TECHNICAL DOCUMENT

Communication strategies for the prevention of HIV, STI and hepatitis among MSM in Europe

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Contents

Figures

Tables

Abbreviations

AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral therapy
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EMIS	European MSM Internet Survey
EU	European Union
GLBTIQ	Gay, lesbian, bisexual, transgender, intersex and queer
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
MSM	Men who have sex with men
NGO	Non-governmental organisation
PEP	Post-exposure prophylaxis
PLHIV	People living with HIV
PQD	Participatory quality development
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection
TasP	Treatment as prevention

Glossary

Communication channels	The pathways and means of transmitting the message from sender to recipient
Evaluation	Systematic assessment of interventions against their stated objectives
Focus group	A group interview method designed to elicit feedback on specific questions
Health promotion	The process of enabling people to increase control over and improve their health. Health promotion moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions [1].
HIV status/ serostatus	Refers to whether an individual is infected with HIV, i.e. HIV is detected in a person's body or not: HIV positive = HIV is detected, HIV negative = HIV is not detected. Serostatus refers to the serum component of the blood, which is the body tissue used to detect HIV infection in confirmatory tests.
Homonegative/ homonegativity	Negative attitudes towards people who are attracted to others of the same gender
Low-threshold	Posing as few barriers to people as possible, e.g. offering multiple languages, minimising bureaucracy or situating services where people can access them easily
Men who have sex with men (MSM)	This term is used to define the population of men, including transgender men, engaged in same-sex sexual behaviour, based on sexual identity (e.g. gay, bisexual, straight, experimenting) or sexual desire (men with no sexual desire for other men but who have sex with men for money or favours). It is used to recognise that not all homosexually active men have a gay or bisexual identity, and has become a standard term within HIV prevention work and research.

Multidisciplinary	Made up of people from a variety of fields of expertise, e.g. medical doctors, communication specialists, target group representatives and social workers
Needs assessment	The systematic investigation and documentation of the requirements and desires of a group of people
Negotiated safety	The process of negotiating sex without condoms within a sexual relationship based on the concordant HIV status of all partners as determined by regular tests
Participatory quality development (PQD)	PQD is an integrated set of tools designed to help improve work practices. It relies heavily on the local knowledge of stakeholders and helps them use it, reflect on it and extend it. PQD includes a selection of participatory and evidence-based methods and processes that are tailored, feasible and useful for HIV prevention projects.
Pre-test	The process of piloting an intervention in a limited fashion before implementing it at scale, usually to discover ways to improve it further
Prevention message	The content of the prevention-based communication to be transmitted, either in words or images
Safer sex	Used to indicate that risk from sex cannot be eliminated completely. 'Safe sex' is often used to communicate a high level of confidence in the effectiveness of this prevention method.
Sex-on-premises venue	A commercial establishment that primarily or secondarily serves the purpose of providing opportunities for men to have sexual encounters with other men during their visit
Social marketing	The dissemination of non-commercial messages using the methods and skills of mass-communication developed mainly by the advertising industry
Subpopulation	A group with particular shared characteristics within a larger group
Target group	The group of people that an intervention is designed for and aimed at
Target-group specific/ target-group oriented	A way of conducting interventions that systematically takes the characteristics, needs and preferences of the target group into account
Viral load	The amount of virus that can be detected in the blood. It is counted in individual viral RNA particles (copies) per millilitre of blood. Depending on the test used, less than 40–75 copies/mL is considered an 'undetectable' viral load. The goal of HIV ART is to consistently suppress virus levels to < 200 copies/mL of blood.

Executive summary

This document should be considered as a supplement to the more comprehensive guidance issued by the European Centre for Disease Prevention and Control, entitled *HIV and sexually transmitted infection prevention among men who have sex with men*[1], and may be used to complement the health promotion section of this document. It aims to provide guidance on developing innovative and effective communication strategies to promote a lower risk behaviour culture in the MSM community, supporting MSM to make decisions that reduce their risk of HIV, STI and viral hepatitis transmission. It is intended as a practical tool for selecting and locally adapting appropriate communication interventions to a variety of contexts in the European Union and European Economic Area.

The content of this guide is derived from a review of current interventions, scientific and implementation research, grey literature as well as combining extensive collective practical experience and expert consensus. The document is written for public health professionals, policymakers and HIV prevention practitioners. It provides an overview of approaches on how to design better communication programmes and interventions that are targeted at MSM. Some of the areas covered in this guide are mass media, printed materials, outreach work, and one-to-one or small group communication/peer education. This guide includes helpful examples of successful prevention messages for MSM, planning concepts, and examples on how to implement and evaluate communication strategies and prevention campaigns.

Chapter 1 provides a brief introduction into the topic and how to use this guide. Chapter 2 summarises topics such as HIV and STI prevention among MSM, the epidemiology of HIV and STI, the vulnerability of MSM as a risk group, and the need for targeted communication strategies. Chapter 3 outlines principles for effective prevention messages, while Chapter 4 explores major barriers to delivering effective communication strategies. An overview of prevention messages for MSM is presented in Chapter 5. The last chapter presents a toolkit for the planning, implementation and evaluation of communication programmes and interventions that target MSM.

[1] Available from: http://ecdc.europa.eu/en/publications/Publications/hiv-sti-prevention-among-men-who-have-sex-with-men-guidance.pdf

1 Introduction

1.1 About this guide

The European Centre for Disease Prevention and Control has produced this guide to inform the development of health communication programmes targeted at men who have sex with men (MSM) on HIV, sexually transmitted infections (STI) and viral hepatitis.

It provides the basic principles of an effective community strategy for MSM, including a review of barriers to effective communication with MSM. Public health professionals, policymakers, and HIV prevention practitioners should understand these principles when designing a communication programme.

This guide also includes practical examples of prevention messages for HIV, STI and viral hepatitis. All examples are targeted at MSM and include sample texts in plain, neutral English. Further examples of historical MSM communication campaigns from various European contexts illustrate how prevention messages can be adapted locally.

A central element of this guide is a toolkit to help with the planning, development and evaluation of health communication programmes. It includes, for example, a template for campaign objectives, help on how to select effective communication channels, guidance on how to choose the most appropriate materials for dissemination, and a framework for monitoring and evaluating campaigns.

The intended audience for this guide are public health professionals, policymakers, HIV prevention practitioners and professionals in governmental and non-governmental organisations (NGOs) who are responsible for funding, planning, implementing, and monitoring prevention initiatives for HIV, STI and viral hepatitis.

1.2 How to use this guide

This guide can be used to complement, improve, or evaluate existing national initiatives, or serve as a basis for developing new initiatives. This guide is intended as a practical tool to help select and locally adapt communication interventions so that they meet specific national and local needs. It can also be seen as an extended version of the health promotion section of the 2015 ECDC guidance *STI and HIV prevention in men who have sex with men in Europe* [2].

A systematic review of the literature, in combination with an expert opinion, identified a number of key measures which should be considered for inclusion in national and subnational public health programmes in Europe. All measures aim to effectively prevent and reduce HIV and STI transmission among men who have sex with men, address the needs of MSM who are living with HIV, and promote sexual health among MSM.

- Vaccinations: Promote and deliver vaccination to protect against hepatitis A and B in line with the national vaccination recommendations. Carefully assess vaccination for human papilloma virus (HPV) of boys during early adolescence. According to the ECDC guidance *Introduction of HPV vaccines in European Union countries – an update*[2] MSM may benefit more from HPV vaccination than the general male population.
- Condoms: Provide easily accessible condoms and condom-compatible lubricants and promote their effective use.
- HIV and STI testing: Provide voluntary and confidential HIV and STI counselling and testing via a variety of easily accessible venues. Voluntary partner referral can support the early diagnosis and treatment of contacts.
- Treatment: Timely provision of treatment for HIV, STI and viral hepatitis. Preventive benefits of treatment are significant.
- Health promotion: Provide accurate and accessible information that enables men to understand and assess sexual health-related risks and prevention efficacy and that promotes awareness of one's own HIV and STI status
- MSM-competent health services: MSM-competent points of care should offer a comprehensive sexual health programme that will increase service uptake. Services should include health promotion, counselling, peer support, prevention, adequate diagnostics and treatment. Ensure target group involvement and training for providers on how to offer comprehensive care for MSM.

[2] Available from: http://ecdc.europa.eu/en/publications/Publications/20120905_GUI_HPV_vaccine_update.pdf

- Targeted care for MSM living with HIV: Provide antiretroviral treatment for HIV and vaccination in line with the national vaccination recommendations; regular STI screening using adequate diagnostics; treatment for STI; individual counselling; sexual health promotion in the context of HIV, STI and viral hepatitis prevention; and peer-support groups.

2 Background information

2.1 Epidemiology of HIV, STIs and hepatitis among MSM

In 2013, every day 80 new HIV diagnoses were reported in the European Union and European Economic Area, which translates into a crude annual rate of 5.7 diagnoses per 100 000 population. Despite prevention efforts, the number of new HIV diagnoses in MSM in Europe has increased by 33% over the last decade. Two in five (42%) new HIV diagnoses reported in 2013 were reported to have been in MSM [3].

MSM are also disproportionately affected by other STIs such as gonorrhoea and syphilis. More than a third (43%) of all cases of gonorrhoea in 2013 were reported in MSM. Between 2008 and 2013, the overall rate of gonorrhoea increased by 79%, mainly due to a rise in diagnoses among MSM [4]. In 2013, syphilis was reported almost five times as often in men than women, with MSM accounting for 54% of all syphilis cases. In recent years, there have been a number of documented outbreaks of hepatitis C and other STIs among MSM [3].

2.2 Vulnerability of MSM

There are many reasons why MSM have an increased risk of HIV, STI, and hepatitis infection. Firstly, some MSM report high levels of high-risk sexual behaviour associated with transmission. For example, the act of condomless anal intercourse is associated with a higher risk of transmission of these infections, compared to vaginal and oral intercourse [5-7]. Other high-risk sexual behaviours such as multiple sexual partnerships, rougher sex, especially under the influence of drugs and alcohol, are also commonly reported by MSM, and are all linked to increased rates of transmission [8]. Men who engage in sexualised drug use ('chemsex') put themselves at risk further, through needles/syringe sharing or compromised judgment leading to high-risk sexual behaviour.

Secondly, homosexuality remains morally, socially, and culturally stigmatised in many countries. The sexual behaviour associated with transmission remains highly stigmatised. This often means that the sexual behaviour of MSM is hidden or unreported and may lead to MSM not self-identifying as gay. MSM may feel uncomfortable or unable to access the sexual health services they need, or to disclose their behaviour to healthcare workers for fear of discrimination, insensitivity, or even prosecution [2].

There is evidence that stigmatising legal and social conditions around homosexuality can lead to internalising homonegativity [9], which in turn is associated with detrimental effects on self-esteem and mental well-being [10,11]. Furthermore, evidence suggests structural inequalities can disenfranchise MSM on an individual level, resulting in less frequent HIV testing and use of condoms [12]. There is clear link between homonegative social and cultural attitudes and increased transmission of HIV, STI and viral hepatitis [13].

The complex interplay between stigmatisation of homosexuality and the onward effect of this on self-esteem, mental health and sexual behaviour mean that MSM are a hard-to-reach group for delivering effective and sustained health education and prevention communication.

2.3 Communicating prevention messages to MSM in Europe

MSM are a diverse population with multiple layers of social and sexual networks, subject to varying degrees of stigma and discrimination, depending on local societal and cultural attitudes toward homosexuality. Successful communication strategies targeting MSM are best delivered as part of a multi-component programme. Such a programme should use a variety of channels and methods to impart a clear, concise message that focuses on key health issues to promote sexual health and support MSM in protecting their sexual health.

Successful communication programmes require evidence-based planning, implementation and evaluation. This guide outlines some of the principles and methods for developing and delivering such communication campaigns. To be effective, these principles and messages will need to be adapted to the local context based on the knowledge of the target group and the social norms surrounding it.

3 Principles of an effective communication strategy

Over the last three decades, a number of principles have emerged that should form the basis of an effective prevention communication campaign targeted at MSM. The following sections present five principles which should be at the core of any such communication strategy.

3.1 Use accurate, complete, and current information

Public health professionals, policymakers and HIV prevention practitioners designing communication strategies must recognise information needs by providing scientifically accurate and current messages. One of the major challenges of health communication is to provide enough information to enable the audience to follow the logic of the recommendations, while at the same time not losing those members of the audience that have a lower level of health literacy.

MSM construct their personalised safer sex strategy based on their understanding of facts, filtered through the level of risk they are prepared to take in exchange for the sexual experience they desire [14,15]. Decision-making based on the two fundamental factors of risk and pleasure has been summarised in the phrase 'the best sex with the least harm' [16]. Health communicators should therefore supply evidence-based, accurate information to avoid misconceptions and erroneous conclusions.

The comprehensive communication of facts is best broken into successive bite-sized messages. For example, communicating the risk of HIV transmission in absolute terms ('condomless sex can lead to HIV infection') is sufficient as an initial prevention message, but once this message is established, MSM will require detailed and differentiated information about the relative risk of their sexual behaviour, e.g. 'condomless sex is riskier in some situations than others, depending on factors such as…'.

Ideally, the content of prevention messages should be based on well-established evidence and/or expert consensus. However, prevention messages need to be updated regularly to remain current and perceived as pertinent. Communication teams should acknowledge unresolved questions, take a clear stance on scientific and public health issues, and lead a balanced debate.

If needed, communication messages can direct recipients to reliable sources for further information. The internet can be an important tool for communication campaigns. However, just like other population subgroups, MSM can fall prey to wrong information, and efforts should be made to direct MSM to reliable and endorsed websites that present accurate information in a more convincing format [10].

3.2 Build trust between the recipient and the sender

A successful health communication message relies heavily on the trust between recipient and sender, whether an individual, an organisation or a public authority. Consequently, it is important that the message is accurate and up to date, and the sender is perceived as authentic and authoritative.

Firstly, the communication product should state who is responsible for the content and distribution of the message. Contact details of the sender should be provided so that recipients are able to ask questions, offer feedback or lodge a formal complaint.

Secondly, communicators should have both the scientific and the institutional authority to communicate a particular message to their audience. If the sender is perceived as lacking in authority, the resulting credibility problem renders the message ineffective. If this is the case, the message can only be delivered convincingly if the sender builds alliances with groups who can then deliver the message with a certain degree of authority. If the recipient has reason to question the sender's motives, the effectiveness of the communication will be severely impaired.

Thirdly, a key challenge to develop communication activities around sexual health in the context of HIV, STI and viral hepatitis prevention is the authenticity of the content provider. The sender of the communication should show a commitment to the health and wellbeing of MSM in order to be seen as authentic, especially if the messages are challenging and provocative. For example, a message that expresses a critical stance towards an activity such as sexualised drug use – which is culturally accepted among many MSM – may be accepted if it comes from 'inside' the group, but rejected if it comes from the outside. Building a relationship and trust will bring the sender closer to the 'inside' and avoid appearing pushy or judgemental. For this reason, many public health practitioners and policymakers collaborate with national or local NGOs to develop communication messages that can credibly take an inside perspective and legitimise the message, i.e. to make it important, trustworthy and meaningful.

Trust can be built by adopting an affirmative stance toward MSM's right to a fulfilling sexual life, rather than defining MSM or their behaviour as a problem. Trust needs time to develop and requires many interactions over time. Communicating challenging, controversial messages at the beginning of a trust-building period is probably premature; messages will be more effective once a certain level of trust has been established.

3.3 Promote self-respect and empowerment

Communication strategies should be designed in a way that leads to an increase in the target group's knowledge so they can protect and improve their sexual health. In this context, the concept of 'shared values' is essential: everyone is simultaneously and equally responsible for protecting their and their sexual partners' health. Equal responsibility implies that all partners who participate in a sexual encounter are jointly accountable for being aware of their HIV status, initiate negotiations about safer sex, and protect their own sexual health. This concept relies on MSM taking charge of prevention actions collectively and individually, with the goal to empower MSM networks and tackle stigmatisation and discrimination.

Because stigmatisation and discrimination still affect MSM, empowering communication is essential. Designing communication activities that reflect the experiences of MSM requires knowledge of their political and social conditions, social class, place of residence, age, ethnicity, level of education, emotional health, interests and desires. Supporting sexual expression and sexual health means addressing topics such as internalised homonegativity, sexual and social networks, drug and alcohol use and their causes within the wider social context. Considerate, thoughtful and authentic support based on respect, integrity and collaboration holds the most potential for successful communication.

Communication programmes can contribute actively to empowerment and promoting self-respect by developing shared objectives that include both sexuality-affirming and health-related objectives [16]. However, communication should not be based on assumptions that all MSM feel able to act on the information and advice they receive. In some circumstances, communication may need to be primarily directed at politicians, health service providers and the general population to create an enabling environment [17].

3.4 Take a participatory approach

The perspective from which messages are communicated is an important factor for health promotion, especially in the context of sex and sexual health messages. A top-down approach can reinforce disenfranchisement and undermine health communication efforts [18].

Ensuring the participation of MSM in all aspects of the communication strategy through community-centred, dialogic and participatory approaches can alleviate negative responses [19]. In countries several decades of successful prevention programmes, civil society organisations led and governed by MSM now play a central role in the implementation of communication programmes. The prevention strategy as a whole is often characterised by a well-structured partnership between experts, government organisations, NGOs and advocacy groups, including the meaningful participation of people living with HIV (PLHIV) at all levels. Many of the staff members and volunteers of those partners are usually MSM themselves and contributing as peer educators, experts, campaign developers, social researchers, journalists, government officials, physicians, project managers, counsellors and social workers. In places where public health agencies and government officials are still solely responsible for the design and implementation of communication strategies for prevention programmes, participation depends on the willingness of the people in charge to involve MSM through advisory groups, committees, focus groups and surveys.

Collaboration and coordination between the public sector, healthcare providers, community-based organisations and volunteers further strengthens the communication programme by ensuring that target groups receive coherent and consistent prevention messages and increases shared ownership. The input of professionals from other sectors like social research, social marketing, writing, graphic design, project management, and monitoring and evaluation will further improve the effectiveness of communication programmes and interventions. A multidisciplinary partnership across the different levels of government and non-government stakeholders supports collective reflection and problem solving, while improving the perception of legitimacy of the communication programme and the message in the eyes of the recipient.

Critics of an integrated, participatory approach to prevention communication argue that providing information about risk reduction strategies other than those most widely endorsed (e.g. abstinence, reducing the number of sexual partners, 100% condom use) may promote risk taking and undermine established social norms. However, over the course of the HIV epidemic, evidence points in a different direction. Many new and successful prevention strategies were developed in the MSM community; condom use among MSM increased as soon as AIDS was linked to sex, and AIDS activists promoted the practice through their networks. The concept of 'negotiated safety' also originated in the MSM community, long before the concept was given a name, defined and promoted by prevention professionals. The same is true for withdrawal and, more recently, emerging risk reduction strategies such as serosorting, and anecdotally probably even for pre-exposure prophylaxis (PrEP).

3.5 Use acceptable language and imagery

There is empirical evidence from the field of communication science indicating the importance of using simple and acceptable language, combined with appropriate and engaging imagery to effectively reach the target audience [20;21]. When communicating about sex and sexual health with MSM as the target group, vocabulary and language should be in synch with the situational context: poster slogans in gay saunas need to be phrased differently from those on display in public health clinics. While slang and local expressions may be beneficial in some communication contexts, they can clearly be unacceptable in others. Similar considerations should be taken when selecting photos, drawings or other images.

When communicating HIV and STI prevention messages to MSM, the best way to identify the most appropriate language and imagery is to collect information directly from MSM, for example through advisory committees, focus groups or campaign pre-tests. Involving the target group in the planning and implementation can positively influence the success of a campaign. Towards the end of a campaign, MSM participation can facilitate data collection and campaign evaluation.

4 Barriers to effective communication

Even the best communication strategy can fail if it does not take into account the special circumstances that MSM as a social group are exposed to. Of particular importance are barriers that prevent the delivery of effective communication. In general, communication teams should first assess the local situation to identify which types of barriers may need special attention before designing a health communication initiative.

4.1 Structural barriers to communication

Social and political conditions impact sexual minorities globally. Levels of discrimination vary depending on a country's legal, social, cultural and religious climate. These conditions are not easily changed and their influence extends deep into public life, including to healthcare services. A continuous effort is required for structural change, a long-term goal for more effective health promotion activities.

Stigma and discrimination

As stated in Section 2.2, homonegativity, discrimination and stigmatisation associated with HIV, STI and viral hepatitis status may limit access to health services and jeopardise prevention efforts. Some MSM face additional layers of discrimination and disadvantages, particularly MSM that belong to racial, ethnic or cultural minorities. These men may face isolation and disempowerment, finding it more difficult to have a sense of belonging either in mainstream gay networks or their culture of origin. To empower men who face these challenges requires specially designed participative and collaborative communication interventions. Supporting grassroots organisations and recruiting popular opinion leaders from networks that would otherwise be highly suspicious of outside interventions may overcome some of these challenges [22,23].

Subpopulations of MSM may face additional risks or barriers and require communication interventions because of prevalence (e.g. the increased potential for hepatitis C transmission among HIV-positive men who practice fisting or chemsex), because of different information needs (e.g. bisexual men, young men or men who travel) or because they face additional barriers (e.g. men with disabilities, men who are migrants or belong to ethnic minorities, rural men or working class men).

Legal environment

Legal barriers to an effective communication strategy include the criminalisation of homosexuality, unequal rights, homophobia, homonegativity – both in society and in the health sector. The criminalisation of disease transmission, particularly in the case of HIV laws, is likely to have a negative impact on prevention efforts. The potential of criminal prosecution is a strong disincentive for MSM to get tested and engage with prevention and health services. It also deepens divisions between HIV-positive, HIV-negative and untested men.

Public policy environment

Hostile political environments that downplay the existence of MSM and promote discrimination and exclusion make it difficult to reach MSM through preventative interventions. Such environments require inconspicuous or even surreptitious communication methods. Messages may have to be coded to avoid unwanted attention. Health promotion agencies may be subject to frequent government scrutiny and may rely to a larger degree on support from abroad. Involving MSM in the design of communication measures may be more difficult if MSM fear retribution. In addition, socially and sexually conservative policies may restrict the use of MSM-oriented content and language, especially if communication interventions are funded by government agencies.

Social structure

The prevailing social structures in any given society will strongly influence the success of communication interventions and the ability to reach MSM, particularly subpopulations that are less visible and integrated. Barriers can result from social class divisions, low levels of education, geographic isolation and limited access to infrastructure such as gay-specific social venues, publications, the internet and mobile networks.

Gay networks also generate their own social pressures, including peer pressure, to conform to certain ways of being gay. There are social norms within the subculture which create pressure to belong to a 'scene'. These can influence self-image and regulate access to friendship networks and community support.

Cultural and religious beliefs and attitudes

Even where the general political and social environment is supportive of MSM, traditional cultural and religious beliefs and attitudes still affect how communication interventions are perceived, which may limit their reach across the diverse range of MSM.

Cultural and religious leaders may publicly criticise particular communication approaches or messages. Decision-makers, especially if newly elected or appointed, may also be under pressure to delay, modify or even discontinue previously agreed-upon communication approaches.

Health services

Health services with limited capacities to deliver prevention, testing and treatment to MSM may also limit the scope of communication interventions. Effective interventions require services that provide low-threshold access to satisfy demand. Barriers to health service access for MSM may include real or perceived discrimination, costs, lack of confidentiality and fear of judgement (as opposed to a gay-friendly clinics which are supportive and non-judgemental).

Personal and professional bias

The potential barriers presented by the personal and professional backgrounds and attitudes of the professionals in charge of communication interventions for MSM are easily overlooked. Their bias may influence the selection of evidence as well as decision-making and implementation. A culture of self-reflection and the involvement of target groups can mitigate this risk.

4.2 Individual barriers to communication

Effective prevention communication considers how homonegativity, social and cultural circumstances, and access to health education affect individual MSM.

Internalised homonegativity

Internalised homonegativity may increase vulnerability of MSM, amplify feelings of poor self-esteem, diminish self-worth, cause social isolation, bring about feelings of depression and anxiety, lead to drug and alcohol use, increase sexual risk-taking, and cause self-harm. MSM who tend towards self-denial may ignore or reject messages targeted at MSM, as they refuse to self-identify with the target group, and fail to notice even well-promoted supportive health services. Internalised homonegativity may also result in a lack of motivation for individual health protection or a general distrust of advice from others.

Sexual identity, gender identity and sexual expression

Sexual identity, gender identity and sexual expression are three distinct concepts. For example, MSM may self-identify as gay, bisexual, queer, or heterosexual/experimenting. Transgender men were not born with a male body and later transitioned to male gender because their gender identity was male.

Most MSM are sexually attracted to other men, but some have no sexual desire for other men but have sex with men for money or in exchange for goods. Furthermore, not all MSM participate in the same sexual practices with other men. The single commonality between all MSM is that they actively engage in sexual behaviour with other men. Prevention messages that specifically name sexual or gender identities to reach particular target groups risk excluding some MSM subgroups.

While some MSM can readily accept a prevention message that refers to a sexual practice (e.g. 'If you like to have sex with men, use condoms and water-based lubricant'), they immediately reject other messages that assume that they call themselves 'gay' (e.g. 'We're gay, we're proud, and we have safer sex'.). Communication experts should consider how subpopulations of MSM construct their social and sexual lives and develop their messages accordingly.

Health literacy

A low level of individual health literacy presents a barrier to communication. An individual's health literacy is dependent on language literacy, level of education, disabilities, history of access to health services, support mechanisms, and social position.

Communication strategies cannot assume that the target audience has any previous knowledge of pathogens and infection mechanisms. Health facts may need to be communicated alongside prevention messages to provide context. Messages may be simple,

> 'Condoms stop HIV. Use condoms',

or detailed:

> 'HIV is a virus that causes serious disease. There is treatment available, but no cure. HIV is transmitted when blood, semen, pre-ejaculatory fluid or vaginal fluid of an HIV-positive person enters the bloodstream of an HIV-negative person through broken skin or certain mucous membranes. Most transmissions occur

through condomless sex or unsterile injecting equipment. HIV cannot penetrate intact condoms. Put on a new condom correctly every time you have penetrative anal or vaginal sex and avoid ejaculation in the mouth. Use new sterile equipment every time you inject.'

The first message does not require a high level of health literacy and can be successfully disseminated as posters or advertisements. However, this message may leave the recipient unable to follow its underlying rationale, let alone explain it if challenged, e.g. by a sexual partner. Such basic messages most likely lose their impact over time, and simple repetition is no longer sufficient.

To remain effective, messages must be constantly reviewed, updated and repackaged. The questions raised by simple messages used in mass advertising may be answered by more complex information, which may be more successfully communicated in interpersonal interactions such as counselling or outreach. To understand this information requires a higher level of health literacy, including an understanding of human physiology, the life cycles of microorganisms, and knowledge of different forms of sexual expression. Once the audience has understood the science that underpins prevention messages, they are more likely to use it as the basis for their long-term choices.

Unintended effects of fear-based communication

This approach refers to using shocking or threatening messages to induce short-term anxiety to raise awareness for a certain topic and discourage certain behaviour. While fear-based communication may succeed in raising awareness of the threat in large parts of the population, it is not clear how much they contribute to the prevention of new infections.

The AIDS campaigns of the 1980s are a prime example. Many countries responded to the emerging threat of AIDS with public awareness campaigns that played on people's fears of an unseen attack on human health and life. The implications of this approach are still debated, but there is evidence that fear-based campaigns can have the unintended consequence of created more stigma around the condition, especially in the context of HIV [24]. There is evidence that fear campaigns that may have discouraged people with HIV to not engage with health services as fear is often ineffective in achieving the desired behaviour change [25,26].

Fear campaigns can induce a hypersensitivity to a topic or can lead to the avoidance of a topic, reducing audience engagement and limiting the effect of future health promotion efforts. Experts in HIV prevention have reviewed the available evidence and published guidance on using fear-based prevention communications.

Consider the following points before proceeding with a fear-based communication strategy [27]:

- Fear-arousing imagery can be good at attracting attention and is often memorable.
- Fear-based campaigns are more persuasive for individuals who are already engaging in the desired, health-protective behaviour.
- Arousing fear in individuals can have unintended consequences, such as denial and increasing stigma around a condition.
- Most homosexually active men are already fearful of HIV.

Arousing fear may increase awareness; but it is not an effective means of effecting sexual behaviour change.

5 Prevention messages for MSM

This section presents a catalogue of the main communication topics for HIV, STI and viral hepatitis prevention. It contains phrases and slogans that can be used for evidence-based messages that should be part of any communication plan targeting MSM. Public health professionals, policymakers and HIV prevention practitioners can draw from this catalogue of stock phrases but should make sure that the final wording has been adapted to the local context for maximum impact.

Messages were written in plain English and in neutral language. Examples from different European contexts illustrate how messages can be adapted locally.

5.1 Message complexity

This guide organises messages using three levels of complexity. These levels are intended to help with the selection of messages that can then be tailored to local requirements, e.g. the local epidemiology, socio-cultural context, and the available resources. A sound communication programme will typically contain messages from all three complexity levels.

While basic messages can be communicated using basic mass-communication methods and channels, more complex messages and message combinations call for higher levels of engagement with the message recipients. This may require personal interactions in outreach, group work and counselling settings. Texts tend to get longer and more detailed in higher levels of complexity. Online formats can include interactive text and graphics. Messages in complexity levels one and two can be disseminated through one-way communication methods, while messages in level three are better suited to two-way communication settings.

'Blunt and direct' messages: These messages contain the basic health information and advice that MSM need to protect their sexual health.

'Detailed and explanatory' messages: These messages contain explanatory information to support informed decision-making. They also target personal and psychosocial factors.

'Nuanced and holistic' messages: These messages enhance communication programmes by either providing additional detail relevant for particular contexts, or by addressing factors in the lived experience of MSM that influence their capacity to protect their health.

Communication can draw on messages from all three complexity levels to build a cohesive programme

Example: promoting condom use

'Blunt and direct' messages:

- Condoms are an effective barrier to HIV, STI and viral hepatitis.
- Use a condom and water- or silicon-based lubricant every time you have anal sex.

'Detailed and explanatory' messages:

- Have condoms at hand when and where you are likely to have sex.
- Condoms are available in a range of types and sizes. Finding one that suits you can make them easier to use.
- To avoid condom failure, check from time to time that the condom is still on and intact.
- To avoid transmission, use a new condom before prolonged intercourse and with each new partner.
- Using condoms for oral sex reduces the risk of STI.
- Heat, sharp objects and oil-based lubricants and creams damage condoms.

'Nuanced and holistic' messages:

- Condoms have advantages and disadvantages. Some men find it easy to always use condoms, some use them some of the time, and others don't like using them at all.
- There are ways to overcome difficulties with using condoms. Consider talking to a gay-friendly service provider if you would like help with using condoms.

5.2 Communication topics and prevention messages

Here are four overarching key objectives for messages about HIV, STI and viral hepatitis prevention targeted at MSM:

- Increase the knowledge on transmission, preventive steps for HIV, STI and viral hepatitis.
- Promote testing for HIV, STI and viral hepatitis
- Support sexual health including safer sex, prevention and control of illegal drug use, negotiated safety, treatment, vaccination
- Address stigma, discrimination and legal issues

The topic areas related to each of these objectives are described in detail in this section, along with prevention messages for each topic.

It is important to note that HIV and STI prevention efforts are currently moving toward an integrated approach focused on the overall health of MSM. It is worthwhile considering combining HIV, STI, viral hepatitis and other health communication messages when targeting MSM.

The messages in this section provide the information men need to protect their sexual health and are not differentiated for different subpopulations of MSM, e.g. bisexual men, transgender men, migrant men, etc. It is the task of communication programme teams to select and adapt messages for the target group they want to reach.

5.2.1 Increasing knowledge of HIV, STI and viral hepatitis

One of the priorities of prevention programmes is to increase knowledge and awareness about various aspects of STIs. Table 1 lists some of the knowledge questions that messages in communications programmes should address and answer.

Table 1: Knowledge questions for messages of HIV, STI, and viral hepatitis prevention

Natural history	• What type of microorganism are we dealing with? • What is it called (scientific name and commonly used names)? • Where does it live in the human body? • How does it multiply?
Transmission	• How can it be transmitted? • How is it most commonly transmitted? • What is the level of risk for different transmission routes? • Is a vaccine available? • How can transmission and infection be prevented? (Condoms, successful ART, PrEP and other interventions) • How can the risk be managed or reduced?
Testing	• How can it be detected? • How is the test done? • Who can do the test? • What next if the result is positive? • What next if the result is negative? • Where can I get tested and how much does it cost? • Is the test anonymous? • Are the results confidential?
Disease progression	• What are the symptoms? • How does it affect the body? • How likely is it that it will get worse? • What happens over time?
Treatment	• What treatments are available (including post-exposure prophylaxis for HIV and Hep B)? • Is the treatment a cure? • What does the treatment achieve? • How is it administered and how long does it take to complete? • How long is it effective? • What are the potential side effects, and how likely are they? • Where are post-exposure prophylaxis and treatment available, and what are the costs?

The following prevention messages help to increase the knowledge of HIV, STI and viral hepatitis – and answer the above questions.

Table 2: Prevention messages about knowledge of HIV

Blunt and direct	• HIV affects us all. • Between men, HIV is mostly transmitted through condomless anal sex. • Condoms stop HIV. • HIV can be detected through blood test or oral swab tests. • Treatment prevents HIV from damaging the body. • Successful treatment reduces transmission risk. • There is no cure for HIV infection.
Detailed and explanatory	• Human immunodeficiency virus (HIV) is a very small organism that multiplies in the human body using human cells as hosts. • HIV can be transmitted when infected blood, semen or vaginal fluid get into the body of an uninfected person through broken skin or mucous membranes. • Touching, closed mouth or 'social' kissing, food and drink, or sharing a household does not transmit HIV. • Sometimes, flu-like symptoms about 10 to 14 days after risky sex indicate HIV infection. Fever, skin rash, body aches, and swollen lymph glands that persist can be a sign of recent HIV infection. • If you have been exposed to a high risk of HIV transmission, a course of anti-viral therapy (ART) might help prevent infection. This is called post-exposure prophylaxis (PEP). It must be started within 48 to 72 hours of the risk event and taken daily for at least one month*. • If your test result is confirmed as 'positive', it means you have HIV. If your test result is confirmed as 'negative', it means you have not acquired HIV up until several weeks to three months before the blood sample was taken. This 'window period' depends on the type of test used. • Antiretroviral treatment (ART) keeps the amount of virus in the body very low and prevents it from damaging the body. It does not eliminate it. • ART means taking pills every day for life. Some people experience short-term or long-term side effects. • Untreated HIV infection weakens the body's immune system so that infections and cancers cause more severe illness. Without treatment, these health effects (also called acquired immune deficiency syndrome or AIDS) lead to an early death in most cases. • HIV only survives outside the body, but only for a very short time. • The oral fluid collected for rapid tests contains enough antibodies to detect infection. • There is no HIV vaccine yet. It is unlikely that one will be available in the near future.
Nuanced and holistic	• If your test was negative, this is a good time to think afresh about the sex you have and the risks you take. Consider talking it through with a counsellor, health worker or friend you trust. • If your test was positive, health and support services can help you adjust to having HIV and protect your health. • People living with HIV still experience stigma and discrimination in many areas of life. Support services and connections to others can help in dealing with these challenges.

** Adjust to local and national guidelines and recommendations*

Table 3: Prevention messages about knowledge of STIs

Blunt and direct	• STIs affect us all. • Some STIs are incurable and can severely damage your health. • Some STIs can be cured easily. • STIs can increase the risk of HIV transmission. • Between men, most STIs are passed on during anal and oral sex. • STIs often have no symptoms. • Only medical tests can confirm STI.
Detailed and explanatory	• MSM get STIs more often than the general population. • Untreated syphilis can lead to severe illness and death. • Human papilloma virus (HPV) infection causes genital warts and some types increase the risk of anal cancer. • Gonorrhea easily develops resistance to antibiotic drugs, which may make it difficult to treat. • STIs stress the immune system and increase the amount of HIV in the blood and semen of people living with HIV. Some STIs damage the moist skin linings of mouth and anus, making it easier for HIV to enter the body. • Regular testing and treatment help reduce STIs.
Nuanced and holistic	• STIs still attract stigma, and some health workers may not ask the right questions or offer the right tests. Talking to a service provider with experience in sexual health (esp. with MSM) can help.

Table 4: Prevention messages about knowledge of viral hepatitis

Blunt and direct	• Vaccination protects against hepatitis A and B. • Make viral hepatitis tests part of your STI checks.
Detailed and explanatory	• MSM get hepatitis A and B through sex more often than the general population. • Hepatitis B and C virus are much more infectious than HIV and can survive outside the body for many hours. • Hepatitis C can be transmitted through sharing injecting equipment, but also through fisting, rough play and sharing sex toys. • Only medical tests can confirm viral hepatitis. • Only blood tests can show whether you are immune to hepatitis A and B. • Hepatitis B and C can have serious long-term health effects, including liver damage. • Hepatitis B and C can make treatment for HIV more complicated. • Hepatitis B and C can be treated to avoid long-term damage to health.
Nuanced and holistic	• Hepatitis still attracts stigma and some health workers may not ask the right questions or offer the right tests and vaccinations. Talking to a service provider with experience in sexual health (esp. with MSM) can help.

5.2.2 Promoting testing

After a positive test, early treatment for HIV, STI and viral hepatitis is essential because it can mitigate negative effects. Proper treatment also reduces the risk of HIV transmission. The promotion of testing should be a central objective of communication programmes aimed at STI and HIV prevention.

Messages about disease testing are usually determined by the potential health benefits for the tested person and should provide detailed information about each of the (relevant) infections and explain the benefits of testing. This should be complemented by information about testing and treatment, the recommended testing frequency, and how to access services locally. It is particularly important to emphasise anonymity, privacy and data protection.

Why test? Knowing your status

Messages with information about the importance of knowing one's disease status generate interest in testing services. Here are three sample messages:

- Knowing your HIV status is necessary for access to life-saving treatment.
- Knowing your HIV status informs personal risk-reduction strategies, for example negotiating sex with partners of the same, different or unknown status.
- Some STIs and viral hepatitis are asymptomatic. Testing is important even in the absence of symptoms, because untreated STIs can increase the risk of HIV transmission by increasing viral load and compromising mucous membranes. They may also carry a significant health risk if they remain undiagnosed for a long time (e.g. untreated syphilis, end-stage liver disease).

How often to test

The recommended frequency of testing varies in accordance with the current expert consensus in different countries. It is important to consult the various European guidelines[3] as well as national recommendations before recommending particular testing frequencies. Before publishing a message, one needs to ensure that the target group does indeed have access to appropriate testing services. Messages encouraging testing need to offer a convenient way to act on the advice, i.e. websites, telephone numbers, addresses, opening times, costs and other pertinent information about the available services.

What to expect from testing

Messages with information about what to expect are intended to lower the threshold for seeking access to testing services. Messages should emphasise the following:

- Drop-in service and/or service by appointment
- Assurance of confidentiality (or anonymity, if available)
- Information about who will perform the test and their qualifications
- Information and counselling (taking a sexual history, talking about risk, providing information materials and referral information)
- Testing procedures (taking swabs, blood and urine samples)
- Delivering the results and post-test information or counselling
- Follow-up referrals and care.

[3] Available at: http://ecdc.europa.eu/en/publications/Publications/hiv-sti-prevention-among-men-who-have-sex-with-men-guidance.pdf

How to access testing

Good messages about testing should include information about access that is clear and easy to follow. This includes:

- Location
- Opening times
- Anonymity/data protection and privacy
- Appointment procedures (if applicable)
- What to bring (e.g. health insurance card or social security identification)
- Cost for testing
- On-site or referral for treatment
- Cost of treatment.

Having this information available on a website with an address that is easy to remember can be helpful. A toll-free information number is also helpful.

If testing services are targeted specifically at MSM, it is important that the message communicates how the testing service meets the needs and preferences of MSM, for example:

- Safe location
- Supportive environment
- Anonymity and confidentiality
- Background and training of testing personnel

The advantages of community- based testing, rapid testing, or home testing should be pointed out. Such facilities/technologies lower the threshold for access and have several advantages:

- Faster access, may be closer to home
- Same-day results
- Short waiting times
- Higher client satisfaction
- Peer-based services
- More individual discussions about personal risk

Table 5. Prevention messages about testing

Blunt and direct	• Get tested for HIV. • Have regular STI checks (at least annually). • You can get (free) HIV and/or STI checks at … (include local access and referral information)
Detailed and explanatory	• Regular tests ensure that you can get the right treatment and avoid damage to your health. • You can have an STI, including one that can damage your health, without any symptoms. • Knowing whether you have HIV, an STI or viral hepatitis gives you options for protecting your health. • The test is voluntary and confidential. • A risky sexual encounter (e.g. condomless sex with a partner whose serostatus you don't know or who is HIV positive) is a good reason to have another test for HIV and STI. • Health services can offer advice, support and referral, no matter what your test result is. • If you are sexually active, an STI check including HIV at least once every year protects your health. • The more sexual partners you have, the more frequently you need to have an STI check to stay healthy. • Symptoms of STI include discharge from the penis, pain when passing urine, and skin changes such as ulcers, sores, rash and warts. If you have symptoms, get an STI check right away. • Syphilis is detected with a blood test. If detected early, it is easily cured with antibiotics. • Chlamydia and gonorrhoea are detected using a urine sample and/or swabs of the penis, anus and throat. They are treated with antibiotics. • There are now strains of gonorrhoea that cannot be cured with most of the available antibiotics. It is important to limit their spread. Treatment for these strains may take longer and may be more complicated. • Ask your doctor about vaccination against human papilloma virus (HPV). Being protected against HPV lowers the risk of developing cancer. • If you have many partners, ask your doctor to consider testing you for rarer STIs, such as Lymphogranuloma venereum (LGV), especially if there is an outbreak in your sexual network. • If you have ever injected drugs, or practice fisting or rough play, get tested for hepatitis C to avoid long-term health effects.
Nuanced and holistic	• Regular STI checks, including HIV and viral hepatitis testing, are part of caring for yourself. • A doctor or health service that knows about the health needs of MSM can help you make sexual healthcare a normal part of your life. • Telling your doctor about the sex you have with other men can help you get the most important STI tests. Apart from HIV and syphilis tests, you should get tested for gonorrhoea (throat, urethra or anal swabs). • If you find it hard to talk with your doctor about the sex you have, you can get assistance from gay-friendly services at… [add local information].

Figure 1: Poster promoting regular testing

Note: Poster explicitly mentions LGV and hepatitis C outbreaks
Source: BCN Checkpoint, Barcelona, Spain

5.2.3 Supporting sexual health in the context of STI/HIV prevention

Messages that communicate the scientific and epidemiological evidence of transmission as well as the insights of social and behavioural research can support MSM in protecting their sexual health. One of the key tasks of health communication for prevention is translating science into messages that are relevant to lived experience. Successful messages explain significant risks and offer practical ways to reduce them.

MSM employ an increasing range of risk reduction strategies in response to the health risks associated with HIV, STI and viral hepatitis. Some of them – e.g. condom use, water- or silicon-based lubricant for anal sex, and avoiding semen in the mouth – are considered the social norm for engaging in 'safer sex'. Additional strategies have emerged in recent years, and prevention practitioners have developed messages based on the relative risk of each strategy. The relative risk of these strategies was calculated based on physiological evidence and behavioural patterns in MSM. Biomedical risk reduction strategies such as PEP and PrEP have added further prevention options that MSM may be able to access in order to influence their personal level of risk for HIV transmission.

Prevention messages can support MSM in their efforts to protect their sexual health by describing risk reduction strategies, offering information about relative levels of risk, and pointing out the advantages, disadvantages, prerequisites and possible consequences of these strategies.

The sections below describe risk reduction strategies that MSM currently use. The suggested prevention messages can be included in communication activities for health promotion and disease prevention.

Using condoms and lubricants

Basic condom promotion consists of information about the benefits of condoms, how to get them, how to use them correctly, and how to deal with potential problems. Comprehensive condom promotion should also address any negative perceptions of condoms in order to maximise the effectiveness of this risk reduction strategy and to foster sustained condom use as part of a long-term safer sex culture.

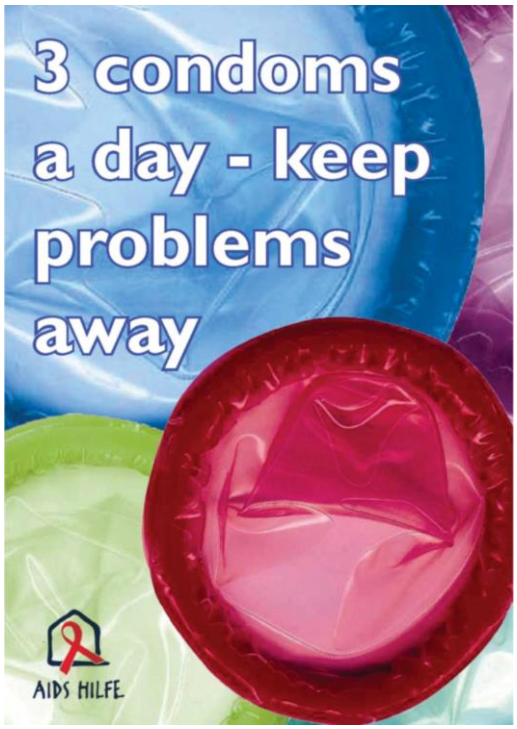
To keep messages about condoms relevant to MSM, it is important to adjust them to the local situation, e.g. target group preferences, the supply situation, and to new products as they become available.

Table 6: Prevention messages about using condoms and lubricants

Blunt and direct	• Use condoms and water-based or silicone-based lubricant for anal sex.
Detailed and explanatory	• It helps to have condoms readily available when and where you are likely to have sex. • Using condoms for oral sex reduces the risk of gonorrhoea and syphilis infection. • Condoms are available in a range of types and sizes. Finding one that suits you can make them easier to use. • It can help to practice putting on condoms so that you don't lose your erection. • It can help to talk to a healthcare worker or friend if you find using condoms difficult. • To avoid condom failure, check now and then that the condom is still in place and replace the condom during prolonged intercourse*. • Use a new condom for each new partner. • Heat, sharp objects, and oil-based lubricants and creams damage condoms. • Alternatives to standard latex condoms are available**.
Nuanced and holistic	• Condoms have advantages and disadvantages. Some men find it easy to always use condoms, some use them some of the time, and others don't like using them at all. • There are ways to overcome difficulties with using condoms. Consider talking to a gay-friendly service provider if you would like help with using condoms.

** Add a recommended time period in accordance with local recommendations and expert consensus*
*** Include details that are locally relevant*

Figure 2. Basic condom message



Source: AIDS-Hilfe, Vienna

Figure 3. Condom user guide

Source: Ath Checkpoint, Athens, Greece

Avoiding semen in the mouth

There is some debate about the physiological and epidemiological evidence regarding transmission of HIV and certain STIs through oral sex. Surveys show that most MSM practice both insertive and receptive oral intercourse, and do so very frequently. Most HIV prevention programmes do not actively promote the use of condoms for oral intercourse because men are unlikely to adopt this practice widely even though this is still the best way to avoid oral STI transmission.

Messages about oral sex should describe the relative risk by pointing out that receptive oral intercourse with ejaculation carries a higher risk than without. Some prevention messages that recommend avoiding semen in the mouth – especially right after brushing teeth, dental procedures, or if cuts, sores or ulcers are present – do not promote the safest possible practice, which is using condoms. However, promoting a reasonable alternative, although not quite as safe as condom-protected oral sex, is justifiable in this context because health campaigners would otherwise risk alienating large parts of their target audience.

Table 7: Prevention messages about avoiding semen in the mouth

Blunt and direct	• Avoid semen in the mouth.
Detailed and explanatory	• The risk of HIV transmission during oral sex is very low (but not zero) if the mouth is healthy and its moist skin lining intact. • The risk is higher if you have semen in the mouth directly after cleaning your teeth, if you have mouth ulcers, bleeding gums, or had dental work recently. • Using condoms for oral sex reduces the risk of gonorrhoea and syphilis. • You can always use a condom for oral sex if you want to reduce the risk further.
Nuanced and holistic	• Different men have different preferences and expectations about oral sex, trying to balance risk and pleasure. Talking with others may help you find out what works best for you.

Drug use

Messages on this topic fall into two categories: messages about safe drug use and messages about how alcohol and other drugs can affect sexual risk. Drug use among MSM is generally higher than in the general population, usually in a party atmosphere/situation [27]. Which drugs are used and how often depends on local supply and demand. Messages need to be adapted carefully to local circumstances. Messages that do not stigmatise MSM further because of their drug use are more likely to be received openly and positively.

Table 8: Prevention messages about drug use

Blunt and direct	• Alcohol and drugs can affect sex. • If you inject drugs, use fresh, new, sterile equipment every time.
Detailed and explanatory	• HIV, hepatitis B and C viruses can be passed on through sharing needles and syringes. • Hepatitis B and C can be passed on through tiny, invisible amounts of blood. • Hepatitis B and C can be passed on through sharing any injecting equipment (needles, spoons, filters, tourniquets). • Alcohol and drugs can change how you feel and act and affect the sexual risks you take. • Both 'poppers' (amyl or butyl nitrite inhalants) and Viagra dilate blood vessels. This can lead to dangerously low blood pressure, fainting and even death. • Some ARTs and other medications can also interact with drugs to produce dangerous effects. • Mixing drugs with alcohol can have unwanted effects. ART and other medication can influence the effects further.
Nuanced and holistic	• Taking drugs in social and sexual contexts is part of many men's lives. If you are concerned about your alcohol or drug use, talking to a healthcare worker or trusted friend can help. • There is a safe and reliable vaccine against hepatitis B (but not C) – talk to a trusted healthcare worker if you have not had this vaccine.

Negotiated safety

Messages about negotiated safety may include the following:

- All partners need to get tested for HIV; after the test, all partners should agree to not having condomless sex for three months and then get retested[4].
- If partners agree on having condomless sex with each other, they should also make an agreement about sex outside their relationship (e.g. 'sex outside the relationship requires condom use' or 'absolutely no sex outside the relationship').
- Partners need to agree that they will talk to each other if they had a risk event or if they want to modify or cancel their agreement.
- If a partner had a risk event, all partners need to go back to using condoms, get tested again, and renegotiate their agreement.

Table 9: Prevention messages about negotiated safety

Blunt and direct	• Not using condoms with other HIV-negative partners requires regular HIV/STI testing and a mutual agreement.
Detailed and explanatory	• If you think you don't have HIV and want to stop using condoms with regular partners, you all need to get tested to confirm that you are HIV negative. • Only have condom-protected sex during the three-month 'window period' after your first HIV test, then get retested. If the second test confirms that you are all HIV negative, you can stop using condoms. • Make an agreement that avoids risks outside the relationship. • If one of your partners engaged in at-risk behaviour for HIV, you need to go back to using condoms. You should all get retested and talk about your agreement again. • Talking openly with your regular partners about the sex you want to have and how to avoid HIV, STI and viral hepatitis transmission is the key to 'negotiated safety'.
Nuanced and holistic	• Many MSM negotiate sex without condoms. It can work well if the partners feel comfortable talking about sex, trust each other to keep their agreements, and feel safe to say when they slipped up. • You can ask a healthcare worker, counsellor or trusted friend for information and help with making agreements about sex. (Include local access and referral information.)

Figure 4: 'Think twice' campaign: telling each other about condomless sex outside the relationship

Source: ILGA Portugal
Translation:
'He's going to freak out when I tell him about the guy the other day.'
'He would have told me if he had unprotected sex with another guy.'
Think twice.

[4] It can take up to three months after coming into contact with HIV before it is detectable in the blood ('window period'). HIV can still be passed on during the window period even though it cannot be detected.

Serosorting

This strategy involves seeking and having condomless sex with partners of the same HIV serostatus. There are serious concerns about this strategy (which appears to be growing in popularity) due to the difficulties ascertaining one's HIV negative serostatus. This of course depends on the time since the last test and any risk behaviour during the three-month window period following the first HIV test.

Messages relating to serosorting need to emphasise these risks and point out the risks and consequences of STI and viral hepatitis transmission.

Table 10: Prevention messages about serosorting

Blunt and direct	• You cannot tell if someone has HIV by who he is or how he looks. • Have regular STI checks.
Detailed and explanatory	• A negative HIV test only confirms the person's status before the 'window period'. • The risk of HIV transmission is highest in the first 12 weeks after infection, before people even know they have HIV. • If you are HIV negative and looking for HIV-negative sexual partners, it is important to talk with them about your last test and the risks you each had before and since. • Sex that carries a low risk of HIV transmission can still transmit STI. • STI and viral hepatitis can seriously affect your health, whether you are HIV positive or not.
Nuanced and holistic	• Selecting sex partners according to negative HIV status can reduce the risk of transmission, but there are many uncertainties. It is difficult to be sure of your own and your partners' current HIV status. • In many sexual situations, partners do not talk to each other.

Figure 5: 'Think twice' campaign about serostatus assumptions

Source: ILGA Portugal
Translation:
'Would he react badly if I told him I'm seropositive?'
'If he was seropositive, he'd have used a condom.'
Think twice.

Preventive effect of antiretroviral treatment

Undetectable levels of HIV in the blood as a result of antiretroviral treatment (ART) have been shown to lower the risk of virus transmission significantly, although there are fewer data regarding the risk of transmission during anal sex. Scientific assessments of the level of risk involved in unprotected sex with HIV-positive people on ART –

compared to safer sex practices and other risk reduction strategies (or a combination of both) – have shown slightly different conclusions.

Messages should cover all aspects of treatment, adherence, success rates, side effects, frequency of viral load testing, and co-infections with STI and viral hepatitis.

It is important that messages focus on the personal benefits of treatment, long-term health outcomes, and reducing transmission risk, especially for serodiscordant couples. Messages should also cover access-to-treatment options (e.g. general practitioners, specialists, gay-friendly clinics), suggest testing intervals, point out associated costs, and mention available psychosocial support.

Table 11: Prevention messages about ART to prevent transmission of HIV

Blunt and direct	• Successful HIV treatment lowers the risk of transmission.
Detailed and explanatory	• The risk of getting HIV from an HIV-positive person who takes ART and has no detectable virus in his blood is likely to be low. • Viral load measures the number of virus particles in a millilitre of blood and is monitored using regular tests. • A high viral load means a high risk of transmission; a low viral load usually means a low risk of transmission. • Successful viral suppression depends on the correct ART and taking the treatment very regularly.
Nuanced and holistic	• Starting ART is about improving and securing your long-term health. • It is an important personal decision to start taking treatment for HIV, it has to be the right decision for you. • Talking to your doctor as well as other people living with HIV can help make treatment decisions that are right for you.

PEP and PrEP

These biomedical prevention interventions require messages that cover both technical information and the resulting medical advice. For post-exposure prophylaxis (PEP) this includes the nature, benefits, limitations and potential side effects of PEP medication as well as local information on guidelines for PEP eligibility, the available time window for PEP, and how to access PEP. Currently, access to PEP is limited by the fact that it is not widely known in the community, that there only few access points, and because patients have to cover the costs in some central and eastern European countries.

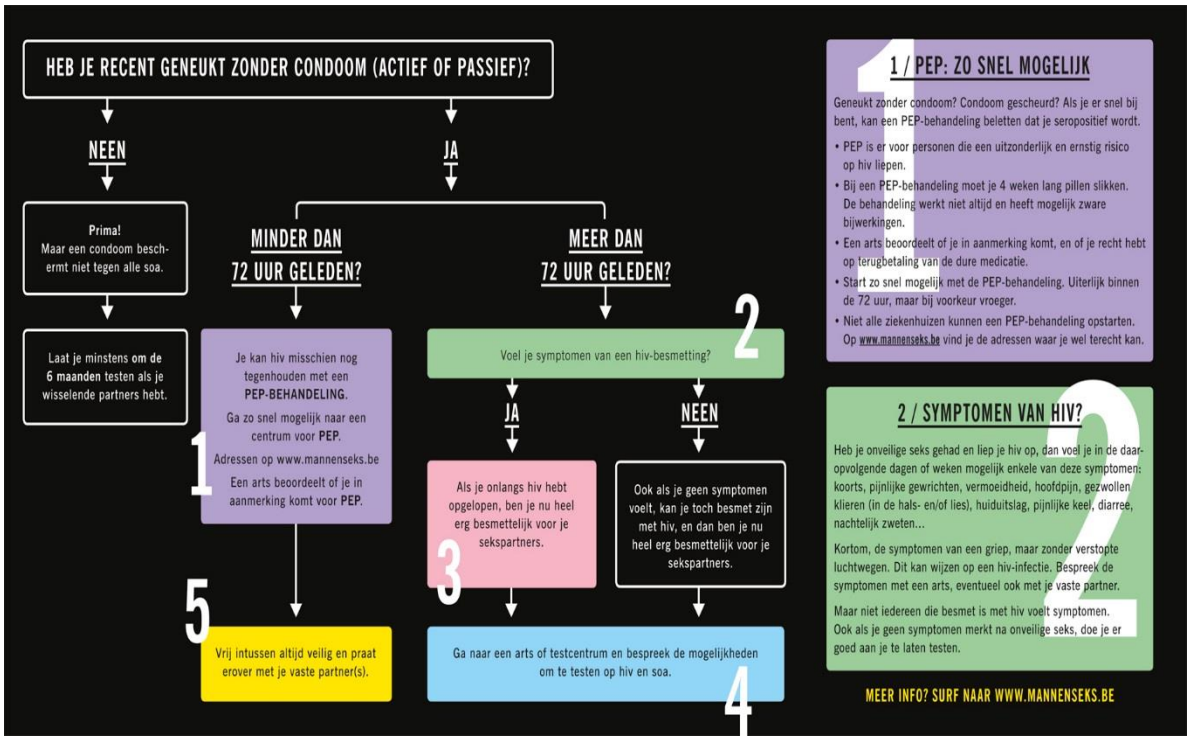
As access to PrEP is improving and it is becoming more widely available, messages need to cover similar topics as PEP messages. This includes information about the level of protection as compared to other prevention strategies. Another topic is the long-term viability of PrEP and its inability to protect against STIs.

Table 12: Prevention messages about PEP and PrEP

Blunt and direct	• If you just had a risk event for HIV, PEP treatment can prevent infection. • You must start PEP treatment within 48 to 72 hours.* • PEP is a one-month course of ART that can prevent infection after a risk event.* • PrEP before sex with an unknown-status partner could help prevent possible infection.
Detailed and explanatory	• The earlier you receive PEP, the higher the chance that it will be effective. • Safe sex while on PrEP will reduce additional risks of getting HIV.
Nuanced and holistic	• Having a risk event and getting PEP is a good opportunity to think fresh about the risks you take. • If you find it difficult to avoid the risk of HIV transmission, talk to a healthcare worker you trust about the option of taking ART to prevent infection (PrEP).

** Adapt to local guidelines*

Figure 6: PEP brochure with risk algorithm



Source: SENSOA Belgium. Available from: www.mannenseks.be

Hepatitis A and B vaccination

Information about vaccination against hepatitis A and B should provide arguments why vaccination is recommended for MSM, its benefits, limitations, potential side effects, costs and where to get vaccinated.

Often, the vaccination costs are not covered by insurance schemes of state programmes. This creates an effective access barrier which leaves many unvaccinated, including those most at risk.

Table 13: Prevention messages about hepatitis A and B vaccination:

Blunt and direct	• Get vaccinated against hepatitis A and B. • You can get (free) hepatitis B vaccinations at… [add local information].
Detailed and explanatory	• Hepatitis B is easily transmitted through sexual contact. • Hepatitis B virus is much more infectious than HIV and easily transmitted through sex when bodily fluids are exchanged. • Hepatitis A can be transmitted during sex through (even tiny traces of) faecal matter. • Men who have sex with men are at higher risk of sexually acquired hepatitis A and B than the general population. • Your doctor or health service can check your immunity to hepatitis A and B and vaccinate you if needed. • A blood test shows whether you have been exposed or vaccinated (and now immune) or if you need further vaccination. • Hepatitis B vaccination is safe for people living with HIV in most cases. If in doubt, ask your doctor for advice.
Nuanced and holistic	• Telling your doctor about the sex you have with other men can help you get the most important hepatitis tests and vaccinations. • If you find it hard to talk with your doctor about the sex you have, you can get assistance from gay-friendly services. [Add local information.]

Hepatitis C

There are continuing outbreaks of hepatitis C infection, mainly among HIV-positive MSM. Hepatitis C is transmitted by sexual practices that involve (even small amounts of) bleeding or through sharing injecting equipment, especially in sexual subcultures that combine injecting drugs with adventurous sexual practices.

Since the prevalence of hepatitis C among MSM is not significantly different to that of the general population, messages about hepatitis C need to be targeted at men who belong to those subpopulations that are most at risk. Messages about hepatitis C should cover information about how the disease is transmitted, how transmission can be prevented, and how testing and treatment are carried out.

In addition, it is important that prevention programmes for people who inject drugs include information about hepatitis C and specific messages aimed at MSM who inject drugs.

Table 14: Prevention messages about hepatitis C

Blunt and direct	• If you are into fisting or rough sex, get tested for hepatitis C regularly. • Never share any injecting equipment. • If you inject drugs, get tested for hepatitis C. • Hepatitis C can be treated.
Detailed and explanatory	• Avoiding any blood-to-blood contact prevents hepatitis C transmission. • Hepatitis C virus (HCV) is much more infectious than HIV and can survive outside the body for many hours. • Hepatitis C infection can cause liver damage (cirrhosis) and liver cancer in the long term. • Hepatitis C treatment often leads to a cure, avoiding long-term health effects. • Some people who are exposed to hepatitis C clear the virus from their body naturally. Others develop chronic hepatitis C infection and are at risk of serious long-term effects, including liver damage and cancer. • Current treatment can cure most chronic hepatitis C infections.
Nuanced and holistic	• If you are into adventurous sex and others in your sexual network have tested positive for hepatitis C, talking about ways to avoid infection with your partners and healthcare workers as well as regular testing will help protect your health. • If you find it hard to talk with your doctor about the type of sex you have, you can get assistance from gay-friendly services. [Add local information].

Personal risk assessment

To assess their own risk, MSM need to reflect on their sexual relationships and their sexual preferences. Messages may define particular levels of risk by describing who does what with whom in which context. Some prevention interventions offer tools (mostly online) for personal risk assessment using multiple-choice questions about partners, practices and serostatus. They then offer tailored messages for reducing the risk and give recommendations for seeking additional support.

Table 15: Prevention messages about making personal risk assessments

Blunt and direct	• More partners = more risk • No condom = no STI protection • Unknown HIV status = unknown HIV risk
Detailed and explanatory	• Your risk of HIV, STI or viral hepatitis transmission depends on how many partners you have and what types of sex you engage in. • Condomless sex carries a higher risk of STI, HIV and hepatitis transmission than protected sex. • Condomless receptive anal sex with a partner whose HIV status is positive or unknown carries the highest risk of HIV transmission. • The risk of HIV transmission is highest in the first 12 weeks after infection, when infected people do not yet know they have HIV. • Successful treatment leading to an undetectable viral load results in a low risk of HIV transmission. • HIV, STI and viral hepatitis are often passed on by people who don't know they are infected. • Knowing your health status and the risk associated with different types of sex helps to protect your health.
Nuanced and holistic	• Speaking to a healthcare worker or friend you trust can help you think about the risks you take. • Thinking and talking about HIV, STI and viral hepatitis risk with support staff can help you relax about your sexual health.

Psychosocial support

Maintaining sexual health requires information about the benefits, limitations and risks of individual prevention strategies and biomedical interventions. Messages that focus on psychosocial aspects of disease prevention can cover a wide range of topics, reaching from empowerment or combating stigma and discrimination to the emotional aspects of sexual expression and sexual cultures. Infection risk and the sustainability of health-promoting strategies should also be addressed.

Messages in this area could cover the following topics:

- Sexual pleasure and satisfaction
- Self-reflection on desire and reasons for having sex
- The effects of stress on a person's emotional state
- What to expect from sexual and social networks
- Self-esteem, self-care and personal goals
- The effects of alcohol and other drugs
- Communication and negotiation with sexual partners
- How to access support in any of these areas

In this context it is also important to acknowledge the collective achievements of MSM in dealing with the HIV epidemic. It is important to reinforce the message that despite being at an increased risk of infection, many MSM have successfully avoided HIV infection through their behaviour.

Table 16. Prevention messages about empowerment and psychosocial support

Blunt and direct	• Take charge of your sex life.
Detailed and explanatory	• Thinking about the sex you want, why you want it, and what you expect from your partners can make it easier to be in charge of your sex life. • Sexual desire and emotions influence sex. • Alcohol and other drugs can also influence sex. • Despite the risks, many MSM have successfully avoided HIV, STI and viral hepatitis infection.
Nuanced and holistic	• Sex and closeness are not the same for everyone. Your reasons for having sex may not be the same as those of your partners. • If you'd like help with talking about sex with your partners, look for support from a healthcare worker, counsellor or friend you trust. • If you don't like what happens when you have sex, or if your feelings about sex and closeness cause you distress, look for support and advice from a healthcare worker, counsellor or friend you trust.

Figure 7: Guide to relationships and sex for PLHIV

Source: ILGA Portugal. Translation: Relationships and sex – a guide for seropositive gays

5.2.4 Addressing stigma, discrimination and legal issues

Without concurrent efforts to decrease discrimination and homonegativity in the broader political, legal, social, cultural and religious environment, prevention messages targeting MSM may have limited impact. The physical and emotional impact of living in a discriminatory and homonegative society can reduce people's capacity to protect their own health.

All messages should be written in a way that respects the target group and recognises their strengths and struggles. The more successful interventions are those that work with, and are supportive of, individual MSM, their networks and community structures.

Messages that combat prejudice and discrimination, for example among healthcare workers or in the general public, can also have a positive influence on general prevention efforts. Messages directed at a general audience should attempt to explain that rethinking negative attitudes toward MSM benefits society as a whole. It is also helpful to communicate directly to MSM that society recognises and defends their rights. Legislative change and official campaigns against stigma and discrimination may support community-level activities that will influence positive changes in social attitudes.

Changing social attitudes takes time. It is therefore particularly important that MSM are empowered with practical information, new skill sets and support in order to deal with discrimination and homonegativity. This may include locally relevant information about current laws affecting relationships and sex between men, where and how to report discrimination, and how to access health and other support services.

Table 17: Prevention messages about stigma, discrimination, and the law

Blunt and direct	• Claim your human rights. • Stand up against homophobia.
Detailed and explanatory	• There is nothing shameful with being sexually attracted to other men. • Discrimination and violence against homosexual people are wrong, no matter whether laws and social norms reflect this yet. • It is not your attraction to other men that is a problem, but discrimination and stigma from others. • It is important to report homophobic crimes to authorities and/or activist organisations, even if you believe it is unlikely that the perpetrators can or will be held responsible. This will always serve to raise the awareness of the authorities and activist organisations and can count them in statistics and reports.
Nuanced and holistic	• Discrimination and stigma can limit your life and affect your health. You can seek assistance from supportive networks and organisations to take action against it. • If you want to support MSM, stand up for their rights in your families, social networks and in public.

5.3 Adapting messages

After the content of a message has been finalised, the message needs to be adapted to take into account the following:

- Local epidemiological picture (e.g. prevalence, behavioural data, outbreak?)
- Communication channel/s or medium (e.g. website banner, mobile phone app, safe sex pack, poster)
- Available services (e.g. testing locations, opening times, cost)
- Local languages (e.g. ethnic languages and slang used by groups at risk)
- Specific subpopulations of the target group (e.g. bisexual men, men who do not identify as gay, men who go to sex parties, men who use sex-on-premises venues)
- Social and cultural circumstances (e.g. legislation, cultural beliefs, taboos)

Messages should use local knowledge and expertise, especially if gleaned directly from the target group.

Content

The messages to be communicated need to be as concise and simple as possible. They must be factually correct, accurate, reliable and up to date. Over time, messages are likely to lose their impact. Repeated messages (e.g. those promoting safer sex and testing) need to be redesigned and repackaged in order to reach the target group and maintain the interest of their audience. When repeating basic messages, it is important to modify the frequency and the design of the message, ideally in consultation with the target group.

Information about a health problem or risk is best combined with a 'call to action'. This means offering a concrete and practical way to solve the problem or reduce the risk (e.g. 'Get your free condoms from…', 'Make an appointment today by calling 555-1234'). For the target group to successfully implement the call to action, messages need to be practical and match the lived experience of MSM.

Effective messages emphasise respect, support and build on established social norms, such as the principle of equal responsibility for protecting one's own health. This implies involving gay men living with HIV or other MSM in the development of messages. Wording, imagery and design of messages tend to work best when they are developed in consultation with the target group, e.g. through focus groups or pre-testing of materials.

It is important to remember that messages targeted at MSM reach both HIV-negative and HIV-positive (as well as untested) men and can inadvertently contribute to stigma and discrimination of PLHIV. This does not imply that

campaigns need to avoid talking about the negative consequences of becoming infected with HIV, or conversely, the advantages of remaining HIV negative.

Overall, developing messages needs to work towards a balance between the considerations mentioned above and the need to be simple, fresh and attractive.

Strategic questions

- What are the facts to be communicated?
- Are the facts accurate and current?
- How are the facts related and connected?
- What is the call to action?

- Who is the sender of the message?
- Who are the recipients of the message?
- What is the language to be used? What is the style to be used?

- What is the role of images?
- What is the desired response?

- How is the message understood?
- How could the language be changed to make the message more attractive?
- Does the imagery lead to the desired response?
- How could the imagery be improved?
- Are there any undesired effects?
- How can the overall message be improved?

- How can the impact of the message be maximised?
- How can the design be adapted to different communication channels and methods?

- How well does the message reach MSM (or subgroups)?
- How well is the message understood?

Figure 8: Call to action and practical information

Source: BCN Checkpoint, Barcelona, Spain

Language

The way a message is expressed is as important as its content. Hitting the right tone depends to a large extent on a detailed knowledge of the audience, their lived experience and communication preferences. On the other hand, whether a message is taken seriously also depends on the authenticity of the sender. It is important to consider who is best placed to communicate different types of information. Information about infectious agents is taken more seriously if it is released by public health institutions, while messages about risk and support may be more credible if they come from NGOs/CBOs, especially if run by MSM.

In contexts with limited options for prevention communication, men may prefer short and concise messages about what to do to prevent HIV, STI and viral hepatitis. MSM who are more candid about their sexuality and tend to make their own informed decisions, respond better to messages that come from people with similar attitudes and perspectives, e.g. 'I am in control. As long as I have the information, I know what I have to do.' Imperatives such as 'Use a condom every time!' can make them feel patronised, and they may end up rejecting the message.

Messages in simple, straightforward language, modelled on language that MSM use or can easily adopt, should explain the relative levels of risk of particular forms of sexual expression. This means finding accurate and unambiguous terms in different styles (neutral as well as colloquial or slang) for types of relationships, body parts, bodily fluids and sexual activities. Because preferred terms vary significantly between subpopulations of MSM, it is important to develop them in collaboration with the target group. Messages are easily dismissed or ridiculed if they use unpopular, outdated, euphemistic or overly colloquial terms.

However, choosing the right words does not simply mean mimicking the language used by the recipients because some audiences may expect health messages from a trusted source to be phrased in a certain semi-formal language and may balk at informal or colloquial language. Again, involving members of the target group in the wording of messages is indispensable to meet expectations and maximise authenticity, legitimacy, credibility, reach and effect.

Figure 9: Neutral, matter-of-fact language

Source: GAT Portugal
The condom: easy and safe.
Headings: HIV in MSM – Why HIV is so common in MSM? – Sexually transmitted infections and HIV: a dual problem

Messages about testing and confidentiality at a clinic need to be expressed in professional language, while in other contexts it is important to use sexually explicit language and imagery so that the target group sees the message as relevant. In all contexts, cultural preferences and different tastes need to be acknowledged. This applies especially to materials to be used in sex-on-premises venues and materials talking about sex practices where the social and cultural norms and preferences of the target group should guide the selection of an appropriate register of language.

Figure 10: Sexualised style

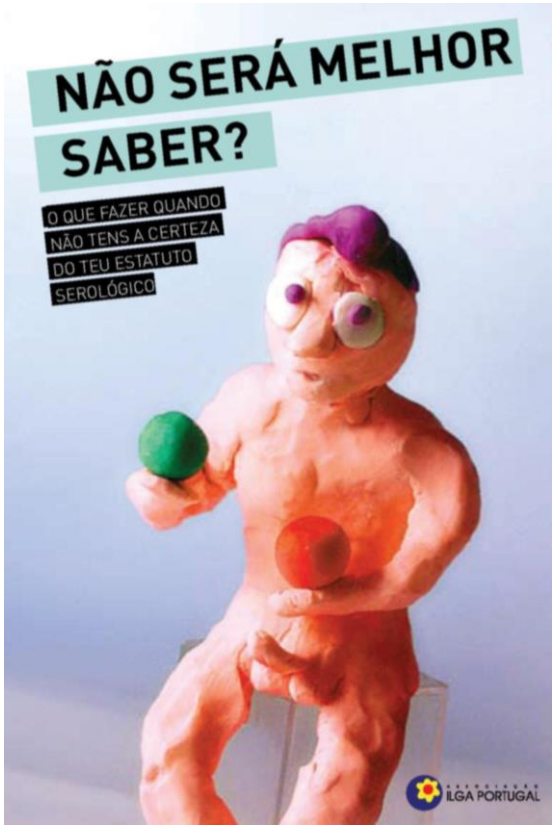
Source: GAT Portugal
Checkpoint LX, an anonymous, confidential and free service for the rapid detection of HIV.
Checkpoint LX is a community centre for HIV testing for men who have sex with men. In its first year, more than 2 000 free tests were given. Money is needed to continue. We are counting on your contribution.

Figure 11: Non-sexualised style

Source: AIDS Hilfe Wien, Vienna, Austria

In some instances, the use of humour and cartoon images can help overcome taboos and embarrassment. Because humour is very specific to each culture and subculture, it is important to pre-test humorous messages carefully with members of the target group.

Figure 12: Using cartoons and caricatures



Source: ILGA Portugal
Translation: Isn't it better to know? What to do when you don't know your serological status.

Images

Style and imagery convey a large part of the overall message and should also be adapted to the context in order to be effective. A poster in a gay bar should use a different visual language than a safer sex pack to be distributed in an outdoor cruising area or a banner advertisement on a gay dating website.

Collaborating closely with the target group is useful to adapt images to local circumstances. There is a range of suggestions for creating better images:

- Recruiting members of the target group as models
- Using professional models to create a specific look
- Using models of different ages, body types and ethnic appearance
- Breaking down stereotypes by combining messages with unexpected images, e.g. an attractive model expressing self-doubt and shyness, or a well-known personality who represents masculine culture (e.g. a famous athlete) speaking out against homophobia
- Using cartoons and caricatures to approach sensitive topics.

Figure 13: Safer sex pack

Source: GAT Portugal

Images and good graphic design are important components of most messages. They play a large role in creating a connection between the sender and the recipient of the message. Visual appearance sets the tone for communication and has a significant influence on reach, uptake and understanding of messages – and therefore on effectiveness. Consequently, a large proportion of preparation time and consultation with the target group is often invested in this component.

How to represent the target group in the graphic design of messages is an important question. Even if no photographs or other images of people are used, the choice of style and colour can determine whether the recipients readily engage with the message.

If images of people are used, it is important to consider the following factors:

Represen-tation

- Which models and images will allow MSM to identify with the message?
- How many different images are needed to represent diversity?

Appeal

- What imagry and design appeals to MSM in the given setting?
- Which other images and messages will the intervention have to compete with?

Unintended effects

- How can we avoid stereotyping MSM?
- How can we avoid negative effects on self-esteem and self-image?
- Are there any unintended reactions to be expected from people other than members of the target group?

Experience in the design of images for health promotion for MSM has shown that the balance between representation, appeal and negative effects (e.g. idealising a body type that is unattainable for most) is different for each intervention.

Figure 14: Non-idealised body type

Source: AIDS Hilfe Wien, Vienna, Austria

6 Toolkit: planning, implementation and evaluation

This section presents a step-by-step guide for public health professionals, policymakers and HIV prevention practitioners to plan, implement and evaluate communication programmes and communication interventions targeted at MSM. This section should be used in conjunction with the previous one when planning, implementing and evaluating health communication activities.

It is essential to adapt communication interventions and health promotion messages to the local context. This can be done most effectively through the active and meaningful involvement of target group members during all phases of the process.

6.1 Strategic planning

Designing a comprehensive communication programme

Health communication on HIV, STI and hepatitis should be integrated into a holistic, comprehensive approach addressing the health and wellbeing of MSM. An effective communication programme does not limit itself to issues of sexual health, but embraces the overall health and social wellbeing needs of the target group. Many MSM experience a syndemic of infections, homonegativity, drug and alcohol use, social isolation and mental health, and this needs to be borne in mind when designing communication strategies.

The initial steps of strategic planning for a communication strategy are detailed below.

Communication theories in health promotion

Communication programmes should be based on well-established theory. A few key theories constructed from social and behavioural psychology have been established as useful tools to guide communication in HIV prevention interventions. For behavioural change communication, theories that try to explain individual behaviour can help define intervention targets. Commonly used theories in this category include the *health belief model*, the *theory of reasoned action* and *social learning theory*.

There are several guidance frameworks that integrate theory and practice and can be applied to communication interventions [28-31]. Social marketing, for example, transferred an approach originally established in the field of commercial marketing to the domain of social change, including public health [32]. The core principles include a clear definition of the desired change as well as a preliminary analysis and segmentation of the target audience in order to produce tailored communications. *Information, education and communication* and *communication for behaviour change* are two approaches often used when designing communication strategies.

Levels of communication interventions

Communication can operate at the individual, group, and community level. It is important to plan a communication strategy that is appropriate to the selected intervention (33-35). Individual-level communication is usually based on face-to-face contact and includes interventions like risk-reduction, counselling, or motivational interviewing. Group interventions also use mainly face-to-face contact but function in group settings and are useful for changing attitudes and beliefs, skills building, increasing knowledge through group discussion, demonstrations, and role play. Community level interventions aim to change attitudes, norms, values, and the context of risk behaviour.

While interventions targeted at the individual may tend to yield inconsistent outcomes, approaches on a group or community level have been found to be more effective and cost efficient, especially when combined with efforts to stimulate participation and active discussion among community members [33,34]. Approaches to health communication, even those implemented at the group or community level, often rely on changes in individuals. Health communication, when part of health promotion activities, can contribute to changes at a broader level (e.g. at the system level) and change the structural or contextual conditions people live in.

Formative research to tailor communication

The challenges a health communication programme faces vary by country as there are specific differences in national policy and social climate. In a multi-national and multi-cultural Europe, the local context has to be taken into account when deciding on communication interventions. Research indicates that tailored, local approaches are needed to effectively reach the target population [12,36,37].

Formative research into the local context is necessary to identify issues that are important to the local community [38]. Formative research conducted in collaboration with the target group enables researchers and

community members to develop communication strategies based on knowledge and the lived experiences of PLHIV. Formative research often leads to innovative, flexible communication solutions, in contrast to relying only on established, evidence-based methods [39]. While these two approaches may be perceived as contradictory, they are best viewed as complementary because they inform and support each other and often prove vital for designing more effective and comprehensive strategies for health promotion communication targeted at MSM.

Combining interventions

Communication interventions based on comprehensive, multi-strategy programmes are rarely adequately supported by the financial and human resources they need. It is therefore common to prioritise communication interventions.

The more sophisticated prevention programmes that exist today have developed gradually over time. Newer communication interventions build upon the success of earlier efforts. For example, promoting 'negotiated safety' builds on a set of skills, knowledge and infrastructure that was promoted in earlier campaigns: an adequate knowledge of HIV transmission, an understanding of the meaning of test results, the willingness to use condoms, and access to condoms and testing. Without these prerequisites, a campaign to promote negotiated safety would remain largely meaningless.

Designing a communication programme that builds upon older interventions that are combining into a new campaign requires a good understanding of the complexity of the intervention, sufficient resources, and ample time to implement the campaign. It takes time for changes to occur in a community in terms of knowledge, attitudes, norms, beliefs and behaviours – and this has to be factored in when designing interventions.

Basic communication programmes aim to raise awareness and promote safer sex (e.g. by distributing condoms). The next level of communication interventions includes more detailed information on HIV, STI and viral hepatitis. It also promotes testing and treatment (PEP and PrEP) and points out the importance of combating stigma and discrimination. A holistic communication strategy may also include anti-homophobia campaigns, engaging with subgroups that are at particular risk, and instigating community debates on risk reduction strategies other than safer sex, challenging myths, affirming rights, addressing drug and alcohol use, mental health and more.

The scope and scale of the communication strategy depends on a number of local factors, e.g.:

- Social, political, legal conditions
- Size and locations (e.g. city, rural) of MSM populations
- Available financial and human resources
- Partnerships (government, public health institutions, researchers, community representatives, NGOs)
- Gay networks and infrastructure (social and activist groups and associations, community-based testing services, gay businesses)
- Potential allies in the health and social services, e.g. general practitioners who are MSM or have a particular interest in MSM's health
- Existing communication pathways (e.g. GLBTIQ press, events, online social networks).

Developing and adapting communication programmes

To respond to changes in the HIV, STI and viral hepatitis epidemics among MSM, communication programmes need to be constantly updated. Programmes have to reflect changes in scientific knowledge; take into account shifts in structural, social and cultural conditions; and adapt to the changing needs of the target group.

A simple message such as 'Use condoms!' may be very prominent in the early stages of a communication programme, but as the campaign progresses, other messages compete for the target group's attention and push the initial messages into the background. Additional effort needs to be put into reframing and redesigning messages to ensure they remain visible and relevant to the audience.

Messages dealing with homonegativity may be more complex to communicate when gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ) networks and infrastructure are not yet fully established, but may become simpler to implement as advocacy organisations gain prominence.

'Get tested!' starts as a simple message which gradually becomes more complex as demand increases for more detailed information on how to access testing and how to interpret test results. As routine access to testing becomes more established and services become more target-group oriented, communication messages will need to evolve further. Repeated, fresh reminders and reinforcing messages become necessary to support routine testing.

Building capacity for communication

Most interventions can be implemented at any level: locally, regionally, nationally or even internationally. A well-planned, small intervention that can be implemented quickly may be preferable to a more complex programme that will take more time and negotiation to put into practice.

Network mapping, community development, training and skill building can be used to maximise the potential of communication interventions in a local setting. Interventions should be based on the characteristics and specific needs of the target group:

- Access to media (e.g. GLBTIQ press, radio, electronic media)
- Use of networks (social scene, community groups, public meeting places)
- Local languages (ethnic diversity, migration status, level of integration)
- Preferences and tastes (language style, imagery)
- Health literacy (e.g. exposure to previous campaigns, educational background).

Implementing a communication programme involves selecting effective communication channels and modes of delivery in accordance with the messages types and contextual factors listed above.

6.2 Project planning

Effective communication interventions require thorough preparation and benefit from a structured approach. Several planning tools are available [40-42].

A project must be justifiable, and its aims, objectives, processes and expected outcomes should be clearly defined. For communication interventions it is essential to define the target group, assess the need for intervention, and explore the setting of the communication project.

Defining the audience/target group

Available epidemiological data and demographic information that is both current and reliable should be used to define and select the target group. MSM are not a homogenous population. As a subgroup of MSM, gay-identified men are most affected by HIV, STI and viral hepatitis. Involving members of the target group at an early stage provides valuable insights, particularly in instances where social research data on the characteristics of MSM are scarce or not available. A good first source of social research data, including regional and local analyses, is *The European MSM Internet Survey* [9].

Planning effective interventions requires knowledge of the lives, social networks, and the social and sexual subcultures of the men to be reached. Local surveys and results from target group meetings provide access to this knowledge. These data can be used to inform the selection of the most appropriate channels (e.g. internet and mobile networks, sex-on-premises venues, outreach locations, etc.) for communicating prevention messages.

One successful strategy to access hard-to-reach subpopulations is targeting prevention messages to close contacts of those at risk, for example owners of gay businesses or general practitioners.

When defining the audience or target group of the communication strategy, the following questions should be asked:

- What are the known characteristics of MSM who are at risk of HIV/STI/viral hepatitis?
- Which gay men and other MSM are most affected/most at risk?
- How do these gay men and other MSM acquire HIV, STI and viral hepatitis?

- How do local MSM identify?
- Where do they live?
- How old are they?
- What is their socioeconomic status and level of education?
- What is their first, second language?
- What is their migrant or ethnic minority status?

- How do local MSM socialise and find sexual partners?
- How do they access information?
- Who else is in contact with local MSM?

Assessing the needs of the audience/target group

Public health problems identified by surveillance and epidemiological research (e.g. increasing HIV infections among younger MSM, low testing rates among MSM with multiple sexual partners, increases in multidrug-resistant gonorrhoea) may not match the subjective priority needs of the target group (e.g. safety from homophobic violence, legal recognition of relationships, or equal access to housing assistance). Any communication intervention needs to take both into account. A formal needs assessment can assist in understanding the current perceived needs of the target group.

A needs assessment is a useful tool to discover and document the needs, not only of MSM collectively, but also of important subpopulations with specific communication needs and preferences. Needs assessments are particularly helpful for designing communications for MSM that do not participate in established networks. These include men who do not self-identify as gay, bisexual men, men from a working class or rural background, migrant MSM, and men who engage in transactional sex. Which MSM subgroups have which communication needs, how to access these subgroups to inform the needs assessment, and how to respond to address the needs of these subgroups depends on the local context.

Needs assessments can guide the content of messages as well as the context in which such messages are most likely to be received and understood. During needs assessments, it is important to include open questions in the formative research to explore how the target group positions health and other needs in the context of their lived experience.

When assessing the needs of the audience or target group, a number of strategic questions should be asked:

- What does this target group need most?
- How does the target group describe its own priorities?

- What are the health needs of the target group?
- How does the target group describe these needs?

- What are the needs of the target group in relation to HIV, STI and viral hepatitis?
- How does the target group describe these needs?

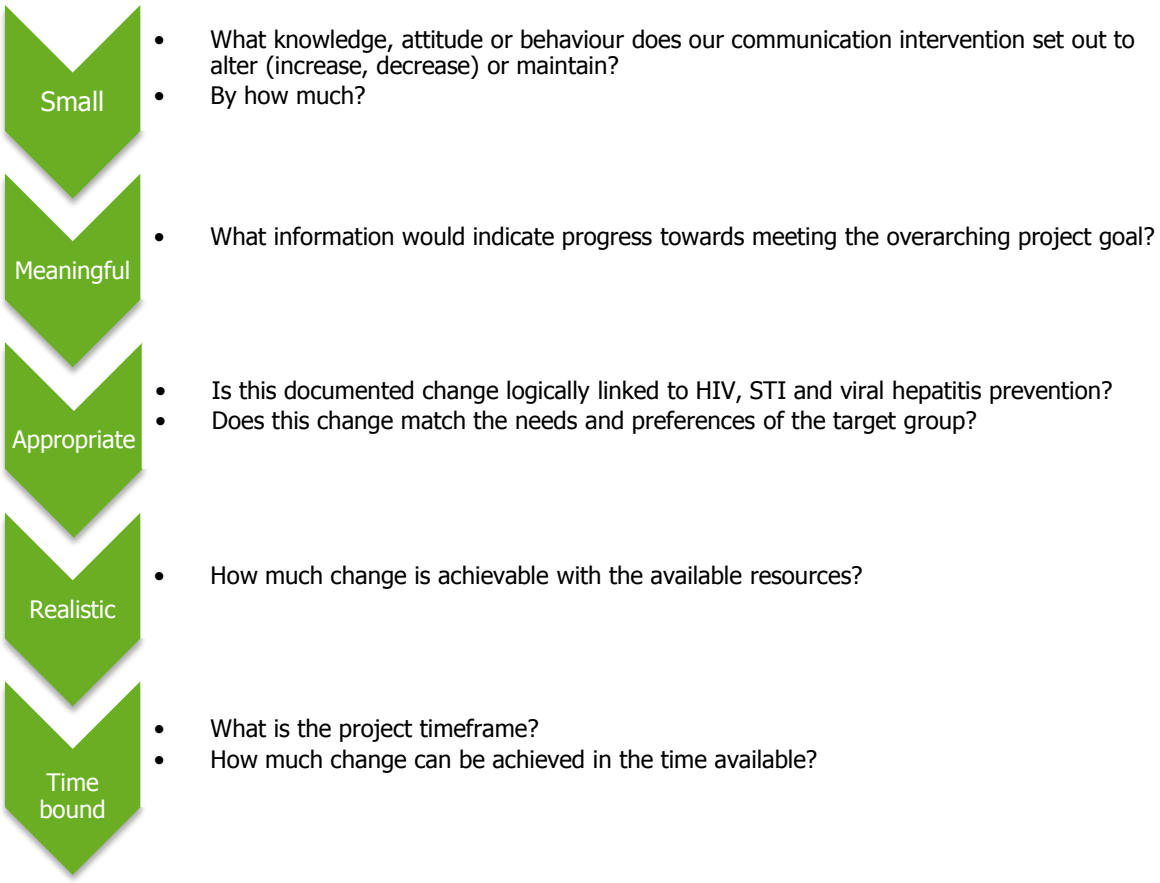
The PQD toolkit and several other online sources offer practical guides to needs assessments in the context of HIV prevention [41,43].

Setting objectives

High-level indicators of effectiveness, such as a reduction in disease transmission, are not useful as objectives for communication interventions targeting MSM. Even decreasing trends detected by surveillance systems that can identify incident infections as a proportion of new diagnoses are not useful when setting objectives because many factors can impact trends in case numbers, for example testing rates and community viral load. Levels of risk also depend on prevalence in particular sexual networks. Social and individual factors also determine risk levels. All in all, it is often difficult to attribute population-wide trends in infection rates to the effects of particular interventions, even with information about context.

When formulating goals and objectives for communication interventions, SMART criteria – specific, meaningful, appropriate, realistic, time bound – can ensure that the objectives can guide implementation and, later, lead to a relevant evaluation.

When setting the objectives of a communication strategy, the following strategic questions should be asked:



Realistic objectives that lead to measurable indicators in communication interventions should be formulated with respect to reach, awareness, knowledge and action (or 'intention to act').

- 'Reach' is the extent to which the target group receives messages.
- 'Awareness and knowledge' objectives describe the increase in recognition of a health problem, advice or recommendation by the target group and the extent to which the new knowledge is integrated into the target group's individual reasoning for making decisions about their health.
- An increase in health-promoting or health-protective action: here, 'intention to act' can serve as a proxy for levels of health-protective action, which are more difficult to measure within shorter time frames.

A practical guide to SMART criteria in the context of HIV prevention is available as part of the PQD toolkit [41,43] and as part of intervention mapping [40].

6.3 Communication channels and methods

Health promotion and prevention campaigns often combine several communication channels and methods, including mass advertising, printed materials, peer mentoring, online materials, outreach and community debate. Some methods are one-way communications (mass advertising, information materials), while others facilitate interaction between senders and recipients. Interaction allows for the communication of more complex messages and gives the sender the opportunity to adapt the communication to the individual needs of the recipient.

Mass advertising

Mass advertising can raise awareness, disseminate health information, appeal to the audience to reconsider attitudes, or ask them to take action. Mass-media prevention messages should be short, memorable and straightforward and aimed at a broad target group. Messages can be disseminated in print, radio, television, online, through social media and mobile networks.

Editorial publications, such as press releases and news articles can support campaigns and offer additional background information for those seeking further information. Interviews, personal testimonials and documentaries can put a human face to campaign messages and assist the target group in identifying with the content.

Websites with or without interactive components such as self-assessment tools, discussion boards and personal advice functions can function as knowledge hubs for self-directed reference, reinforcement and referral.

Some government organisations/institutions are bound by internal rules and cannot disseminate explicit, target-group specific messages. A mass advertising approach can circumvent this problem by, for example, promoting condoms to a broad population, with messages that do not exclusively target but include MSM.

Information material

Information materials, both printed and online, are a fundamental component of communication activities in prevention programmes because they provide complex background information and document scientific knowledge, consensus health advice, and referral information. They also develop and promote a common language and set the tone for messages targeted at different subgroups and cultures of MSM.

Printed information materials come in a range of formats (pamphlets, brochures, booklets, condom/lubricant packs). Many of them come in smaller formats so they can be picked up and stored discreetly or are tailored to particular distribution methods (e.g. free postcards for display in gay businesses) or contexts (e.g. safer sex packs containing condoms, lubricants, and printed information). They can also be used for dissemination during outreach work and other personal interactions, such as clinic consultations and counselling sessions.

Outreach work

Outreach is an indispensable component of communication programmes targeting MSM. The fact that some MSM do not actively participate in large gay networks and may not acknowledge their sexual identity or sexual lives to mainstream health service providers makes it especially important that information for these subgroups is easily accessible. Outreach can be conducted where MSM meet, e.g. in venues for socialising and for finding sexual partners, in virtual spaces, and through mobile networks. Some organisations have developed specific guidelines for conducting outreach services [44].

Community debate

Talks, lectures and debates can stimulate discussion and facilitate engagement in health issues. Communication programmes can actively instigate and encourage community debates to raise awareness of new developments, generate interest in new campaigns, and discuss the social norms and sexual cultures of the MSM community. This approach is particularly suited to topics that are likely to be sensitive or controversial, such as emotional health and wellbeing, drug use, certain sexual practices, or PrEP. It is also appropriate for topics that address a common concern (e.g. depression and anxiety, ageing). It is important to remember to embed HIV, STI and viral hepatitis into the broader context of health and wellbeing using a holistic approach.

Individual communication

Individual counselling, support and advice (face-to-face, telephone, online, mobile) may be opportunistic (e.g. in combination with HIV testing and sexual health checks) or targeted (e.g. by referral from a health service provider). I can also be provider-initiated or target-group initiated, professional and/or peer-based. Such interactions are more suited to discussing topics such as complex health information, rationales for behaviour change, and personal barriers to health-promoting and health-protective action. Interaction can consist of standardised interventions or client-directed approaches.

Individual interactions offer a valuable opportunity to communicate messages with greater impact. For best results, it is important that staff members who communicate directly with MSM receive appropriate training, regular accreditation and support/supervision. It is also essential that clients/recipients are able to provide feedback and report problems. Standards and guidelines are available for certain types of interventions [45,46].

Online communication, social media and smartphone applications

The internet has proven to be a reliable and cost-efficient tool for health promotion communication, particularly in Europe [9,47]. Online communication can form part of mass media campaigns or can be used for separate interventions. Peer information and education may be offered online on websites (especially dating sites) or through smartphone apps that MSM use to find sexual partners.

There are several options for online communication: paid advertising on commercial websites, free content on existing agency or public sites, and interactive methods such as online advice in chat rooms or on discussion boards.

Paid advertising on commercial websites frequented by MSM, such as social networking and dating websites, can be used to target a broad range of users, for example with web banners. Pop-up ads can be used to target users with particular customer profiles. The formats, targeting techniques and prices are subject to rapidly changing market conditions, as are the user preferences of MSM.

As an alternative to placing ads on websites popular with MSM, communication teams can also develop new sites that are tailored to the needs of the target group.

Messages can also be propagated through social media and smartphone apps. Communication interventions using social media should be planned carefully, as not all social media are equally suited to a given target group, objective or message: maintaining a Facebook page may be an effective and efficient component of a prevention campaign, but an interactive Twitter account requires more maintenance, and interest may be short-lived.

Many MSM are early adopters and frequent users of new technologies [48], but communication teams should still answer the following strategic questions before deciding to invest time and resources into a social media-based campaign:

- Why do we want to use social media?
- Which MSM subgroups can be reached through social media?
- Which men do not have access to the technology?

- Which social media are useful?
- For what purpose are they useful?

- How much time and money will be needed to develop a social media communication programme?
- What resources are needed to maintain an interactive online presence?

It is useful to draw on current commercial experience and expertise when planning a social media campaign. A scoping exercise can highlight the reasons, purpose and resources available and help set out clear objectives for the use of social media. Potential negative effects, such as a loss of reputation if the social media presence is not adequately maintained, should also be considered. It is important to recognise that social media are international and the target audience may be frustrated if coming across inconsistent advice from different sources.

ECDC organised a meeting in February 2015 on 'Understanding the impact of smart phone applications on MSM sexual health and STI/HIV prevention in Europe[5]. Several key issues emerged from the meeting:

- There are insufficient quantitative data on the extent to which apps are influencing the source or number of sexual partners or sexual networks.
- Mobile apps have significant reach and offer considerable potential for public health in terms of health promotion and data generation.
- Experience suggests that, approached correctly, apps may help promote the uptake of HIV testing and other services when linked to specific events such as Testing Week or through push messages about nearby services.
- Available evidence suggests that patterns of recreational drug use have changed, although patterns vary between countries.
- Data on the link between apps and recreational drug use are insufficient, although apps appear to play a role in organising and finding sexual group gatherings that also include the use of recreational drugs.
- Existing harm reduction services are generally not well placed to provide services for MSM or to address recreational and sexualised drug use.

Peer education and role models

Peer education in communication – defined as members of the target group delivering messages to other members of the same target group – is a key method for communication interventions. It has been a core element of

[5] Meeting report available from: http://www.tht.org.uk/~/media/O23%20Media%20centre/UNDERSTANDING%20THE%20IMPACT%20OF%20SMART%20PHONE%20APPLICATIONS.pdf

prevention since the beginning of the HIV epidemic. Peer education approaches make it possible to easily integrate target group involvement into the design, implementation and evaluation of interventions. Recruiting peers involves considering a range of attributes such as gender, sexuality, age and identification with particular subcultures or 'scenes' in order to maximise the impact of local knowledge and empowerment. Involving peers in a meaningful way can increase the trust of the recipient in the legitimacy and credibility of the sender and the messages.

Including MSM as role models in communication interventions, especially if they provide personal stories and testimonials, will likely help the audience in identifying with the sender and in perceiving the message as relevant to their lived experience.

Peer education is a core element of building networks that are committed to prevention. For members of the target group to remain interested and satisfied with their contribution to prevention as peer educators, they need to experience successes. This requires setting achievable targets and communicating and celebrating results. To be successful on an individual level, peer educators need high-quality training and ongoing development and support. Many interventions use peers as role models and active participants in communication interventions.

Communication channels and methods

It is useful to select channels and methods based on their suitability for reaching the target group and on the availability of resources. An equally important consideration is the level of complexity of the information in the message and the suitability of communication channels and methods to convey that information.

The three categories of messages used here reflect three levels of complexity and can be used to select potential communication channels and methods:

Blunt and direct messages contain the basic health information and advice that MSM need to protect their sexual health.

Detailed and explanatory messages contain explanatory information to support informed decision-making. They also address personal and psychosocial factors.

Nuanced and holistic messages enhance communication programmes by providing additional detail relevant for particular contexts or by addressing factors in the lived experience of MSM that influence their capacity to protect their health.

Some strategic questions to be asked when choosing communication channels and methods can be found below:

- Which sources of information are accessed by the local MSM community?
- How can MSM be reached most effectively and efficiently?

- How complex are the messages to be disseminated?
- Which channels and methods can disseminate these messages?

- What financial and human resources are available and what is the timeframe for development and implementation?
- Which channels and methods would work best under the current resource limitations?

It is important to recognise that well-targeted simple communication interventions, e.g. a short message printed on a safer sex pack, can have a large impact and can be achieved on a small budget.

In general, mass advertising is suited to delivering blunt and direct messages. Printed and online materials can be used for detailed and explanatory information, while personal interactions (face to face, telephone or online communication) are better suited for more nuanced and holistic content. Mass advertising is ill suited for conveying

detailed explanations, and blunt and direct messages do not suffice when engaging in personal interactions (Table 2).

Table 18: Comparison of common communication channels and methods

Channel/ method	Message complexity	Reach	Advantages	Disadvantages	Resources
Mass advertising	Blunt and direct	Wide but not targeted	Can reach large number of people quickly	Targeting is difficult, short-term impact, expensive	High goods and services costs, specialist marketing skills required
Printed information materials	From blunt and direct to detailed and explanatory	Depends on existing distribution networks	Detailed discussion of the topic possible	Need expert consensus and input, requires time and professional skills	High goods and services costs, time-intensive
Outreach work	From blunt and direct to nuanced and holistic	Limited but targeted	Targeted effort, potential for participation of MSM	Needs high level of ongoing support	Low goods and services costs, time-intensive, local knowledge required
Community debate	Nuanced and holistic	Small, but with flow-on effect[6]	Can create long-term flow-on effects, can be done quickly	Unpredictable outcomes	Low goods and services costs, local knowledge required
Face-to-face communication	From detailed and explanatory to nuanced and holistic	Small but targeted	Flexible, targeted, high individual impact	High level of structural support needed	Low goods and services costs, needs trained staff, supervision and support
Online and new media communication	All levels of complexity	Wide and targeted	Flexible, fast	High level of technical skill and marketing knowledge needed, volatile and short-lived	Medium costs, active maintenance needed
Peer education	Nuanced and holistic	Limited but targeted	Flexible, high individual impact	Difficult to define short-term outcomes	Low goods and services costs, time-intensive

6.4 Project implementation

Messages

As described earlier, prevention messages need to be as concise and simple as possible. They must be factually correct, accurate, reliable and up to date. Since messages are likely to lose their impact over time, they have to be repeated (e.g. those promoting safer sex and testing) and eventually redesigned and repackaged to continue to reach the target group and keep the interest of their audience.

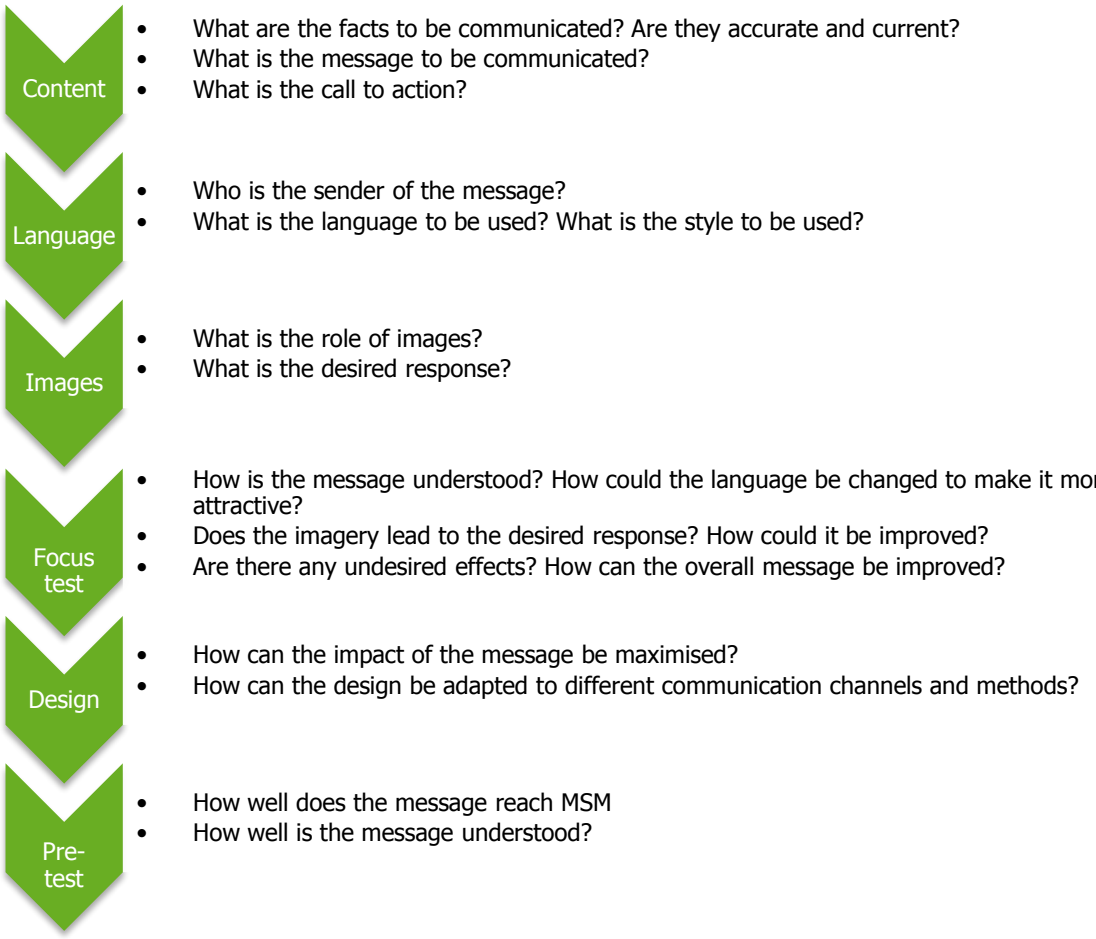
Information about a health issue or health risk should always be combined with a 'call to action', a concrete and practical way to address the health issue or reduce one's risk (e.g. 'Get your free condoms from…', 'Make an appointment today by calling…'). For the target group to be able to implement the call to action successfully, messages need to have a realistic perspective and match the lived experience of MSM. For example, a message encouraging MSM to get tested at a public health clinic that they experience as unsupportive and judgemental will not have the desired effect.

Messages should respect, support and build on established social norms, such as the principle of equal responsibility. MSM and PLHIV who are MSM should always be involved in the development of messages. It is important to remember that messages always reach both HIV-negative and HIV-positive (as well as untested) men and can inadvertently contribute to stigma and discrimination of PLHIV. This does not imply that campaigns need to avoid talking about the negative consequences of becoming infected with HIV, or conversely, the advantages of remaining HIV negative [49], but such messages should always be developed in consultation with PLHIV.

Wording, imagery and design of messages work best when developed in consultation with the target group, e.g. through focus groups or pre-testing.

Some strategic questions to be asked during development of the communication strategy and messages can be found below.

6 Something that happens as a result = additional benefits continue to be seen even after the event



Language

The way in which a message is expressed is as important as its content; the language must be suitable for the context in which the message will be received. The appropriateness of the tone is connected to knowledge of the audience, the audience's lived experience, and its communication preferences. However, whether a message is adopted by the target audience also depends on the authenticity of the sender. It is important to consider who is best placed to communicate certain information. For example, messages about health threats may be taken more seriously if they are released by respected government organisations, while messages about risk can be less stigmatising if disseminated by NGOs run by MSM.

However, phrasing a message does not just involve mimicking the language used by the recipients. The social and cultural norms and preferences of the target group will help select the appropriate level of language. In addition, the audience holds certain expectations regarding health messages from a trusted source and may balk at a language that tries to imitate the way MSM communicate among each other in the gay community. Again, involving members of the target group in the wording of messages is indispensable to meet expectations and maximise authenticity, legitimacy, credibility, reach and effect.

In some instances, the use of humour (and cartoon images) in communications can help overcome taboos and embarrassment. Because humour is very specific to each culture and subculture, it is important to focus-test humorous messages carefully with members of the target group.

Images and visual representations of the target group

Style and imagery convey a large part of the overall message and should also be adapted to the context in order to be effective. A poster in a gay bar should use a different visual language than a safer sex pack to be distributed in an outdoor cruising area or a banner advertisement on a gay dating website.

Explicit language and imagery can be used to gain audience attention and highlight the message the communication aims to convey. To do this successfully, a comprehensive assessment of the local context and the needs and preferences of the audience is required [50]. Pre-testing material with sample audiences and using focus groups to tailor material to emerging subpopulations is therefore crucial.

Images and graphic design are important components of most communication interventions. They play a significant role in creating a connection between the sender and the recipient of the message. Visual appearance sets the tone for communication and has a significant influence on reach, uptake and understanding of messages, and therefore on effectiveness. It is for this reason that a large proportion of preparation time and consultation with the target group is often invested in this component.

How to represent the target group in the graphic design of a communication intervention is an important question. Even if no photographs or other images of people are used, the choice of style and colour can determine whether the recipients readily engage with the message.

If images of people are used, it is important to consider the following factors:

- Which models and images will allow MSM to identify with the message?
- How many different images are needed to represent diversity?

- What imagery and design appeals to MSM in the given setting?
- Which other images and messages will the intervention have to compete with?

- How can stereotyping of MSM be avoided?
- How can negative effects on self-esteem and self-image be avoided?
- Are there any unintended reactions to be expected from people other than members of the target group?

The balance between representation, appeal and negative effects (e.g. idealising a body type that is unattainable for most) usually differs between interventions. Close collaboration with the target group is essential for adapting the design to local requirements.

There are several options for creating images:

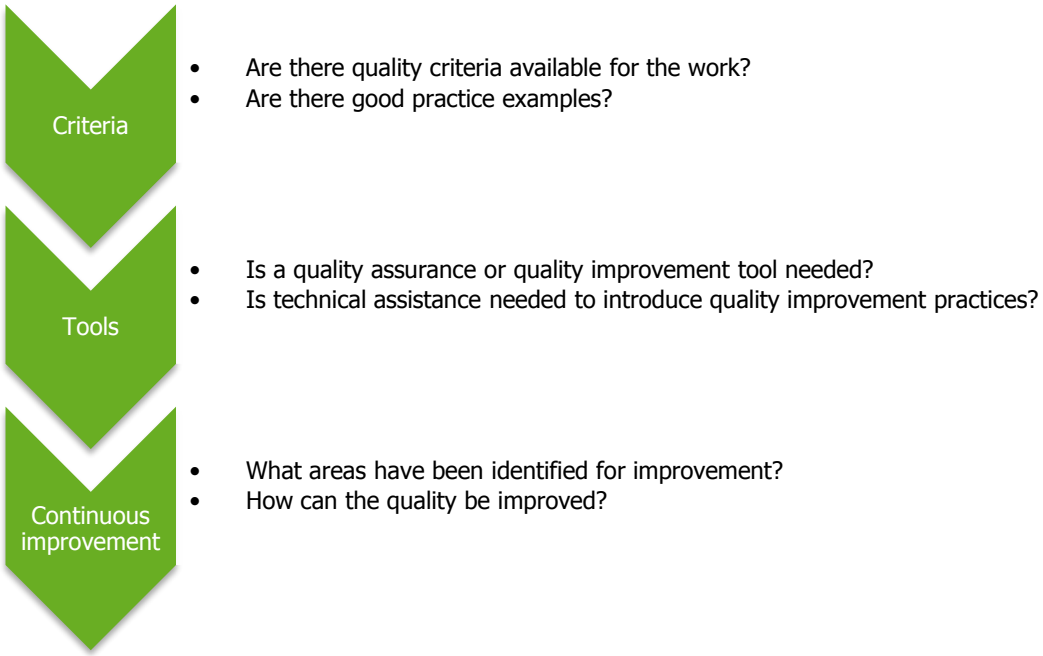
- Recruiting members of the target group as models
- Using professional models to create a specific look
- Using models of different ages, body types and ethnic appearance
- Breaking down stereotypes by combining messages with unexpected images, e.g. an attractive model expressing self-doubt and shyness, or a well-known personality who represents masculine culture (e.g. a famous athlete) speaking out against homophobia
- Using cartoons and caricatures to approach sensitive topics.

6.5 Quality and sustainability

Quality

A focus on quality should help maximise the potential effectiveness of a chosen communication intervention. For some interventions and methods, quality criteria are available in the form of guidelines, toolkits, checklists, good practice examples, or case studies.

Some strategic questions to be asked to help ensure the quality of a communication strategy.



Quality assurance approaches can encourage reflection during the communication strategy development process. It may identify areas of improvement that may result in concrete and practical steps to improve the campaign.

Measuring the reach and impact of communication interventions through evaluation becomes more meaningful when the steps to maximise implementation quality were properly planned, implemented and documented. Quality improvement tools are available that provide guiding questions and methods to improve quality across all aspects of an intervention [41,42].

Sustainability

To ensure greater effectiveness, communication interventions must be supported by current data and evidence, should be adapted to the local context, and should be able to respond to changing needs and preferences in the target group. While some communication content remains relevant over time, prevention messages, channels and methods may have a limited lifespan. Continuously adapting and changing prevention messages ensures that a campaign maintains its momentum.

6.6 Monitoring and evaluation

A monitoring and evaluation plan needs to be incorporated into the communication plan. It should be developed at project inception. Evaluation planning includes developing questions for process and impact evaluation, formulating indicators that parallel the project objectives, and deciding on suitable methods for data collection and analysis.

It is important to ensure that the time and effort required to perform the project evaluation is proportional to the overall campaign efforts. As a rule of thumb, dedicating between 10% and 20% of a project's financial and human resources to evaluation should be sufficient to obtain meaningful results without straining resources for intervention implementation.

When designing the evaluation, it is important to look at the communication context and its ethical implications, and then decide whether the selected evaluation method is feasible. For example, asking every single person contacted through outreach services to fill in a questionnaire may appear too confrontational for the target group. Collecting anonymous personal anecdotes posted in an online discussion forum may provide valuable data, but using them for evaluation without the consent of the participants would be unethical.

Furthermore, evaluating health communication activities can be difficult, particularly selecting appropriate and measureable indicators and the limited evidence base of what constitutes 'effectiveness'. The lack of evidence to identify or describe the success of behavioural interventions limits the application for public health professionals [34].

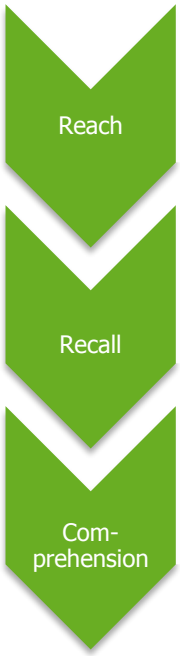
Given the difficulties of evaluating health promotion campaigns, it should be considered to include process evaluation indicators and outcome-dependent indicators. These indicators use real-time feedback from participants and facilitators to identify areas for improvement and allow investigators to monitor the effectiveness of a campaign before its official end date [51].

Indicators

If SMART criteria were used to design campaign objectives, they can also be used to develop evaluation indicators. Good objectives call for measurable indicators that are based on data that can be obtained without unreasonable effort.

Possible indicators for communication interventions include the proportion of the target group that the intervention has reached, message recognition and message recall in the target group, and the extent to which the target group has understood the message and integrated it into its decision-making processes. The first two are examples of process indicators, while the latter seeks to provide information on the effect of the intervention (output evaluation). To assess the reach of a communication intervention, a baseline measurement or estimation of the population size to be reached is necessary. Secondary surveillance and social science research reports may also provide a baseline of the target group's level of knowledge, its attitudes and health-protective activities. Recall/recognition and comprehension/integration can then be measured based on the total group reached by the intervention.

The following strategic questions should be asked when developing evaluation indicators:



- Has the communication reached the MSM it was directed at?
- What proportion of MSM was reached?

- How well do recipients recognise or recall the message?
- What proportion of the target group recall the messages?

- To what extent have recipients understood the messages as intended?
- To what extent have recipients integrated the messages into their decision-making process?

Data collection

The quantitative and qualitative data required for the selected indicators may be available from existing sources (e.g. number of visits to a website, number of safer sex packs distributed, social research reports). Alternatively, specific instruments can be designed to collect this data (e.g. rapid assessment surveys, questionnaires, interviews).

Sometimes, tools for communication intervention can be added to existing data collection instruments, e.g. client questionnaires or feedback forms used by clinics and service providers frequented by MSM. Utilising existing data collection mechanisms can reduce the demands on the target group who may become reluctant to participate if asked to provide similar feedback on multiple occasions.

Issues of bias cannot be ignored in this context: the health-promoting effects of participating in evaluations, especially in individual interviews using open questions, is underestimated and under-researched. Some researchers believe that participating in a semi-structured interview is not unlike a counselling session, and even filling in a simple survey form may reinforce prevention messages.

Sources of quantitative and qualitative data relevant for the evaluation of communication interventions include:

- Print runs, distribution and uptake of materials
- Radio airtime, magazine circulation numbers, responses to online and social media postings, website hits
- Responses to representative surveys, including online surveys linked to online materials
- Records of outreach interactions
- Interviews with representative samples of the target group
- Feedback forms from face-to-face interactions

Below are some strategic questions to be asked when planning data collection to monitor the communication interventions.

- What is the the measured or estimated size of the target group?
- What is currently known about the knowledge, attitudes and behaviour of the target group?
- What data can be sourced from existing statistics and monitoring activities?
- What data can be sourced from other surveys and reports?
- What sample size is needed for a meaningful analysis?
- How can a maximum of information be collected while minimising the demands on the target group?

Analysis

Basic statistical analysis of quantitative data collected for evaluation can provide meaningful insights into the process and impact of the communication intervention, i.e. whether and to what extent an intervention was successful. Comparing numerical results with the baseline is often sufficient to illustrate levels of success or progress towards a target.

Some strategic questions to be asked when analysing data from the communication intervention can be found below.

- How many of the project objectives were successfully met?
- How successul were the communication messages, channels and methods in changing behaviour and/or preventing infection?
- What was the response from the target group?

Useful measures include:

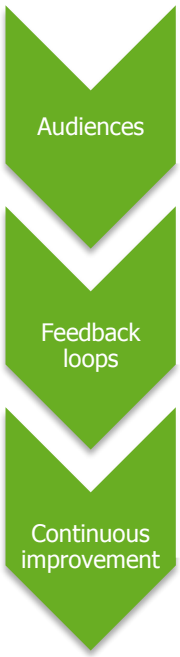
- Number of members of the target group reached/total (estimated) size of target group
- Number of respondents who recall the message/total number of respondents
- Number of respondents who are satisfied with the intervention/total number of respondents
- Number of respondents who understood messages as intended/total number of respondents
- Number of respondents who report integrating messages into their decision-making/respondents who understood the message as intended

Qualitative data – in the form of verbal or written feedback about the intervention – can explore why an intervention was successful and can be summarised through thematic analysis.

Reporting and dissemination

It is important to report evaluation results not only to funders, management, advisory committees and other governance structures, but also to the target group, particularly intervention participants and evaluation survey respondents. Feedback loops can be created by posting short summaries of evaluation results on websites, publishing articles in the gay press, and by integrating findings into the next version of the intervention (e.g. '60% of you liked the last safer sex pack, and 40% wanted more information about syphilis: so here it is!'). Such feedback loops highlight the involvement of the target group and can contribute to a sense of collective ownership of prevention efforts.

Some strategic questions to be asked when planning the reporting and dissemination strategy can be found below:



- To whom do the results of the communication intervention have to be disseminated to?
- Who else would benefit from viewing the results?

- What can be reported back to the target group?
- How can the reported results be presented in a meaningful way?

- What are the key findings of the intervention?
- How can the results be used to inform future communication projects?

Graphical representations can often communicate quantitative results more effectively, while a selection of quotations can be used to link the themes emerging from qualitative data back to the lived experience of the respondents.

Given the need for constant change and innovation in developing communication interventions, it is useful to feed evaluation results directly into the planning process for future interventions.

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