence you've used', I

should be able to go down there right now.

Neil, who after leaving GAA had undertaken research on how commissioning decisions are made, suggested that commissioners frequently used evidence to support their prior decisions. Alex, a commissioner, hinted, in his own account, that commissioners have a yearning for evidence that suits their prior purposes:

I think some of the controlled trial stuff is our over-reaction... you know, it screams out from the spreadsheet, God almighty what is this CRAP we're buying, I can't bear it, what is our mechanism for saying no to it... we'd much rather have a one page thing which said, 'ALL this community mobilisation stuff is TOTAL bollocks, pull the money now!'

Although the commissioning decisions in question had not been completed by the time fieldwork was concluded, commissioners appeared intent on: not extending the LHC contract further; and providing GAA with a reduced level of funding but only on condition that GAA would develop a co-ordinated plan of work with other HIV prevention agencies. Evidence from the LHC2 evaluation did not appear to have influenced these decisions. Commissioners have since implemented these decisions with only some controversy in the gay press and among gay men.

ii. New processes for reviewing evidence

A number of new processes were developed within GAA to encourage the collation and review of external evidence. These included: journal clubs for workers and for volunteers; a seminar series which featured external speakers, most of whom were researchers; and a series of newsletter articles reviewing research. The General Manager was said to have been involved in the initiation of all of these. Many of these new processes were said to have been instituted in response to a general pressure from commissioners for GAA to develop EBP. This pressure was expressed in contract monitoring meetings and correspondence, and was welcomed, it was said, by GAA managers and directors, who saw it as fitting in with their own priorities. Tom, a GAA

director, commented:

The interesting thing is that the evidence-based stuff suddenly becoming quite explicit. [This] was, I think, quite welcome by a lot of people. So funders do give us that kick. I think quite a few people thought, 'Oh, maybe funder-leadership is not all a bad thing.'

These new processes were welcomed by most GAA workers and volunteers. A few directors and co-ordinators were said to oppose these new developments, since they were viewed as de-prioritising GAA's use of the experiences of ordinary gay men. Although the processes were generally welcomed, it seems that some were implemented with only partial success. The worker's journal club, and the seminar series were both said to be poorly attended. In contrast, the volunteer's journal club was said to have boosted attendance at Research Group meetings.

These new processes focused largely on external research evidence, often of effectiveness. None of the processes sought to review evidence systematically, using structured criteria. Research appears to have been chosen by workers and volunteers using informal criteria of: relevance to GAA activities; interest; and variety. Tim, Research Group's worker, commented:

We find one lead paper [on a particular topic] and two other papers back-up papers, which we feel cover the topic in a way we feel comfortable with, which is useful, which has got something to say... We look through the papers, and say, 'Well, this one's really interesting, it's an approach we've never read before, or seen before, this one's arguing for one thing, and this one's arguing for a different approach'. So, between three, we've got a balance of different things which would be useful for the organisation.

The extent to which evidence reviewed in the new processes influenced GAA operations is uncertain.

iii. Use of evidence in operations

External research evidence was said to have been used in the development of the group-work intervention. The research in question was said to be from an RCT of the

effectiveness of group-work conducted in Australia (Gold & Rosenthal 1995).

Graham suggested GAA's use of research was improving over the last 2 years. Others said that the use of external research evidence within volunteer cells was improving, but was still rather limited. Tony, a worker, commented:

> We use experiential and anecdotal, and with more than a nod to traditional research, but the experiential and anecdotal is, I think, the stronger bent within GAA.

Several GAA participants cited one worker, in particular, as encouraging volunteers in his group to undertake literature reviews to inform their work. This worker denied this was the case, however. Experience, articles in the gay press, and evidence from internal research, continued to be cited as the major influences on cell activity. Some cells were said to continue to prioritise their own experiences, as a matter of principle. One volunteer group was also said by several workers to use their worker only in an administrative support role, rather than in a guiding manner, again as a matter of principle. The co-ordinator of this group did not however agree to be interviewed.

There was no suggestion at any point that GAA services should be guided by protocols, whether these were evidence-based or not. This may have reflected GAA's reported concentration on developing new interventions, rather than on delivering existing interventions in a consistent manner.

4. Conclusion

GAA initially, at least, viewed both experience and research as forms of evidence, and often sought to blur the distinction between them. GAA founders asserted a preference for qualitative, rather than quantitative, research, and for internal, rather than external, research. The organisation did, however, produce quantitative, and use external, research from its foundation. GAA's orientation to research gradually modified, the role of quantitative and external research receiving recognition, and the distinction between research and experience increasingly being accepted. These appeared to reflect both

certain individuals changing their views, as well as new individuals joining the organisation.

GAA produced a considerable amount of research, much of which it used in various campaigning activities, and in asserting its legitimacy as a provider of HIV prevention. The amount of research produced was especially considerable, given the small income which the organisation received, in comparison to, for example, KGC. However, as indicated in Chapter 1, this study makes no attempt to consider the quality of the research, or even prescribe what criteria of quality might be. GAA's research was often controlled by an elite, comprising some staff and volunteers, who had been involved in founding the organisation. Some other research, especially small-scale process evaluation and needs assessment, was undertaken by the rank and file.

Commissioners were generally dismissive of this research, but did not seek to de-fund it. Commissioners did, however, increasingly seek to direct GAA's general activities, and saw research, from other sources, as a useful tool in this. Commissioners sought to commission an external evaluation, which would enable them to ration GAA's services. They had a particular interest in evidence on effectiveness, and from RCTs, as this evidence was seen by them as most useful in informing their decisions. The external evaluation, however, proved extremely difficult for commissioners to control, because commissioners lacked the time, specialist expertise, and inclination to manage it. The evaluators used a number of resources to protect their autonomy, such as playing on stereotypes of academic authority.

GAA itself attempted to develop an RCT, partly to question the 'gold standard' status which commissioners had ascribed to this design. GAA also referred to a wide variety of evidence to question commissioners' commissioning decisions, and even the way in which the commissioning of gay men's HIV prevention in London was organised. Commissioners did appear to have successfully encouraged GAA to develop specific means of incorporating research evidence into its practice, though the impact of these processes on GAA's services was uncertain.

Chapter 9 examines these activities, in terms of the power conditions within which they unfold, and their implications for various interests.

CHAPTER NINE: DISCUSSION

This chapter considers the strengths and weaknesses of the research design, before going on to: summarise the findings and develop conclusions in relation to the research questions; consider the generalisability of the conclusions developed; and discuss the wider implications for sociological thought of the thesis.

1. Scope and limitations of the study

A retrospective case study approach, using interviews and documents as sources of data, proved valuable, and presented no major problems. Some minor problems were apparent. Interviewees were sometimes reluctant to be constrained to discussing a particular period in the past, and focused instead on current events. This sometimes made building up a clear historical picture difficult. The views people reported in field work may also not have reflected their views at the time of the focus of the study. Ideas about EBP appeared to be developing quickly, and people probably sometimes changed their minds. They may understandably have been reluctant to acknowledge this in interviews. The study also could not always follow through events all the way to some kind of conclusion, but this problem would have occurred with a prospective, as well as a retrospective, study. Indeed, Chapter 2 anticipated that only short term interests could be considered because only short term developments could be investigated.

This chapter presents an analysis of how interests are implicated in the definition, production and use of evidence. Chapter 2 recognises that any analysis of interest is value-laden, and suggested this was acceptable, as long as a serious attempt was made to elucidate what values the researcher brings to the research. A summary of all my pertinent interests would swamp this chapter. However, it is worth relating that I am an HIV prevention researcher, with an interest in: evaluation; the application of research to practice; and the combining of qualitative and quantitative methods. I am likely, then, to be sceptical about arguments suggesting the irrelevance of research or evaluation, or the incompatibility of qualitative and quantitative methods. As reported earlier, I have

also previously been a medical student, and an employee of both a health authority and an HIV voluntary agency. These experiences may have made me somewhat sceptical about these groups, or may, conversely, have imbued me with some empathy, and sharing of assumptions and views, with doctors, commissioners and voluntary sector workers.

A lack of distancing between me and some individuals within the cases may well have been a problem in the course of analysis. However, some analytical distance was provided by my supervisors, who were not so involved in the HIV prevention field, and who, I believe successfully, tried to put many of their own views on evidence and practice aside, in the interests of guiding the development of a sociological account. However, I think it is possible that the GAA case received a greater depth of analysis than the KGC, as a result of conflict in GAA being the subject of much informal analysis in the HIV prevention field, which energised and influenced my own thinking.

This thesis is unapologetic in trying to develop a singular and coherent account, rather than presenting the accounts of interviewees, and accepting that these are not open to judgment regarding their facticity. Different sources of data were compared in the course of data analysis, in order to try to establish a factual base. For example, interview accounts about GAA's attitude to health promotion were compared with accounts about, and job descriptions for, GAA's workers, to assess whether GAA's criticism of health promotion was at the level of rhetoric only, or was embodied in its actions. Chapter 5 acknowledges, however, that all accounts, sociological and otherwise, are built on unempirical assumptions, some less obvious than others, and so, while truth can be strived for, a recognition is needed that this is ultimately an uncertain and social construction.

Despite these limitations, the empirical component generated a number of insights which are now discussed, compared between cases, and related back to literature presented in Chapters 1 to 4, to develop a sociological account of 'evidence' and the social relations surrounding its definition, production and use.

2. Conclusions in relation to the research questions

This section develops general conclusions from the specific findings presented in Chapters 6, 7 and 8. In discussing the views and activities of central agencies, points raised in Chapters 3 and 4, as well as in the findings chapters, are referred to.

Emergent generalisations are tested in comparison with these findings. Possible exceptions, or contradictions, are examined, in order to refine the analysis. The section suggests that, where providers' views on evidence differ from commissioners', commissioners themselves attempt to steer processes of evidence production and use, but where providers' views converge with commissioners', commissioners allow providers considerable autonomy in producing and using evidence, since they anticipate that this will support their own interests. Evidence and EBP, it is argued, are embraced within various strategies employed by the centre, and by its local agents, commissioners, in the control of providers. In the case of statutory providers, strategies of control via *action* at a distance predominate, whereas, with voluntary providers, strategies of control via *steering* at a distance are more apparent. However, it is argued that, in the case of both of these strategies, evidence is a problematic resource of control, and a useful resource of resistance, for a variety of reasons which are detailed.

a. How are the definition, production and use of evidence determined by existing relations of control and resistance?

i. Central and peripheral agencies

In line with Bennett and Ferlies' (1994) remarks, discussed in Chapter 4, there was some divergence noticeable between agencies, in terms of their orientations to the definition, production and use of research. These distinctions were not always clear however; sometimes very different agencies showed some convergence in their orientation. Views differed within organisations too, and are discussed later. The distinctions that were apparent between agencies are, however, summarised and discussed here.

Official definitions of evidence, developed by central agencies, emphasised evidence being produced by systematic enquiry, and being generalisable in its application. In Chapter 3, the view of Baker (1996) was reported, that there seems to be a particular emphasis, within the R&D programme, on: evaluation of effectiveness; prospective experimental methods; and application of evidence via guidelines open to clinical audit. The two projects which the NHSE actually funded within the KGC case study focused, respectively, on prospective experimental evaluation of effectiveness, and systematic reviews of effectiveness. NHSE staff suggested, however, that not all their projects focused on effectiveness. No reference was made to the use of evidence from experience, unmediated by formal research methods. Central definitions of evidence and EBP thus resembled the view of EBP first set out in Chapter 1, centring on the basing of practice on protocols (Haynes and Haines 1998) directly based on evidence, especially, but not exclusively, of effectiveness (Baker et al. 1997), and especially, but not exclusively, from prospective experimental studies with control groups (Muir-Gray 1997).

At the periphery, health authority commissioners tended to prefer: formal 'research' rather than informal, unmediated 'experience' of practitioners or clients; quantitative over qualitative data; evaluations of effectiveness over other topics; and prospective experimental over other designs. Thus, commissioners' orientation, at the level of definition, approximated the view dominating central agencies. These preferences were not, however, always reflected in the evidence-producing and -using activities of health authorities. The reasons for this seeming contradiction are discussed later.

In terms of the definition, production, and use of evidence, KGC and LUSH could be considered as one organisation. Overall, the clinic prioritised evidence from formal research over evidence from informal experience, and did not blur the distinction between the two. It viewed qualitative research as a complement, rather than as an alternative, to quantitative research. There was a particular interest, within the clinic, in using experimental designs to evaluate the effectiveness of services. There was also a focus on applying this evidence, where possible, via the use of protocols to guide services.

In the context of EBP, evidence was sometimes regarded as referring to evidence, specifically, of effectiveness. There remained, however, an appreciation that evidence could refer to other topics, such as appropriateness, acceptability and need. The importance of EBP, and of generating and using evidence of effectiveness, were expounded by what could be described as a social movement within the clinic. This movement appeared to have links with similar individuals in the wider NHS, as well as further afield. These alliances resembled the social movement which, in Chapter 1, Davis and Howden-Chapman (1996) suggested was campaigning for the wider implementation of evidence-based health services.

The health promotion unit located in the same trust as KGC had an ambiguous orientation to evidence. Staff indicated a preference for evidence from formal research. They stressed their interest in evaluating the effectiveness of services, and had indeed participated in the evaluation of a non-GUM clinic service, using an experimental design. However, many of the unit's projects and services had received very little evaluation, regardless of whether this was of effectiveness or not. Clinic and academic staff appeared dubious about the unit's commitment to producing and using evidence.

The voluntary agency appeared to have initially actively blurred the distinction between evidence from research and from experience. Most, within the organisation, modified their view as to the distinction between research and experience some time prior to the commencement of fieldwork. Where previously, many sought to blur the distinction, by assessing research in the light of their own experience, by seeing their experience as a form of small scale research, or by undertaking 'guerilla' research which often lacked a formality of method, most now viewed research and experience as distinct activities. Research was increasingly distinguished from experience in terms of: a need to use systematic and agreed processes viewed as rigorous; and a focus on using samples which were viewed as more representative than any individual's own experience could be. There were increasingly systematic attempts to collate and use evidence, though many projects still remained uninformed by research. The agency came to take a position similar to that reported by Altman (1993) in Chapter 4; stressing the importance of using the

experiences of those affected by the HIV epidemic, but recognising the importance of other sources of evidence too.

The agency also initially stressed, at least rhetorically, a preference for qualitative over quantitative data, internal over external research, and non-academic over academic-produced research. Thus, initially at least, providers certainly held views on evidence which diverged from those both of commissioners, and from the views embraced by the NHS R&D programme. Arguments favouring qualitative research appeared to have dissipated over time, and, anyway, were said to have rarely actually informed the research which was done, the methods generally being determined by their practical feasibility and perceived potential for influencing research audiences. A preference for in-house, non-academic research, in line with Mukasa (1997), continued to be held by some within the agency, and seemed to have influenced production of evidence.

The importance of evaluating the effectiveness of services, and of basing services on a consideration of evidence from research as well as from experience, were both stressed by some within the voluntary provider. Both of these arguments appeared to have entered the agency via HIV-specific networks. Effectiveness and EBP were, however, viewed as distinct issues: evidence was never taken to mean evidence only of effectiveness. There was a mixed response to these developments. There was considerable enthusiasm for evaluating effectiveness from some, who saw it as an extension of previous re-gaying efforts. Some, however, saw a focus on evaluating effectiveness as part of the commissioners' general project to reduce provider autonomy, and even partially or totally de-fund the provider. In line with Bennett and Ferlie (1994), there was some antipathy to evaluating effectiveness and some complacency regarding effectiveness, but this did not imply total opposition. There was a heated debate about the value of experimental methods, though this was conducted in terms of their practical feasibility and utility, rather than their philosophical appropriateness. Thus, the provider's assessment of experimental methods did not incorporate the points which Davies and MacDonald (1997) suggested were criteria in statutory health promoters' assessment.

In producing evidence using a mixture of what it regarded as formal and informal means, the agency appeared to be undertaking what Davison et al. (1992) call 'lay epidemiology'. However, because the GAA included staff and volunteers, some of whom are considered - both within and outside the organisation - as expert, this term is arguably an inappropriate one to describe GAA's activities.

It was clear from the case studies that central agencies influenced evidence definition, production and use in the periphery in a number of ways. Firstly, central agencies may have exerted direct influence by developing an 'official' view of the production and use of evidence. However, although health authority commissioners' own views on evidence were very much in line with this central view, they were only vaguely aware of what the central view was.

Secondly, central agencies exerted direct influence on the periphery by funding research in the peripheral agencies included in fieldwork. The NHSE funded two projects, GBG and the EBM Front-line Site, both at KGC. The LHC1 evaluation in the GAA case study was funded by Region, but this was prior to RHAs being absorbed into the NHSE, as well as being prior to the NHS R&D programme getting underway, and so is not here considered an example of central research funding. NHSE funding for GBG was more responsive than pro-active, despite the commissioning rhetoric which surrounded it. Although an RCT was funded, this was more a result of interest at the periphery, rather than central priorities being imposed. Therefore, regardless of whose interests GBG served, it is not an example of control via steering at a distance. In contrast, the EBM Frontline project was centrally-led; KGC had little say in the approaches used, and the NHSE itself had prioritised doctors as a target, and systematic reviews of experimental evidence of effectiveness as a method. However, the impact of this project was limited by weak management on the part of the NHSE.

Thirdly, central agencies exerted indirect influence by setting frameworks for health authority activity. It defined the remit of health authorities, as delegated local investment agents, accountable to the NHSME (DoH 1989), and charged with maximising the health

of their residents (DoH 1992a). Health authorities aimed to undertake this role, using criteria in line with their remit. Commissioners stressed value for money, and, more specifically, cost and effectiveness of services, as their key criteria of investment. Commissioners emphasised their role in prioritising services on the basis of these criteria. This was despite there being little pressing financial need for the rationing of services. Commissioners appeared keen to ensure that their investment decisions were as risk-free as possible. Commissioners needed to defend their decisions, using appropriate evidence, in the face of scrutiny from central agencies, and also the media.

Their responsibility to maximise the health of their local population was contrasted with regional funders' approach, which was seen by health authority staff as being more focused on developing providers. Health authority commissioners distinguished their focus on the evaluation of effectiveness from the focus of previous funders, which reportedly had centred on the evaluation of process. Commissioners preferred quantitative evidence, since this was seen as more easily informing decisions to invest or not, than was the case with qualitative research. Health authority staff did not explicitly focus on their responsibility to meet Health of the Nation targets when discussing their remit. This may have been because, in relation to HIV prevention, these targets were widely perceived as inappropriate and unambitious.

The fact that health authorities were constituted as organisations employing public health specialists may also have affected their orientation to evidence. Although public health specialists appeared to have only minor roles in the commissioning of HIV prevention services, they were involved in producing and using evidence in other service areas, and were said, generally, to regard evidence of effectiveness derived from RCTs as the ideal basis for determining investment decisions. This appears to have influenced commissioners, who suggested their interest in evidence of effectiveness partially resulted from their perceived need to justify continued investment in HIV prevention in terms of the standards applied to other areas of commissioning.

Fourthly, central agencies appeared to exert some indirect influence in the case studies,

via funding research projects at sites other than the case studies, which were taken up by groups or individuals in the case studies as exemplars of good research. The EPI Centre had received project funding from a variety of sources, including the Medical Research Council, DoH, and the NHSE, to undertake systematic reviews of the effectiveness of health promotion interventions. This encouraged the effectiveness/EBP movement, both within KGC and, to some extent, in various health authorities. This indirect influence occurred within a context of the wider adoption of certain versions of EBP internationally. These developments had influenced both KGC and GAA, especially the former because of its connectedness to international networks discussing and developing these ideas.

Fifthly practitioners within statutory providers were also said to have been influenced by the general expectation, within the NHS, that health professionals base their practice on guidelines incorporating research evidence. This is indeed embodied in central documents (DoH 1989; NHSME 1993).

Thus, overall, it appeared that health authorities, in developing a view on evidence, acted in line with central orientations as a result of indirect factors, rather than as a result of direct intervention by the centre. The suspicion of NHS central agencies that, without their own intervention, research would be downgraded (Culyer 1994) was therefore not confirmed. However, while the preceding discussion suggests central definitions and priorities influenced peripheral activities, it is also clear that some peripheral agencies' orientations to evidence were not in line with those of central agencies. How this came to be is discussed below.

ii. Commissioners and statutory/voluntary sector providers

Chapter 4 raised the possibility that providers whose orientations to EBP converge with those of commissioners and other funders, are more likely themselves to lead on the production and use of evidence, whereas providers whose orientations to evidence differ from those of funders are more likely to have these processes imposed on them. This

section considers whether this was the case in those agencies studied.

Statutory sector providers

Commissioners were not greatly involved, either in determining the provision of HIV prevention and SHP services, or in the development of research within KGC and LUSH. In both cases, this appears to stem from their lack of anxiety about these agencies' practice and research, compared to other providers. HIV prevention at KGC seemed, to commissioners, both less problematic than similar activities in other providers, and less problematic than treatment and care activities in KGC. Commissioners felt a high degree of trust in both clinic staff and academics, despite their receiving relatively little information on the SHP-related activities of both groups.

The health authority saw the provider as holding similar views on evidence as itself, and accepted provider authority in research production and use. It viewed KGC and LUSH as a single unit, and perceived the authority of this combined provider to be enhanced as a result. Thus, an approximate convergence in views on evidence meant that provider autonomy in producing and research was not challenged; providers acted, and were not steered.

Voluntary sector providers

GAA's view on evidence production and use was perceived by the health authority as diverging from its own, particularly regarding the evaluation of services. The health authority did not view the provider as trustworthy in evaluating its own services using methods which the health authority would regard as rigorous, and identified leading the evaluation of GAA as within its own role. It gathered the support of what it saw as expert evaluation advisers who did share its views, in order to help it develop a rigorous evaluation. It also sought the assistance of what it regarded as 'insider' evaluators, the team who had previously evaluated GAA, in order that the implementation of what might have been, to GAA, threatening methods would be as smooth as possible.

However, the health authority did not succeed in steering the evaluation. Commissioners and the insider evaluators entered into what was, at times, overt conflict and, at other times, conflict expressed within each agency but not in encounters between the agencies. The insider research agents were unable or unwilling to use the methods favoured by the health authorities. Commissioners opposed these views, but were unwilling and unable to become involved in the operational management of the evaluation, because of a distaste, on the part of some commissioners, for what was viewed as the detailed operational management of process, and because of an expressed lack of both time and specialised research skills. Time problems resulted from commissioners having very broad remits, and having to contend with frequent health authority re-structures. Although they attempted to spend some time in developing their research skills, and organised several meeting in order to direct the work of the researchers, commissioners generally were extremely reluctant to become heavily involved. Research also proved atypical of the services which health authorities commissioned; whereas commissioners felt able to scrutinise health care services, they found research provision almost impossible to monitor.

Commissioners attempted to enforce their authority upon the insider researchers. If successful this would have exemplified Lukes' (1974) first dimension of power. This was, however, largely resisted by the researchers, who mostly succeeded in asserting their own authority in determining appropriate methods. In managing their relations with commissioners, the researchers were conscious of presenting themselves in terms of conventional academic stereotypes, used as a resource of authority. This resistance itself exemplifies Lukes' first dimension of power in an act of resistance. A commissioner also claimed that researchers sometimes successfully resisted commissioner authority by side-stepping, rather than confronting, matters raised by commissioners, an example, perhaps, of Lukes' second dimension of power.

Other than this evaluation, GAA were left to undertake a great deal of research autonomously, despite commissioners' beliefs that the providers views on research differed from their own. This, at first sight, appears to contradict the notion that, where

provider's views on evidence differ from commissioners, commissioners attempt to steer processes of evidence production and use. It therefore needs further consideration. It appeared that GAA's autonomy to undertake its own research projects had been established in the period prior to health authority commissioning, and had yet to be fully challenged, since it was not a priority for health authorities. Health authorities also saw this undertaking of research as a means of developing volunteers' skills, rather than as a means of developing evidence useful either to the provider or to the commissioner. Health authorities did, however, appear increasingly keen to dictate certain key areas of evidence production and use by GAA, such as contracts specifying that all materials produced by GAA be pre-tested by them.

Regarding the evaluation of group-work by GAA, commissioners encouraged the voluntary provider to manage the production of evidence. This appears to contradict the earlier suggestion that, where provider's views on evidence differ from commissioners', commissioners attempt to steer processes of evidence production and use. The health authority funded the provider to undertake its own RCT, because commissioners hoped that GAA's apparent new-found interest in RCTs signalled the provider's views beginning to converge with commissioners'. However, this was far from the case; the provider's views were not converging with those of commissioners. It is suggested below that, rather than exemplifying control via action at a distance, this evaluation, in fact, exemplified a subversive use of EBP.

iii. Managers and practitioners in statutory/voluntary sector providers

This section considers how, within each of the case studies, orientations to evidence varied according to the occupational or volunteer groups to which individuals belonged. This is done to explore whether Bennett and Ferlie (1994) were correct in suggesting group identity might, at least in part, determine these preferences. It is acknowledged however that individuals' identities are unlikely to be reducible to the occupational and volunteers roles they undertake (Patton 1990) and so the analysis also aims to examine the limitations of the labels given to these groups.

Statutory sector manager and practitioners

Within KGC, service and academic doctors in many ways comprised a single group, with common training, professional identity and, in many cases, overlapping roles. Doctors from both a service and an academic background took key roles in the management of the clinic, working closely with other practitioner-managers and with the clinic's Business Manager. Most doctors shared the view of evidence which predominated at KGC, and which has already been described. No doctors interviewed differed markedly from this position, though there was some variation as to the practical feasibility of applying experimental designs to the evaluation of services. This was not, however, predicated on whether doctors were employed by the clinic or by LUSH.

Most non-medical practitioners and managers within KGC also appeared to be supportive of the view of evidence predominant in the clinic. Some differed from this view, again on questions such as the feasibility of experimental designs. A small proportion, including a nurse and a health adviser, appeared less enthusiastic than others about the value of experimental evaluation.

Current KGHU staff appeared largely to share the view of evidence and EBP predominant in the clinic, though a former manager was more sceptical. This manager had not advocated an experimental approach when considering the evaluation of the first district HIV prevention strategy. Although not opposed to evaluating the effectiveness of services (cf. Ewles 1996; Smithies and Adams 1993 reported in Chapter 4), she saw this as extremely difficult, and was particularly sceptical about the value of experimental evaluation. Regarding the latter however, practical, rather than philosophical or political, points were raised (cf. Davies and MacDonald 1998).

Most practitioners, medical and non-medical, stressed ethical and scientific concerns when explaining their enthusiasm for producing and using evidence. Some focused on the ethics of maximising the benefits to individual patients and minimising the harm; some also mentioned the importance, within a resource-limited NHS, of prioritising those

services which were most effective. Many practitioners and academics mentioned their intellectual interest in developing what was seen as the scientific basis of practice. While these factors could be dismissed as the ideological epiphenomena of determinants concerning the distribution of power, it is argued in a later section that this is not necessarily the case.

Senior service doctors and senior medical academics exerted most influence in the undertaking of research. The group's transcending the division between service and academic doctors may have strengthened its authority in this area; service doctors often working closely with academic doctors in developing and implementing research. Other groups, such as nurses and CPs, did not so thoroughly transcend this divide. Doctors appeared influential in developing specific projects. The GBG project appeared to have been led largely by academic and service doctors. The involvement of other groups in planning was contested in accounts, but, overall, appeared less pro-active.

Senior service doctors also led a number of multi-disciplinary groups which focused on planning audit and research. These groups prioritised, but did not totally restrict, their focus to evidence on effectiveness and from experimental studies. Other practitioners had a secondary role in multi-disciplinary groups, advising on the practical aspects of undertaking research and utilising findings. For example, the multi-disciplinary group which led on HIV partner notification research appeared to be dominated by doctors. Doctors sitting on this appeared to initiate action, while other groups reacted to these initiatives. Non-doctors sitting on research groups had received less training and possessed less research experience than their medical colleagues, and so may have possessed less authority to initiate action.

KGHU staff appeared particularly marginalised. One group, the SHPG, had, initially at least, not been dominated by doctors, although doctors were amongst its members. KGHU staff had been influential on this group, both because they had been key to setting up the group, and because those KGHU staff who originally sat on the group had acquired respect within the clinic as a result of their activities. It seemed that, during

this earlier phase, KGHU practitioner-managers had been influential regarding the production and use of evidence. Health promotion staff had been involved in planning the evaluation of the first district HIV prevention strategy. At the time of fieldwork, however, the SHPG had become less active and other research-focused groups dominated by doctors were more influential on both practice and research.

Other practitioners, at various levels of seniority, generally accepted medical authority in leading on research. What research skills these groups possessed had often been developed, either formally or informally, with support from academic doctors. This fact, as well as a general acceptance of doctors' overall authority within the clinic, may have explained these other practitioners' acceptance of medical authority regarding research. There were exceptions to this trend; the CP-Manager, for example, stressed CPs' own authority in leading evaluation; CPs had, indeed, initiated some research. CPs did not seek to challenge the view of EBP possessed by doctors, since they shared this view.

The Business Manager did not influence research. He accepted the authority of doctors, supporting their research activities, since these brought funding and credibility to the organisation. He facilitated other practitioner-managers developing links with the academic doctors, thereby extending the latter's influence. Thus, doctors, rather than managers, led on EBP. The effects this had on the regulation of practice are considered below.

Voluntary sector managers and practitioners

Within GAA, an elite existed, which comprised both salaried managers and some volunteers. This contrasts with Freeman's (1992) identification of an AIDS elite comprised solely of salaried managers. GAA's elite was extremely influential in the development of certain projects. In doing so, it by-passed the spirit, if not the letter, of volunteer leadership mechanisms. It prioritised research asserting the legitimacy of GAA, and the illegitimacy of other agencies, including commissioners. It did not initially prioritise any particular methods, but a preference for what were regarded as quantitative

methods developed over time, this often being seen as more easily conducted by volunteers, and more authoritative among research audiences.

A rank and file, comprising other volunteers and non-elite workers, was autonomous in undertaking other research projects. It was difficult for the elite to control this activity because it exemplified volunteer leadership. Amongst volunteers, research was often less valued than what was seen as the unmediated experiences of volunteers themselves. Most of the projects surveyed in Chapter 8 were initiated by the elite, rather than by the rank and file. Where the rank and file volunteers actually undertook projects which were viewed as research, they generally prioritised interest-led research, formative evaluations and needs assessments. They did not prioritise summative evaluations or the systematic application of evidence. Nor did they prioritise any particular methods, but increasingly had some preference for quantitative methods, because of what was seen as their feasibility.

Some recent changes relating to the use of evidence were noted in Chapter 8. Volunteers engaging in research became required to show their questionnaires and other research tools to the Research Group Co-ordinator, so that he might check their quality. The elite also initiated a number of projects in which evidence from externally-conducted research was reviewed, with the intention of being applied to GAA practice. The elite, therefore, increasingly attempted to steer the production and use of evidence. The success of this is considered in a later section.

The next section explores whether, in each case study, evidence was expressedly used as a resource within strategies of control and resistance, and, if so, what form these strategies took.

b. Is evidence defined, produced and used by different organisations and groups in order to modify relations of control or resistance, particularly in the prioritisation of services?

i. Central and peripheral agencies

In implementing its R&D programme, the NHSE did articulate a need, generally, to impose some control on peripheral activity. It explicitly sought to impose a particular kind of evidence 'currency' on the market. In so doing, it aimed to specify both that local commissioners were to be the delegated agents of prioritisation, and that evidence of cost and effectiveness were to be the criteria of prioritisation. In launching a formal and purportedly centrally-directed R&D programme, it also explicitly sought to correct what it perceived was a tendency of the unchecked market to down-grade research. However, the NHSE did not specifically include HIV prevention or sexual health as a priority within the R&D programme.

ii. Commissioners and statutory/voluntary sector providers

Statutory sector providers

The health authority saw no reason to steer the production and use of evidence in order to control the statutory provider. As mentioned earlier, the provider was viewed as an unrisky investment, competent, and having the same broad aims as the health authority. The provider was seen by commissioners as being able to develop and prioritise its own services, using evidence. The commissioners appeared to hope that the provider, in taking forward its own interest in producing research, would also serve the commissioner's interest in developing an array of services, prioritised on the basis of evidence of effectiveness. Whether this was the case is considered in a later section.

The health authority also sought to enroll the statutory provider as an expert producer and applier of evidence. It was anticipated that these activities would support the health authority in commissioning services from other, more problematic, providers. For

example, the health authority supported the GBG evaluation, since it required information to inform its wider decision making about investing in group-work interventions. It anticipated that the GBG trial would provide evidence on the effectiveness of group-work based on social psychological methods which could be used to inform decisions on the commissioning of similar interventions from other providers. Whether these processes did further commissioners' interests is considered later.

The health authority also invited various staff from the clinic and LUSH on its district HIV prevention strategy group. These individuals were to bring to this group evidence useful to the development of what was explicitly a commissioning strategy. Staff from the provider attempted to exploit this position as expert adviser in a number of ways. In the course of developing the strategy, academic and clinic staff, sought to develop, as they saw it, the sophistication of the commissioner's views on experimental methods. They stressed that, while experimental methods were useful, they were sometimes unfeasible. The provider also aimed to exploit the expert authority it held in the eyes of commissioners within a campaign to encourage commissioners to provide ear-marked funding for SHP. Several participants acknowledged that one, and perhaps the main, aim of the effectiveness review, and the audit of staff time spent on SHP, was to provide ammunition for the clinic in this campaign. Thus, evidence became a resource, not actually in resisting health authority control, but in attempting to influence health authority thinking. The success of this strategy is considered below.

Voluntary sector providers

The health authority did, itself, seek to steer the production and use of evidence in order to control GAA. The provider was viewed as a risky, but necessary investment, questionably competent, and with different aims to the health authority. GAA was viewed by commissioners as having a different, and inferior, approach to producing and using evidence to themselves. The health authority sought to control the work of the organisation via the setting and monitoring of targets. Thus, in contrast to the statutory provider, the commissioner aimed to control the voluntary provider via steering at a

distance, something which, previously, regional funders had apparently not attempted.

As well as this use of targeting and monitoring as resources of control, a minority of commissioners also espoused the importance of direct intervention in GAA activities, seeing this as appropriate in the commissioning of services from a relatively new, and what was viewed as an under-developed, organisation. Other commissioners were extremely dismissive of this approach, it being viewed as 'process-management', and therefore not the province of commissioners, who should instead focus on targeting and monitoring health gain, and leave the details of how this was to be achieved to providers.

The health authorities sought to exercise control regarding the provider's priorities. It saw itself as the locus of decision-making regarding prioritisation and sought, preferably, to use RCTs to provide answers to questions of whether, or not, to invest in certain services. Commissioners indicated that they viewed rationing as part of their role, and indicated that this would include the de-prioritisation of services on the basis of their relative, and not just absolute, lack of effectiveness. This view of rationing is therefore in line with Klein et al's (1996) definition, discussed in Chapter 3.

In the LHC2 evaluation, commissioners aimed to develop RCT evaluations of GAA's services. They commissioned the support of two research teams to undertake this, as discussed earlier. Commissioners excluded GAA from this process. Commissioners' failure in implementing the evaluation has already been described.

Commissioners repeatedly stressed their desire to obtain at least one RCT, without a great deal of discussion as to which interventions were priorities for this form of evaluation, or which GAA services were developmentally ready for RCT evaluation. As suggested in Chapter 8, commissioners more seriously committed to developing an evaluation strategy including experimental evaluation might have worked with the provider on developing interventions ready for, and amenable to, RCT evaluation, rather than excluding the provider from planning. An emphasis on attempting 'at least one' RCT suggests, less a focus on the production of useful information (although this was clearly

their avowed aim), than on deployment of RCTs as a symbolic gesture. RCTs were viewed as symbolising a rigorous approach, something which the provider was viewed as lacking, which needed therefore to be imposed on the provider.

The provider's own view was that resistance against the health authority was necessary. The health authority was generally viewed as an illegitimate authority, lacking expertise and being pathologically controlling. The provider viewed itself as possessing the appropriate expertise, and orientation to the community, to be the real source of authority in the planning and providing of gay men's HIV prevention.

The provider itself had used notions of what constituted useful evidence in lobbying, which led to its initially receiving statutory funds. Upon its foundation, GAA had stressed the importance of gay men's experience as a form of evidence. A focus on experience was intended to: distinguish GAA's work from previous projects; assert the organisation's authority to sympathetic funders; and mobilise potential volunteers. In its strategies of resisting steering by commissioners, GAA came to use evidence in novel ways.

GAA sought to subvert health authority control via several processes involving reference to evidence. These echo the possibilities for subversion raised in Chapter 3 (eg. Coulter 1991). GAA referred to evidence which contradicted the health authorities' criticism of GAA's services. Firstly, it used evidence from various studies, including various experimental studies, to assert the effectiveness of its own approaches, contrary to health authority criticism, but referring to commissioners' own criteria of sound evidence. Secondly, it attempted to produce evidence which would contradict the health authority's criteria of effectiveness. For example, one of GAA's aims in attempting an experimental evaluation of group-work was actually to demonstrate what GAA saw as the limitations of this form of evaluation. Rather than indicating GAA's convergence, in terms of orientation to evidence, with those of commissioners, GAA's own RCT can actually be regarded as a component within a strategy of resistance, though this was not explicitly stated by GAA to commissioners. Thirdly, GAA produced evidence which was used to

criticise the legitimacy of health authorities more generally. For example, it used analyses of gay men's mobility to criticise health authorities' whole approach to commissioning.

The success of these strategies, of control by the commissioners, and resistance by the provider, are considered later.

iii. Managers and practitioners in statutory/voluntary sector providers

Statutory sector managers and practitioners

Evidence was not used by any managers to develop a hierarchial 'command system', whereby managers' instructions would be implemented by practitioners. Neither general nor practitioner-managers saw this as feasible or desirable. Control via steering at a distance therefore was not an aim. Managers did aim, however, to maximise consistency in the work of individual practitioners. Practitioner-managers explicitly worked towards developing a norm, amongst their colleagues, of following guidelines which were to be developed collectively by groups, based, where possible, on evidence. This was evident in the SHPG requirement that groups develop their own guidelines on SHP to ensure consistency, and that these were then audited by the clinic. This model appealed to the scientific-practitioner view, widely held within the clinic. It fitted with pre-existing notions, both of ethical practice, and of career and professional advancement. Evidence, here, functioned as the key to the legitimisation of the authority of the group over that of the individual, via guidelines. This legitimation functioned at a general level in that, while it was widely agreed that guidelines should, where possible, be based on research evidence, most of those concerning HIV prevention and SHP were not, because of a lack of what was regarded as relevant evidence.

There was an acceptance amongst all groups that doctors would lead these processes. There was also a view that other practitioner groups had significant roles in developing, and implementing, guidelines. Overall, it seemed that, as predicted in Chapter 3, doctors succeeded in controlling the development and policing of guideline-based practice. Few

seemed to resist these developments. While health advisers were initially reluctant to have their practice audited, this group increasingly came to embrace audit. Whether this exemplifies control via action at a distance depends on whether these processes promoted or oppressed practitioners' own interests. This is considered later.

Voluntary sector managers and practitioners

Again, evidence was not used by managers to develop a command system, whereby managers' instructions would be implemented by practitioners. The aim of the manager-volunteer elite appeared, instead, to promote a new form of worker/volunteer co-operation. Within the revised model of volunteer leadership, volunteers would retain their ability to initiate projects. Volunteers would, however, be guided by priorities agreed between the provider's elite and commissioners. They would also accept more guidance from workers. This revised model did not aim for guideline-based practice. This was not seen as practical, either by the elite, or by the rank and file, since GAA was viewed as an organisation concerned with constantly developing innovations in provision, rather than consistently delivering previously-developed interventions.

The elite did not hope to enforce this model on the rank and file, but, rather, to encourage volunteers to embrace it. Evidence was central, both to the practical enablement of the new model, as well as to its political legitimation. The elite stressed its view that volunteers had a responsibility, not merely to do something in preventing HIV infection, but to do something effective. As part of this, volunteers should understand the importance of using research, as well as experience. As well as this positive encouragement, there was also some accompanying reference to the threat of de-funding, if this new model was not embraced.

The new model suggested a strategy of control via action, rather than steering at a distance. Whether this was the case depends on the extent to which the strategy was successful, and, if so, the effect it had on the interests of the elite, compared to those of the rank and file. Amongst the rank and file, and amongst a few of the elite, there was

some opposition to these arguments. Some continued to assert the validity of existing notions of volunteer leadership, such as prioritising use of gay men's own experience. Research itself was not enlisted in this opposition.

c. Does the definition, production and use of evidence modify relations of control and resistance?

i. Central and peripheral agencies

It may be that the rise of EBP within the NHS may not aid central control, since doing and using research are specialist functions, and specialists tend to gather within peripheral, rather than central, agencies. Specialist researchers and practitioners also tend to gather in providers, rather than health authorities. Thus, it may be that EBP fails to act as a valuable resource in central control of peripheral agencies, because commissioners, who are responsible for planning local provision on behalf of the NHSE, are less able to control the production and use of evidence, than are providers. This proliferation of expertise in providers may well facilitate the serving of interests other than those held by central agencies. Whether this happened in the case studies is considered below.

ii. Commissioners and statutory/voluntary sector providers

As already mentioned, health authorities attempted to exert control via evidence with some providers and not others.

Statutory providers

The last section suggested that health authorities did not challenge the autonomy of the statutory provider in producing and using evidence. It was suggested that commissioners assumed that, in undertaking these activities, the provider would itself act as an agent of prioritisation (cf. Klein et al. 1996), in so doing, would use criteria acceptable to the commissioners, and would further the interests of the commissioner. Commissioners also supported the evidence producing and using activities of the provider because it was

anticipated that these would be of use to the commissioner in the control of the activities and priorities of other, more risky, providers.

These assumptions may, however, have been misjudged. Riskiness was judged, by the commissioners, according to approximate heuristics of competence, rather than according to the presence or absence of evidence of effectiveness. The evidence base for the statutory organisation's provision actually appears to have been more or less as questionable, according to the commissioners' own frameworks of evidence of effectiveness, as that of the voluntary organisation. It is not necessarily the case that commissioners' interests are served in the processes by which evidence is actually produced within KGC; the evidence produced may be of less use than commissioners anticipate, both in the provider's prioritisation of its own services and in the commissioners' prioritisation of other providers' services. Commissioners indicated that their general wish was to use information about existing services' costs and effectiveness in order to commission more effective services and less ineffective services. Gray et al. (1997) suggested some evaluations might not provide the kinds of evidence which are required in the making of commissioning decisions.

The GBG evaluation did appear to provide some of the evidence for which commissioners express need. GBG should, for example, produce evidence on cost and on effectiveness, with the latter involving outcome measures broad enough that the service can be compared with other SHP interventions (Maynard and Sheldon 1997). However, the GBG evaluation, rather than producing evidence about the effectiveness of a service that health authorities already commissioned, will give commissioners evidence about the effectiveness of a new service. Though GBG had some resemblance to existing services, many of those closely involved in funding and undertaking the evaluation questioned whether it was a typical, or even a valid, example of group-work based on social psychological models. Thus, the GBG evaluation appears to be the sort of evaluation that Baker (1996) suggested would commonly occur within the NHS R&D programme, and which would do little to further rationing, and might, in fact, spur the expansion of new services. Staff at KGC recognised that GBG would not provide clear-

cut information on the future provision of group-work at the clinic.

It may have been that GBG served the interests of academics, in developing and reporting on technical and intellectual innovation, more than it did the interests of commissioners, in gaining and using evidence to inform their own decision-making. Thus, the GBG evaluation does not represent a relationship of control via action at a distance between the provider and commissioners.

KGC's own strategy of convincing commissioners to provide ear-marked funding for SHP by using evidence was likely to fail. This use of research by KGC to support arguments appeared unlikely to convince commissioners because the facts under investigation were not what was regarded by commissioners as at issue in disagreements. For example, it seemed that the commissioner's opposition to explicit funding of GUM-based HIV prevention did not arise because of his lack of belief, either that HIV prevention was occurring within the clinic, or in the effectiveness of some or all GUM-based provision. Therefore, research evidence deployed to demonstrate the provision of HIV prevention, and the likely effectiveness of this, was unlikely to persuade commissioners to change their views.

Voluntary providers

As mentioned earlier, health authorities attempted to control the management and prioritisation of services in the voluntary provider, and this control involved commissioners steering processes aiming to produce and use evidence. Commissioners did use targets to insist on the voluntary provider undertaking some activities. However, most targets were said to have been agreed with the provider, and remained vague enough to leave the provider some autonomy. Thus, the development of control via steering at a distance was not clearly apparent here.

In commissioning an evaluation of LHC2, commissioners appeared motivated by an aim of establishing which elements, if any, of LHC2 were effective so that these could be

prioritised for future funding. Commissioners originally hoped for an evaluation of LHC2's overall cost-effectiveness. Although this was widely held to be unfeasible, the evaluators did however promise, and attempt, an analysis of the costs and the effectiveness of different LHC2 elements.

In attempting to prioritise the more effective elements of LHC2 for future funding, as well as being motivated by a desire to ration services, commissioners also voiced a desire to use evaluation in the legitimation of continued funding for HIV prevention services. They argued that, although currently, HIV prevention is relatively well resourced, in the future this might not be so. They also anticipated that ring-fencing might, in future, be removed by HIV prevention allocations, and so they considered it important that HIV prevention could meet the criteria which health authorities would, in general, come to use to prioritise services; these criteria being maximal effectiveness and minimal cost. Commissioners were thus seeking to use evidence as a resource in legitimating continued investment, as suggested by Harrison et al. (1990).

In all this, commissioners saw themselves, rather than the provider, as the agent of rationing. It would be they who would assess the evidence produced in an evaluation, and who would consequently determine which services to prioritise for future funding, and which services to de-fund. This situation contrasts with the case study in the statutory sector, in which the provider was left to evaluate and to prioritise its own services. However, as discussed earlier, commissioners did not succeed in managing the evaluation. The production of evaluation evidence proved an extremely difficult process to control. The evaluation was intended to provide evidence on cost and effectiveness, information which commissioners identified as useful in their prioritisation decisions (cf. Gray et al. 1997), and did provide information on existing rather than newly developed interventions (cf. Baker 1996). However, the evaluation did not, in the end, actually supply what commissioners had earlier identified as valid evidence of effectiveness. In this case, then, commissioners appeared to become embroiled in a failed strategy of control via steering at a distance.

In spite of the failure of their strategy to use evidence as a resource in their control of prioritisation of GAA services, commissioners did actually make decisions, but in the absence of the evidence which they had originally sought. GAA funding was reduced and, in spite of this not being informed to any large degree by evidence from the evaluation, these decisions were implemented with minimal controversy.

In contrast to the above, the support which commissioners offered to GAA in their attempted undertaking of an RCT of the group-work intervention appeared to resemble a strategy of control via action at a distance. Commissioners saw GAA's suggestion of this trial as indicating the provider's gradually coming round to the commissioners' views on evaluation gold standards. However, this was not the case. Providers, though possessing a number of motivations, appeared largely motivated by a desire to lead the debate on evaluation methods, and demonstrate the practical limitations, as they saw it, of the RCT. The provider was thus attempting to apply the commissioners' own evidence gold standard as a means of subverting commissioner authority in this area.

GAA's attempt appeared largely successful. In the context of a continuing debate on the feasibility and utility of experimental designs in evaluating HIV prevention, GAA argued in various presentations that, despite their best efforts, the RCT had proved both impractical and not useful. GAA were quite explicit in criticising commissioners' standards of evidence. Commissioners did appear influenced by these arguments, and, in a later round of evaluation commissioning, health authorities did not insist on evaluators using RCTs, as they had previously done. Thus, commissioners funding of the group-work evaluation appeared to represent a failed strategy of control via action at a distance. In funding the evaluation, commissioners saw themselves as acting in line with their wants, whereas by the end of the evaluation, they appeared to have acted against their own interests, at least in terms of maintaining their authority in the effectiveness debate. This situation appears to be an example of Lukes' (1974) third dimension of power, embodied in an act of resistance.

In general, research appears to have been highly problematic as a resource of

commissioner control because of its very transparency. This, as well as the fact that both sides can produce and use research, means it can be taken up as a resource of resistance on the part of groups who are the object of strategies of control. Conversely and paradoxically, commissioners had great difficulty controlling the research which they themselves commissioned, since it was undertaken via processes which commissioners had difficulty scrutinising.

However, the lack of value of EBP as a resource of control did not necessarily impinge on commissioners' overall authority to decide which gay men's HIV prevention services were commissioned and which were not. Commissioners did not need cultural authority in cases where they were virtually a monopoly funder with a number of providers engaged in what was viewed as genuine competition, atypical perhaps of the NHS as a whole (Ham 1994). This also echoes the suggestion made in Chapter 4 that commissioners perhaps do not need to legitimate politically their decisions to disinvest in health promotion provision as much as they would clinical services (Leichter 1991).

iii. Managers and practitioners in statutory/voluntary sector providers?

Statutory providers

The proliferation of guidelines did suggest a move away from the considerable individual autonomy which some groups, especially doctors, had enjoyed. It was not the case however that this reduction in individual practitioner autonomy reflected an increase in the authority of general managers or commissioners over practitioners. Commissioners and the Business Manager alike were content to leave the development and auditing of guidelines to practitioners, and to doctors in particular.

This situation of doctors appears to mirror the outcome suggested by Elston (1991), in that group authority was maintained, while individual autonomy was somewhat circumscribed. Guidelines did not totally hamper individual practitioners' autonomy. Doctors reported that they were free to differ from the practice recommended in

guidelines, so long as they could justify this. This situation is as predicted in Chapter 3's discussion of the importance of clinical judgment as a resource in the defence of doctors' individual autonomy (Muir-Gray 1997). Guidelines focusing on HIV prevention and SHP were also less common than guidelines on the clinical elements of practice. These guidelines also appeared generally less directive than those guiding clinical decisions; the guidelines for SHP included in the SHPG focused largely on referral criteria and expectations of what information clients should receive, rather than on the methods which practitioners should use.

The increasing focus on *evidence-based* guidelines had not, per se, increased the extent to which practitioners' activities were constrained, since guidelines had existed prior to the newer focus on increasing their evidence-base. Evidence did appear important however in legitimating the use of guidelines. The new model of evidence-based guidelines informing practice appealed to the notion of the 'scientist-practitioner'. Practitioners also saw their involvement in guideline development and audit as likely to benefit both group and individual advancement.

Doctors, involving themselves in the development, use and auditing of guidelines, did not appear to have acted against their own interests. This activity cannot be regarded within our formulation as control via action at a distance. However, for other practitioner groups, guidelines may have been implicated in practitioners' continuing lack of authority and autonomy. Where guidelines were used by other practitioners, notably nurses working in the nurse-led women's clinic, they were said to determine practice more rigidly. They were often referred to as 'algorithms', rather than the less directive-sounding 'guidelines'.

While all practitioner groups had some authority in developing and auditing the protocols they used, doctors appeared to have most authority. Doctors had most authority in managing multi-disciplinary audit. The remit of other groups' single-disciplinary audit appeared to be defined by the gaps left behind, after doctors had decided what multi-disciplinary audit should focus upon. In some cases, doctors dictated the terms of other

groups' single-disciplinary audit. Senior doctors had, for example, considerable authority in the development of the algorithms that determined nurse practice in the women's clinic. While nurses had increased the breadth of their practice, and may have increased their group authority in the course of implementing nurse-led practice, they did not appear to have developed a role as more autonomous practitioners. This might, then, exemplify control of nurses via action at a distance. This conclusion echoes Harrison's and Pollitt's (1994) suggestion that guidelines may be implicated in the increasing routinisation of nurses' work.

Practitioners actively embraced EBP, as defined and undertaken by doctors, partly because they saw individual and group benefits in this. Being involved in producing and reviewing evidence and developing guidelines may aid individual career development as well as occupational group status. It may, however, be that, in becoming involved in these activities, non-medical practitioners are, in fact, active in the restructuring of medical domination. This might be an example of agency being expressed in the very act of domination, as discussed with reference to Lukes' (1974) third dimension of power in Chapter 2.

The rise of EBP may have, more indirectly, reduced the authority of statutory health promotion staff. Within the clinic, involvement in producing or using evidence of effectiveness became something of a symbol for general rigour. The commitment of KGHU in this regard was often questioned. Their involvement in evaluations and evidence reviews in the clinic was viewed as minimal, as was their own evaluation and EBP. KGHU staff were, however, actually involved in an experimental evaluation of some of their work outside the clinic.

This change in authority might have a number of consequences for the provision of SHP within the clinic. The new leadership from academic and service doctors, dominating multi-disciplinary research groups, or acting outside of these, differs from the previous leadership from the SHPG, in that it is less informed by ideas from health promotion literature. Those KGHU staff who were originally involved in the SHPG were educated

in health promotion theory, and applied these ideas in developing SHP in KGC, whereas those doctors now dominating innovation are not trained in these areas.

Voluntary provider

Some of the processes of evidence definition, production and use described in Chapter 8 were implicated in more general changes which swept the organisation in the period centring on 1996/7. GAA managers and directors, who can be grouped together as a single elite, succeeded in re-defining what was meant by volunteer leadership, despite some opposition from some co-ordinators and rank and file volunteers. The importance of using evidence served as a relatively uncontested element in the array of arguments which were used in justifying such a change. Almost all within GAA accepted that volunteers, whilst remaining at the centre of GAA activity, needed to use research as well as their own experience in developing projects.

The elite's strategy of changing the nature of volunteer leadership implied some increase in the authority of the elite (and workers) and some decrease in the autonomy of individual volunteers. The elite did not see these developments as acting against volunteers' interests. They were seen as increasing the likelihood of GAA's continued funding, an interest shared by the elite and by the rank and file. A widespread adoption of the revised approach to volunteer leadership would, however, have acted against the short-term interests of the rank and file, in that it would have reduced their authority. Therefore, a widespread adoption of the new approach by volunteers would have represented control via action at a distance

The extent to which these changes affected activity within volunteer cells in uncertain. There is some evidence that volunteers continued to prioritise the use of their own experiences and that, in a few groups, volunteers did not look to workers for anything more than administrative support. Some volunteers were apparently very reluctant to accept the authority of GAA's elite or of commissioners. Unlike practitioners in statutory organisations, volunteers are unlikely to perceive that, as individuals or as a group, their

status will be advanced as a result of their involvement with evidence-related processes. These factors make the likelihood of control of volunteers via action at a distance extremely unlikely.

d. Summary of conclusions

In conclusion, the case studies do appear to describe a set of relations resembling what has been described earlier as 'advanced liberalism'. Key features of this era which have been identified include: a delegation of the planning of provision from central agencies to peripheral commissioners and providers; a pluralism in the groups involved in the planning and provision of services; and a scrutiny of the work of these planners and providers, both in the form of self-scrutiny and external scrutiny. Within this set of relations, evidence is indeed implicated in strategies of control. Strategies of control via action at a distance on the part of commissioners were identified in the case of statutory providers. Here orientations to evidence on the part of commissioners and providers largely converged. Strategies of control via steering at a distance on the part of commissioners were identified in the case of voluntary providers, where orientations to evidence on the part of commissioners and provider noticeably diverged.

However, evidence does not seem to have served as a very useful resources of control within these strategies. Neither of the above strategies appeared to serve commissioners' or central agencies' interests. EBP may not make for very good control via *action* at a distance because it requires the presence of expertise at the periphery. Because the authority of this peripheral expertise in producing and using evidence is mostly supported by central agencies and commissioners, it is likely that peripheral interests, some of which differ from those of the centre and of commissioners, are served.

Similarly, EBP may not make for very good control via *steering* at a distance, because the commissioners of research do not possess the resources, or even the inclination, to control the production and use of evidence, as these strategies would really demand. Thus once again, local experts come to control these processes, resisting attempts by

commissioners to control them. This is likely to mean, again, that interests, other than those of the centre, and of commissioners, are likely to be served.

Doctors appear particularly likely to maintain their authority and autonomy with the advent of EBP. The group transcends the academic-service divide in a way that other occupational groups do not. Doctors have considerable authority in the production and implementation of evidence. This remains largely unchallenged by commissioners and central agencies. In producing and using evidence, doctors appear to be serving many of their own interests, such as: developing new technologies of research; maintaining the concept of clinical judgment in preserving some individual autonomy in an era of guideline-based practice; and influencing the practice of other groups, via having considerable say in how other groups develop and audit the use of clinical guidelines.

Other clinical groups did not appear to gain increased authority or status via their involvement in EBP, and did, in fact, appear to have their practice routinised in some cases. The workers and volunteers in the voluntary agency did not have their work determined or guided by protocols, although evidence was implicated in changes in the model of work embraced by the organisation. The degree to which this affected the actual work of the organisation is, however, uncertain.

3. Generalisability of conclusions to other settings

KGC is likely to resemble other NHS GUM clinics in possessing a similar array of staff, including doctors, nurses, CPs and health advisers. Most other GUM clinics lack an academic department, and so are likely to be much less active in developing EBP, and particularly in doing research. However, it is quite possible that some GUM practitioners, especially doctors, will have links with networks asserting the importance of using evidence, particularly of effectiveness, in the development of services. The Cochrane Collaboration, for example, is a highly structured and widely located network which many doctors are involved within. This may encourage them to be active, in the use, if not the production, of research. Interviewees suggested that using evidence is

becoming a normal expectation of clinical staff in the NHS. However, because of the presence of the academic department, the use of research in KGC is likely to have been more than in most GUM clinics.

KGC was unusual in being managerially integrated with a HIV prevention unit, as well as having a high proportion of gay men amongst attenders, resulting in HIV prevention being regarded as more of a priority than is likely to be the case in clinics with fewer attenders judged to be vulnerable to infection. Other clinics are less likely to be so pro-active in developing evidence-based HIV prevention, therefore.

GAA bears some resemblance to many other HIV voluntary agencies, in that it is funded mainly from statutory sources, and possesses both workers and volunteers. It is unlikely to be representative of a sector which, for example, Weeks et al. (1994) identify as extremely internally diverse. Many agencies are likely to lack an in-house research team, and therefore may be less active than GAA, in producing research evidence, and less focused on questions of what constitutes evidence. Weeks et al. (1994) report that many organisations do not involve volunteers. Many of those that do are not guided by any form of volunteer leadership. Those lacking volunteers and volunteer leadership may be less resistant to being steered by health authorities, as a result of not having an 'alternative constituency' in the form of a volunteer membership. GAA's volunteers, although not, per se, facilitating greater autonomy on the part of the provider, did appear to encourage GAA's management in resisting direction from funders.

Other HIV agencies might focus more on developing guidelines, perhaps based on evidence from research, since they may view their work as concerning the delivery of standard services, rather than the ongoing elaboration of innovations. This may be the case with organisations contracted to provide more specific services, such as counselling or outreach work, than is the case with GAA. Other agencies may be worse or better funded. It is difficult, therefore, to comment on the generalisability of the conclusions developed from the GAA case study to other HIV voluntary agencies.

Overall, HIV prevention resembles other areas of what is commonly termed health promotion or health education in a number of ways. Other areas similarly employ social, rather than clinical, interventions. Other areas of health promotion are also likely to involve the voluntary sector, as well as doctors and nurses working in statutory agencies. Like HIV prevention, other areas vary in the extent to which they are influenced by ideas from the health promotion literature. It may be the case that, in other areas of health promotion, commissioners will be less active in encouraging or undertaking the production and use of evidence, because these areas involve smaller investments, do not involve ring-fenced allocations, and perhaps involve less stigmatised groups and potentially controversial activities. It may, however, be that commissioners are pro-active despite the absence of these factors. Some generalisability seems likely.

KGC is likely to resemble other NHS clinical providers in employing many of the same practitioner and managerial groups. It is likely that doctors will dominate any production and use of evidence in other providers, because of their traditional dominance in most areas of clinical provision. Most clinical providers will, however, lack academic departments and so, once again, are less likely to be so involved in the production, if not the use, of evidence than was KGC. Nurses may play a more central role in health promotion in other areas of health promotion than is the case with GUM nurses and SHP. They might therefore be more involved in debates about evidence-based health promotion.

Although most clinical services are not funded from ring-fenced allocation, as HIV prevention is, it is likely that commissioners will be greatly focused on questions of the effectiveness of services, given the enormous amount of resources health authorities commit to clinical providers. Findings presented in Chapter 6 suggested that commissioners are likely to be less 'hands-off' with the clinical aspects of GUM provision, than they are with the SHP aspects. Chapter 6 also suggested that commissioners are more likely to trust in the expertise of clinical providers than those involved in voluntary-sector HIV prevention. This finding is likely to be generalisable to other clinical services. While this study reported that the health authority

commissioners de-funded some voluntary-sector based HIV prevention services without providing much justification in the form of evidence of lack of effectiveness, commissioners of clinical services are likely to find this more difficult, because of the reasons discussed by Leichter (1991). Therefore, if commissioners wish to ration clinical services, they may feel the need to gather more substantial evidence in support of their decisions.

GAA might resemble other voluntary agencies involved in other areas of health service provision in that it receives considerable statutory income, and possesses workers as well as volunteers. Other voluntary agencies might, again, lack in-house research teams, and so be less active in doing research, and less concerned with how evidence is defined. Other voluntary agencies may, or may not, have an alternative constituency in the form of a volunteer membership, and may, or may not, have an alternative source of income in the form of membership fees, which may increase the influence of volunteers, and/or decrease the influence of external funders. Marshall (1996) reports on the diversity in the voluntary sector as a whole, regarding these points.

Voluntary sector autonomy may be influenced by other factors. Non-HIV voluntary agencies may differ markedly from the HIV voluntary sector in that they may have developed prior to the advent of 'contracting culture', which according to Kendall and Knapp (1996) arose in the late 1970s and early 1980s. They may, thus, have experienced a period of greater autonomy during a prior era of grant-funding, which might engender greater resistance to direction from the current generation of NHS commissioners. In addition, those voluntary agencies of greater longevity than the HIV voluntary sector may have had more time to develop links, perhaps, with research agencies, or to resolve their orientation to evidence. In the absence, however, of empirical evidence on these possibilities, generalisability is difficult to assess.

4. Implications for sociological thought

Governmentality is of use in considering how questions of power might be implicated in

the production and use of evidence. It provides a set of metaphors to describe EBP in novel ways. The notion of the Panopticon, for example, can be used to provide metaphors for experimentation. Foucault (1977: 204) even suggests that the Panopticon was actually viewed, in accounts from the early 19th century, as allowing for experimentation on human subjects:

> The Panopticon is a privileged place for experiments on men [sic], and for analysing with complete certainty the transformations that may be obtained from them.

Foucault (1977: 204) reports the views of one contemporary on how the Panopticon could be used for experiments in child-rearing:

> one could bring up different children according to different systems of thought, making certain children believe that two and two do not make four or that the moon is a cheese... one would then have discussions that would be worth a great deal more than the sermons or lectures on which so much money is spent.

The randomised controlled trial, as the name suggests, requires control and scrutiny, both of those conducting trials and those being investigated. In visualising the RCT as a Panopticon, one side of the Panopticon's periphery houses the intervention group, and the other, the control group. The progress of individuals in each group is scrutinised by the investigator, housed in the central observatory. The fidelity with which the co-investigators deliver the intervention can also be observed.

The metaphor can also be applied to the use, by practitioners, of evidence embodied in guidelines and protocols. The development and audit of guidelines can be as occurring within a Panopticon. Metaphorically, practitioners are placed in cells, and their progress in following guidelines is observed. However, in this case, rather than being scrutinised by one all-seeing director at the centre, the practitioners actually observe their own progress. Metaphorically, the Panopticon's own inmates decide in which cells they reside, and organise for their own observation. The force of the metaphor is underlined by the frequent usage of the term 'transparent' in reference to evidence and EBP.

Governmentality, as a framework, is useful in highlighting the often subtle processes by which power is exercised: control does not always involve obvious domination; can operate via bottom up mechanisms in which agents act with no obvious constraint; and can occur as a ramification of activities where control is not explicitly strategised. However, Chapter 2 suggested that governmentality contained several methodological weaknesses. These are now revisited, in the light of the empirical findings of this thesis. Governmentality's value will be considered in terms of how it can explain the *conditions* under which techniques are developed, and the *consequences* of their deployment.

According to governmentality, developments in the exercise of power in society provide the explanation for the rise of new techniques. Intellectual or ethical developments are not viewed as occupying a realm distinct from power, and are not viewed as an independent motor of change. In other words, power relations provide the key *conditions* for the development of new techniques. Foucault was not interested in whether these conditions are acknowledged by actors, or not. As mentioned in Chapter 2, Foucault suggested that an examination of power need not consider the intentions of those involved in deploying its techniques.

This study, contrary to Foucault's advice, did examine whether intentionality lay behind the deployment of techniques of evidence production and use. The study identified cases where techniques were deployed with the intention of exerting power. For example, commissioners appeared primarily motivated by a desire to increase their control of GAA, in their commissioning of LHC2. The study also identified cases where techniques were deployed with no stated intention of exerting power, but where power relations were affected by this deployment. The continuing dominance of doctors in KGC as a result of their leadership of the production and use of evidence is a case in point. Most doctors involved in these processes were motivated by intellectual or ethical concerns. However, as a group, doctors benefitted. It is worth differentiating between these different situations on the basis of their different conditions of action. Without such a differentiation, intellectual and ethical concerns would necessarily become reduced to insignificant epiphenomena of power relations. It is suggested that this latter view would

imply a one dimensional a view of causality.

Just as Marx has frequently been criticised, fairly or unfairly, as viewing all action as economically-determined (Giddens 1982), or Webster (1995) criticises those who view the development and implementation of innovations in technologically-determinist fashion, Foucault could be criticised as viewing all action as 'control-determined'. Habermas (1987) criticises Foucault in just these terms, arguing that Foucault's (1977) dismissal of the development of juridical forms of power in modern societies, as a smokescreen for the covert disciplining of the population, obscures a more complex picture. Habermas suggests that the development of judicial processes has encouraged gains in civil rights, as well as increases in discipline. Interestingly, in Foucault's own historical studies (eg. Foucault 1977), he did not, himself, adopt such a reductionist approach. He indicated how intellectual developments were predicated on political circumstances, and contributed to the success of political strategies, but did not reduce the realm of ideas merely to symptoms of power-play. However, as a framework, governmentality does encourage an unhelpfully reductionist approach to the study of technologies, and these aspects should, as Chapter 2 suggested and fieldwork illustrated, be rejected.

In terms of the *consequences* of action, Foucault saw governmentality, not as a totalizing system of control, but as a web of different techniques, the consequences of which depended on local action. However, it has been suggested, for instance by Flynn (1997), that Foucault tended to emphasise domination, more than resistance, in his writings. This partially results from his refusal to consider interests; so that all conduct is viewed as resulting from the operation of power, rather than some conduct resulting from oppression, but some not. This study has adopted Lukes' (1974) notion of interests, as a means of differentiating oppression from other relations. It has suggested, for example, that some nurses may be acting within a system of relations which is oppressive to their interest, as an occupational group, in seeking greater authority over the work they undertake. It has suggested, conversely, that doctors may be acting to promote their own occupational group interests, as they lead on the development of guidelines.

This study has suggested that evidence production and use are not always effective as techniques of control of expert activity, either by via action at a distance, or via steering at a distance. Foucault himself acknowledged the possibility of control being resisted or otherwise failing. Flynn (1997) suggested that this aspect of governmentality was not, however, emphasised either in Foucault's own, or his followers', writings. Resistance as a concept would be difficult to identify without some notion of interests. This study identified possible cases of resistance, such as GAA's subversive use of research in questioning commissioners' decisions and standards of evidence. Without some assessment of what interests GAA was trying to promote, such an identification would be difficult.

In conclusion, this thesis has developed and applied a framework for the study of power which remains alive, as governmentality is, to the subtleties of power-play, but which unashamedly attempts to differentiate between oppressive, and non-oppressive, relations on the basis of a value-laden, but nonetheless rigorous, assessment of interests. It has used such a framework to develop potentially generalisable conclusions about a phenomenon receiving little sociological analysis, the implication of evidence in relations of control and resistance in advanced liberal health systems.

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Appendix 1: Interviewees

Initials	Description
Both cases	
James	Liaison Worker, KGC/KGHU
Matthew	KGHU Manager
Roger	HIV Commissioner, Aldbridge Health Authority
Trevor	Non-medical Academic, LUSH
KGC case only	
Angela	GUM Co-ordinator/Medical Academic, LUSH
Anne	Former KGHU Manager
Christine	Charge Nurse, KGC
David	R&D Programme Manager, NHSE Office
George	Medical Academic, LUSH
Greg	Acting CP-Manager, KGC
Jane	Medical Academic, LUSH
Jenny	Former KGHU Manager
Joanne	CP, KGC
John	Business Manager, KGC/KGHU
Jonathan	Clinic Director/Consultant, KGC
Justin	Non-medical Academic, LUSH
Kate	Clinical Services Manager, KGC
Laura	Medical Academic, LUSH
Paul	Medical Academic, LUSH
Peter	Non-medical Academic, LUSH
Richard	Senior Health Adviser, KGC
Simon	Registrar, KGC

Sue	Health Adviser-Manager, KGC

GAA case only

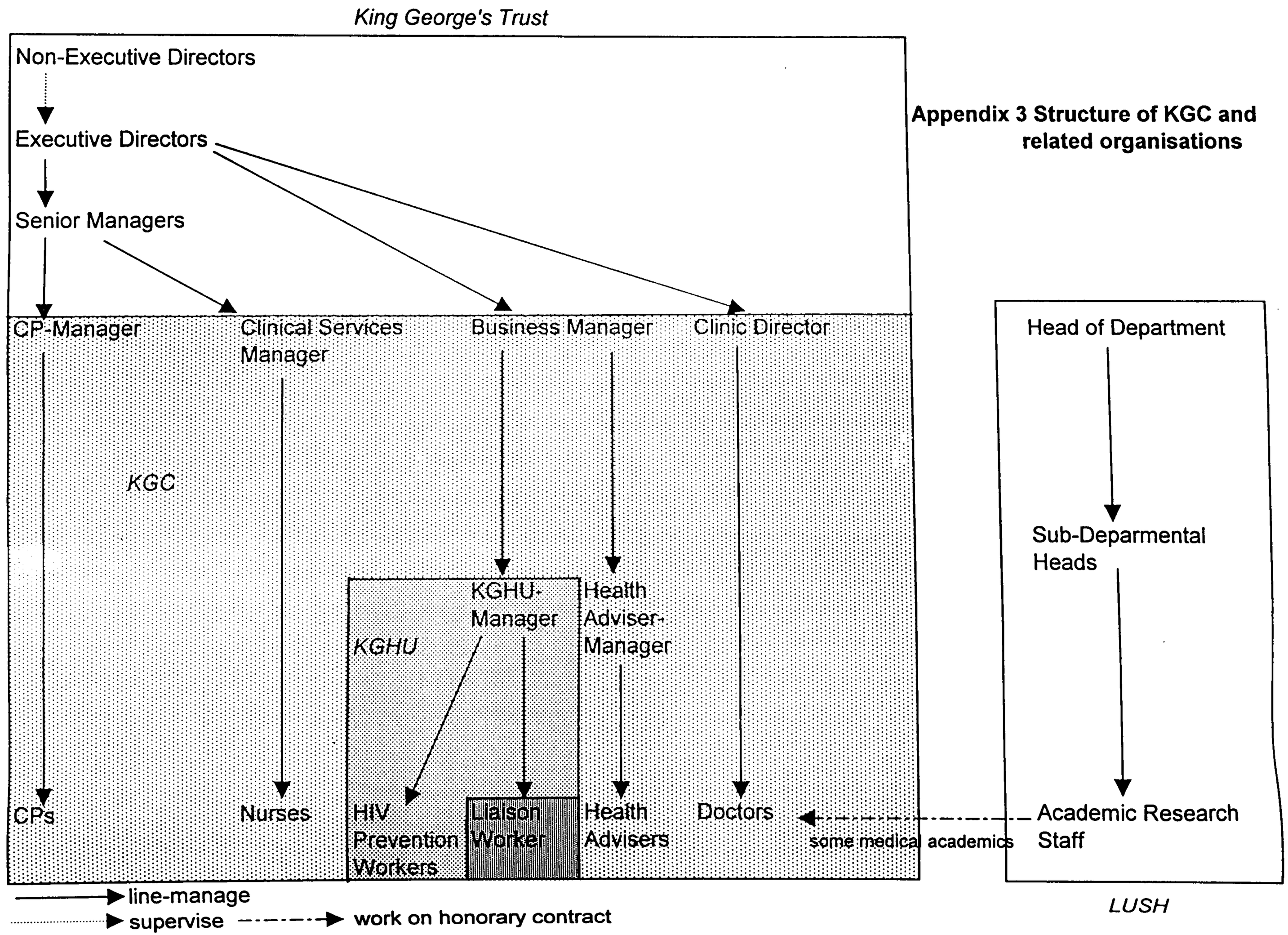
Alex	HIV Commissioner, Cherrington Health Authority
Andrew	Founder and Former Chair, GAA
Anthony	Former HIV Voluntary Sector Commissioning Adviser
Ben	Researcher, PPRU and Former Volunteer, GAA
Brian	Administrative Support Worker and Volunteer, GAA
Colin	Founder and Former Chair, GAA
Edward	HIV Commissioner, Burkington Health Authority and Founder, GAA
Gavin	Research Assistant and inactive Volunteer, GAA
Gordon	Research Group Co-ordinator, GAA
Graham	Founder and General Manager, GAA
Joe	Administrative Support Worker and Volunteer, GAA
Keith	LHC Operational Manager and Volunteer, GAA
Lisa	PPRU Researcher
Lynne	EPI Centre Researcher
Mark	HIV Voluntary Sector Commissioning Adviser
Neil	Founder, GAA
Robbie	Founder and Administrative Support Worker, GAA
Steven	University Researcher
Tim	Administrative Support Worker (Research) and Volunteer, GAA
Tom	Director, GAA
Tony	Volunteer Development Worker, GAA
William	Former HIV Commissioner, Cherrington Health Authority and Former Volunteer, GAA

Appendix 2: Acronyms used

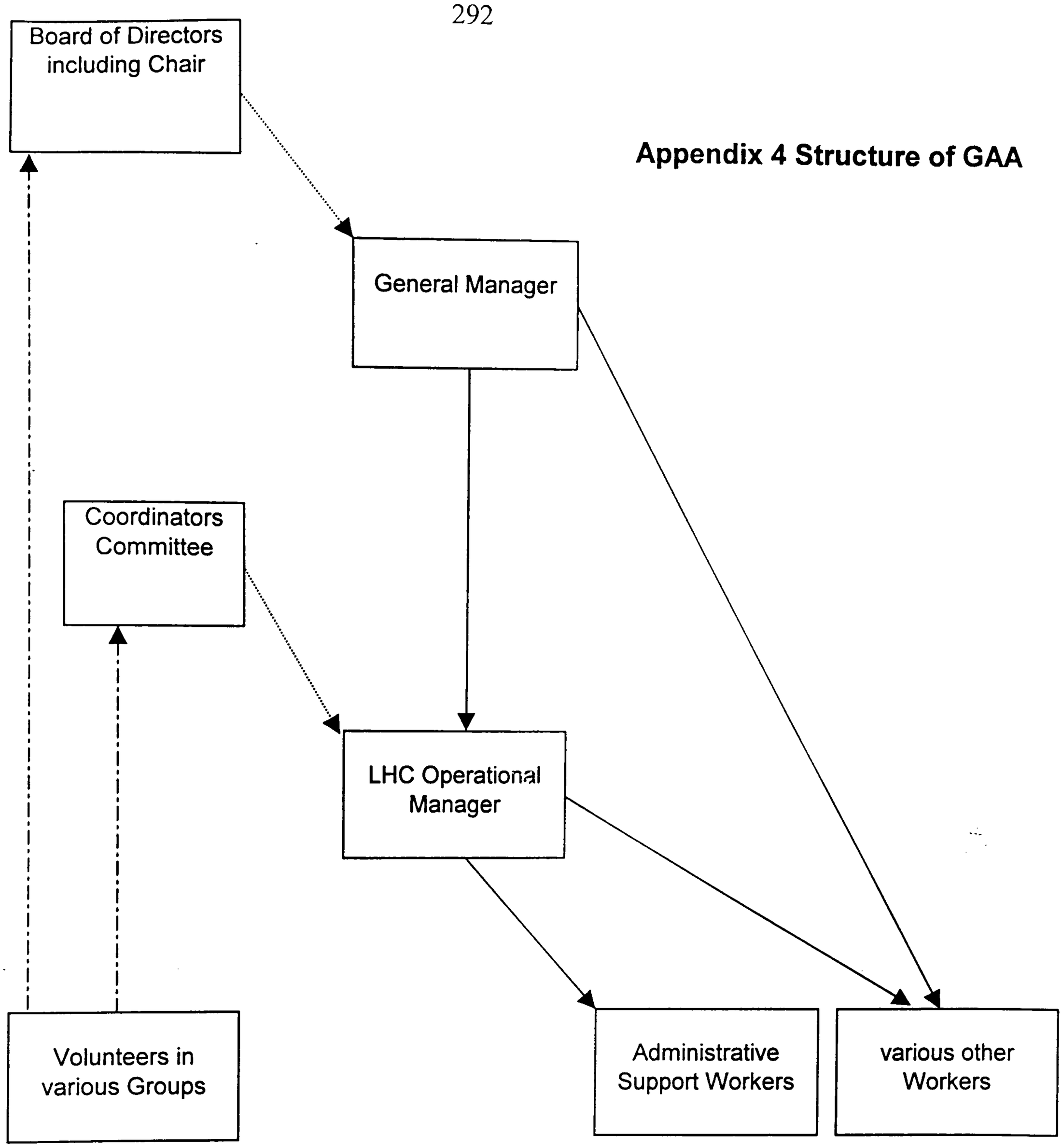
AIDS	Acquired Immune Deficiency Syndrome
CP	Clinical Psychologist
CRDC	Central R&D Committee
DHA	District Health Authority
DHSS	Department of Health and Social Security
DoH	Department of Health
EBM/EBP	Evidence-Based Medicine/Evidence-Based Practice
ENB	English National Board for Nurses
GAA	Gay AIDS Action
GBG	Group-work Behavioural Intervention for Gay men
GG	Gay Group
GUM	Genito-Urinary Medicine
HIV	Human Immuno-deficiency Virus
LHC	London HIV Campaign
LUSH	London University Department of Sexual Health
KGC	King George's Clinic
KGHU	King George's HIV Prevention Unit
MESMAC	Men who have Sex with Men: Action in the Community
NCVO	National Council of Voluntary Organisations
NHPIS	National HIV Prevention Information Service
NHS	National Health Service
NHSE/NHSME	NHS Executive/NHS Management Executive
PHLS	Public Health Laboratory Service
PPRU	Public Policy Research Unit
R&D	Research & Development
RCN	Royal College of Nursing
RCT	Randomised Controlled Trial
RHA	Regional Health Authority
SHP/SHPG	Sexual Health Promotion/Sexual Health Promotion Group

UKCC	United Kingdom Combined Council for Nurses, Midwives and Health Visitors
WHO	World Health Organisation

Appendix 3 Structure of KGC and related organisations



Appendix 4 Structure of GAA



line-manage
supervise
elect

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