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Executive summary

One of the most common phrases heard from Camp attendees and Camp staff at Freedom 2 Be 2015 was, “It’s just a virus.” This phrase embodies the essence of the aims of Camp - to increase knowledge about HIV and confidence in how to live well with the condition, whilst creating a space where individuals are not defined solely by their HIV status.

This report describes the key elements of the 2015 Camp, how the evaluation of its impact was conducted, and key findings. The evaluation consisted of two sub-studies: a quantitative repeated measures design with pre, post and six-month follow-up time-points (n=67, n=67 and n=49 respectively), post-camp surveys with Camp attendees (n=64), and Camp staff (n=29) as well as semi-structured interviews at post-Camp (Camp attendees, n=11; Camp staff, n=6), and six-month follow-up time points (Camp attendees, n=8; Carers, n=7; Clinic staff, n=10).

The findings suggest that Camp was experienced very positively by Camp attendees, with the opportunity to meet other young people living with HIV in a supportive setting, particularly highlighted. Young people both enjoyed Camp and learned more about how to live well with HIV. Issues associated with sharing one’s HIV status was a major theme throughout Camp.

Self-report measures suggest improvements in pro HIV disclosure beliefs at the end of Camp that were maintained at six month follow-up. There were also increases in HIV knowledge that were maintained at follow up, increases in pro-medication adherence beliefs from pre to follow-up data points, and improvements in self-perception from pre to post-Camp. Semi-structured interviews revealed evidence of increased confidence, improved ART adherence and willingness to help others in some young people after the end of Camp. There were many reports of ongoing communication between Camp attendees and improved communication more generally. Self-report measures did not show changes in HIV-specific communication or onward HIV disclosure across the group as a whole, however. Findings are discussed and suggestions are made for how further benefits could be gained from Camp in the future.
Introduction

Since 2010, the Children’s HIV Association (CHIVA) has run a weeklong yearly residential support camp for young people living with HIV in the UK called “Freedom 2 Be” (F2B). Previously, the Camp was available for young people aged 13-17 living with HIV from the UK and Ireland. The age range for the 2015 Camp was reduced to 12-16 year olds. The goals of the Camp are to address isolation and facilitate peer friendships, increase knowledge and understanding of living with HIV, and improve confidence and self-esteem.

There is evidence in other chronic conditions of increased youth self-esteem after attending residential interventions (Odar, Canter, & Roberts, 2013). There is limited published literature on evaluating residential interventions for young people living with HIV (Gillard, Witt, & Watts, 2011; Pearson, Johnson, Simpson, & Gallagher, 1997) with only qualitative methods used and no follow-up of outcomes. The 2015 evaluation of F2B involved a more extensive use of both quantitative and qualitative data, over pre, post and six-month follow-up time points than has been reported to date.

The aims of the overall evaluation were to:

- Measure psychological, behavioural and clinical outcomes from before F2B to after the intervention (immediately and at 6 months).
- Capture the experience and perceived impact of the Camp for young people (Camp attendees), Camp staff, Clinic staff and Carers.
F2B 2015 Overview
The 2015 Camp ran from 4th to 8th August. Camp attendees from across the UK spent five days participating in workshops and creative activities as well as enjoying free time with each other. Tables 1 to 5 show the Camp programme.

<table>
<thead>
<tr>
<th>TUESDAY</th>
<th>ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 pm onwards</td>
<td>Young people arrive; Registration - Collect packed lunch; Room allocation; Medication check in; Phone check in; Collect T shirt; Meet key worker; Badge making; Decorate T shirt (with name); Human Bingo/games led by Camp Leaders</td>
</tr>
<tr>
<td>15:00</td>
<td>Whole camp meeting; Instructions for orienteering</td>
</tr>
<tr>
<td>15:30</td>
<td>Orienteering/Treasure Hunt in key worker groups</td>
</tr>
<tr>
<td>16:45</td>
<td>Evaluation with key workers; Ice breakers</td>
</tr>
<tr>
<td>17:45</td>
<td>BONFIRE/BBQ</td>
</tr>
<tr>
<td>After dinner</td>
<td>Volleyball; Football; Rounders; ‘Get to know you’ games led by Camp Leaders and Key Workers</td>
</tr>
<tr>
<td>22:00</td>
<td>House meetings</td>
</tr>
</tbody>
</table>

Table 1 Camp schedule – Day 1
<table>
<thead>
<tr>
<th><strong>WEDNESDAY</strong></th>
<th><strong>ACTIVITIES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>From 8:00</td>
<td>BREAKFAST</td>
</tr>
<tr>
<td>8:45</td>
<td>Key worker time</td>
</tr>
<tr>
<td>9:00</td>
<td>Whole camp briefing</td>
</tr>
<tr>
<td>9:30-12:30/</td>
<td>3x workshops:</td>
</tr>
<tr>
<td>14.00-17.00</td>
<td>General HIV information;</td>
</tr>
<tr>
<td></td>
<td>knowledge and understanding</td>
</tr>
<tr>
<td></td>
<td>Creative activities- Art;</td>
</tr>
<tr>
<td></td>
<td>Performance Poetry; Drama</td>
</tr>
<tr>
<td>12:45 - 13:45</td>
<td>LUNCH</td>
</tr>
<tr>
<td>17:45</td>
<td>DINNER</td>
</tr>
<tr>
<td>19:15</td>
<td>Sexual health workshops</td>
</tr>
<tr>
<td>20:30</td>
<td>Dance session; Football; Volleyball; Rounders match; Cards/table tennis; Pampering room (nails/hair)</td>
</tr>
<tr>
<td>22:00</td>
<td>House meetings</td>
</tr>
</tbody>
</table>

Table 2 Camp schedule - Day 2

<table>
<thead>
<tr>
<th><strong>THURSDAY</strong></th>
<th><strong>ACTIVITIES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>From 8:00</td>
<td>BREAKFAST</td>
</tr>
<tr>
<td>8:45</td>
<td>Key worker time</td>
</tr>
<tr>
<td>9:00</td>
<td>Whole camp briefing</td>
</tr>
<tr>
<td>9:30 – 16.00</td>
<td>White Water rafting trip</td>
</tr>
<tr>
<td>17:45</td>
<td>DINNER</td>
</tr>
<tr>
<td>19:00</td>
<td>Whole camp briefing - Star of the Day;</td>
</tr>
<tr>
<td>20.30</td>
<td>Movie night</td>
</tr>
<tr>
<td>22:00</td>
<td>House meetings</td>
</tr>
</tbody>
</table>

Table 3 Camp schedule - Day 3
<table>
<thead>
<tr>
<th><strong>FRIDAY</strong></th>
<th><strong>ACTIVITIES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>From 8:00</td>
<td>BREAKFAST</td>
</tr>
<tr>
<td>8:45</td>
<td>Key worker time</td>
</tr>
<tr>
<td>9:30</td>
<td>Whole camp briefing</td>
</tr>
<tr>
<td>10:00-12:15/14.00-16.15</td>
<td>3x workshops: Experiences growing up with HIV</td>
</tr>
<tr>
<td>12:30 - 13:30</td>
<td>LUNCH</td>
</tr>
<tr>
<td>16:30</td>
<td>Whole camp briefing – Star of the Day and departure day information; Show of Wednesday and Friday creative work</td>
</tr>
<tr>
<td>17:30 - 18:30</td>
<td>DINNER</td>
</tr>
<tr>
<td>20:00 - 22:30</td>
<td>Party in canteen</td>
</tr>
<tr>
<td>23:00</td>
<td>House meeting</td>
</tr>
</tbody>
</table>

Table 4 Camp schedule - Day 4

<table>
<thead>
<tr>
<th><strong>SATURDAY</strong></th>
<th><strong>ACTIVITIES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>From 8:00</td>
<td>BREAKFAST</td>
</tr>
<tr>
<td>9:30</td>
<td>Whole camp briefing in the canteen; Key worker final meeting and evaluation; Phone collection; Medication collection</td>
</tr>
<tr>
<td>11:00</td>
<td>Closing ceremony</td>
</tr>
<tr>
<td>12:30 - 13:30</td>
<td>COLLECT PACKED LUNCH</td>
</tr>
<tr>
<td>PM</td>
<td>Young people leave</td>
</tr>
</tbody>
</table>

Table 5 Camp schedule - Day 5
Camp attendees and Staff

77 young people attended Camp: 34 (44%) male, 43 (56%) female. Figure 1 shows the distribution of age by gender.

![Camp attendee age and gender](image)

Figure 1 Camp attendee age distribution by gender

Forty eight (62%) had never attended Camp before (47/101 (47%) in 2014). The Camp attendees all lived in the UK, with 40 (52%) born in Africa, 32 (42%) born in Europe and 5 (6%) born in other global regions. The UK regions where attendees' HIV care was accessed are presented in Figure 2.

![Current HIV Care by UK region](image)

Figure 2 Camp attendees’ HIV care sites by UK region

Camp staff consisted of 31 adults: 20 Key Workers and 11 Camp Leaders. Key workers were adult volunteers, from a range of professional backgrounds. Many also live with HIV and previously attended camp as participants. Each key worker was responsible for
supporting a small group of Camp attendees throughout the week. Camp Leaders were volunteer young adults with HIV aged 18-24, most of whom had attended camp as a participant previously. They had practical responsibilities throughout the week to help with the overall organization of camp, and also peer mentoring roles with the Camp attendees.

Activities

The HIV workshops were run by CHIVA staff and visiting facilitators (including individuals working with support and advocacy organisations within the HIV community). The workshops were interactive, using games and tasks to facilitate engagement and focus:

- The information workshop aimed to give Camp attendees a strong knowledge base about HIV, including information about transmission, and their rights as HIV-positive individuals. Camp attendees were split into sessions according to age (older and younger Camp attendees) but all were presented with the same information. During the sessions with older Camp attendees, facilitators allowed for additional flexibility and encouraged participants to guide the conversation towards subject matter that was more important to them.

- The experience workshop began by questioning what Camp attendees find important in life before prompting them to consider how HIV affected this. Role-plays of HIV disclosure scenarios were used, with advice on how to share one’s status.

- The sexual health workshop was run predominantly by CHIVA staff and a key worker. This aimed to give Camp attendees the opportunity to ask questions anonymously about sexual health (on slips of paper dropped into a box) and how this relates to their HIV status. There was an open discussion session during which the facilitator tried to answer each question before the group explored the topic further, sometimes sharing their own experiences. At the end of the workshop there was a condom demonstration and young people were given the chance to try putting condoms on bananas. Participants were split by gender and further into two groups according to age so that topics were relevant to the majority of people attending.

Camp attendees also participated in music, poetry, yoga, football, drama and art workshops. These were facilitated either by key workers or visiting adults, and supported by Camp leaders.
Methodology

Design

The elements of the evaluation reported here consisted of two sub-studies:

1. A quantitative repeated measures design with three time-points, pre-intervention, post-intervention and six-month follow-up, using self-report measures (n=67, n=67, n=49 at each respective time point).

2. Workshop and Camp surveys, and qualitative interviews. More specifically:
   a. Surveys on individual workshops
   b. Camp surveys with Camp attendees (n=64) and Camp staff (n=29)
   c. Interviews with:
      i. Camp attendees (post-Camp, n=11; 6-month follow up, n=8)
      ii. Camp staff (post-Camp, n=6)
      iii. Carers (6-month follow up, n=7)
      iv. Clinic staff (6-month follow up, n=10)

Ethics

The study received ethical approval from Royal Holloway University of London Psychology Department Ethics Committee. A proposal to use data from the Collaborative HIV Paediatric Study (CHIPS) was also successfully submitted, with participant identifiers allowing anonymous linkage of data for each individual (initials and dates of birth).

Sampling

All Camp attendees with parental/carer consent and Camp attendee assent/consent to take part (67/77, 87%) were invited to complete the self-report measures and the post-Camp surveys. All Camp staff were invited to complete the post-Camp survey. For the Camp attendee interviews at the post-Camp data point, sampling occurred in the following stages. Camp attendees were firstly selected using random sampling stratified by age. Of the initial 12 people that were approached, two did not want to participate and one had not consented to taking part in the evaluation. The remaining interviewees were subsequently selected using convenience sampling to ensure that the target sample was reached, with equal numbers of males and females of different ages living in different
regions. We used stratified sampling by role to approach Camp staff members for interviews. All Camp staff who were approached agreed to participate.

For the six-month follow-up interviews, all 11 of the Campers who were interviewed at the post-Camp stage were invited to participate again. Eight interviews were completed. We approached these Camp attendees’ carers to participate and seven completed interviews. We also contacted members of each of these Camp attendees’ clinic teams (HIV consultants, nurses and social workers). Eight interviews with clinic staff were completed.

**Procedure**

Parent consent (opt out) for Camp attendee participation was sought before Camp. If parental consent was obtained, key workers presented information sheets, allowed time for questions and sought written Camp attendee assent/consent during a session on the first day of Camp. On the last day of Camp a session was allocated for completion of the post-intervention self-report measures. Post-camp surveys were also distributed to both Camp attendees and staff members at this point. In addition, Camp attendees were asked to fill out workshop evaluations at the end of each workshop session.

During the last few days of Camp, those young people and staff members that were selected to be approached were invited for interviews. Interviews were scheduled to take place with the researcher at either a hospital clinic or at a known support organisation approximately six weeks after the end of Camp.

Seven group six-month follow-up assessment sessions were organized in cities throughout the UK to complete the follow-up questionnaires. Camp attendees were assigned to a particular location based on where they lived. For Camp attendees who did not attend a follow-up assessment session, an invitation was sent home with a paper copy of the questionnaires and a URL link for them to complete them either on paper or online.

After the face to face follow-up sessions were completed, the Camp attendees who were previously interviewed were invited to be interviewed again, as well as their parents/carers and a member of their Clinic team. All Camp attendees who completed interviews or the follow-up questionnaires were compensated with an Amazon voucher worth £10.
Evaluation Materials Development

Questionnaires
A mixture of pre-existing measures (where available) and questionnaires developed for this evaluation were used. For the latter measures, individual questions were sourced from published research, generated by the research team and piloted with members of CHIVA and the CHIVA Youth Committee.

HIV knowledge
A 19-item measure was developed to cover general HIV knowledge, transmission, medication and reproduction information. Items were either new or sourced and adapted from other measures (e.g., Aaro et al. 2011; Carey and Schroder 2002). Young people ticked whether the statement was ‘true’, ‘false’ or ‘don’t know’. Items included, “A woman can transmit HIV to her child through her breast milk” (T) and “HIV medication can reduce the amount of virus in the body.” (T). The measure had a minimum score of 19 and a maximum score of 38.

Antiretroviral (ART) adherence
This 13-item measure was developed to cover the following areas: ART information, motivation and behavioural skills. Items were sourced from LifeWindows Project (2006) including: “I am confident I can take my HIV medication whatever else I’m doing” and, “I get frustrated taking my HIV medication because I have to plan my life around them.” The response options were on a five-point likert scale ranging from “strongly disagree” to “strongly agree”. The minimum score was 13 and the maximum score 65. An additional item asked about doses missed in the last 3 days.

HIV disclosure/sharing
This 18-item measure was developed to assess attitudes towards sharing one’s status, normative disclosure beliefs, disclosure affect and disclosure self-efficacy. This measure included items from pre-existing measures (e.g., Semple 1999, Murphy 2011). The minimum score was 18 with a maximum score of 90. For each item, participants were asked. “How much do you agree with the following statement about telling people who do not know your status that you are HIV positive”. Examples of items included, “It will affect my relationship with them” and “I am confident that I can choose the right time and place to share my HIV status with others.” The response options were on a five-point likert scale.
from “strongly disagree” to “strongly agree”. Additional items assessed the young person’s intention to share their status with others over the next six months and the extent of HIV disclosure in the previous six months (the latter question only asked at the pre and follow-up data points).

**HIV communication**
This seven-item questionnaire assessed thoughts and feelings about communicating about HIV with people whom were already aware of the young person’s HIV status (outside of one’s health care teams, e.g., friends and family). The minimum score was seven and the maximum score was 35. Young people were asked, “How much do you agree with the following statements on talking about your HIV with people who know that you are HIV positive?” Examples of items included, “It makes me feel better” and “I am confident that I can talk to people about my HIV if I need to.” The response options were on a five-point likert scale from “strongly disagree” to “strongly agree”. Additional items assessed intention to communicate about HIV, frequency of recent HIV communication and whether there had been any HIV communication within the last six months (only asked at the pre and follow-up stages).

**HIV stigma**
Seven questions were derived from an existing measure of HIV stigma for HIV-positive children (Wiklander et al, 2013). The questions assessed HIV disclosure concerns, concerns with public attitudes about HIV and personalized stigma. An example item was, “I have lost friends by telling them I have HIV”. The minimum score was seven with a maximum score of 28. The response options were on a four-point likert scale from “strongly disagree” to “strongly agree”.

**Quality of Life, general health and self-perception**
Sixteen items from The KIDSCREEN quality of life measures were used (Ravens-Sieberer et al. 2005, 2010). These were the KIDSCREEN-10 index (minimum score 10, maximum score 50), a general health question (1-5) from the same index as well as the five self-perception items from the KIDSCREEN – 52 (minimum score 5, maximum score 25). Examples items included, “Have you been happy with the way you are?” and “Have your parent(s) treated you fairly?” The response options for the general health item were on a five-point likert scale from “excellent” to “poor”. The response options for the KIDSCREEN-
10 index and the self-perception items were on a five-point likert scale from “never” to “always”.

Surveys and Interviews
Questions were generated by the research team, sourced from previous F2B evaluations, and an evaluation of a residential camp for HIV positive youth in the United States (Gillard et al., 2011). Piloting was conducted with CHIVA staff and members of the CHIVA Youth Committee.

Post Camp surveys for YP and staff
The post-Camp surveys measured overall experiences at Camp and asked both Camp attendees and Camp staff about what they enjoyed most and least about their week, as well as how Camp could be improved. Camp attendees and Camp staff were also asked to rate administrative and organizational aspects of camp such as the food or the balance between activities and free time. These responses were scored on four-point likert scales from “poor” to “excellent” with the additional option of “n/a”.

Workshop evaluations
Surveys at the end of each workshop consisted of four questions, aiming to elicit feedback on what was learned and how enjoyable the workshop was.

Qualitative interviews
Semi-structured interview guides were developed for the post-Camp interviews to assess experiences of the Camp. Additional interview guides were developed for follow-up interviews to assess any changes perceived to be due to the Camp. Care was taken to avoid leading and closed questions throughout.

Demographic information
At Camp, we collected information from Camp attendees on their initials, date of birth, country of birth, current HIV care hospital, how long they had known their status, what support services they accessed, and previous Camp attendance. At follow-up, we collected information from Camp attendees to enable linkage with the previous time points, changes in medication, school, close relationships and health as well as psychosocial support.
Analysis plan

Both parametric and non-parametric statistics were used where appropriate to compare pre, post and follow-up time points for the self-report measures. For the workshop and post-camp surveys, qualitative answers were grouped by themes and frequencies were calculated. Content analysis was used for the interview data with verbatim quotes extracted to exemplify key themes.
Findings

Overall feedback

The overwhelming feedback about the Camp from surveys and interviews was positive.

“There was a spirit of unity overall.” [Staff – post camp]

“When I went to camp, it made me free. […] I learned more about it through workshops there and it made me realize that you can live with it. A lot of people live with it, not just me.” [Camp attendee – follow up]

“Talking to people and the workshops were really good because before I literally did not know anything. I just knew I had it and that was really it but now I know sort of the basics of how it’s functioning in my body and how it works and just speaking to people in general, it helps a lot.” [Camp attendee – follow up]
“I can tell that camp made a big difference, not just for her but for us as her carers as well. It made things easier to cope with.” [Carer – follow up]

“He needed it because he doesn’t mix with anyone his own peer group. That’s got him out of himself. It’s one of the best positives we’ve had of [NAME].”
[Carer – follow up]

“The young people have found it an incredibly valuable experience. They’ve made contacts that continue for a long time through social media and find that ability to spend that week living without a secret an incredibly uplifting experience and realizing they’re not alone; they’re not the only one.”
[Clinic – follow up]

**Pre-Camp expectations**

During both post-camp and follow up interviews, Camp attendees were asked what they expected of Camp and how this compared to their experience. All of the Camp attendees interviewed believed that Camp would be a fun or interesting experience. Though some also expressed initial worries;

“Going there I was really nervous, I don’t know why. I can’t name it but I didn’t know what it would be like to meet people. Especially at the train station waiting, I felt just scared to walk over to them.” [Camp attendee – post camp]

This fear quickly dissipated upon arrival.

“[It] made me a bit scared and then when I went to Camp it was different because everyone had it and I didn’t know that everyone was going to have it but everyone had it and everyone was talking about it and that made me confident” [Camp attendee – post camp]

Carers and Clinic team members hoped that the young people would meet others like them and make friends, begin to feel that they are not alone and boost their confidence in their knowledge of how to live well with HIV.
“He needed it because he doesn’t mix with anyone his own peer group.”
[Carer – follow up]

**Camp experience and outcomes**

**Camp logistics**

Camp attendee interviewees and Clinic staff thought that Camp could be extended in length or run more frequently as they had experienced and observed so much benefit.

“I think people wanted more time with each other because the last 2 to 3 days was getting better and everyone started talking and making more friends and stuff and at the end, everyone didn’t’ want to go back.” [Camp attendee – post camp]

“I just feel like in that space of time it’s really short and [...] it could be longer.”
Camp attendee – follow up

“Have it more often! Personally, as a healthcare professional and what I’ve seen, they get a lot out of it.” [Clinic – follow up]

Another area of focus in the interviews was the new age-range for Camp. Most interviewees were very positive about the change.

“I was quite excited to be back and there was also kind of a different atmosphere because it was now 12-16 year olds and obviously the whole time I’d been doing it with 13-17. [...] At first I was kind of like oh that’s a bit young but then if somebody’s told at 10 and then don’t go to camp until 13… that’s 3 years to deal with something on your own.” [Staff – post camp]

“I think the younger kids bring something to it. Cause like the 17 year olds, there’s too much drama but with the younger kids, they’re not really there for drama. They’re just there for fun…. It’s a nice dynamic.” [Camp attendee – post camp]

There were, however, some differences of opinion regarding the age range.
“I know you’re starting to tell them at 11 and everything but no, should be 13.”
[Carer – follow up]

It was commonly expressed that free time was beneficial to promoting open
communication and sharing.

“Being able to talk about it and just normalizing it is incredibly empowering and I
think one of the things that probably gets overlooked is that a lot of probably the
more beneficial conversations that take place are probably in the bedrooms at night
when they’re just chatting with their friends.“ [Staff – post camp]

“I think the main thing is just that prolonged… peer support group meets for an hour
or two once a week. When you’re getting that many hours a day for a week, that’s
totally different.” [Clinic staff – follow up]

The respite role of Camp was also highlighted.

“At least two of them that I know have very complex lives outside of camp and a lot
of caring responsibilities so I think for them it’s about […] respite and it allows them
to be children or teenagers. […] It was very powerful to see the impact it had […]
cause they just leave their lives behind.”
[Clinician – follow up]

“I think for me one of my hopes was actually that it would be a fun time for her as
well. It’s good for her in terms of learning to manage her health better but there was
definitely the element of a break.” [Clinician – follow up]

Relationships between Camp attendees and between Camp attendees and staff

In the Camp attendee survey, the most common answer to the question “What was the
best thing about the Camp?” was meeting people, more specifically people ‘like me’
(Figure 3).
Camp attendees reflected on the benefit of being with other HIV positive peers.

“[We] were closer and it felt natural to be able to talk about things like that cause I’d like to bring it up with my other friends who aren’t HIV positive but they would […] be trying to react appropriately so they’d try to react like it was a really horrible thing or it’s ok or to help but actually sometimes you just want to talk. You’re not trying to get a reaction and that’s, that’s what was much easier at Camp cause we’d just talk, we wouldn’t have to say.” [Camp attendee – post camp]

“What I enjoyed the most was meeting new people and getting to know them and learning about my illness. Because it’s not every day that I go out and […] get to meet a new person and especially with people that have the same illness as you. That is just, you can see how they’re doing in their life and like how you’re doing and compare it and have support and talk about it and like, it won’t be weird.” [Camp attendee- post camp]

“My friends were all in the corridor and we would just stay up late and sit in the hallway talking and we could talk about anything. We could be talking about the past and all the stuff that we wouldn’t talk to our normal friends about.” [Camp attendee – post camp]
Camp staff, Carers and Clinic staff also commented in a positive way about relationships between Camp attendees.

“I really like that they (Camp attendees) can be free and just be like young people like everyone else. I could see all these friendships and romances going on and you know, people getting together and sharing secrets and it was great. I don’t think it was any different to any camps I did with other children who didn’t have the same status so it was good to see that they’re just typical children.” [Camp staff – post camp]

“So I think that’s the most, those are the benefits of the camp, that he’s made friends – some of them that are like him then it’s good for him to open up and maybe they can lift each other” [Carer – follow up]

“The most useful thing about Camp, I think is sort of brings people together that think they might be alone or that feel that nobody accepts them or like they can’t be like anybody else in the world but Camp brings all those people together and sort of tells them that you’re still you and you are important, as important as everyone else and nothing about you is different really, just apart from the fact that you found out something about yourself, just like people do every day.” [Camp staff – post camp]

There were many examples of young people helping each other, and this continued after Camp ended, online or in clinic.

“I didn’t understand some stuff so she (another Camp attendee) explained it to me.” (Camp attendee – post camp)

“Basically just talk about life, how we’re coping, how we’re finding it, how are we telling people that we have it. Like if we’ve got questions, I wouldn’t ask my mum… I’d ask them cause they have it as well and I try to have their view…” [Camp attendee – follow up]
Staff experience

In interviews and surveys, Camp staff reported the benefits of the relationships formed at Camp, being able to interact with Camp attendees while seeing them grow, feeling supported, and the continued opportunity to gain further knowledge about HIV. Organisational support was also noted.

“CHIVA have been really good in terms of […] providing training for the staff that work there so that’s really really good, even from the cleaners to the kitchen staff.” [Camp staff – post camp]

“The CHIVA team are really open to suggestions, they’re really adaptable to change. They’re very flexible in the moment and they’re so calm and how they organize that is incredible. They always listen to ideas and thoughts and they try things and sometimes they don’t work and sometimes they do and you can see how the camp has evolved and changed from year to year to grow into this.” [Camp staff – post camp]

“Every year they’ve taken on feedback and every year that has changed so that’s really positive. I always leave very inspired from camp.” [Staff – post camp]

Camp staff spoke about the personal importance of their Camp role.

“It was an opportunity for me to give back because I remember being in their shoes. […] Because I remember at that time I was at a low point in my life and attending Camp sort of brought me out of my cage a bit more and enabled me to develop the confidence. Otherwise at the time I didn’t really see much of a point in life.” [Camp staff – post camp]

“The way I see it is that I did go through struggles but now I’m at a place where I can handle those struggles and it’s only right for me to be like a mentor inspirational person and pass the lessons down.” [Staff – post camp]
Workshops

*Information Workshop*

All workshops were experienced positively at camp.

“I think it’s really good that the workshops are including up to date, new kind of like information and development.” [Camp staff – post camp]

“Basically it was the knowledge and understanding of HIV because I had some but not a lot of understanding about it. The workshop helped me out with like, it helped me because people had like stories behind their workshops and it made me realize that everyone’s been through this. I thought I was the only one.” [Camp attendee – follow up]

Figure 4 shows Camp attendees’ feedback about the information workshop.

![Bar chart showing how useful and enjoyable the information workshop was](image)

**Figure 4 Information Workshop Survey**
Figure 5 shows the main topics that Camp attendees answered as the most important thing they learned about during this workshop. Other than general facts about HIV, the two main topics were disclosure and the law/their rights.

![Pie chart showing the most important things learned in the workshop.

Figure 5 Information Workshop Survey

The importance of discovering that HIV is legally considered a disability with associated rights was mentioned in both the post-Camp survey and interviews.

“I hadn’t been interested but being this age and wanting to know about my college and work and relationships and stuff, I would be more interested in the law.” [Camp attendee – post camp]

“I found out that I have a lot more rights than I thought I did.” [Camp attendee – post camp]

Another issue mentioned by Camp attendees and adults in their lives was the information about reduction of risk of transmission of HIV from mother to child

“She spoke about the adults educating her about her diagnosis ……..for example that she can have kids and she won’t have to pass on her diagnosis to her kids” – [Carer – follow up]
“I learned that if you keep on taking your medication, it’s under 1% that if you get pregnant your baby will be HIV positive and that, that makes an impact on everyone’s life even the people that may not know because you could be so worried about that. That can impact your future but knowing that if you just keep yourself healthy, you won’t have to worry about your child being the way you are if you just keep yourself all well” [Camp attendee – post camp]

“After I got that fact then I was like “if I stay healthy then I can still live the happiest future ever.”” [Camp attendee – post camp]

One topic that all suggested may need more time was medication, more specifically how different medications work and side effects.

“There’s one who’s got a very scientific mind who likes to know exactly how things work.” [Clinic staff – follow up]

“They could do like sciency stuff at some of the workshops.”
[Camp attendee – follow up]

Experience Workshops
Responses shown in Figure 5 indicate that Camp attendees also rated the experience workshop positively.

![How useful and enjoyable was the experience workshop?](Figure 6 Experience Workshop Survey)
In the experience workshops, Camp attendees often shared stories about their personal experiences. These appeared to resonate strongly with Camp attendees, many of them engaging with the topic by asking questions and contributing to a conversation within the group. Figure 7 shows that sharing one’s status was the most frequently reported learning point from the workshop.

Figure 7 Experience workshop survey
Sexual Health Workshops

The sexual health workshops were generally well received with Figure 8 showing that the majority found the workshop both useful and enjoyable.

**Figure 8** Sexual health workshop survey: usefulness and enjoyment
When asked about what they learned from the workshop, the most common answer was “sex” or “safe sex” followed by “how to use condoms” (Figure 9).

**What was the most important thing you learned from the sexual health workshop?**

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
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<td>How to use condoms</td>
<td>17</td>
</tr>
<tr>
<td>Safe sex/sex</td>
<td>5</td>
</tr>
<tr>
<td>A lot/everything</td>
<td>4</td>
</tr>
<tr>
<td>Transmission</td>
<td>4</td>
</tr>
<tr>
<td>HIV + people can have (safe) sex</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
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</tr>
<tr>
<td>Nothing</td>
<td>7</td>
</tr>
<tr>
<td>Missing data</td>
<td>26</td>
</tr>
</tbody>
</table>

Figure 9 Sexual health workshop survey: learning points

Some Camp attendees were satisfied with this workshop but others felt they would have benefited from more time to ask further questions.

“More on sexual health and relationships, […] they didn’t offer quite as much as I was hoping for.” [Camp attendee – post camp]

Some of the older Camp attendees suggested they would have enjoyed more detail (and more new information) on topics relevant to their age group.

“They were very informative because I was, I’m one of the older people we didn’t have… we weren’t given much more new information because we’d already learned about all this stuff before so it just basically renewing what we already knew.” [Camp attendee – post camp]

Sharing one’s status/HIV disclosure

This topic of onward HIV disclosure/sharing one’s status was prevalent throughout the interviews.

“As the young … camp leaders, they became key workers and young people became camp leaders… that has been totally amazing and I saw that this year in a
workshop for the first time where I think one of the most, perhaps the most successful workshop I’ve seen over 6 years occurred when one of the key workers who used to be, she started as a young person, was a camp leader, then became a key worker… the most successful workshop was when she shared her experiences of disclosure. […] You could hear a pin drop in those workshops. […] I think that is something they need to develop more.” [Camp staff – post camp]

“I figured out […] it’s not going to work if you hold it all inside and actually that doesn’t help but you have to talk to somebody whether that’s an adult, a friend, a parent, you have to talk to somebody. It doesn’t work on your own.” [Camp attendee – post camp]

Camp attendees often spoke about wanting to know how to deal with specific situations where sharing their status might be relevant. For the younger Camp attendees, some of their worries about HIV disclosure related to friends asking questions about pills, or situations at school.

“They [Camp attendees] want to know how do you disclose to your best friend who you’re going for sleepover with tomorrow.” [Staff – post camp]

“I would want to talk about it more but what I’m scared about it if it comes up in a school subject or something like that because in my school it hasn’t come up yet but normally in other peoples’ school it has.” [Camp attendee – post camp]

For older Camp attendees, some had anxieties stemming from disclosing to a sexual partner and being unsure about timing or whether they should share their status at all, while others felt comfortable with the thought of sharing.

“If I tell her before having sex with her she’d probably get angry and wouldn’t talk to me again but if I tell her after we have sex… My friend had a girlfriend and then I talked to him […] ‘why did you tell her?’ and he said ‘because we’ve been through a lot and I know stuff about her and I felt like she needed to know because I think, we’ve been together long enough.” [Camp attendee – post camp]
“I feel like she needs to know, you know what I mean? She’s the only person that I’ve been with that I feel like I might tell her some day and I think she’ll cope with it well.” [Camp attendee – follow up]

After the workshop, Camp attendees were sometimes more confident about how to manage situations, drawing on the material covered.

“Cause I know like what to say, when to say it, who to tell and be careful. Like I wouldn’t tell someone I met today because obviously they’ll just tell people but if you knew them, like if it’s a family member or best friend, you can be, I’ll be comfortable enough to tell them.” [Camp attendee – post camp]

“We got to do what you would do and what you would say to them kind of yeah, so I think I would use what they said and apply it to her.” [Camp attendee – follow-up]

Returning to F2B

Camp attendees often spoke about their desire to return as Camp staff members in the future, to continue educating others or to get involved in the community:

“I want to make other people feel comfortable around Camp and stuff plus other key workers made me feel comfortable so I want to make other people feel comfortable when I’m around them.” [Camp attendee – post camp]

“As soon as I have the time to, that’s something that I’m going to reach out for and try to get involved in and now I read things online and I listen to people who mention it and I just try to be more, more of an [advocate].“ [Camp attendee – follow up]

Clinic staff also highlighted the benefits of young people being in the Camp staff role after having been Camp attendees in the past.

“The other thing I think is great […] is once they’re old enough to come back and be the Camp leaders. […] I’ve been able to do a lot of references for our young people
which they find important for jobs or voluntary work just to say they’ve volunteered and helped to run a support group.” [Clinic staff – follow up]

Self-Report measures

There was no evidence that the proportion of the sample who completed the follow up measures differed in age, gender or in their scores on measures with those who did not.

HIV Knowledge

The median HIV knowledge score was 32.5 before Camp (IQR 30-34.8), 34 after Camp (IQR 32-36) and 34 at follow-up (IQR 31-36). There was strong evidence that this change was not due to chance, with an increase in score from pre to post, and from pre to follow-up. There was no difference in scores from post to follow-up data points, indicating that improvements had been maintained over 6 months.

At the post-Camp point, all 15 of the 19 items were answered correctly by 70% or more of the sample. The exceptions were the following questions:

- The CD4 count measures the amount of HIV in the body (F) – 33% (32% at follow up).
- An HIV positive person whose viral load is low is likely to transmit the virus if they are having sex without a condom with an HIV negative person (F) – 50% (50% at follow up).
- Some medications for HIV need to be taken on an empty stomach (T) – 48% (43% at follow up).
- If an HIV negative person has sex without a condom with someone who has HIV and they take HIV medication afterwards, this can reduce the risk of HIV transmission (T) – 59% (55% at follow up).

ART adherence

The mean score for the adherence measure pre-Camp was 48.80 (standard deviation (sd) 7.68), 50.52 post-Camp (sd 6.88) and 51.69 (sd 7.70) at follow up. There was strong
evidence that these differences were not due to chance with an increase in score from pre to follow up but no difference between pre and post or post and follow up.

In relation to the question about how many doses of medication were missed in the three days prior to camp, only 15 Camp attendees responded (11 had no missed doses, two had one missed dose and two had missed two doses). At the follow up stage 40 of 48 young people who responded had not missed an ART dose in the previous 3 days (83%), six has missed one dose (13%) and two had missed two doses (4%).

_**HIV disclosure/sharing**_

The mean for this measure pre-Camp was 55.82 (sd 8.36), 61.44 (sd 8.88) post camp and 60.00 (sd 9.60) at follow up. There was very strong evidence that these differences were not due to chance with an increase in score from pre to post, and from pre to follow-up. There was no difference in scores from post to follow-up data points, indicating that improvements had been maintained over 6 months.

The mean intention to disclose at pre-Camp was 2.69 (sd 1.22), 2.88 (sd 1.29) at post camp and 2.55 (sd 1.09) at follow up. Twelve of the 48 Camp attendees who completed pre and follow-up measures (25%) stated that they had disclosed to someone in the 6 months prior to camp while six young people stated they had done so between Camp and follow up (14%). There was no evidence that either disclosure intention or behavior differences were not due to chance.

_**HIV communication**_

The mean scores for this measure pre-Camp was 25.93 (sd 4.83), 27.12 (sd 4.70) post camp and 25.11 (sd 4.55) at follow up. There was evidence that these differences were not due to chance with a decrease in score from post to follow up but no difference between pre and post or pre and follow up. The pattern of scores was different for males and females. Male scores increased from pre to post, then decreased to follow up.

The mean score for intention to communicate about HIV pre-camp was 2.87 (sd 1.26), 2.83 (sd 1.36) post camp and 2.47 (sd 1.28) at follow up. There was no evidence that these differences were not due to chance. Females had higher intention to communicate about HIV than males. Twenty-two Camp attendees (45%) replied that they had
communicated with someone about HIV (outside of their care team) in the previous 6 months while fifteen of this sample (31%) had done so at follow up. There was no evidence that this difference was not due to chance. There was also no evidence that differences in the frequency of HIV communication was not due to chance (pre: 2.14 (sd 1.22); follow up 2.05 (sd 1.25)).

**HIV stigma**

The mean score for this measure pre-Camp was 18.17 (sd 3.30), 17.85 (sd 4.29) post Camp and 16.89 (sd 3.61) at follow up. There was no evidence that this difference was not due to chance.

**Quality of Life**

The mean for the quality of life screening measure pre-Camp was 39.28 (sd 7.24), 40.20 (sd 6.50) post camp and 38.93 (sd 8.82) at follow up. There was no evidence that this change was not due to chance. There was weak evidence that lower quality of life was associated with increased age.

The mean for the self-perception items pre-Camp was 17.87 (sd 5.07), 19.36 (sd 4.31) post camp and 18.93 (sd 5.29) at follow up. There was weak evidence that this increase was not due to chance with evidence of an increase in score from pre to post, and no difference in scores from pre to follow up or post to follow up.

The mean for general health item pre-Camp was 4.17 (sd 0.89), 4.17 (sd 0.83) post Camp and 4.35 (sd 0.78) at follow up. There was no evidence that this change was not due to chance.
Post-Camp Accounts

Psychological changes after camp

Several changes were noted in the time between the end of Camp and the interviews, including both post-camp and follow up time points.

Confidence

Increased confidence was frequently reported by young people from Camp and observed by Clinic staff:

“I’m glad. I was expecting it to just be like a fun time and then yeah, I’d have some more friends but it has actually changed me cause I don’t know, I’m more confident and happier in myself. Yeah, so I’m really glad it happened.” [Camp attendee – post camp]

“Life has been good, I feel like it’s been easier for me to communicate with other people and make friends more easily.” [Camp attendee – follow up]

“I have more of a confidence in my decisions after camp … I’ve just felt like whatever I decide, I can do it and I can choose that and that it was it is for me and I don’t need to go asking people and making sure everything’s good with them if it’s good with me.“ [Camp attendee – follow up]

“[Camp] did change a lot for me because before I was like so scared […] scared of what people would think but […] it’s hard not to tell someone and really talk about it but now I feel I can be open.” [Camp attendee – post camp]

“She openly stood up and spoke about her own experience of telling friends and telling friends at school about her own diagnosis as well so she shared that with the group. I don’t think she would have been as confident before camp.” [Clinic staff – follow up]
“Camp has really improved his confidence and self-esteem and normalized his health condition really and he’s made some real good links in terms of friendships.” [Clinic staff – follow up]

Camp staff also reported witnessing positive change from year to year in Camp attendees.

“You saw an awful lot of those young people come back and had just grown… in their understanding of HIV, they’d grown in the way they held themselves, in their confidence, in their self-esteem. They weren’t letting HIV rule their lives. They were talking openly about it.” [Camp staff – post camp]

“I feel like they got a sense of belonging and not feeling alone and that they can be confident in achieving what they want to achieve.” [Camp staff – post camp]

**Maturity**

Camp attendees reported feeling more responsible and mature after Camp, with Carers also noticing a difference.

“My maturity of my HIV has changed. Cause I used to think it’s not a problem and I still think that but I understand it… each year I understand it a bit more and get on with my life. I’m more independent.” [Camp attendee – post camp]

“I think that she’s able to think about the subject more deeply and therefore she’s able to make decisions for herself much more easily than she would if she hadn’t gone to the camp. She’s empowered to think for herself a bit more.” [Carer – follow up]

**Transition to adult care**

In the follow up interviews, it was reported that four Camp attendees were either newly in adult care or at various stages of the transition process. Although this topic was not explicitly covered at camp, some interviewees felt that this could have been beneficial. Despite this, the confidence gained at Camp may have helped some young people to manage transition positively.
“Oh I definitely think it should be covered at camp.” [Clinician – follow up]

“She had been talking at camp about going to transition and she did talk about that when she came back but she then decided that maybe it wasn’t quite the right time to go […] We met her half way and she’s now seeing us on her own without a parent so it gave her the confidence to tell us that really.” [Clinic staff – follow up]

Willingness to help/engage in community

Camp attendees reported a desire to give back and get involved in volunteering and advocacy work as well as continue to support other young people living with HIV. This was also recognized by the adults in their lives.

“I definitely want to be involved with CHIVA charity and HIV in my life. […] So being at Camp like, it didn’t open my eyes cause I knew it was happening already but I was more aware of [people struggling] and I’m more motivated to help.” [Camp attendee – post camp]

“It’s kind of like there are kids who have just found out that they’ve got it that haven’t been to Camp yet and I’d like to help them, to support them to say this is what it is and this is what you need to do. Just say “I’m here for you so if you have any questions, just come ask.” [Camp attendee – follow up]

“He’s quite supportive to other young people [in clinic] I’m thinking it might be because of the Camp. He understands his diagnosis better than those who don’t go to Camp and don’t know other young people who’ve got HIV.” [Clinic staff – follow up]

Some young people mentioned being part of the CHIVA Youth Committee as something that had been rewarding or could be beneficial in the future. Again, this was also commented upon by their carers.
"Hopefully, I’ll be part of the youth committee [...] My cousin was on the youth committee and actually I quite liked the whole thing and I thought I could do good on there.” [Camp attendee – follow up]

"I think being part of the CHIVA youth committee gives him another added factor cause of the sense of responsibility.” [Carer – follow up]

"I think that's where he has quite a strong sense of family and family unit when he talks about the youth committee" [Carer – follow up]

"It’s made me, it’s definitely improved my confidence because I was not confident at all, I was barely able to speak to anyone and now I can stand in front of a crowd of people and talk for hours about stuff" [Camp attendee – post camp]

"He does mention a lot about the committee. He loves it. [...] It gives him a feeling of self-, or importance really. He is doing something great.” [Carer – follow up]

Behavioural changes after Camp

Adherence

The impact of Camp on adherence to Campers' medication regime was extensively discussed in interviews after Camp.

“Every time I took them I felt like it was a reminder like that I had HIV but then at Camp it was just, it was a lot like not letting it define who you are and just being you and in life I was like “yeah I’m gonna do that” and ever since Camp I’ve been taking my medication.“ [Camp attendee – post camp]

“It changed in many ways like, I felt like I’m not the only one that deals with it… they all take their medication and to live well I need to do the same even though I may not like them but they’re gonna help.” [Camp attendee – post camp]
“It’s improved quite a lot, I’ve been doing well so far so I’m happy about that and I find it much more easier. […] cause I know more about it. Before I didn’t know what it was, just took it and just made sure.” [Camp attendee – post camp]

Self-reported improvements in adherence were also backed up by accounts from Carers and Clinic staff.

“My sister, she came back enlightened about her diagnosis which was really great and it worked especially well for us because […] we had trouble with [NAME] taking her medication. […] Before it used to be a battle to get her to take her medication but [now] she’s more forthcoming to take her medication. We don’t have to remind her, she even reminds us and calls upon us to supervise us taking her medication.” [Carer – follow up]

“She’s been more consistently undetectable since camp.” [Clinic staff – follow up]

One member of Camp staff talked about how returning to Camp as a Key Worker helped him change his perspective on taking his medication:
“Once I was in Camp and I was held responsible to give other children pills, I just reflected on myself and said if I can do this for these other children and make sure every day that they take their pills and make sure that they see the value… it was almost like […] I had to become that person and […] ever since Camp so I’ve just been like you know what, I can do it.” [Camp staff – post camp]

Other Camp staff commented on the importance of speaking about medication at Camp as a way of promoting good adherence:

“I think normalizing it, having those little conversations, they really do make a difference and in that respect you can be effective.” [Camp staff – post camp]

Meanwhile Clinic staff reported that Camp could be used to encourage adherence and viral suppression throughout the year.

“You can’t talk about resistance without adherence and those are sort of imprinted a bit so in between the first Camp at the second one, all the experience of what she’s told me happened… we’ve used that to encourage her, to look forward to the next one.” [Clinic staff – follow up]

**Communication**

Camp attendees were asked whether they are still in contact with people they met at Camp and to describe the frequency of their communication at both post and follow up time points. Camp attendees reported using multiple social media, such as WhatsApp, Instagram, Snapchat and Facebook, to stay in touch with friends. Immediately after Camp, everyone was excited about new friendships and hopeful about keeping in touch. Carers and clinic staff also reported ongoing communication.

“I talked to everyone! Like right now, as soon as Camp finished, there was a group that was made and there were like 40 of us in it. […] We’re so tight.” [Camp attendee – post camp]
“Yeah I still talk to her quite a lot. We connect in so many ways and she’s there to talk to. She’s a very open person and yeah just really nice.” [Camp attendee – follow up]

“I’d say 20-30 cause we’re in a group chat and everyone talks.” [Camp attendee – post camp]

“I’m glad she did go because she made loads of friends that she keeps in touch with.” [Carer – follow up]

“It’s nice that they can keep in touch with all the young people. I had a young person […] and she’s really struggling with her medicines and she said that last week some people that she’d been doing that with started a whatsapp group and they’ve been supporting each other with taking their medicines every night” [Clinic staff – follow up]

At follow up, Camp attendee reports were more varied. Though there was continued communication among young people, they also reported people falling out while chatting and group numbers diminishing in the group chats over time. This was partly due to lack of interest and the difficulty of keeping in touch long-distance without face to face contact.

“That died cause everyone started going back to school and people just started leaving…” [Camp attendee – follow up]

Despite this, there was ongoing communication between some young people, and Camp attendees talked about ongoing peer communication and ways that this could be helpful.

“Every day. They’re thick as thieves. They’re planning on getting together sometime.” [Carer – follow up]

“We […] still go through issues whilst you’re not at Camp. It would be very useful if we could talk to each other after Camp as well.” [Camp attendee – post camp]
“I don’t think anybody in the chat has even done it (shared their status with others) themselves. If I knew someone that has, then I would definitely ask them.” [Camp attendee – follow up]

Carers and Clinic staff also reported improved communication and openness in general.

“Yeah because I think, not necessarily with us but with his peer group he’s shared some of his problems and it’s a good thing.” [Carer – follow up]

“I would say he talks more about it [HIV] in the last 18 months than he did before.” [Carer – follow up]

“Since coming to clinic after camp as well, he’s been a lot more chatty and relaxed. [...] The camp experience in general has made him a little bit more confident in speaking to us and when he comes to clinic [...] he smiles a lot more and is starting conversations whereas before he would just answer your questions.” [Clinician – follow up]

**Discussion**

F2B is a complex intervention. Therefore, evaluating whether and why it is effective is challenging, particularly in the absence of a comparison group. Nevertheless, the findings from this evaluation are promising. Self-report measures showed significant improvements in pro-HIV disclosure cognitions and affect, and HIV knowledge, from before to after Camp that were maintained six months later. There was also evidence of increases in pro-ART adherence cognitions from before Camp to six months after Camp, and of self-perception improvements from pre-Camp to post-Camp. Post-Camp benefits in medication adherence were reported in interviews, although there was not enough data to establish whether this was corroborated by self-reported adherence changes. The interviews also suggested increased self-confidence, maturity, a willingness to help/engage with the HIV community, and improved communication with others (although there was no evidence of changes in HIV communication cognitions, self-reported frequency of HIV communication or intention to communicate about HIV). There was no evidence of change in external HIV stigma, quality of life or general health, from self-report measures.
The HIV disclosure findings were particularly interesting. There were numerous ways that HIV disclosure was discussed at Camp, often outside of the context of specific workshops, which might explain the disclosure affect and cognition results. For example, Camp attendees mentioned the increased confidence about sharing their status arising from hearing other peoples’ experience as well as receiving specific tips of how to manage disclosure situations. There was no change, however, in the intention to disclose or in HIV disclosure frequency. Therefore, Camp attendees appeared to feel more confident in their ability to share their status, and more positive and less concerned about the outcome of disclosure, but these changes did not yet translate into intending to or actually disclosing their status more in the six months after the end of Camp. A more intensive intervention, perhaps focusing on increasing motivation and skills to share one’s status, or a more frequent intervention, might be needed to facilitate changes in these outcomes if these are seen as desirable.

Increases in HIV knowledge may be explained by the lengthy HIV information workshop sessions and the fact that certain facts were repeated throughout Camp in multiple workshops. Comments about the beneficial effect of Camp on thoughts about having children in the future are particularly encouraging. There remain, however, some specific aspects of HIV knowledge that may require further input given incorrect responses at the post-Camp and follow up time points.

In the clinic setting, the interviews suggested increased comfort in young people communicating with staff members. According to self-report measures, however, levels of communication about HIV with people outside of one’s care team remained low. Non HIV-specific communication with other people living with HIV appeared to be enhanced by Camp, though, according to the interviews. This contact, if maintained, has the potential to decrease isolation, increase practical and emotional social support and enhance wellbeing. There was evidence that Camp attendee peer communication reduced over time. It may be that Camp attendees could benefit from the promotion of existing or new online spaces specifically for them (e.g. private Facebook groups) to maintain ongoing contact. Changes in communication levels about HIV in particular, may be more resistant to change than other areas, as they are to some extent dependent on the perceived beliefs and behaviour of others (e.g., families). It may be helpful to consider how to
communicate with families about the content of Camp to facilitate ongoing familial communication.

Self-report measures did not show change in pro-ART adherence cognitions and affect before and directly after camp but did show an increase from pre camp to the follow up time point. It may be that the ongoing focus on ART adherence in clinic contributed to the changes after the end of Camp. It may also be that some aspects of medication adherence would need to be addressed in greater depth for pre-post changes to be seen. The interviews elicited a number of comments regarding improved adherence, although there was not enough data to establish whether there was any evidence of a reduction in missed doses. Clinic data will be used in the ongoing evaluation to assess the effect of Camp on CD4 counts and viral load.

The positive improvements in self-perception at the end of Camp were not maintained, although there were many comments from the interviews relating to improved maturity, confidence and a willingness to engage with and contribute to the HIV community (e.g., through the CHIVA Youth Committee or as Camp staff in the future). These aspects may not have been captured with the self-report measures used in the evaluation. External HIV stigma (beliefs relating to how others think about HIV) did not change, although it may be unrealistic to expect such changes relating to an intervention focused on young people living with HIV rather than those not living with the condition. Future evaluations could assess internal HIV stigma in a sensitive manner. The sample, as a whole, reported good quality of life and general health and these areas did not change over time.

In relation to specific workshops, the sexual health workshop was well received but there was evidence that Camp attendees would like these to be more closely tailored to their individual needs. This feedback could be related to the fact that two age groups were combined due to a facilitator be unable to attend. Regarding the experience of Camp, there were many Camp attendee suggestions to increase the duration of Camp to maximize its benefits. This may allow for more of a balance between activities and free time. The latter was also a common request from Camp attendees.
**Evaluation Strengths and Limitations**

This evaluation used mixed methods and repeated objective measures with multiple informants. The response rate was good and representative sampling methods were used as much as possible. The most significant limitation is the lack of a comparison group in the evaluation thus far. Additionally, there was a need to develop new measures (in the absence of appropriate alternative measures) in a short period of time, restricting the possibility for extensive piloting and assessment of reliability and validity (although some such work was undertaken). A formatting issue meant that there was limited data for self-reported adherence at the pre-Camp data point. The retention rate at follow up was good (73%), although the number of young people with data at all three time points may have been too low to show strong evidence of change on some measures.

**Next phase of the evaluation**

Clinic data will be sought for the year prior to and the year after Camp to assess any changes in clinic attendance, CD4 count and viral load. These will be used to determine whether there are changes in these clinical outcomes for young people who attended camp and to what extent F2B attendance may be related to this. We are also interested in the possibility of comparing experiences of young people living with HIV within the CHIPS cohort that have attended the 2015 Camp to those who did not.
Conclusion

This evaluation sought to assess the impact of attending CHIVA’s Freedom 2 Be Camp and to explore the experience of Camp attendees, Camp staff, Carers and Clinic staff. The evaluation showed that there was good evidence of benefits in several areas, with corroboration between self-report quantitative measures and qualitative data.

The unique environment at Camp as well as specific activities and workshops appeared to facilitate HIV knowledge gains and enhance pro-HIV disclosure beliefs, in particular, as well as helping young people to develop positive relationships and an enjoyable experience away from home in a safe space. In addition, Camp attendees were able to access peer and professional support, and to feel more confident about living well with HIV.
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References


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