

George House Trust Positive Speakers Programme



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Pilot Stage Evaluation Report JULY 2008 –MARCH 2009

george house trust
still life with HIV



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Background

George House Trust is the leading HIV social care provider in the North West. In addition to the services provided to those living with or affected by HIV in the North West region, GHT is committed to campaigning for the best quality of life for people living with HIV. The Positive Speakers Programme forms part of the campaigning and educational objectives of GHT by raising awareness of the issues surrounding HIV.

The main aim of the Positive Speakers Programme is to challenge the stigma and prejudice surrounding HIV and reduce the discrimination towards people living with or affected by HIV. The pilot stage of the Programme was funded by the Equalities and Human Rights Commission and ran from the beginning of July 2008 until the end of March 2009. In addition to the 3 existing Positive Speakers, 12 new speakers from various backgrounds were recruited and trained to go out to various organisations and groups to share their personal experience of living with HIV in order to challenge the myths surrounding HIV and educate people about the reality of living with HIV.

Evaluation Methods

In order to evaluate the impact of the talks on the audience members, participants completed questionnaires immediately before and after the talk. The questionnaire completed prior to the talk asked the participant how much they agreed or disagreed with a set number of 'attitude statements', which were designed to measure levels of stigma towards HIV positive people. It also asked them to identify the main routes of transmission of HIV in the UK. Following the talk, the participants were again asked to state how much they agreed or disagreed with the set list of attitude statements in order to see if their opinions had been altered by hearing the experiences of the Positive Speakers. Participants were also asked to rate the different aspects of the session.



Throughout the pilot stage of the programme, Positive Speakers have spoken at a variety of venues and to diverse groups of people. Some have been stand alone educational and awareness raising sessions, other sessions have contributed to in-depth HIV courses, some have been showcase events, others have been part of public remembrance ceremonies. It therefore was not practical or appropriate, at every Positive Speaker session, to use the full questionnaire.

During the pilot stage of the Positive Speaker Programme, the Positive Speakers spoke directly to over 900 people. Of these, 596 completed the full evaluation questionnaire, while a further 71 completed a shortened evaluation questionnaire asking them to rate the session and asking what they would do differently as a result of hearing the Positive Speakers' testimonies. In three other sessions evaluation questionnaires were not conducted by GHT; these were evaluated by those responsible for organising them and general feedback was sent through to GHT about the Positive Speakers but this will not be used to inform this report.

Throughout this report, participants are separated into groups in order to examine trends amongst distinct groups. These groups are:

Schools: 235 participants

FE Colleges: 227 participants

Healthcare professionals and trainees: 109 participants

Youth groups: 25 participants

A further ten sessions were delivered to groups who did not fit into these categories but full questionnaires were not gathered at these sessions, and as such no robust evaluation data exists for groups other than those listed above.



Attitude Statements

A total of 8 attitude statements were measured on the evaluation questionnaires:

1. It is only gay men who get HIV
2. These days in the UK many people with HIV die young
3. HIV positive people shouldn't have sex
4. You can tell if someone has HIV by how they look
5. I wouldn't be friends with someone with HIV
6. It's your own fault if you've caught HIV
7. I have the right to know if someone I work with is HIV positive
8. It is right to deport HIV+ people refused asylum to countries where treatments aren't available

Participants were asked to state how much they agreed with each statement by allocating a score from 1 to 5, 1 being '*strongly agree*' (we deemed this the most negative response), and 5 being '*strongly disagree*' (this was deemed the most positive response). The aim of the session was to make people's attitudes as positive as possible (awarding a score of 4 or 5).

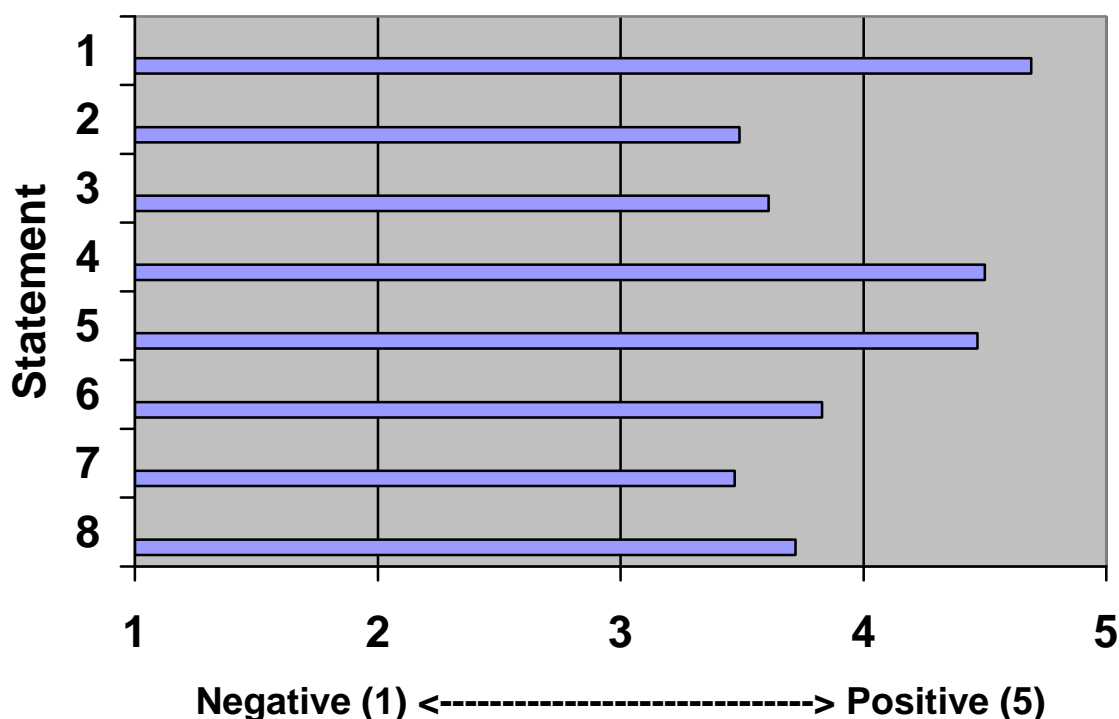
Average Scores Before

When monitoring the attitudes people held before the sessions, the following became apparent:

- People had the most positive attitudes to statement 1
- Statements 4 and 5 also elicited very positive responses overall
- Statements 2, 3 and 7 received the most negative responses



Overall average scores given to the statements before the talk

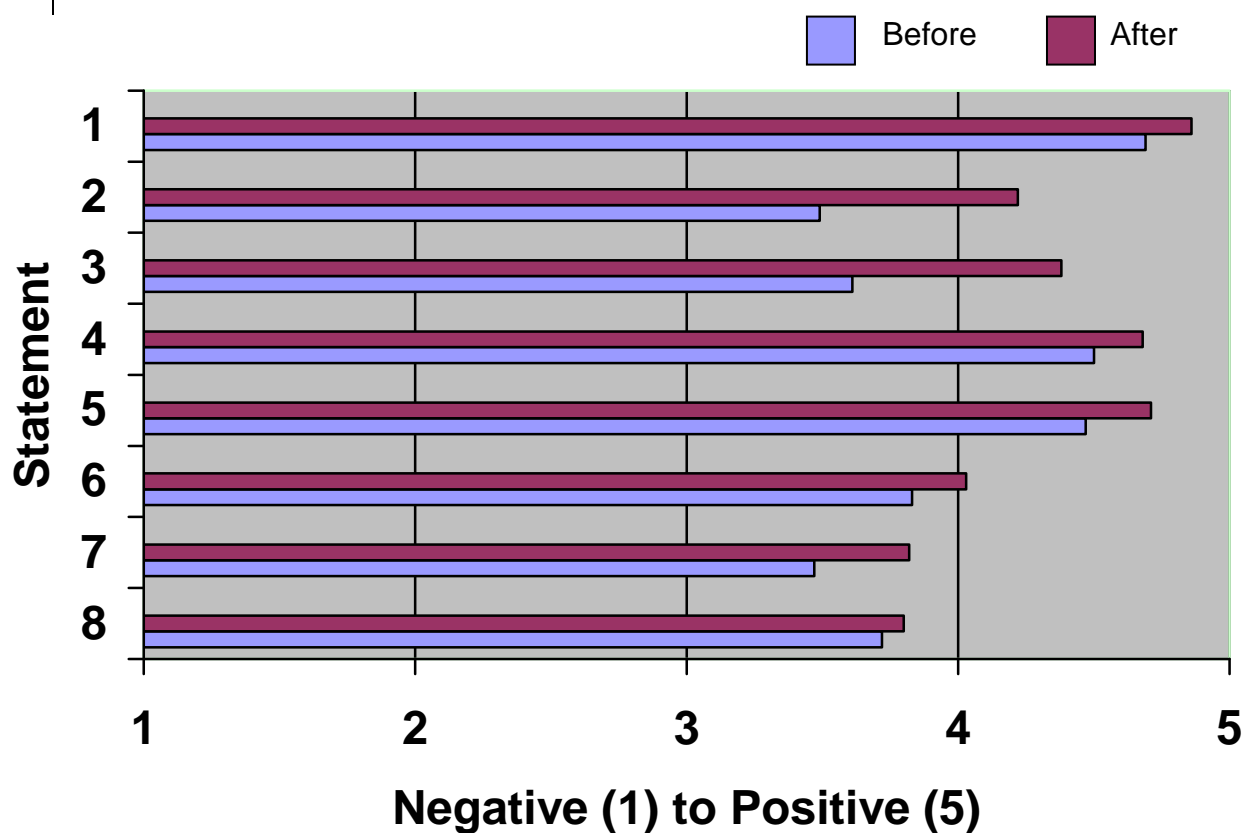


The positive response to *statement 1* gives hope that homophobia's role in HIV related prejudice may have diminished in recent years, however further research on this area is needed to discover why this is, whether other prejudices have replaced it / now run alongside it, and what role it does still play in HIV related discriminatory practices of today. This may also demonstrate the success of wider health promotion messages that HIV can affect anyone.

The overall positive response to *statements 4 and 5* before the session are also very promising and indicate that levels of awareness and stigma on these issues do not need as concerted an effort as others. The responses to *statements 2 and 7* show that knowledge around the impact of HIV on someone's life expectancy and positive people's rights as covered under the DDA are particularly poor.



Average shift in scores after the talk



Following the session, there was a positive shift in average scores given to *all* of the attitude statements compared to the average scores given before the talk. *Statements 1 through to 6* scored positively with an average of between 4 and 5 (the most positive scores that could be allocated) following the talk, and *statements 7 and 8* scored an average of between 3 (neutral) and 4 (positive) following the talk.

The statements with the most improved responses were *statements 2 and 3*, those measuring participants' perceptions of life expectancy with HIV, and whether an HIV positive person should be sexually active. There was also a significant improvement in the responses following the talk to *statement 7* which addressed the confidentiality rights of positive people at work.



The statement with the most minimal positive shift in the responses following the talk was *statement 8*, which measures attitudes around HIV related asylum issues. From this we can conclude that more specific information is needed with regards to immigration issues and access to treatments in other countries in order to make a bigger impact on attitudes in this area. However, with asylum and immigration attracting a high degree of negative media coverage any positive shift achieved in a one-hour session has to be seen as an achievement. Challenging prejudice around asylum/immigration and homophobia, although both extremely important issues, are secondary aims of the Positive Speakers Programme.

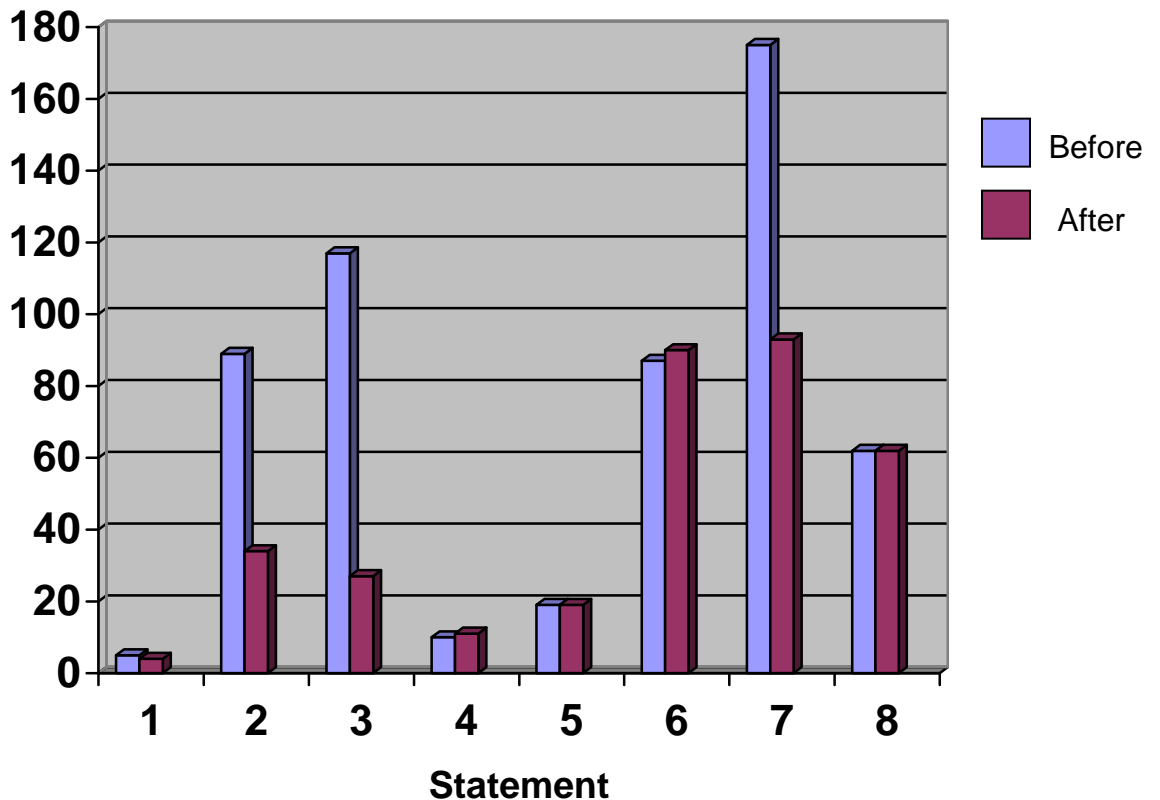
Changing Opinions

In addition to analysing the overall shifts in attitudes in terms of the average of all scores given to statements before and after the Positive Speaker sessions, we also tracked changes in attitudes, of those who held the most stigmatising attitudes before the talk was tracked. This was done in order to evaluate the impact of the talks on those participants *most likely* to discriminate.

In the questionnaire completed immediately before the Positive Speakers session, the statements that elicited the most negative responses were *statements 2, 3 and 7*: life expectancy, sexual activity, and right to confidentiality at work. The percentage of people completing the questionnaires that held negative views and scored just 1 or 2 for these statements prior to the talks was 15% (*statement 2*), 20% (*statement 3*) and 29% (*statement 7*) respectively.



Number of People with Negative views (Scoring 1 or 2)



Following the talks, the percentage of people scoring negatively (giving a score of just 1 or 2) for *statement 7* was reduced to 16%, almost a half of what it was prior to the Positive Speaker session. Negative views for *statement 2* were also significantly reduced; after the talk the percentage with negative views was just 6%, almost a third of what it had previously been. The biggest reduction however was with *statement 3* which was cut to 5%, a quarter of that prior to the talk. In real numbers this translates to 90 less people (out of the 596 completing evaluations) thinking that HIV positive people shouldn't have sex.

Despite being halved as a result of the session, the fact that 15% of participants still held negative views for *statement 7* suggests that the speaker session alone is not enough to change attitudes in this area and that education about the rights of people living with HIV, particularly in terms of the



DDA, is required. 93 people (out of the 596 completing full evaluations) following the talk still thought they had the right to know if someone they worked with was HIV positive.

Statement 8 also retained a high number of people (10%) with negative attitudes, following the talk. As discussed above, this reflects the level of prejudice within society towards asylum seekers and whilst positive speakers are trained in challenging prejudice, there is not scope within the Positive Speaker sessions to provide in depth training/information about asylum/immigration. Organisations such as Refugee Action have specific training programmes designed to address these issues.

Statement 6, 'It's your own fault if you've caught HIV' was the only statement that saw an increase in the number of people with negative views following the talk, albeit a minimal one at 1%. From reading the accompanying comments on the questionnaires of those with negative views for this statement it appears that this increase is a result of the ambiguity and emotiveness of the word 'fault' in this statement. This statement was originally intended to measure people's attitudes around the 'blameworthy' and 'innocent' categories that positive people are often labelled with. However, throughout the positive speaker sessions we promote a safer sex message that a person's sexual health is their own responsibility.

Despite the number of people with negative attitudes for *statement 6* increasing slightly, the overall average score given to this statement did see a positive shift. From these two contradictory results it seems as though the statement 'It's your own fault if you've caught HIV' has been interpreted as 'HIV positive people are blameworthy' by most of the participants and as 'HIV positive people should have practised safer sex / needle procedures' by a minority. Following the evaluation of the programme, this statement will either be removed or reworded to more accurately capture data around the impact on the blameworthy and innocent categories.



Conclusion

It is clear from the evaluation data that people are no longer seeing gay men as the only group affected by HIV; however it is important that in further evaluations we discover peoples current perceptions of who *is* at risk as this will help us raise awareness and challenge stigma more effectively, not just in the Positive Speakers Programme, but in all our organisational campaigning efforts.

The 'iceberg' images, the myths about routes of transmission, and the media portrayals of life with HIV and of positive people are still effecting people's perceptions of positive people and of life with HIV. In practical terms for positive people this leads to problems at work with colleagues and employers believing they have the right to know someone's status, which leaves positive people far more vulnerable to work-based discrimination and to problems accessing employment opportunities.

Educating people about today's reality of life with HIV should therefore be a priority of educational programmes. However, the difficulty of marrying the information about the increased quality and quantity of life with HIV and the prevention message is no small issue. If we are portraying HIV as no longer being a 'death sentence' as the governments tombstone adverts in the 1980's depicted, but as a chronic and manageable illness (albeit one that is still accompanied with severe health problems and tremendous amounts of stigma) there is the risk that the safer sex / reduced risk taking messages are adversely affected. The Positive Speakers Programme is one of the most effective ways of dealing with this problem as the complexity of the issues and the true extent of the daily difficulties faced by positive people, and the differing health implications for each positive person are told in the most palatable format, through a story. It is in this format that any potential contradictions can be best negotiated, and the prevention message can be reinforced; through the power of the emotional impact that speaking to a real person has.



Sector Specific

Positive Speakers share their experiences with a wide variety of people in different settings and the bookings for Positive Speaker sessions come from a range of organisations. However, the bulk of bookings for Positive Speaker sessions can be divided into the following groups: Healthcare (trainees and professionals), FE colleges, Schools, and Youth Groups.

When the evaluation results are divided into these groups, the following became apparent:

- The biggest attitudes shifts were made with the youth groups*, followed by the FE students.
- The participants at schools held the most negative attitudes before and after the talk, and had the least positive shift as a result of the talk. (Although there was a still a significant positive shift)
- Minimal attitude shifts were achieved with the Health Care professionals. However, this was the group that held the most positive attitudes before and after the talk.

* Only 2 sessions were held at youth groups and so the data is not robust enough to draw concrete conclusions about this group.

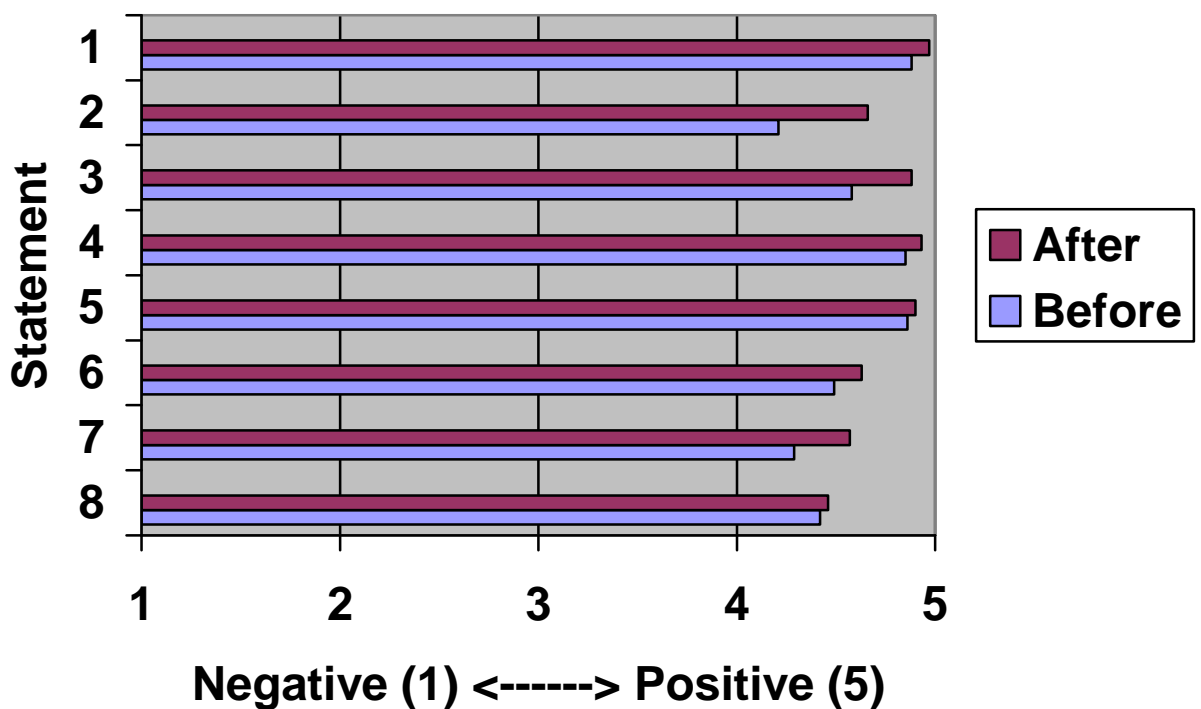
Healthcare

When examining progress with the individual statements, the only significant shift for healthcare trainees and professionals was for *statement 2*, regarding life expectancy. However this was the group with the most positive attitudes across all statements after the talk; with all statements scored between 4 and 5 (the most positive scores that can be given). Evidence of any



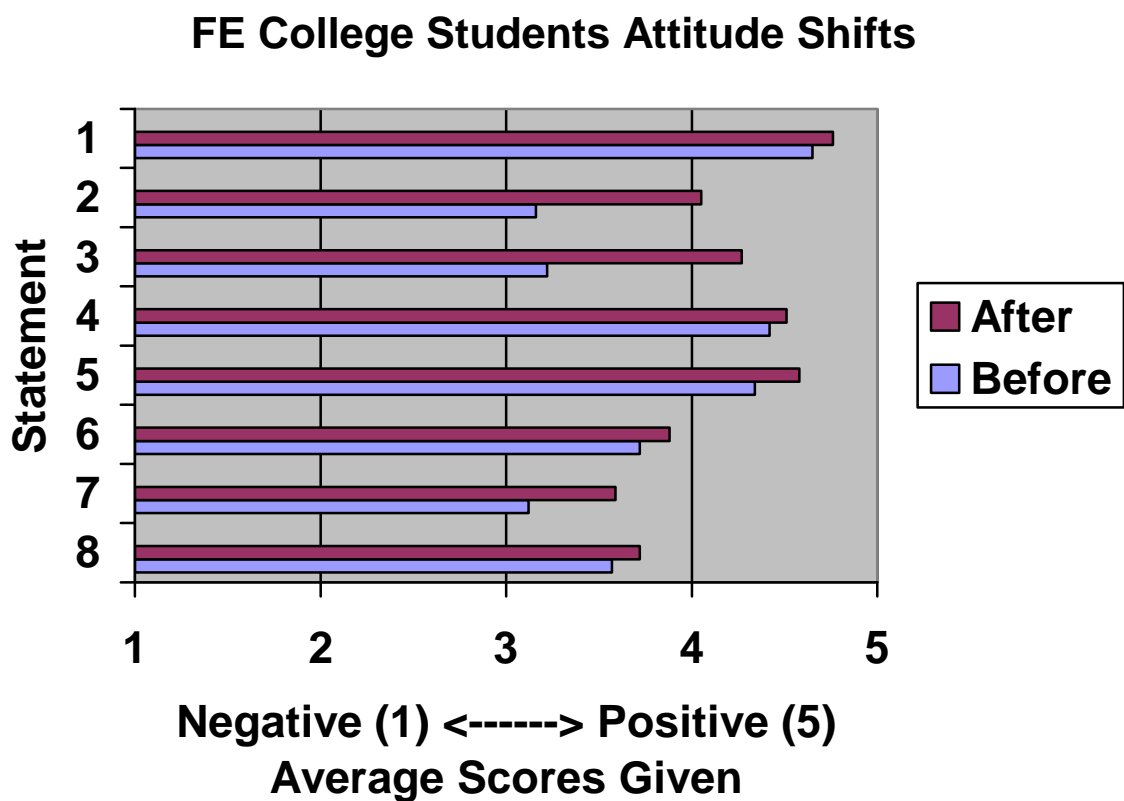
negative/stigmatising attitudes was almost completely eradicated amongst participants in the healthcare group. The statement retaining the highest number of people with negative views, following the speaker session, was *statement 7* (right to know the HIV status of colleagues), with just 6% of participants. The shift in attitudes with this group may have been the smallest, but improvements were still made, and this fact underpins the importance of continued work to change attitudes within healthcare professionals and trainees.

Healthcare Attitude Shifts (Average Scores)



FE Colleges

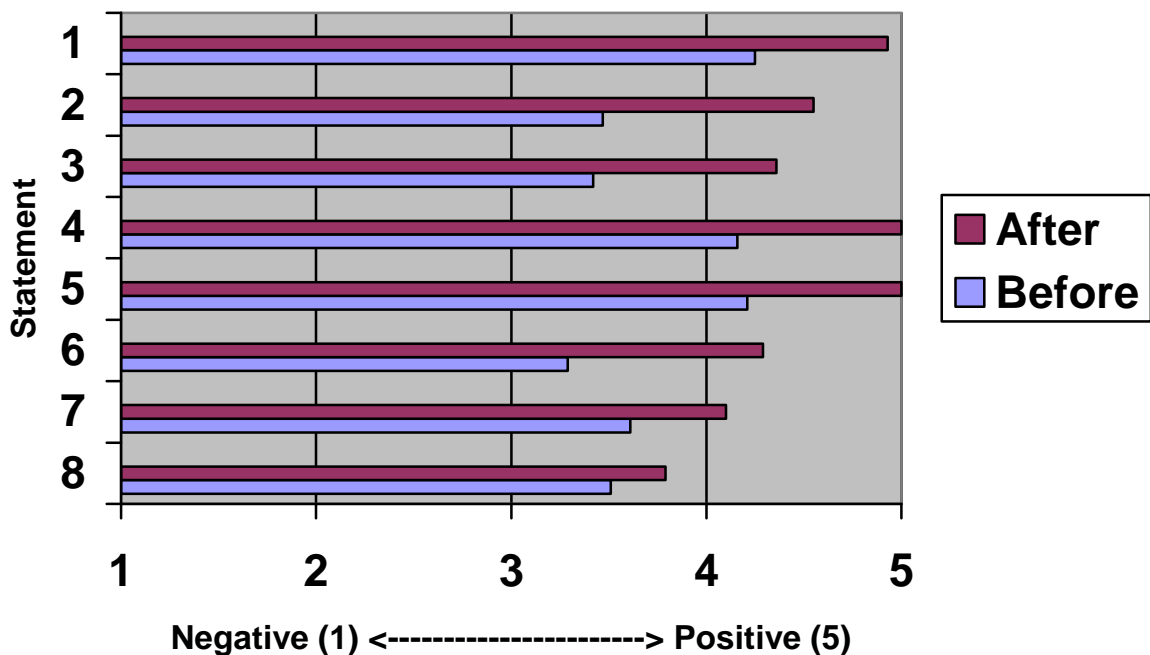
Following talks at FE Colleges, attitudes for *statements 2 and 3* underwent the most significant improvement. While *statements 6 through to 8* had the smallest positive shift following the talk. When looking at the difference in the number of people changing from a negative view (scoring just 1 or 2) to a positive view (scoring 4 or 5) following the talk, *statement 7* saw a remarkable positive shift, with the number holding a negative view being more than halved from 23% to just 10%. This is a fantastic outcome for the attitudes surrounding confidentiality in the workplace for positive people from a group soon to enter the world of work. However even greater progress was made on *statement 3* (whether positive people should have sex), with the number of people holding negative views reduced from 16% to just 3%.



Youth Groups

Only 2 sessions were delivered to youth groups, and so more research needs to be done in this area. However, what we discovered with the groups we delivered sessions to is worthy of note. Significant improvement was made for almost all statements following talks at youth groups, with the resulting average scores given following the session being only marginally less positive than that of the healthcare professionals. Despite the small number of participants in this group these shifts still highlight the need and rewards of providing education in these more informal settings.

Youth Group Attitude Shifts (Average Scores)



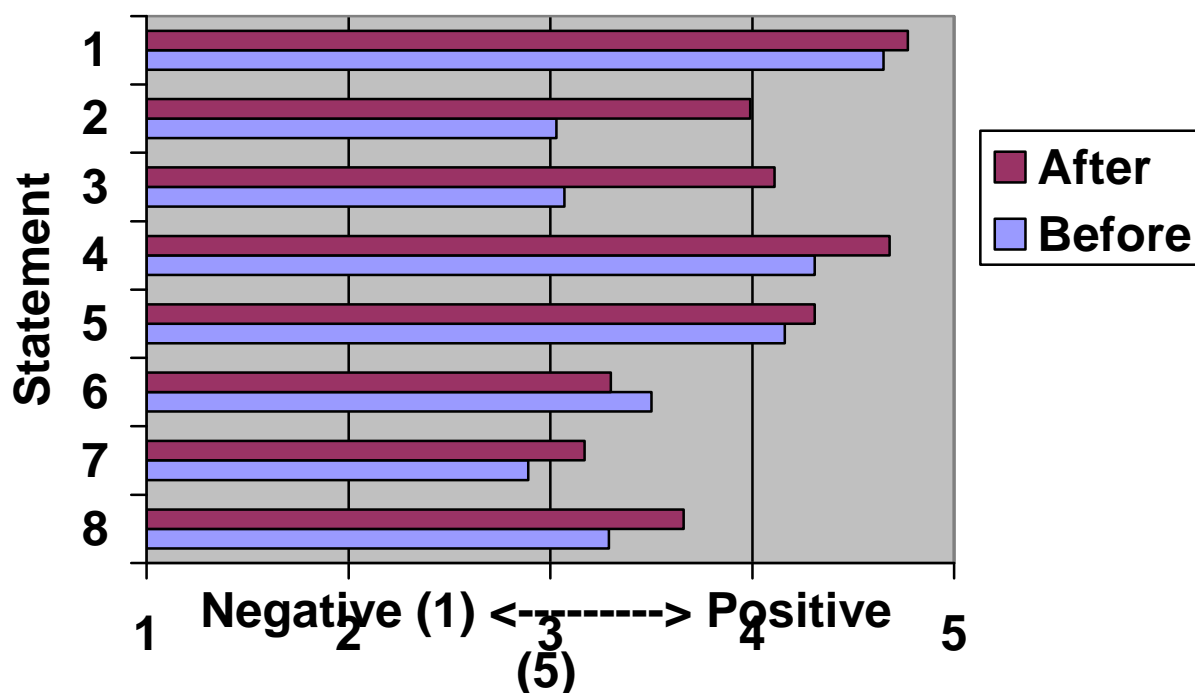
Schools

This was the group with the most negative attitudes both before and following the talks. However, progress was made and the most significant attitude shifts for the schools groups, were for *statements 2 and 3*. These were the statements where the most participants changing their attitudes from negative to positive also occurred. Prior to the talk, 13% agreed with *statement 2* (life



expectancy) and 22% agreed with *statement 3* (sexual activity), both these were reduced to 6% as a result of the talk, a remarkable decrease.

School Pupil Attitude Shift (Average Scores)



When looking at the number of pupils changing from scoring negatively (scoring 1 or 2) to positively (scoring 4 or 5), the least progress was made for *statement 4* (you can tell if someone has HIV by how they look) and *statement 8* (right to deport people even if treatments aren't available) prior to the talk.

Conclusion

The above strongly suggests that the age at which stigma is most prevalent is 15 – 16, however the optimum age for challenging stigma towards HIV positive people using Positive Speakers is 16 – 19. A probable reason for this is the increase in emotional maturity that occurs between the two development stages, as well as the difference between the two learning environments of the school (associated with childhood) and the FE College (the beginning of adulthood). As all groups saw significant improvements in attitudes overall, continuing to work with these groups and others is a priority of the programme.



Speaker Combinations

On the Positive Speaker Programme our diverse bank of speakers reflect the range of people affected by HIV. In order to give a wider representation of people's experiences of living with HIV we endeavour to send two speakers from different backgrounds to each session whenever possible.

Speaker Breakdown

4 African heterosexual women

7 British gay men

3 British heterosexual women

1 British gay woman

1 British heterosexual man

In order to discover the most effective combination of speakers in a Positive Speaker session, the average attitude shifts for each combination of speakers were analysed. Due to speaker availability, the majority of the sessions in which evaluation data was able to be collected during the pilot stage were delivered by British heterosexual women and British gay men. During this time there were also sessions delivered by African women, heterosexual men, and gay women and several different combinations of speakers. However, there was only sufficient data available to analyse along gender lines.

The different speaker combinations tracked were:

- A. 1 male and 1 female
- B. 2 males
- C. 2 females
- D. 1 male
- E. 1 female

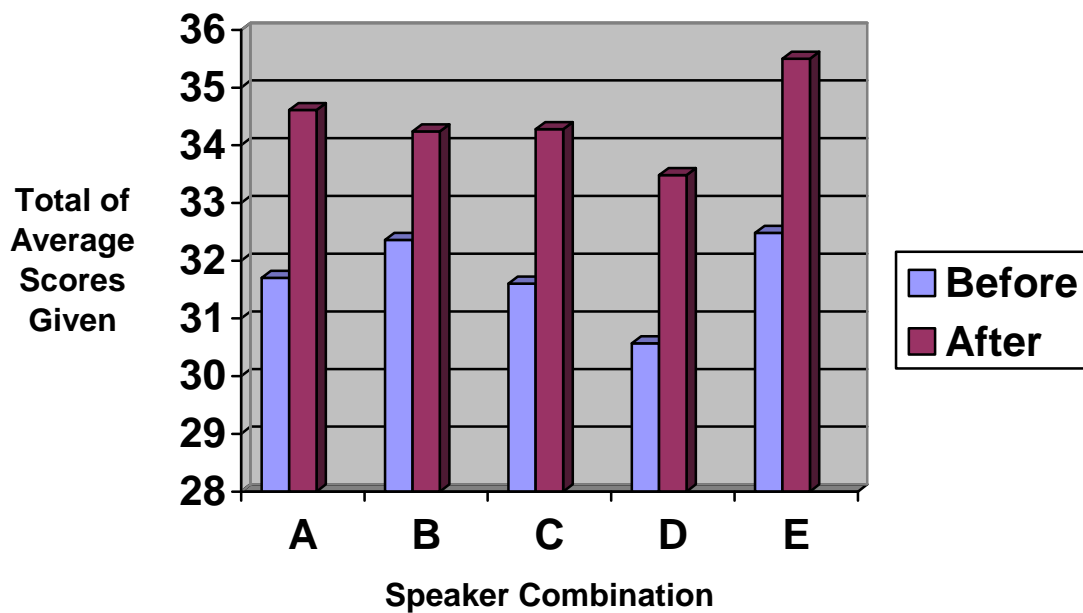
In talks with 2 speakers, one or both of the speakers also delivered the myths and facts part of the session. For talks with just one speaker, the project



coordinator attended the sessions and delivered the myths and facts part of the session.

From looking at the difference in the average scores given before and after the session, the most effective combination was E, one female speaker, followed by combinations A and D, one male and one female, and one male speaker respectively, which were equally effective. By far the least effective combination was B, 2 male speakers.

Difference in Total of Average Scores given to All Statements Before and After



The sessions with one female speaker (combination E) resulted in a positive shift for all attitude statements following the talk. A total of 7 out of the 8 statements following the talk were marked as positive (scored as 4 or 5), with *statement 3* seeing the most significant positive shift. The sessions with one male speaker (combination D) and the sessions with one male and one female speaker (combination A) also both had positive shifts on all statements



following the talk, and both resulted in 6 of the 8 statements receiving an overall positive average score (between 4 and 5) following the talk.

The sessions with 2 female speakers (combination C) although having slightly less impact than the combinations above, nevertheless saw significant improvement for *statements 2, 3, 7 and 8*. A total of 5 of the statements following the talk received positive overall scores. However, *statements 4 and 5* saw no change in the average score following the talk.

The combination with the least impact was that of 2 males delivering a session (combination B). Following the talk 4 out of the 8 statements were marked as either disagree or strongly disagree, *statement 1* saw no change and *statements 6 and 8* actually saw a slight negative shift following the talk. However, this combination was only used in 2 of the 32 sessions and so conclusive conclusions cannot be drawn.

Conclusion

From the above it is interesting to note that if the combination of genders is not available, it is better to have just one speaker than two speakers of the same gender deliver the session. Perhaps hearing 2 speakers with relatively similar experiences (even though no two testimonies are the same) somehow invokes a lesser emotional connection than hearing a unique testimony.

There may well also be an advantage to having the myths and facts part of the session delivered by someone who is not a speaker. A possible reason for this may be the difference in presentation style and skill sets required by someone imparting purely factual information and someone sharing their personal story.



Transmission Routes

In the questionnaire completed immediately prior to the session, participants were asked to identify the main transmission routes in the UK today from a list of possible routes. From this information, we discovered the following:

- 70% could not identify **all** main routes of transmission
- 25% could not identify the **most common** routes of transmission
- 48% believed that HIV could be transmitted through *donating* blood
- 20% believed that HIV could be transmitted through organ transplant
- 6% identified sharing a toothbrush as a transmission route
- 4% identified kissing as a transmission route

For the purposes of this section, the term 'all main routes of transmission' refers to unprotected anal sex, unprotected vaginal sex, mother to baby, breastfeeding, and sharing needles. The term 'most common transmission routes' refers to unprotected anal sex, unprotected vaginal sex and sharing needles. These are termed 'most common' for the purpose of this study, as these are the routes from which people are most at risk of infection.

When the results were split into sectors, the following became apparent:

Healthcare professionals and trainees*

- 48% couldn't identify all main routes of transmission
- 15% didn't know the most common transmission routes
- 27% believed that HIV could be transmitted through donating blood
- 16% believed that HIV could be transmitted through organ transplant
- 1% identified sharing a cup or plate as a transmission route



*When the knowledge of just practicing healthcare professionals is evaluated (a total of 40 participants in 3 separate sessions), 42% could not identify all main routes of transmission and 22% could not identify the most common transmission routes.

Schools

- 75% couldn't identify all main routes of transmission
- 30% didn't know the most common transmission routes
- 51% believed that HIV could be transmitted through donating blood
- 20% believed that HIV could be transmitted through organ transplant
- 1% identified sharing a cup or plate as a transmission route

FE Colleges

- 91% couldn't identify all main routes of transmission
- 72% didn't know the most common transmission routes
- 53% believed that HIV could be transmitted through donating blood
- 22% believed that HIV could be transmitted through organ transplant
- 9% identified sharing a toothbrush as a transmission route
- 2% identified hugging as a transmission route
- 2% identified sharing a cup or plate as a transmission route

Conclusion

As can be seen in the above percentages, an alarmingly high number of individuals had very little knowledge about transmission routes of HIV prior to the Positive Speaker session. In addition to the positive shift in attitudes, this highlights the need for the programme, not only among young people but also among professionals.



PARTICIPANT COMMENTS

In the evaluation questionnaires there were a few open questions that allowed the participants to put in their own words the effect that the session had on them. These questions included: 'What have you learnt?' 'What will you do differently because of what you have learnt today?' and 'Any other comments?' Not all participants completing the questionnaires wrote comments and not all those that did commented in each section. Below is a brief analysis of the key themes arising in the comments of each group.

Schools

Positive Speakers delivered sessions to a total of 235 school pupils, out of these, 143 wrote comments on the evaluation forms they completed. In this group, the overwhelming majority of the comments (119 out of the 143) for the 'What will you do differently because of what you have learnt today?' section of the questionnaire refer to practising safer sex and getting STI screenings. 8 of the 24 remaining comments were to do with not judging positive people and a further 6 were to do with being more aware.

"I will look after myself more & be careful. I thought the talk was amazing and the personal stories were very good. Thank you!"

School pupil, Withington Girls School, 27th March 2009

FE Colleges

Sessions were delivered to a total of 227 FE College students, out of these, 89 wrote comments on the evaluation forms they completed. Approximately two thirds of the comments (63 of the 89) from the FE College students were related to practicing safer sex and getting regular sexual health screenings. Approximately a quarter (21) of the comments stated the deeper understanding they felt they now had, the greater respect they would now have for positive people and statements about 'not judging' people on the basis of their status. The remaining comments related to specific pieces of information that they had found interesting during the session.



"I learnt what HIV is and what AIDS is. It's changed my opinion on it totally; I thought it was a dirty disease now I understand that it is not."

College student, Hopwood Hall College, 1st December 2008

Healthcare

Out of the 109 healthcare professionals and trainees that Positive Speakers delivered sessions to, a total of 67 wrote comments on their completed evaluation forms. Most of the comments (45 of the 67) from the 'What will you do differently?' section were to do with how much they had learnt about the personal side of living with HIV and how now they will be more understanding and challenge any stigmatising attitudes and behaviour towards positive people. The majority of the comments (49) from the 'Any other comments?' section complimented the speakers themselves, their openness and their courage in speaking out.

"Excellent, great insight from client perspective. I will try to keep in mind the difference between appearing empathetic and sympathetic. Also lead by example when it comes to treating patients without prejudice."

Qualified nurse, Manchester University, 25th March 2009

Conclusion

From the above it is clear that what a participant gains from a session largely depends on their prior knowledge and experience. School pupils, who have some basic knowledge of transmission routes but the least life experience, seemed to process and retain the safer sex message above all others. FE college students had less basic knowledge prior to the session but are slightly more mature and have the benefit of being in an arena where independence in both thought and action is much more likely than in a school environment. In their comments it is therefore not surprising that although they also focussed on the safer sex message, this was in conjunction with a level of understanding of the personal perspective of living with the virus, and most stated an anti-discriminatory stance towards positive people.



Healthcare professionals are the group with the most prior knowledge about HIV and the most likely to have come into contact with positive people either in their professional or personal lives. What they gained from the sessions is therefore quite different to the other two groups. These were the ones who were arguably most likely to relate to aspects of the speakers stories (being a parent, relationship issues, financial hardships etc.) due to a greater life experience and therefore process the information in a different way. They were also able to relate the experiences of the speakers to how they themselves behave at work and / or in their personal lives and see a way that they could make a significant difference personally to how positive people are treated and feel about themselves. The situations relayed by the speakers whether in a healthcare setting or in a family / community setting were situations that the participants in this group, if present, would have at least a degree of power in. This is why in the 'what would you do differently because of today' section; most comments were to do with making a difference to other people rather than about protecting themselves.



QUALITY OF SESSIONS

The quality of each Positive Speaker session was monitored through the attending Positive Speaker Mentor, Project Coordinator, and feedback from the session organiser and by each participant in the questionnaires completed immediately after the Positive Speaker session. In addition to sessions being rated by participants completing the full questionnaires, a total of 596 people, the sessions were also rated by those completing mini questionnaires, a further 58 people, making the total number of people referred to in this section, 654. Participants were asked to rate different aspects of the session by allocating a mark from 1 to 5.

For questions 1 to 4, the scores referred to the following terms:

1 = poor 2 = not satisfactory 3= satisfactory 4 = good 5 = very good

For question 5, the scores referred to the following terms:

1= nothing 2 = a little 3 = some 4 = quite a bit 5 = a lot

Q	Aspect of session	Average Score	Number scoring 1 or 2	%
1	Overall	4.75	1.00	0.15
2	Personal testimonies by speakers	4.70	1.00	0.15
3	Information and facts	4.63	1.00	0.15
4	Audience involvement	4.31	9.00	1.38
5	How much did you learn	4.41	10.00	1.53

The data above demonstrates the consistently high quality of the Positive Speaker sessions, with the average score for each aspect of the session being rated between 4 and 5. The scores for the personal testimonies and for the overall session are particularly high. The number of people rating the aspects of the sessions as being 'poor' or 'not satisfactory' was very low, with only one person out of 654 rating the first three questions as 1 or 2. Even the fifth question, which has the highest number of people scoring it as 1 or 2, has only 10 participants stating they learnt little or nothing in the session.



The consistent high quality of the Positive Speaker sessions is indicative of the level of training and support that the speakers receive from George House Trust. In addition to 3 days core training, speakers receive training updates at the bi-monthly speaker meetings; have access to the variety of training sessions on the volunteer development calendar and specific stand alone speaker training sessions. Speakers are given a Speaker Handbook, which details procedures, responsibilities, and practical presenting tips, and an information manual which gives facts and figures about all aspects of HIV. There is also a Speaker Newsletter once a month which gives information on upcoming meetings and training sessions that they can attend, details of any programme developments or session feedback we have received and the news headlines from the GHT website for those without access to the internet.

In addition to the support from the Project Coordinator, speakers are supported by Positive Speaker Mentors who are longstanding volunteers who provide advice and support prior to and following sessions, regularly observe and give feedback on performance, and provide skills development support. They also receive peer support when they deliver sessions with other speakers, at training sessions and when they share good practice at the bi-monthly speaker meetings. The combination of the training and support ensures that all speakers have the skills and confidence to consistently deliver high quality sessions.



IMPACT ON SPEAKERS

Interviews were conducted by an external researcher with a cross section of the Positive Speakers in order to evaluate the impact of the Positive Speakers Programme on the speakers themselves. Four out of the twelve active speakers were interviewed. Speakers were asked open questions about their life before starting the positive speakers training, questions about being a Positive Speaker, about disclosure generally, feelings about their status, and questions about their current situation and their future plans.

The speakers all have unique backgrounds and set of experiences, they have been living with HIV for differing amounts of time, and have had various things going on in their lives during the time they have been involved with the Positive Speakers Programme, and so it would be impossible to say any changes were solely as a result of being a Positive Speaker. However, the following became apparent from the answers they gave when interviewed:

- All speakers interviewed had a positive view of their HIV status
- When asked for 5 words to describe themselves (without any suggestions or prompts), all the words used were positive words
- All speakers interviewed used the word confident to describe themselves
- All felt their skills in speaking to groups of people had improved
- All stated that they felt more comfortable talking about HIV with people in their personal life than they were before being a Positive Speaker

Key themes that arose in the answers to the question “What was it that led you to be a Positive Speaker?” were: giving something back to George House Trust, helping other positive people accept themselves / deal with their diagnosis, challenging stigma and discrimination, and raising awareness / educating people about HIV myths and facts.



“Because GHT had been so great with me, because they completely turned my life from it being really rubbish to being really good and made me see a light at the end of the tunnel I wanted to be part of it and made me want to give something back and pass on what I learnt.”

(Quote from speaker 4 in the evaluation sample)

When asked what their favourite thing about being a Positive Speaker, all said being able to see people’s attitudes changing and the sense of achievement that this gave. The gratitude and recognition from the participants in the audience was also a recurring theme in this section:

“The evaluations that we collect definitely, I take a lot from them, some of them are quite emotional... just hearing people’s opinions change... School kids shaking my hand and telling me I was really brave, and how much they admire me that was just amazing” (speaker 4)

One of the ‘most challenging’ aspects for speakers was dealing with the emotions that came up whilst preparing testimonies, both in terms of “having to try and formulate how I felt about being a positive person” (speaker 2) and the emotions that come up whilst delivering the session. The other common challenging aspect identified was the pushing of comfort zones, the speakers found it more challenging to speak to groups who they had similar backgrounds to, and were considered “close to home” (speaker 2). However the two speakers out of the sample of four who identified this as being the most challenging aspect both expressed pride in having challenged themselves in this way:

“I’m glad I done it” (speaker 3)

“At the end of it I felt fantastic” (speaker 2)

In terms of feeling supported and developing speaking skills, the speakers all identified different aspects of the training and support as being the most effective for them: the core training, the session briefings, the guidelines in the speaker handbook, consistent post-session support from the project coordinator, and the support and feedback they receive from the other speakers.



“I know there’s always after support... I’ve got that safety net... They totally support you, they make it easy for you” (speaker 3)

Speakers were asked about how they now felt about disclosing their HIV status to people in their personal life, the speakers differed in their responses from “it’s a private and personal thing to myself” (speaker 2) to “fine, everybody knows really” (speaker 3). However all speakers said that being a Positive Speaker had made them more comfortable talking about HIV than they had been before becoming involved with the programme:

“I had one friend who thought you could pass it with glasses so its helped me, to enable me to talk to my friends and people I’ve disclosed to, enabled me to tell them this is the routes of transmission, which I already knew but its enabled me to be more assertive... It has been quite handy for me, its been a source of help” (speaker 2)

When asked how they felt about being HIV positive, all speakers responded positively. Three out of the four speakers also stated that they feel that being HIV positive has resulted in some improvements in their life:

“So now I see it as its opened up all these new doors, I get to do this, go there, meet all these nice people and groups. I’ve never wished to be in this position but I’ve sort of embraced the fact that I am” (speaker 3)

Conclusion

Sharing personal and emotive experiences with groups of strangers is an emotionally draining process and one that potentially puts the speaker in a very vulnerable position. However, the benefits of HIV positive people going out into organisations and engaging and educating people are clearly documented in the preceding chapters of this report. It is therefore crucial that all positive speaker programmes provide the support and benefits that the speakers need.

People become involved with the programme in order to make a difference, to change people’s attitudes, it is therefore vital to their sense of achievement and continuing involvement that they know that this has happened. Speakers



should always be afforded the opportunity to speak to the participants following the session, and given any feedback from the organisation and session participants that comes through following the session. Feedback from the project coordinator and any other speaker present is also essential so that the speaker feels appreciated and that they have delivered something of quality.

The value of the support provided to the speakers cannot be underestimated, even if a speaker does not express a need for support, the consistency of the availability is fundamental to the process. The support also needs to come in different forms (resources, personal contact etc), from different people (other speakers as well as from the project coordinator) and at the different stages of the speaking process: in the planning stages, before the session, during, and afterwards. The positive speaker training should be comprehensive and ongoing in order to ensure that the speakers have sufficient confidence in both their skills and knowledge to deliver a session, as this can help minimise the number of things that they may be worried about before a session.

Positive Speaking can be extremely beneficial for the speakers if the above is put in place. As shown in this evaluation, it can increase their confidence generally, make them more comfortable talking about their status with people in their personal lives, and help them see their HIV status in a positive light.

“Empowering, that’s the only way I can describe it” (speaker 2)



PROJECT MANAGEMENT

The Positive Speakers Programme was managed by the Project Coordinator, with input from the Positive Speakers Steering Group and George House Trust's Senior Management Team. The project was managed according to the Monitoring and Evaluation Framework, which was developed in response to the project plan as set up in the funding application to the Equality and Human Rights Commission. This management structure was reviewed at the end of the pilot stage of the programme and the following conclusions were drawn.

Project Coordinator Role

Having a full-time dedicated staff member coordinating the project during its development stages ensured that marketing was more widespread, more training materials for the speakers and for use during sessions were produced, consistent support for the speakers was provided, and that the impact of the project was able to be evaluated.

During the pilot stage of the programme it also became apparent that the presence of the project coordinator (or an equivalent) in the sessions was necessary to ensure the quality of the sessions, the accuracy of the factual information provided, and the consistency of the key messages conveyed throughout the sessions. Being present at the sessions also provided the Project Coordinator with first hand knowledge of the effectiveness of the different aspects of the session and what information was being most regularly requested. This information was invaluable for continuously improving and developing the sessions, the speakers, the training materials, and the speaker support systems.

The staff time required for the running of the programme after the development stage will largely depend on the number of sessions being booked. This need will become apparent over the next stage of the programme.



Senior Management Team

Input from the Senior Management Team ensured that the programme was in line with George House Trust's organisational objectives. This need will be ongoing as the programme develops further.

Positive Speakers Programme Steering Group

The Steering Group held a governance / advisory role in the management of the programme and ensured accountability in meeting targets set in the Monitoring and Evaluation framework. The Steering Group consisted of 5 members: 2 positive speakers, a GHT trustee, the GHT Volunteer and Development Manager, the Senior Public Health Development Advisor from Manchester Public Health Development Service.

Steering Group meetings were held bi-monthly during the pilot stage of the programme, however attendance was not consistent and some meetings were held with only 2 members and the project coordinator present. Despite low attendance the Steering Group meetings were constructive and provided a valuable forum for discussion on the development of the programme with external representatives. Feedback from the steering group members who were able to attend all meetings highlighted that member's feelings about their involvement and input into the programme were positive and that they would like to continue that involvement if required.

It is unlikely that external involvement in the governance of the Positive Speakers programme is needed now that the programme has been developed and any external advice that is required can be sought from our partner organisations. Appropriate forums within GHT for the governance and accountability of the programme already exist and positive speakers have regular input into the programme through bi-monthly speaker meetings, supervisions and informal feedback following every session they deliver. As such it appears at this stage that a dedicated Steering Group for the Positive Speaker Programme is no longer required, the project coordinator will now



report to the Membership and Volunteering Sub Committee on the progress and developments of the programme.

Monitoring and Evaluation Framework

The Monitoring and Evaluation Framework for the Positive Speakers programme was used as a basis for the project coordinators workplan and for the progress reports to the Positive Speaker Steering Group and to the EHRC. The framework document was a useful tool in breaking down project sections and setting deadlines for individual targets and tasks that were then used for reporting purposes. It also helped ensure that the outcomes of all tasks within the programme were inline with GHT's organisational objectives and on that basis was an effective project management tool.



Summary

In its inception the aim of the Positive Speakers Programme was to raise awareness and challenge HIV related stigma and discrimination. Following the evaluation of the pilot stage of the programme it has become apparent that in reality the programme does this and more. Positive Speakers are a very effective tool for combating HIV related stigma and discrimination; they raise awareness, inform people of the facts about transmission and life with HIV, and they have a positive impact on the attitudes of participants towards HIV positive people.

In evaluating the impact of the Positive Speaker Programme we were not only able to see how effective the speakers were but also to gather some invaluable information on people's knowledge and attitudes towards HIV and HIV positive people. This information is priceless as it demonstrates how far other educational and campaigning approaches are working, and what areas need further work. In addition to these benefits, being involved in the programme also had a positive impact on the speakers themselves; it gave them more skills, confidence in themselves and a sense of purpose and achievement. The involvement of HIV positive people in awareness raising campaigns benefits positive and negative people alike.

Knowledge of HIV transmission routes is poor across the board and is especially lacking for FE students; this suggests that information imparted from other parties such as teachers or employers, is either lacking, or is not comprehensive or reinforced enough for the key information to be retained. Positive Speakers therefore perform a vital and unique function in challenging stigma and in educating people about transmission routes.

The success of the pilot stage of the programme has ensured that Positive Speakers will continue to play a part of GHT's campaigning and educational objectives. We will endeavour to develop the programme further and to reach a wider audience and deliver sessions to more organisations to continue this success and broaden the range of people reached through it.

