Buzzwords

An HIV outreach glossary

To talk about HIV outreach, you need to know the language; the problem is, it's changing fast

"OUTREACH" IS A WORD that has gained enormous currency in the context of recent harm reduction and HIV prevention initiatives targeting drug users. For some, it signifies merely the latest move in the step by step progress of harm reduction; for others, it is the long-awaited panacea in the race to change HIV transmission behaviour among the hardest-to-reach drug injectors.

Today the notion is under increasing investigation and re-evaluation. What's sometimes forgotten – or selectively remembered – in this process, is that outreach has a history. For some this dates back to the 1860s and the philanthropic 'community spirit' ethic of the professional classes intervening in deprived areas of London. For others, the preferred history is that of 1950s 'street-corner' work with Chicago street gangs. For others still, outreach began in the context of youth and community work in the 1960s. Whichever is your preferred history, there is no doubt that the development of outreach has taken yet another turn in the last five years.

In 1988 the first *AIDS and Drug Misuse* report of the Advisory Council on the Misuse on Drugs (ACMD) recommended that "services must now make contact with as many of the hidden population of drug misusers as possible". Drug services were encouraged to "experiment with a variety of [outreach] approaches and monitor their effectiveness in reaching drug users not in touch with services."[1]

This was to symbolise a shift away from conventional notions of 'help-seeking' towards 'reaching-out' to drug injectors most in need of services. Five years on and the debate has moved on to a re-conceptualisation of outreach itself.[2,3,4] Nothing in this debate has diminished the perceived importance of outreach. The term is now an integral and everyday part of purchasers' and providers' *Health of the Nation* vocabulary, and has kept the readers and writers of *Druglink* (and other similar journals) in torrid debate since the late 1980s.[5]

For the drugs field outreach came of age when in 1993 the third ACMD AIDS report, *AIDS and Drug Misuse: Update*, devoted a whole chapter to its future.[6] It notes the continuing importance of outreach as a "key component of an overall strategy which aims to influence greater numbers of drug users". Where it moves forward is in suggesting that "achieving community change should be the focus of outreach work at least as much as securing individual change". One of the renewed objectives of outreach should, said the ACMD, be "to help clients themselves to bring about changes in other injectors with whom they are in contact" (see figure 1).

These developments have introduced a variety of seemingly new words and concepts to the vocabulary of outreach, words which have as much to do with *community* change as with individual risk reduction.[7,8] Little of this is new, though it might appear new to some workers, whose vision of 'outreach' begins with HIV and ends with AIDS, despite its extensive pre-AIDS foundations as a method of community intervention.

In particular, the tendency to *re*-invent 'outreach' in the context of HIV/AIDS has been accompanied by a tendency to *un*-invent the methods of 'health promotion', of which HIV outreach is a part. Such a limited vision may fail to see what *is* new in outreach today.

by
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Outreach has a long and varied history in health promotion and other community interventions. Some of the key concepts from those spheres are only now being incorporated into the language of HIV outreach in the UK. Central to these developments is the notion of changing communities as opposed to just individuals and enabling communities to control their own health. An initial attempt is made to define the key concepts in this area so that debates over the future of outreach benefit from a common language.

A shared language

'Outreach' is in a state of change.[9] Conscious of the increasing confusion, we outline here the beginnings of an *HIV Outreach Glossary*. Mindful of our own strictures, we have been careful to include key concepts and key words from health promotion which help to describe the context for outreach work and the principles and practices which might underlie an emerging philosophy – perhaps even a theory – of HIV outreach work.[10]

Following the precedent in health

WHAT IS A COMMUNITY?

In health promotion a *community* is "a specific group of people usually living in a defined geographical area who share a common culture, and exhibit some awareness of their identity as a group".[38] For the purposes of community-based HIV prevention, the US National Institute on Drug Abuse has broadly defined a community as "a set of formal or informal relationships that has some established criteria for membership".[39] In practical terms, these relationships are determined by "the everyday shared norms, values and practices relevant for change or endorsement when targeting modifications in health behaviour".[40] *Community-based work* can be broadly defined as any work undertaken directly in the community, outside of formal health service agencies, institutions and organisations.

promotion,[11] our intention is not to determine what 'outreach' *really* is, but to start clearing up some of the confusion which surrounds community-based HIV prevention. Such a glossary can only form part of the skeleton on which to hang and generate debate on selected 'keywords'. The aim of that debate is to arrive at a common vocabulary (and a common understanding of that vocabulary) which we can use to talk about the principles and practices of HIV outreach work.

It may be that no one definition of 'outreach' can be arrived at. Different purchasers and providers from different health sectors understand the fundamental aims, objectives and practices of 'outreach' very differently[12] – no surprise, for the word conflates a myriad of meanings, practices and promises. But if purchasers are to purchase outreach effectively, and if providers are to provide it efficiently, there needs to be mutual understanding of the basic models and elements of HIV outreach work. Whether one decides to celebrate or to criticise 'outreach' depends largely on *whose* outreach we are talking about and what exactly we expect it to achieve.

This glossary is an initial attempt at defining some of the key concepts integral to HIV outreach and community-based prevention work. There are many participants involved in the purchasing, provision, consumption and evaluation of outreach services. While each might have differing and competing expectations and desires, it is important that to some extent they speak the same language. Here are some of what we believe are that language's most important sound bites.

The key concepts for HIV outreach in the '90s

What it is

HIV outreach can be defined as: "A community-based activity with the overall aim of facilitating improvement in health and reduction in the risk of HIV transmission for individuals and groups not effectively reached by existing services or through traditional health education channels".[13]

Where it happens

Detached outreach[14] takes place outside of any agency or organisational setting – on the streets, on station concourses and in pubs, bars and cafés.

Peripatetic outreach[15] focuses on organisations rather than individuals. This includes work undertaken in hostels, syringe exchanges, youth clubs, schools and prisons.

Domiciliary outreach[16] focuses on visiting the homes of target populations. This tactic may be adopted in the absence of clearly defined street-based sites where target individuals or groups congregate. It may also be additional to detached and peripatetic work.

What it aims to change

There are two main types of HIV outreach strategy:

Individual outreach[17,18] targets individuals on a one-to-one client-worker basis, aiming to facilitate changes in individual risk behaviour. Workers may approach this by trying to enhance their clients' 'self-empowerment', 'self-efficacy', 'self-assertion', 'self-esteem', and so on. Such approaches are closely aligned with information-giving and self-empowerment models of health education.[19,20]

Community outreach[21,22] targets 'communities' rather than simply individuals. The aim is to achieve 'community change' as opposed to individual change, 'community empowerment' as opposed to individual or self-empowerment. Community outreach approaches are closely aligned with community action and community-oriented models of health education (see below and figure 2).[23,24]

What kind of change?

Individual change refers to changes in the target individuals' perceptions, beliefs and behaviours with regard to HIV-related health behaviour. Individual change interventions are targeted towards individuals, often on a client-centred one-to-one basis.

Community change means change in the norms of communities as a whole rather than change restricted to the individual members of that community. Such changes will influence the behaviour of existing and new members of the community, helping to sustain and replicate the changes despite the turnover of individuals. New norms may develop into a shared, collective sense of what is acceptable or unacceptable, good or bad. 'Community outreach' interventions aim to target and facilitate changes in the 'unhealthy' norms, values and practices of whole 'communities'.

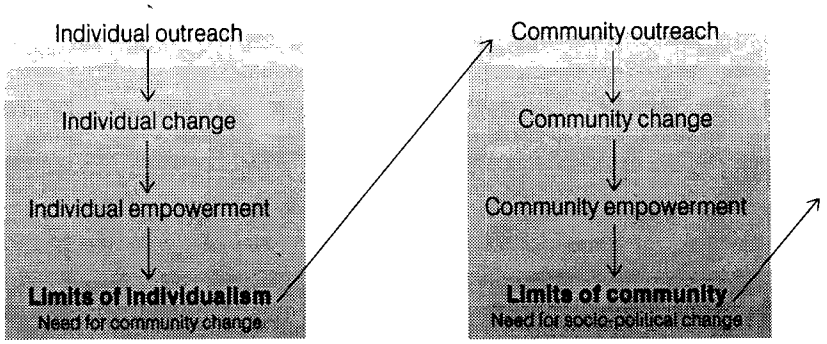
Social and political change refers to changes in wider structural factors such as in the social, political and material conditions which influence communities and environments, for example, changes in the law on soliciting and prostitution.

Where change happens

Direct change[25] is facilitated by outreach interventions actually in the community settings where outreach happens – on the streets, in homes, etc – through the provision of prevention and treatment services *in situ*.

Indirect change[26] is also facilitated by outreach interventions, but by encouraging people to access *other* helping and treatment services, rather than by the outreach intervention itself.

FIGURE 1. INDIVIDUAL AND COMMUNITY OUTREACH



How change happens

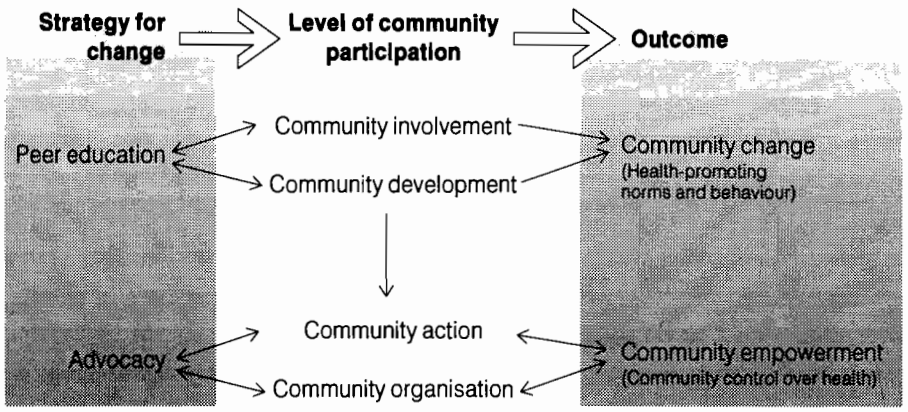
Community involvement means the "active participation of people living together in some form of community in the process of problem definition, decision-making and action to promote health".[27] Also termed 'community participation', this is a weaker form of community action (see below).

Community development involves collaboration between agents of change from outside the community and the affected communities themselves. It encourages "self-organisation and mutual assistance within groups of like-minded people".[28]

Community action is defined in health promotion as the "deliberate organisation of community members to accomplish some objective or goal".[29] Communities acheive these goals via activities "under their own control in order to improve their collective conditions"[30]. Beyond achieving particular changes, such as less needle sharing, there is the broader goal of "communities having their own power and ... control of their own initiatives and activities".[31]

Community organisation takes community action a step further by attempting "to form temporary or permanent organisational structures involving members of a community".[32] These may take the form of committees, agencies, membership organisations, voluntary groups, neighourhood groups, etc, through which change can be achieved.

FIGURE 2. A MODEL OF COMMUNITY OUTREACH



Like community action, the aim is collective ownership and control over health-related choices and activities. Community organising may also engage with forces outside the community to seek 'socio-political changes' in health policy and material conditions – an 'advocacy' role (see below).

Advocacy refers to health action which aims to "influence the decisions and actions of communities and governments which have some control over the resources which influence health".[33] Health advocacy work often targets 'social and political change' as well as 'community change' and is closely related to its more politicised cousin, *health activism*.

Empowerment is "the notion of people having power to take action to control and enhance their own lives, and the processes of enabling them to do so".[34] The aim is to "improve health by developing people's ability to control their health status within their environmental circumstances".[35]

Self-empowerment aims to enable individuals to make 'informed' and 'rational' choices in their health-related behaviour. It does this by encouraging 'self-assertion', 'self-efficacy' and 'self-esteem', and by providing people with the means (eg, condoms, bleach) to make 'healthy' choices or to put them into practice.

Community empowerment is achieved when communities have complete collective ownership and control over defining what is 'healthy' and 'unhealthy', and over health-related choices and activities.[36,37] To achieve this, they may also need to gain collective control over the wider social, political and material factors which influence their access to health. Community empowerment can be viewed as the long-term goal of 'community action', 'community organising' and health activist initiatives.

Peer education is what happens when members of a community actively educate their friends and peers about HIV-related health behaviour. The aim is to endorse social relationships which support safer drug use and safer sexual practices, and to facilitate changes in those relationships where this is not the case. Peer educators work by endorsing 'healthy' norms, beliefs and behaviours within their own peer group or 'community', and challenging those which are 'unhealthy'. ❍

Comments on the glossary are welcomed and should be addressed to: Tim Rhodes, The Centre for Research on Drugs and Health Behaviour, 200 Seagrave Road, London, SW6 1RQ, phone 081-846-6565, fax 081-846-6555.

1. Advisory Council on the Misuse of Drugs. *AIDS and Drugs Misuse: Part One*. London: HMSO, 1988.
2. Rhodes T.J. "Time for community change: what has outreach to offer?" *Addictions*: 1993a, *88*, p.1317-1320.
3. Rhodes T.J. *Outreach, community change and community empowerment: contradictions for public health and health promotion*, 1993b (forthcoming, available from author).
4. Stimson G.V. *et al. Potential development of community oriented HIV outreach to drug injectors in the UK*, 1993 (forthcoming, available from author).
5. Instances of this debate are adequately captured by a cursory glance at volume 8 issue 4 of *Druglink* (1993). See, for example, Peter McDermott's contribution entitled "The personal touch".
6. Advisory Council on the Misuse of Drugs. *AIDS and Drugs Misuse: Update*. London: HMSO, 1993.
7. Rhodes T.J. 1993b, op cit.
8. Stimson G.V. op cit.
9. ACMD. 1993, op cit.
10. Many of these are well established concepts in health promotion. Many are also subject to a range of competing definitions. We provide definitions which are of practical utility with regard to understanding and undertaking HIV-related community-based prevention.
11. Nutbeam D. "Health promotion glossary." *Health Promotion*: 1986, *1*, p.113-127.
12. Rhodes T.J. *et al.* "Innovation and constraint: management of an HIV outreach intervention." *International Journal on Drug Policy*: 1992, *4* (3), p.141-152.
13. Rhodes T.J., *et al. Hard to reach or out of reach? An evaluation of an innovative model of HIV outreach health education*. London: Tufnell Press, 1991.
14. Rhodes T.J. *et al* 1991, op cit.
15. Rhodes T.J. *et al* 1991, op cit.
16. Stimson G.V. op cit.
17. Stimson G.V. op cit.
18. Rhodes T.J. 1993b, op cit.
19. Homans H. *et al.* "Health education about HIV infection and AIDS." *In*: Aggleton P. *et al, eds. Social aspects of AIDS*. Lewes: Falmer Press, 1988.
20. French J. *et al.* "Health education: from analysis to synthesis." *Health Education Journal*: 1986, *45*(2), p.71-74.
21. Stimson G.V. op cit.
22. Rhodes T.J. 1993b, op cit.
23. Homans H. *et al*, op cit.
24. French J. *et al*, op cit.
25. Rhodes T.J. *et al* 1991, op cit.
26. Rhodes T.J. *et al* 1991, op cit.
27. Nutbeam D. op cit.
28. Beattie A. "Knowledge and control in health promotion: a test case for social policy and social theory." *In*: Gabe J. *et al, eds. The Sociology of the Health Service*. London: Routledge, 1991.
29. Brown R.E. "Community action for health promotion: a strategy to empower individuals and communities." *International Journal of Health Services*: 1991, *21*, p.441-456.
30. Gorna R. *Action on AIDS in UK communities*. Research and Policy Paper No. 7. London: Community Projects Foundation, 1990.
31. Ashton J. *et al. The new public health*. Buckingham: Open University Press, 1988.
32. Brown R.E. op cit.
33. Nutbeam D. op cit.
34. Grace V.M. "The marketing of empowerment and the construction of the health consumer: a critique of health promotion." *International Journal of Health Services*: 1991, *21*, p.329-343.
35. French J. *et al*, op cit.
36. Rhodes T.J. 1993b, op cit.
37. Rhodes T.J. "HIV outreach, peer education and community change: developments and dilemmas." *Health Education Journal*: 1994 (forthcoming, available from author).
38. Nutbeam D. op cit.
39. Amsel Z. "Introducing the concept of 'community prevention'". *In*: Leukefel C. G. *et al, eds. AIDS and intravenous drug use: future directions for community-based prevention research*. Rockville: NIDA, 1990.
40. Rhodes T.J. 1993a, op cit.