European Commission

Training Programme

for Community Health Workers (CHW) engaged in work with men who have sex with men (MSM) in Europe

Toolbox-training package for CHW, aiming to improve access, quality of prevention, diagnosis of HIV, STI and Viral Hepatitis and (sexual) health care for gay and other MSM.

Terrence Higgins Trust

Deutsche Aidshilfe

Public Health

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Authors Barrie Dwyer, Takudzwa Mukiwa, (THT); Matthias Kuske, Dr. Dirk Sander (DAH)

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You can download the ESTICOM training material and access the E-Learning modules on the ESTICOM training website. ESTICOM training material and programme website: **www.msm-trainings.org**

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Consumers, Health, Agriculture and Food Executive Agency Unit:
Health unit – B

Contact: Chafea
E-mail: CHAFEA@ec.europa.eu
European Commission L2920 Luxembourg

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[1] https://www.esticom.eu/Webs/ESTICOM/EN/about-project/about-project-node.html
[2] https://ec.europa.eu/commission/index_en
[3] http://ec.europa.eu/chafea/index_en.htm
[4] https://www.aidsactioneurope.org/en/civil-society-forum
[5] https://ecdc.europa.eu/en/home
[6] http://www.emcdda.europa.eu/emcdda-home-page_en
[7] https://ec.europa.eu/health/funding/programme_en

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1. ESTICOM Training material and programme outline

1.1 Introduction to this training

This manual provides step-by-step guidance to the facilitators implementing this training course. It is divided into two parts.

— The first part provides an introduction for the facilitator, namely: how and why the training course has been developed; how to prepare for the training; how to implement the training and details on the evaluation.

— The second part provides a description of the training modules and includes: an overview of the module; instructions on how to use the module; aims and learning objectives of the module and suggested preparatory reading. It also outlines whether that module is provided Face-to-Face with participants or is only available as E-Learning online.

In addition, for each module, guidance notes have been prepared for the trainers to help them when presenting the slides and facilitating the activities. These can be found **here**. The material required for the activities can be found **here** for each module in a print-ready format.

Note on terminology

In this manual, 'Facilitator' refers to the person who conducts/facilitates the training and their co-facilitator whereas 'Participants' refers to the people who attend the training course. See note later about the distinction between 'Trainer' and 'Facilitator'.

Gay and other MSM will be generally referred to as 'service users' or just 'users' as generally CHW do not see the men they work with as 'patients' or 'clients'. You have the option of asking the group of participants you are working with how they refer to the men they work with and use their definition if you feel comfortable with that.

The training package uses a mix of 'MSM' (or men who have sex with men) or 'gay and other MSM' to describe the people CHW are generally working with. The issue is that 'MSM' is not usually a term understood or used by the target audience (the MSM themselves) and many of the issues faced are faced by all men who are sexually attracted to and engaged with other men; however they may describe themselves. The issue is the stigma and discrimination that is experienced, not what the target audience of our work is identified as.

1.2 About this training

1.2.1 Concept behind the approach and materials

It is understood that HIV/STI-Prevention among MSM is a comprehensive and holistic approach based on scientific evidence, theoretical approaches, experience and community knowledge.

It's obvious that behaviour is influenced by environmental structure, e.g. results show that one insidious consequence of society's stigma towards homosexuality is the internalisation of that stigma by gay and bisexual men themselves; therefore drawing attention to the importance of promoting social equity for self-acceptance around gay identity to help build a positive sense of self is a major part of any work hoping to impact positively on MSM health.

In this view Prevention includes:

- Strengthening of self-acceptance and self-confidence.
- Promotion of society's acceptance of diverse lifestyles.

- Empowerment for self-responsibility.
- Protection, promotion and creation of sexual habitats/sanctuaries (e.g. safe places).
- Mediation of 'individual social skills'.

Further to this we have to tackle health consequences which originate from environmental circumstances and influence behaviours (the syndemic approach): protective behaviours, substance use and emotional wellbeing are seen as intertwining and reinforcing epidemics.

"A syndemic is 'the aggregation of two or more disorders or diseases in a given population where some level of interaction extends negative health outcomes of any or all of the syndromes included in the syndemic'. Some of the disorders (…) (i.e., depression, PTSD, anxiety, social anxiety disorder, alcohol or other drug abuse) are conditions syndemic with HIV and thus should be addressed in order to achieve optimal patient outcomes for both HIV-uninfected as well as HIV-infected individuals'." (Mimiaga et al. 2015).

Understanding this, a major key within the development process for this training was the understanding of and need to challenge these detrimental effects that stigma, prejudice and homonegativity have both on the main audience of gay and other MSM and also on the CHW who are the audience for the training modules.

The impact of expectations of masculinity, 'good' behaviour and lack of 'disease' in any form are among the many things that are key influencers of the attitudes and barriers that inhibit the proper offer and function of services for gay and other MSM. One purpose of the training is to help challenge those received and perceived messages and break down barriers that could have workers judging users of a service; for example, men who have been treated for gonorrhoea multiple times being quizzed about their sexual behaviour and being made to feel less worthy because they have been infected with a bacteria. The way that language is used can 'other' people and become judgemental, talking about 'risky' behaviours and populations. The use of research to blame gay men/MSM over the rise in STI and HIV incidence gives the impression of 'if only they would behave themselves.'

Helping people to face and challenge these attitudes will have greater influence over the building, uptake and use of services rather than solely providing CHW with the current information we have on good practice. A major purpose of Face-to-Face (F2F) training is to help challenge attitudes within course participants, build their skills and competencies alongside referring on and providing links to validated sources of information and support to help them inform both local and national work. The use of already existing and approved EU support work from ECDC, EATG and others will help to impact upon the European levels of skills, knowledge and competency and provide a 'harmonisation' of CHW's working across the region.

This approach is supported by the findings and recommendations of the research carried out as preparation work for course material development.

Using these considerations and the influencers from this research led to a broad approach for the module development of:

— A use of competency based skills development alongside appropriate levels of information and knowledge-based training.

— Less focus has been given than in previously available training on 'imparting knowledge' only.

— Using the professional and personal skills and experience of the participants within the training space to model and shadow skills, using short 'intervention' building sessions.

— Inclusion of explicit and implicit Communication and Interpersonal skills building, as well as some focus on anti-homonegativity models – focusing on developing skills and developing awareness of ongoing personal needs.

– Opportunities to use personal experiences to both develop culturally appropriate interventions and models of work and better understand the messages around and sources for homophobia, homonegativity and stigma (both sexuality and HIV related).

— The use of common and community experiences within a Cultural Competence[1] framework.

— Using a culturally competent approach within the modules e.g. language, approach, policies, agreements etc.

— The use of established and approved EU resources, such as the ECDC Guidance, Technical Reports, Modules etc. to inform work within the modules and as case studies e.g. The NAM European Test Finder.

— Knowledge and knowledge changes: to lessen the need for the information contained within the modules to be constantly updated, the training will both refer and link to the most up-to-date information available online.

The approach to the development of the E-Learning element of the programme has been:

— A concentration on providing the information and knowledge-based elements of the training as E-Learning only.

— A move away from a 'webinar' element as time differences/constraints, trainers' and CHW's availability would impact upon available numbers to take part and the large range of topics would hinder uptake.

— To be hosted on a range of platforms for economic and future-proofing reasons.

1.2.2 Use of the materials

The materials are comprised of a number of elements that fit together to create the training session. It is important to remember to use all the elements suggested to allow the training session to function properly.

These elements are:

Group Agreement: A Group Agreement is different to 'Ground Rules'. A Group Agreement is something that you as a facilitator build with the input of the participants. It's used to create a safe, functioning training space that allows the participants to work together and the facilitator to work in conjunction with them. In effect, it's an agreement that the facilitator and participants sign up to rather than something that is being imposed on them. This allows the facilitator to remind the participants of any 'transgression' from the agreement and their agreement to it. Contents of a Group Agreement usually include issues such as confidentiality, working in a safe space, taking part, allowing the facilitator to move things on and having fun. There are more, and the advice is to be led by the participants while using your knowledge and intelligence to accept them.

Icebreakers: These short exercises are used to help the participants get to know one another and make it easier for them to work together. Therefore it's important that a suitable exercise is chosen to run at the start of the training, and if running training over multiple days, that Icebreakers are used to start the days again.

Energisers: These short exercises help rebuild the energy in the participants after a long exercise or break like lunch. Be aware with Icebreakers and Energisers, as with any training exercise, that people may have different issues with mobility so be aware how the exercises you have chosen will work with the participants in the room. As with Icebreakers there should be Energisers in any training programme being compiled.

Communication Skills: These exercises are to practice people's communication skills, usually in ways that they don't normally use. It helps participants build awareness of their own ways of communicating and gives them help in identifying other, complimentary ways of communicating, both Face-to-Face and via media like texts and emails.

[1] Cultural Competence: a defined set of ethics and principles, demonstrated behaviours, attitudes, policies and structures that enables work to happen effectively across cultures.

Interpersonal Skills: These exercises help build participants awareness of how they can build on their ways of working with service users. They build awareness of personal space, body language and communication without speaking to allow a whole way of working with people to develop.

Face-to-Face (F2F) exercises: The majority of the material available is to be run in a Face-to-Face training session. This gives the participants the best chance of learning from each other's skills and experiences and helps the facilitator to challenge old ways of thinking that could be a barrier to effective working with gay and other MSM.

E-Learning: A number of exercises are only provided as E-Learning modules. This is mainly because they are very knowledge and information heavy exercises that do not use the Face-to-Face setting in an effective way. Providing them as E-Learning allows participants to access and work through them at their own speed and at a convenient time for them. The E-Learning material can be accessed via the ESTICOM training platform **www.msm-training.org**.

Needs Assessment: A Needs Assessment is carried out to find out what are the most important needs of the group you are working with. Although some needs will be general over a local region it is always better to work with the specific needs of the participants you are working with. This needs to be carried out at least six weeks before the date of the training to allow the development of an appropriate training programme. See the section about the Needs Assessment later in the document.

Evaluation: It is important to evaluate the training that has been run to make sure that it is effective. To this end a pre and post-course evaluation is provided for use. See the section on Evaluation for more details.

1.2.3 Settings

The training can be carried out within any suitable setting (see Venues) as long as it is a useful space to work in. Therefore it can be held within the services accessing the training, or other suitable spaces such as specific training or conference venues. This, of course, is dependent on any budget being available to pay for these venues.

1.2.4 Audience for the training

The main audience for these training sessions are Community Health Workers working mainly with gay and other MSM. The basic description of a CHW is anyone who works with gay or other MSM around their sexual health in a community setting. This could include volunteers who do outreach work with gay or other MSM right through to doctors who support the community testing initiative a service is involved in.

1.2.5 How the materials were developed

This training course has been developed as part of the ESTICOM project by a consortium of European partners working together on three objectives:

- Objective 1: EMIS 2017 Robert Koch-Institute (RKI), Germany. Sigma Research at London School of Hygiene and Tropical Medicine (LSHTM), UK.
- Objective 2: ECHOES Centre d'Estudis Epidemiològics sobre les ITS i la SIDA de Catalunya (CEEISCAT), Catalunya, Spain. University of Brighton, UK. AIDS Action Europe (AAE). European AIDS Treatment Group (EATG).
- Objective 3: A toolbox-training package for CHW working with MSM in Community Settings. Deutsche Aidshilfe, Germany. Terrence Higgins Trust, UK.

The structure and content of this training course have been built on the basis of the extensive research carried out in the first phase of both the ECHOES research and the ESTICOM training development, which included a review of existing training modules available throughout Europe. For this training material this then went onto the development and provision of a Training of Trainers stage and the eventual piloting of the materials in 19 EU Member States, involving CHW from 24 countries, which was evaluated to ensure effectiveness. More information about this process, including the evaluation of the material, is available at www.esticom.eu

1.2.6 How this training is an addition to your training schedule

Many services and local regions already have training programmes in place for CHW. We know from research carried out to support the development of the training modules that over 90% of this is informational, knowledge-based work. As such, this training compliments this by using an 'experiential' approach, helping them with practical skills as well as knowledge. It helps people understand how to turn information and data into practical working initiatives for MSM.

1.2.7 The structure of this training

This training is a modular toolbox-training programme. This means that as the facilitator you will choose from the range of modules available to you to build a suitable training session for your participants having carried out a Needs Assessment with them.

There is a Course Structure outline and Curriculum which can help you assess which of the exercises to choose and whether they fall into the Face-to-Face or E-Learning sections available to use.

ESTICOM Training – Course Structure

Face-to-Face training

KNOWING THE COMMUNITY YOU ARE WORKING WITH (Cultural Competence)

- When I Was Young… : understanding how messages we receive affect our attitudes
- How to improve access, services and retention in care
- Working across MSM Communities or Populations

CHALLENGING STIGMA AND DISCRIMINATION

- Vulnerable MSM groups and their sexual health needs
- Building awareness of the drivers of stigma about HIV/AIDS and sexuality
- Creating a non-judgemental service or environment for gay and other MSM
- Engaging and involving the users of your service
- Understanding Syndemic Production Models and how they influence our work
- Recognising complex health-related systems and how they can be addressed

WORKING IN PARTNERSHIPS

- Identifying and building good practice for partnership work involving statutory and community health services
- Partnership working with and between LGBTQI+ organisations and other services

PREVENTION
• Using Motivational Interviewing techniques in y/our work • Awareness about and the use of TasP (U=U), PrEP, PEP and Self-Testing or Self-Sampling for MSM • 'Frontline Interventions': working with MSM using One-to-One and Group advice and information interventions; Motivational Interviewing and Counselling, and Community HIV and STI testing

Face-to-Face plus E-Learning content training

PREVENTION
• STIs: symptoms and treatments • ChemSex: sexualised substance use • 'What is safer sex now?' • Understanding the epidemiological dynamics of HIV infection in MSM in Europe

The E-Learning material can be accessed via the ESTICOM training platform www.msm-training.org

E-Learning training

PREVENTION
• Using Health Promotion Models to aid behaviour change

SETTINGS AND INTERVENTIONS
• Useful settings for interventions aimed at MSM • Improving linkage and retention in care • Anti-Stigma campaigns: learning from HIV/AIDS and MSM/LGBTQI+ interventions

SKILLS BUILDING
• Using Social Marketing to engage with MSM • Building tailored training for specialised services

The E-Learning material can be accessed via the ESTICOM training platform www.msm-training.org

Curriculum for Regional and National Trainings

These are the curriculums for the Regional and National Training Programmes based upon the ESTICOM materials.

To ensure that all participants develop a range of skills across disciplines, it is strongly recommended that at least one element dealing with Communication and Interpersonal skills is contained within every piece of training. Other subjects for training are compiled into groups that suggest the probable best options for the needs of the different regions running the training.

It is also strongly recommended that all training provided using these materials concentrates on the issues covered in **Knowing the Community you are Working With** and **Challenging Stigma and Discrimination** sections.

Ultimately, decisions about which subject modules will comprise that training event will be made after the Needs Assessment has been carried out for that region and indicators of need have been identified. Additional knowledge areas not identified by the Needs Assessment can be also used alongside these if so desired.

The training has been divided into three approaches:

- Face-to-Face: all of the exercise is run by a facilitator with participants in the room.
- Face-to-Face plus E-Learning: Parts of the exercise are run as Face-to-Face and extra important information is provided as E-Learning modules.
- E-Learning: Mainly information and knowledge-based, these modules are provided only as E-Learning, to be completed when appropriate for the user.

In this document these distinctions are indicated by the following key:

F2F = Face-to-Face modules

EL = E-Learning modules

Curriculum A: Skills

- Communication and Interpersonal Skills (F2F):
  - Back to Back Communication
  - Body Language and Exploring Relative Distance
  - Communication Origami
  - Follow All Instructions
  - Going to a Party
  - Listen Without Speaking
  - Samaritans
  - Situational Awareness
- Knowing the Community you are working with (F2F):
  - 'When I was Young …'
- Knowing the Community you are working with (F2F):
  - How to improve access, services and retention in care.
- Knowing the Community you are working with (F2F):
  - Working across MSM Communities or Populations.
- Challenging Stigma and Discrimination (F2F):
  - Building awareness of the drivers of stigma about HIV/AIDS and sexuality.
- Challenging Stigma and Discrimination (F2F):
  - Vulnerable MSM groups and their sexual health needs.

Curriculum B: Basics

- Prevention (F2F):
  - Using Motivational Interviewing techniques in your work.
- Settings and Interventions (EL):
  - Useful settings for interventions aimed at MSM.
- Prevention (F2F and EL):
  - Understanding the epidemiological dynamics of HIV infection in MSM in Europe.
- Prevention: (F2F and EL)
  - STIs – symptoms and treatments.
- Working in Partnerships (F2F):
  - Identifying and building good practice for partnership work involving statutory and community health services.
- Working in Partnerships (F2F):
  - Partnership working with and between LGBTQI+ organisations and other services.

Curriculum C: Good Practice

- Prevention (F2F and EL):
  - What is Safer Sex now?

- Prevention (F2F):
  - Frontline Interventions working with MSM using One-to-One and group advice and information interventions; Motivational Interviewing and Counselling and Community HIV and STI testing.

- Challenging Stigma and Discrimination (F2F):
  - Engaging and involving the users of your service.

- Challenging Stigma and Discrimination (F2F):
  - Creating a non-judgemental service or environment for gay and other MSM.

- Settings and Interventions (EL):
  - Improving linkage and retention in care.

Curriculum D: Development

- Prevention (EL):
  - Using Health Promotion Models to aid behaviour change.

- Challenging Stigma and Discrimination (F2F):
  - Understanding Syndemic Production Models and how they influence our work.

- Challenging Stigma and Discrimination (F2F):
  - Recognising complex health-related systems and how they can be addressed.

- Prevention (F2F):
  - Awareness about, and use of, TasP (U=U); PrEP; PEP; Self Testing or Self Sampling for MSM.

- Prevention (F2F and EL)
  - ChemSex: sexualised substance use.

- Settings and Interventions (EL):
  - Anti-Stigma Campaigns: learning from HIV/AIDS and MSM/LGBTQI+ interventions.

- Skills Building (EL):
  - Using Social Marketing to engage with MSM.

- Skills Building (EL):
  - Building tailored training for specialist services.

1.2.8 Do I need permission to use these materials?

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It is important that this material is used with the intention it was developed with, that understanding negative attitudes and challenging stigma and discrimination around HIV/AIDS, sexual orientation and behaviours including substance use are key to linking people into appropriate care and getting people onto treatment. Judgements about people or behaviours are not welcome on this course and are to be challenged appropriately and talked through with anyone expressing them.

1.3 Structure of this document

1.3.1 Objective of the training

The overall objective of this training course is to raise awareness about the societal influences on health inequalities for gay and other MSM and how stigma and discrimination work as barriers that increase these health inequalities. The training is for Community Health Workers (CHW) who work with gay and other MSM in community settings (mainly around HIV/AIDS, STIs and Viral Hepatitis, but also other health-related issues including Mental Health) providing them with experiences, skills and knowledge to overcome the identified barriers in linkage to care and care provision for gay and other MSM.

1.3.2 Course Materials and examples

The training course is made of the following components:

Facilitators' manual

- Structure and contents of the training course.
- Detailed description of the content of the training course (slides, training documents, training materials).
- Recommendations for managing a proper delivery of the training modules.

Training materials

- PowerPoint (PPT) slides.
- Participant worksheets.

Evaluation materials

- Description of the training evaluation tools, timing and procedures.
- Questionnaires.

The content of the training modules (including group activities, case studies, and selection of slides) can be adapted in accordance to the local context and specific training needs. See the section on Additions and Updates to the materials.

Training Session and Programme examples

Here is an example of a possible half-day training session dealing with attitudes, stigma and discrimination:

1. Open the group
2. Introductions
3. Group Agreement
4. Icebreaker: How much do you use?
5. Module One: 'When I was Young…'
6. Energiser: Sharks and Penguins
7. Module Two: Building awareness of the drivers of stigma about HIV/AIDS and sexuality
8. Feedback and close

Here is a possible approach to developing a training programme for a set of participants, probably who all work at the same Checkpoint or service. Choose from the section indicated, guided by results of the Needs Assessment you carried out.

1. Building their Communication and Interpersonal Skills
2. Basic work:
   - Knowing the Community you are working with
   - Challenging Stigma and Discrimination
   - Understanding Prevention
3. Good Practice - Understanding what 'Good Practice' is across service provision for MSM
   - Prevention
   - Working in Partnerships
4. Further Development
   - Prevention
   - Settings and Interventions
   - Skills Building

1.4 Preparing the Training

1.4.1 Needs Assessment

There is a Needs Assessment document attached to these materials which allows you to focus in on the training needs of the group of participants you are working with.

It is important to remember:

- To carry out the Needs Assessment at least 6 weeks before the training date to allow for completion of the assessment by participants, the processing of the data from the completed assessments and the selection of the training materials.
- That the document includes a complete list of needs and will provide an ongoing idea of the training needs for that group that are unlikely to be met in just one or two sessions. Prioritise the most important needs of the group first, and understand that the focus on stigma and discrimination and attitudinal work is not likely to be identified by the participants as a need, while we know from other research that they are strong needs.
- That you will need to complete a new Needs Assessment for every new group of participants.

1.4.2 Facilitators' Preparation

It is of key importance for the facilitators to prepare themselves to run this training. Regardless of whether the facilitators have prior knowledge or experience on health inequalities of LGBTQI+ people, both trainers should take time to study all necessary materials as follows:

- Read and study this training manual
- Read the information about the ESTICOM project at www.esticom.eu
- Familiarise yourself very well with the whole glossary
- Identify local information to compliment the chosen training material/s.

In addition, the required reading for each module is specified in the introduction section of the module descriptions.

Facilitators should also divide responsibilities among themselves, both in terms of preparation and management of the training course.

1.4.3 Materials required

The materials required for each exercise are outlined in the module for that exercise. Very little is usually required beyond: a flipchart easel, pad and pens; paper and pens for the participants; and the Training Manual modules for the session being run. In some instances exercises will require the showing of the relevant PPT slide/s and the use of the relevant Participant Worksheet. Certain support exercises use other resources, all of which are listed in their exercise description.

1.4.4 Venue

It is recommended that the training course be held in a venue that is appropriate, quiet, comfortable and accessible for **all** participants. This may be a room in the offices of the hosting service where the majority of the participants work to facilitate their participation. It could also be a space in a venue such as a hotel, Conference Centre, or the offices of a partner agency.

The room should be large enough for all of the participants who will be attending, and you should be able to move chairs around in order to facilitate the activities. A slide projector for PPT presentations and a flipchart have to be available.

It is recommended to prepare the room with the seats in a semi-circle. This will encourage both participation and at the same time, ensure the visibility of the slides.

As the facilitator, forward preparation is important so that the training course can be conducted in an efficient and timely manner.

For this reason, it is important to:

- Ensure the room temperature is comfortable, the lighting is adequate, and slides readable.
- Know the Health and Safety issues for the venue, including but not limited to: fire alarm testing, fire escape routes, location of toilets, refreshment and smoking break locations (and times).
- Ensure the room is the appropriate size.
- Arrange refreshments or access to refreshments for the participants.
- Set up any electronic devices for the training course.
- Provide the correct logistical information to participants (e.g. map of the venue, location of bathroom, indication of break and lunch times, agenda).
- Stick to the agenda.

1.4.5 Recruitment

Although it is strongly encouraged that you recruit course participants from the Needs Assessment you carried out, you may not have all the information you need about them to make the course as effective as possible.

When sending out letters of invitation to the course, alongside the usual information you need to provide such as date and start time of the training, location and how to get to the venue, you will also need to ask some additional questions about the participants themselves. These are known as 'demographic' questions and usually consist of things like ethnicity, age, gender identity, sexual orientation/identity.

It is very important that alongside any of these questions you choose to use, that you always ask if people have any additional needs, such as 'Are you a wheelchair user?', 'Do you need a sign language interpreter?' and 'Do you have any dietary requirements?'. In this way people can inform you of their needs and you are prepared and knowledgeable about the choices you can make for the Icebreaker, Energiser, Communication and Interpersonal Skills exercises you are choosing to use and be mindful of any amendments you may have to make to ensure that all participants can take part in the training you are planning.

1.4.6 Additions and updates to the materials

Certain terms, concepts or sayings in the other languages this material is available in may not be easily translated into other languages, and vice versa.

Some languages do not have equivalent words to describe the various terms within this document. For this reason, if these modules are translated into languages other than those available, great care should be taken to ensure that the meanings of terms will be accurately translated. Be aware that some terms may be appropriate in some languages, but could be considered as derogatory in another language.

It is possible and indeed encouraged to integrate relevant local information into the training modules provided here. An example of this could be the epidemiological data around HIV for the local city as well as country/region.

Facilitators might also want to work with other local services, especially if the training is for people working in a clinical setting. It may be useful to contact local MSM/LGBTQI+ organisations and associations for links and possible co-operative work and information sharing to help enhance the training experience.

1.5 Implementing the Training

1.5.1 Approach

The main method used is a practical experiential approach to the training materials, using the skills, experience and knowledge of the participants to inform the discussions happening throughout the training.

Throughout the training course, it is recommended to encourage the active participation of participants. This includes the sharing of their personal and professional experiences, skills and knowledge to enable their contribution to the discussions, while ensuring the larger discussions and group cohesion are not damaged.

1.5.2 Managing Practical Activities

For each activity, it is important that participants are clear about what is expected from them and about how much time they have to complete the activity. The material required for each activity and the instructions for carrying out the activity are described in detail in this manual in the relevant segments together with the assigned time.

Working in small groups:

Encourage participants to work with different people throughout the sessions, and if you are training participants from more than one Checkpoint or service, encourage them to work in mixed pairs/small groups.

Move through the different groups to observe the dynamic, help the participants and facilitate and prompt the discussion if necessary.

A quick word about 'role plays'. Some of the exercises require the participants to practice skills in the working space; these are traditionally called 'role plays'. However, that term causes many people great anxiety and creates a barrier to them being able to work effectively and get the most from the exercise. Therefore, it is always better to call these practice sessions 'small group practices'.

Working in large groups:

If you feel it is helpful to use the flip chart to summarise the main topics that emerge from the discussion then do so, but please remember that you do not have to write down everything that every participant says. Remind participants that there are no right or wrong answers in order not to inhibit participation.

Try to elicit responses from the group, before offering your own suggestions. Try a prompt by changing the words of your question while retaining its meaning.

If you do offer a suggestion, make sure that the group agrees with it before you write it on the flipchart.

1.5.3 Being a Facilitator NOT a Trainer

It is very important to understand the distinction between 'Trainer' and 'Facilitator' in the context of this course.

A 'Trainer' is generally someone who imparts knowledge and information to others, usually via reading from PowerPoint slides or from other resources. The knowledge and information flows from 'Trainer' to 'Participant' in one direction only. This is known as 'Pedagogic Learning'.

A 'Facilitator' makes it easy for everyone in the room to learn, from the 'Facilitator' to the 'Participants', the 'Participants' to the 'Facilitator' and the between the 'Participants' themselves, everyone using the experiences and skills they bring with them to the training session. The knowledge and information flows between the 'Facilitator' and 'Participants' in both directions. This is known as 'Andragogic Learning'.

It is important here because the skills and experience of everyone in the room is equally valid in obtaining as much learning as possible from the subjects covered in these training modules, and to properly use the resource of the skills and experiences of everyone in the room in helping to discuss possible solutions to the issues faced in the work of CHWs.

1.5.4 Difficult Conversations

It is your job as a facilitator to:

- Stimulate discussion.
- Provide safe, comfortable, and stimulating training sessions.
- Ensure all the participants have the opportunity to express their opinions.
- Respect their differing viewpoints and their silence.

You can do this by building an effective Group Agreement and ensuring you remind participants of it if it becomes necessary.

In addition, participants may have varying types of reactions to the contents and activities in the training course. Negative feelings may come up for participants who identify as LGBTQI+ or a peer to gay and other MSM during some of the exercises, and some internalised homophobia may leach out into the answers given and discussions had.

Direct attacks against LGBTQI+ people, including to other participants based on their identity or background, including (but not limited to) of their sex characteristics, gender identity or sexual orientation are very unlikely given who the audience for this training is, but however they appear – even if they are said as 'humour' – they should not be allowed to pass without comment.

It is your responsibility to address these incidents when they occur and make sure they are not repeated. This should be made clear at the very beginning of the training course, when you establish the Group Agreement that it is to be respected throughout the training, including any 'safe space' rule that may have been included.

Facilitators should clarify this, having in mind that participants need to respect the safe space rule and, at the same time, feel free to express their doubts and misconceptions.

It is more likely that participants will make comments that are not directed at anyone in particular, but are still negative or based on stereotypes and are about LGBTQI+ people in general. Some of the issues and topics included in this training may be new for many participants who might knowingly or unknowingly hold prejudicial, stereotypical or negative views on LGBTQI+ issues. Such views might arise through difficult comments or conversations during the training course.

Your responsibility remains to maintain a safe space for all participants during the training course, but also to educate participants through this training.

This means that the space you provide is a space for people to be open and honest, for them to make their mistakes and learn there rather than when they are out working with gay and other MSM. It also means that you look for comments or stereotypical views expressed by participants about other members of the LGBTQI+ communities and help challenge those views calmly and supportively.

This section provides you with guidance on dealing with LGBTQI+ phobic behaviour and difficult conversations during the training course.

Here are some steps to deal with negative comments or conversations:

Educate and prepare yourself by reading all materials related to this training, making sure you know the

proper terminology, and feel comfortable about the topic. Keep in mind that difficult comments can come in many forms and shapes and be about other members of the LGBTQI+ community not just gay and other MSM.

Do not directly confront participants on their views or tell them they are wrong. Show acceptance and interest in what the participants bring into the training course (e.g. using open questions and paying attention to avoid any judgemental nonverbal behaviour). Make sure to acknowledge what they say: 'This is your opinion, however I would like to stress that…' or 'I am sure this conversation is important for you; however I would like to stress that…' You may also use help from other participants by saying: 'This is your opinion/ experience, do other participants have different opinions or experiences?'

Use one of the following approaches to address the problematic comment or conversation:

- Training scope approach: if it is the case, remind participants that the topic discussed is out of the scope of the training course, and time is too scarce to get into this conversation.
- Training goals approach: remind people of the goal of the training course: increasing awareness among CHW about stigma and discrimination as well as the health inequalities for gay and other MSM and equipping them with tools to counter these inequalities.
- Health approach: everyone should have access to the highest standard of health, regardless of who they are or what rights they have been given in a given country/setting.
- Terminology approach: bring back participants to LGBTQI+ terminology, and remind them of the importance of using positive, respectful and appropriate terminology when talking about LGBTQI+ issues.
- Guidelines approach: remind participants that, as CHW or Healthcare Professionals, they should follow the national and international guidelines and standards of care, including the ones that are specific to healthcare provision to LGBTQI+ people.
- Diversity approach: to avoid negative generalisations, remind participants of the diversity of people within the LGBTQI+ community (participants might know a LGBTQI+ person who behaves in a certain way or says certain things, but that does not mean it is applicable to all people in the LGBTQI+ community).

1.5.5 Exercise conclusions and wrap up

Some exercises have seemingly 'natural' conclusions and with others, you as the facilitator will have to decide when the exercise needs to be ended. Often it's about how long you can allow a conversation that is interesting and useful to everyone in the room to go on. These issues are covered in the instructions for each module, as well as in the Facilitator Preparation. Many times prompt questions are given and when the discussion has included these, or the time given for the exercise has ended, that's when to close that exercise. Many discussions flow over and between exercises, so there may be time to hear what someone was going to say during another exercise.

The remaining 5 minutes of each training day are reserved for the wrap up.

Ask participants to think about:

- something that they have learnt
- something that they would put in place after the training course.

As an example you can ask:

'Now you have 5 minutes to think about something that you have learnt during this training session and something that you would put in place once you return to your service. Feel free to share it with the person next to you and then with the group – it could also be inspiring for other participants.'

1.6 Evaluation

1.6.1 Importance of evaluating your sessions

It is important to know that the training sessions you provided had some effect and helped the participants develop their knowledge, understanding and skills. This is why it is important to provide a pre and post-course evaluation questionnaire on every piece of training.

As there are many more modules than would be able to be used in one training session, you will have to create a specific evaluation based upon the materials you have chosen to run, by compiling the questions relating to each exercise into one pre-course questionnaire and a complimentary post-course questionnaire.

When assessing the results you are looking for people to move towards a better understanding, although we also need to realise that some people's confidence in their approaches can be shaken if challenged by the course materials and what they learn, and so this can sometimes be reflected in a downward movement in scores given.

1.6.2 Materials to evaluate

A full evaluation document is available with this document, as well as a format to build your own pre- and post-course questionnaires.

1.7 Re-Cap

Checklist for Facilitators

Before the training

Run a Needs Assessment
To help decide which of the exercises are the most important to run in the session you are planning.

Study
The full training package and other materials required to run the sessions you have chosen.

Identify
Any local data, work or initiatives that could be added to the training materials to enhance them for these participants.

Adapt the training materials
Using any local material you have identified.

Discuss and divide roles
With your co-facilitator, if you have one.

Recruit participants
It makes sense to recruit those people who have completed the Needs Assessment as much as possible, so the training suits their needs. Remember to ask participants if they have any requirements like a wheelchair accessible venue and space or sign language interpreter as well as their dietary needs if you are providing refreshments.

Select a venue
for the training, remembering the guidelines given.

Translate the training materials
If they are not provided in the language you will be using with the participants, use the language easiest for you to translate from – it doesn't have to be English.

Prepare and print
all the supporting materials that you will need during the training course. These include:

- pre- and post-course evaluation questionnaires
- the agenda for the session/s – including breaks and lunch
- worksheets and materials for the activities if required
- participant attendance forms
- any other documents requested e.g. certificates of attendance.

During the training
Before starting the training course, distribute out the empty pre-course evaluation sheets and collect back the completed pre-course evaluation sheets.

Encourage active participation of participants, their contribution to the discussion and facilitate group discussions, while keeping in mind participants' expectations.

Provide clear instructions on how to conduct the activities and on the time allocated for each activity.

Keep track of time and adjust the time according to the amount of time that you feel is appropriate for the discussion and elaboration of the slides or for the activity.

Ensure the group maintains the Group Agreement and refer to the guidelines on dealing with LGBTQI+ phobic behaviour guidelines if necessary.

After the training course has ended and before wrapping up the sessions completely, distribute out the empty and collect back the completed post-course evaluation questionnaires.

Collect and safely store all forms, including: the participant attendance form; the pre- and post-course evaluation questionnaires, and any other administrative support you have in place for the training.

After the training
Debrief with the co-facilitator.

Evaluate the training using the pre- and post-course questionnaires with the co-facilitator and make decisions on the running of sessions in the future.

2. Face-to-Face Training Material

2.1.1 Overview

Knowing the Community you are working with

- When I Was Young… and participant worksheet
- How to Improve Access, Services and Retention in Care, and online support materials
- Working Across MSM Communities or Populations, and online support materials

Challenging Stigma and Discrimination

- Vulnerable MSM Groups and their Sexual Health Needs, and participant worksheet
- Building Awareness of the Drivers of Stigma about HIV/AIDS and Sexuality, and participant worksheet
- Creating a Non-Judgemental Service or Environment for Gay and other MSM, and online support materials
- Engaging and Involving the Users of your Service
- Understanding Syndemic Production Models and how they Influence Our Work, and online support materials
- Recognising Complex Health Related Systems and How They Can Be Addressed and online support materials

Working in Partnerships

- Identifying and Building Good Practice For Partnership Work Involving Statutory and Community Health Services, and online support materials
- Partnership Working With and Between LGBTQI+ and Organisations and Other Services, and online support materials

Prevention

- Using Motivational Interviewing Techniques in Y/Our Work, and participant worksheet and online support materials
- Awareness about and the use of TasP (U=U), PrEP, PEP, and Self-Testing or Self-Sampling, and online support materials
- 'Frontline Interventions': Working with MSM using One-to-One and Group Advice and Information Interventions; Motivational Interviewing and Counselling and Community HIV and STI Testing, and online support materials

2.1.2 Knowing the Community you are working with

Informal Exercise Title:
When I Was Young…: understanding how messages we receive affect our attitudes

Study Area/Group:
Knowing the Community you are working with: 'Cultural Competency'

Exercise Aim and/or Purpose:
This exercise allows participants to explore the messages that MSM get about being men, having sex with men etc. and how these messages may affect them and their choices. If participants are MSM/LGBTQI+ themselves, how it may affect them and the work they undertake. It also considers 'resilience' as an adaptation made in the face of stigma and discrimination.

Expected exercise outcome:
Participants will have a better understanding of the types of message that we get around gender and sexuality. Participants will understand how these can continue to influence our attitudes to each other, the work we are involved in and how MSM have developed strategies to lessen their impact.

Materials Required:
- When I Was Young… printed forms – one for each participant.
- Pre-prepared flipchart sheets (see Facilitator Preparation).
- Flipchart easel, pad and pens.
- Paper and pens for participants.
- PowerPoint (PPT) slides (Resilience).

Facilitator Preparation:
- This exercise is aimed at people who work with all men who have sex with men regardless of how they identify their sexuality. The messages we get about having sex with men are very associated with being 'gay', which can sometimes make it difficult for some men to integrate this into their sexual identity. Other MSM may have an issue with identifying as 'gay' because of cultural or language differences, 'gay' being a very white, western idea of sexual identity.
- Approach the exercise with a 'problem solving' mindset.
- This exercise can contain a lot of negative messages, and although that is what the exercise builds from it can feel overwhelming for some people. The point of the exercise is to trigger this; it's not an unwanted effect of the exercise. It's OK for negative feelings to be in the room and to process them, and it's useful if you can think of some methods to move people on. It helps if you know the participants although some additional questions and tips are given in the Method to help with this processing.
- It's good if you have taken part in the exercise yourself and know how it develops.
- The When I Was Young… section of the exercise does not have an 'end', which is why it's important that you as a facilitator can conclude the discussion in this section, encouraging thought and discussion outside this session. Remember the exercise moves on to discuss 'resilience' and many discussions can and are concluded there.

Helpful hints for facilitators:
- You will need quite a bit of wall space to put up the flipchart sheets you have prepared for the participants to write on. Make sure you've prepared these sheets with the headers i.e. 'Gay men are…' 'Men should be…' before you start the exercise.
- This exercise can have a high impact on the rest of the training, and participants are likely to come back to the discussions they have in the following sessions. These discussions link closely to other exercises such as Syndemics, Whole System Approaches and Building Non Judgemental Services.

- The accompanying slide 'Resilience' introduces other concepts such as stigma, discrimination, cultural marginalisation, syndemics etc. that could trigger questions to the facilitator from the participants. It would be useful to at least check out what is said about these issues in the glossary before running the exercise.
- Don't go through the exercise too fast because you think others are feeling uncomfortable; to get the best from the exercise the processing is very important.
- Keep to the time you have. It can be easy to let discussions go on for a long time; give enough time to discuss things without everyone giving their own history.
- Choose 3 questions you think it would be good for your group/participants to consider. There are some listed in the Method section; see if you can develop some complimentary ones using your local situation.
- Although 2 methods are given, it's always best to use the longest one as you will get the most from it. Use the second method if time is limited or you are using the exercise as a reminder for a mixed group, where some participants have done the exercise before and some participants are new to it.

Method: (50 mins total)

Method 1:

1. Facilitator introduces exercise and explains that to better understand issues around working with men who identify as Gay, Bisexual or as other MSM we are going to do an exercise called When I was Young…
2. Facilitator to give out the question form that has a series of short questions (see below for an example of the form)

When I Was Young... I got the message that...	
• Men should be…	
• Men never…	
• Men always…	
• Sex between men was…	
• Gay men are…	
• Gay men should…	
• Gay men never…	
• Relationships between men are…	
• I was left feeling…	
• The most important source of these messages was…	

3. Facilitator informs the group that they are to think for a short time (5 mins) about the messages they used to get around these questions.
   - Think of what you heard when you were around 8 to 10 years old; NOT what you wanted to hear, think you should have heard, or you might hear now.
   - Complete the forms from a personal perspective – leave your 'work brain' alone for a while.

4. Participants are to fill out the form, answering the questions in 3 to 5 words maximum.
   - Tell the group it is best if they do not 'overthink' this, just respond with the first word/s that comes into their head.
   - If people say they can't remember or didn't get messages about these questions tell them to move to the next question. If this happens remember to point out during the discussion that not hearing anything about gay men indicates they don't exist, which is as bad as negative messages about them.
5. They have 15 mins to do this task.
6. While the participants are doing this, the facilitator/s are to put up the already prepared flipchart sheets on the wall/s of the training room, with the questions they are answering replicated at the top of the sheet.
7. When the time has ended (or everyone has finished, whichever is sooner) give each group member a flipchart marker pen and ask them to now transfer their answers onto the relevant sheets around the walls.
8. When the group has done this ask them to take some time to read all the sheets.

Method 2:

1. Follow Method 1 up to point 5.
2. Instead of placing flipchart sheets with every headline from the question sheet up on the walls, place 3 sheets up together; on 1 sheet write 'Gay men…', leave the middle sheet clear, and on the last sheet write 'Men…'
3. Ask the group to write their answers on the sheets where they think they fit across the 3 sheets.
4. When the group has done this ask them to take some time to read the sheets.

Facilitated Feedback:

Facilitator asks "What are your thoughts about what you see?"

Facilitator to go through each sheet pointing out similarities in the answers given – it's usual in the question 'Men never…' that it's answered 'Cry' or 'show emotion' – list/link all the similar messages together across the sheets.

Similarly, point out where the lists conflict in their messages, for example, 'Men are emotionless…' and 'Gay men are overemotional…' etc. etc.

Below are a list of prompt questions you can use to help the discussion:

- Have you thought about these messages before in this kind of way?
- Does anything surprise you?
- Do you agree with anything you see in these messages?
- Do you use these kind of judgements with anyone you work with?
- What influence do you think these messages have on the MSM you work with?
- How do you think these messages influence the work that you do with MSM?
- Do these messages influence other people's work with MSM?

Below are some questions to help deal with any negative feelings that may be there after the processing. This depends on the conversation that has happened in the group and may already be resolved.

- What has changed in regard to these messages?
- How do we/could we challenge these types of messages?
- How have you moved on from these kinds of messages? Or negative messages about you if you are not Gay, Bisexual or MSM? (think about the negative messages women get).
- How have the MSM you work with moved on from these messages?
- How has society moved on? Are there better legal recognitions of rights for people who have same-sex sexual and emotional relationships?
- Does anyone have an idea about what to do with these messages (in other words, does anyone want to rip them up)?

Method

1. Now move the discussion onto Resilience, using the examples the group has given you.
2. Share the definitions of Resilience and Sexual Resilience on the PPT slide and then take the group through the list of characteristics of resilience. (Challenging Social Norms etc.)

Resilience

- Resilience is defined as positive adaptation to the experience of stigma and discrimination.
- Men who have sex with men experience high rates of psychosocial health problems such as depression, substance use, and victimisation that may be in part the result of adverse life experiences related to cultural marginalisation and homophobia.
- MSM show great resilience to both the effects of adversity and of syndemics. Using these natural strengths and resiliencies may enhance HIV prevention.
- MSM are involved in: challenging social and societal norms and stigmatising and discriminatory behaviour; activism around issues such as HIV/AIDS, civil rights and equal marriage; care of others they personally know, as well as care of community and community involvement.

3. Split people into groups of 3–5.
4. Ask the groups to work on 2 tasks. First, ask them to discuss and provide a few examples of resilience displayed by MSM around the characteristics listed earlier and from their discussions about the negative messages. When they have done this, ask the groups to think of and describe an intervention that would enable these resilience characteristics to be further supported or developed for MSM. They have 15 mins for both tasks.
5. When the time has ended, ask the groups to feedback to the large group on their intervention ideas. When they have finished close the exercise.

Participant Worksheet: Knowing the Community you are working with

When I was Young

When I Was Young... I got the message that...
• Men should be…
• Men never…
• Men always…
• Sex between men was…
• Gay men are…
• Gay men should…
• Gay men never…
• Relationships between men are…
• I was left feeling…
• Most important source of these messages was…

Informal Exercise Title:

How to Improve Access, Services And Retention In Care

Study Area/Group:

Knowing the Community you are working with: Cultural Competence

Exercise Aim and/or Purpose:

Using the model of Cultural Competence to explore and examine how it could be integrated into work with and for gay and other MSM to help improve the linkage and retention in care, as well as quality of care, involving treatment for HIV/AIDS, STIs and Viral Hepatitis infections by knowing the community you are working with.

Expected exercise outcome:

Participants will have discussed and considered how Cultural Competence issues and strategies help build relevant interventions for MSM and why it's important to know the communities you are delivering services to.

Materials Required:

- PowerPoint (PPT) slides.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:

- ✓ Decide if you want to cover all four work areas;
  - Patient/Client/User Involvement
  - Peer Mentoring
  - Capacity Building
  - Community Engagement

  or concentrate on only 1 or 2 of them.
- ✓ Decide of the topics you'd like the groups to discuss such as PrEP, HIV/STI Testing, Counselling, Outreach Work etc. etc. One topic, covering all 4 areas, works best. A maximum of 2 of these topics is recommended.
- ✓ Identify concrete local examples of good practice (i.e. involving volunteers as Capacity Building) and bad practice (i.e. providing PrEP services without discussing with PrEP users what their wants and needs are) about your chosen areas if you are able.

Helpful hints for facilitators:

- You don't have to know everything to run the exercise; let the experience and knowledge of the participants inform their discussions.
- Prompt questions are provided in the exercise. You may also include questions about issues that affect you locally; for example, how working with minority or vulnerable groups like minority ethnic groups, migrant or MSM living with HIV could be improved using cultural awareness etc.

Method: (60 mins)

1. Begin the exercise by asking the group what (or if) they understand is meant by the term Cultural Competence. You can explain it as basically 'knowing the community you are working with'. This could involve examples such as community members' life experiences, the stigma and discrimination they may face, the language (including sexual language) used by that community.
2. Take the group through the PPT slide containing the information about the 'elements' around Cultural Competence; Awareness, Attitude, Knowledge and Skills. If you have run 'When I Was Young…' – which is concerned with awareness, attitudes and knowledge – you can link back to the discussions had in that exercise.

Cultural Competence has four main components: Awareness, Attitude, Knowledge and Skills.

Awareness:
It is important to examine our own values and beliefs in order to recognise any deep-seated prejudices and stereotypes that can create barriers for our learning, personal development and work we are involved in. Many of us have blind spots when it comes to our beliefs and values; diversity training/education can be useful for uncovering them.

Attitude:
Values and beliefs impact effectiveness across cultural issues because they show the extent to which we are open to differing views and opinions. The stronger we feel our beliefs and values, the more likely we will react emotionally when they collide with cultural differences.

Knowledge:
The more knowledge we have about people from different cultures and backgrounds, the more likely we are able to avoid making mistakes. Knowing how culture impacts problem solving, managing people, asking for help etc. can help us remain aware when we are in cross-cultural interactions.

Skills:
One can have the 'right' attitude, considerable self-awareness and a lot of knowledge about cultural differences, yet still lack the ability to effectively manage differences. If we have not learnt skills or have had little opportunity to practice, our knowledge and awareness are insufficient to avoid and manage cross-cultural landmines.

3. Inform the group that we will now be using those 'areas' and our thoughts about them as the basis for a discussion and development exercise around 4 areas involved in work with MSM:
   - Patient/client/user involvement
   - Peer Mentoring
   - Capacity Building
   - Community Engagement.
4. Split the group into smaller groups, 1 group per work area. If you are only asking them to discuss 1 or 2 issues it's best to have multiple small groups discussing the same issue. It could be useful to encourage participants who either work together or come from the same region to be in the same group together. If 'experts' in an issue are identified, it could be useful to allot them to their area of expertise.
5. The task for the groups is to consider 1 or 2 work areas you have decided upon, for example PrEP or HIV/STI testing services:
   - How could Community Engagement help provide or develop testing services?
   - How could Peer Mentoring help with PrEP?
   - How would Awareness, Attitude, Knowledge and Skills help with identifying how to build a better service using Patient/Client/User Involvement 'or' Peer Mentoring 'or' Capacity Building 'or' Community Engagement?
6. Ask the groups to note down their ideas for how to use those ideas and skills to improve the service, remembering to include things small as well as big (what small things can indicate a service would welcome you as a user of that service?)
7. The groups have 20 minutes for this task. Ask the groups to note down their thoughts as well as their idea for the initiative/intervention.

Facilitated Feedback:

When the allotted time is over, ask the groups in turn to feedback to the larger group their thoughts and ideas for their initiative/intervention.

- What work area did they discuss and what are their ideas?
- Are they already providing work or support on the work area they discussed?
- Is what they discussed different to the work happening at the moment?
- What are the changes they could make?
- If change would improve the work, what support do they think is needed for it?
- How do they consider their ability to influence or affect the work they do to involve culturally competent elements?

When all the groups have fed back, ask if anyone has anything to add or additional thoughts. When those have been dealt with, close the exercise.

Extra information:

It may be useful to refer to the following if the groups have any issues or difficulty with the exercise.

Cultural Competence in sexual health practice could be defined as:

- Creating a safe, non-judgemental environment.
- Considering, challenging and changing barriers to effective communication. (knowledge about common words used by gay and other MSM for sexual practices for example).
- Considered social-cultural history taking; gendering partnerships appropriately, acknowledging partnership and marriage status.
- Considered sexual history taking: the language used and the questions asked.
- Appropriate medical record documentation: who sees and has the right to see that documentation? Could this negatively affect the patient/client/user?

Online Support Materials

Knowing the Community you are working with (Cultural Competence)

How to improve access, services and retention in care.

"Cultural Competence refers to an ability to successfully negotiate cross-cultural differences in order to accomplish practical goals."[1]

The main goal may be:

- selfish, as in dating someone who speaks a different language
- socially responsible, as in trying to create a more inclusive society, or
- collaborative, as in working as a member of a cross-cultural team.

"Cultural Competence has four main components: Awareness, Attitude, Knowledge and Skills."[2] [3]

Awareness:

"It is important to examine our own values and beliefs in order to recognise any deep-seated prejudices and stereotypes that can create barriers for our learning, personal development and work we are involved in. Many of us have blind spots when it comes to our beliefs and values; diversity training/education can be useful for uncovering them.

Attitude:

Values and beliefs impact effectiveness across cultural issues because they show the extent to which we are open to differing views and opinions. The stronger we feel our beliefs and values, the more likely we will react emotionally when they collide with cultural differences.

Knowledge:

The more knowledge we have about people from different cultures and backgrounds, the more likely we are able to avoid making mistakes. Knowing how culture impacts problem-solving, managing people, asking for help etc. can help us remain aware when we are in cross-cultural interactions.

Skills:

One can have the 'right' attitude, considerable self-awareness and a lot of knowledge about cultural differences, yet still lack the ability to effectively manage differences. If we have not learnt skills or have had little opportunity to practice, our knowledge and awareness are insufficient to avoid and manage cross-cultural landmines.

It is not enough for the healthcare provider to merely say they respect a client's values, beliefs, and practices or to go through the motions of providing a culturally specific intervention that the literature reports is effective with a particular group.

Focusing on Cultural Competence not only raises awareness about why learning to manage differences can pay off for everyone, but also takes the primary focus off social engineering and squarely places it where it rightfully belongs – on making people more competent in their cross-cultural interactions. In an organisation, this means finding ways to close competency gaps so that people can work more productively together.

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[1]Billy Vaughn, 2007, High Impact Cultural Competence Consulting and Training DTUI Publications

[2]Definition of Cultural Competence based in part on Paul Pedersen's (1997) characterisation of multicultural counselling competences, What is Cultural Competence?

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Cultural Competence enables people to work more effectively in diverse organisations. It allows people to understand where their attitudes to certain people and behaviours have been built from and gives them an opportunity to understand how to change any attitudes that are causing problems.

Individuals and organisations can be culturally competent. A culturally competent healthcare organisation offers at least some of the following:

- A culturally diverse staff that reflects the community they work with.
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- Fairness in retention and promotion.
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On the individual level, Cultural Competence offers:

- Providers or translators who speak their clients' language/s including sign language.
- Cross-cultural skills.
- An ability to recover from inevitable cultural issues.
- Inclusive decision-making.
- Considerable knowledge about cross-cultural differences.
- Cross-cultural communication skills.
- Diversity management skills.
- Inclusive beliefs and values.
- Awareness of personal biases and stereotypes.
- Leadership commitment.

Notice that at the organisational level practices such as inclusive policies and retention are included in Cultural Competence. Cultural Competence reduces inequalities in promotion, retention, service delivery, healthcare delivery and health risks, as well as protecting organisations legally.

Beyond healthcare, Cultural Competence can lead to reductions in the number of cultural collisions that occur and the impact of those that inevitably surface.

Increasing Cultural Competence supports a productive, supportive workplace, which provides both legal protection and an innovation-led environment."

Creating and sustaining LGBTQI+ affirming LGBTQI+ services

"Individual/practitioner

Take initiative to examine one's own beliefs, attitudes and behaviours towards LGBTQI+ people, and LGBTQI+ clients in particular. Honestly decide to change through information, consultation, personal reflection and taking action.

Direct service level

Create daily procedures, tools and habits in order to deliver health services that are LGBTQI+ welcoming and respectful. Reinforce LGBTQI+ affirmative values in employee training, supervision and evaluation.

Agency level

Create agency-wide policies and practices that are non-discriminatory and openly welcome LGBTQI+ individuals.

Community level

Promote LGBTQI+ tolerance in one's community and speak out against intolerance or discrimination. Forge relationships with LGBTQI+ groups and resources by attending their events, meeting to discuss common interests, supporting their efforts and sharing resources.

Policy level

Support and advocate for LGBTQI+ positive legislation and candidates on local, state and national levels. Know the status of one's local and state non-discrimination statutes regarding their in/exclusion of sexual orientation and gender identity, support enforcement if they are included, and support their addition if they are not.

Cultural Competence in sexual health practice could be defined as:

- Creating a safe, non-judgemental environment.
- Considering, challenging and changing barriers to effective communication.
- Considered social-cultural history taking: gendering partnerships appropriately, acknowledging partnership and marriage status.
- Considered sexual history taking: the language used and the questions asked.
- Appropriate medical record documentation: who sees and has a right to see that documentation? Could this negatively affect the patient?"

Now that you have read through the information around Cultural Competence and knowing the community you are working with, it would be useful for you to consider these 4 areas involved in work with MSM and what you could suggest or do to improve the engagement of gay and other MSM with the work your service provides using:

- Patient Involvement
- Peer Mentoring
- Capacity Building
- Community Engagement

Taken from: **Rainbow Heights LGBT Project (United States)**

To help, you could consider these questions:

- How could Community Engagement help provide or develop testing services?
- How could Peer Mentoring help with PrEP?
- How would Awareness, Attitude, Knowledge and Skills help with identifying how to build a better service using Patient Involvement 'or' Peer Mentoring 'or' Capacity Building 'or' Community Engagement?
- Are you already providing work or support around any of the 4 issues outlined above?
- Is what they thought about different to the work happening at the moment? What are the changes you could make?
- If change would improve the work, what support do you think is needed for it to happen?
- How could you influence or affect the work they do to involve 'culturally competent' elements?

Informal Exercise Title:
Working across MSM Communities or Populations

Study Area/Group:
Knowing the communities you are working with: Cultural Competence

Exercise Aim and/or Purpose:
Helping to achieve better outcomes with MSM communities/populations across a range of issues, including, but not restricted to:

- sexual identity (how someone identifies who they are sexually attracted to)
- gender and gender identity (the gender assigned at birth and the gender identified as)
- language (any specific language including language relating to sexual acts)
- community (what is an MSM/Gay/Bi community and what does it mean to belong to it?)
- sexual practices (what sex gay and other MSM have)
- homophobia
- mental health (any issues that may affect someone's mental health related to being MSM)
- age (how a person's age may be viewed by others in the same community)
- ethnicity (the ethnic group a MSM identifies as and how this is viewed alongside his sexuality)
- religion (the religious view of same-sex relationships – sexual and emotional).

Expected exercise outcome:
Helping participants understand why certain topics and issues are important to the communities they work with. Understanding that 'culturally competent' responses to some of the main issues faced by MSM accessing services improves the work carried out with those communities.

Materials Required:

- PowerPoint (PPT) slides.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:

- Identify the topics you think are important to cover, from the listing in the exercise aim above and from your local situation.
- Read the E-Learning module of this exercise, which has a full description of culturally competent approaches to working with MSM communities, some of which is replicated in the Extra information section below.

Helpful hints for facilitators:

- It's useful to link discussions had during When I Was Young… to the discussion had during this exercise.
- It's probably best to do a maximum of 5 topics and group them to aid the discussions.

Method: (80 mins)

1. Introduce the subject to the group by defining Cultural Competence as 'knowing the communities we work with'. It's good to also acknowledge that we ourselves may be part of the community we work with and, although this gives some insight, no one has experienced everything.
2. Take the group through the information around the model of the four baseline areas of Cultural Competence (Awareness, Attitude, Knowledge and Skills), and remind or inform the group of how they work together to inform culturally competent decisions. Remind the group to use their own experiences and knowledge to inform these discussions, from outside this group and if you have run When I was Young… with the group use those conversations.

Cultural Competence has four main components: Awareness, Attitude, Knowledge and Skills.

Awareness:
It is important to examine our own values and beliefs in order to recognise any deep-seated prejudices and stereotypes that can create barriers for our learning, personal development and work we are involved in. Many of us have blind spots when it comes to our beliefs and values; diversity training/education can be useful for uncovering them.

Attitude:
Values and beliefs impact effectiveness across cultural issues because they show the extent to which we are open to differing views and opinions. The stronger we feel our beliefs and values, the more likely we will react emotionally when they collide with cultural differences.

Knowledge:
The more knowledge we have about people from different cultures and backgrounds, the more likely we are able to avoid making mistakes. Knowing how culture impacts problem solving, managing people, asking for help etc. can help us remain aware when we are in cross-cultural interactions.

Skills:
One can have the 'right' attitude, considerable self-awareness and a lot of knowledge about cultural differences, yet still lack the ability to effectively manage differences. If we have not learnt skills or have had little opportunity to practice, our knowledge and awareness are insufficient to avoid and manage cross-cultural landmines.

3. Split the group into smaller groups of 3–5 people.
4. Tell the groups that the task for each group is to work with some of the topics we are considering, thinking about how what we know or don't know about the culture of MSM informs and affects the work we do with and for them. There are a number of these topics already suggested for the groups to work with, although if you have identified any additional topics you feel are also important for the work you carry out locally, add them to this list. The topics have been put into suggested groupings as they can be somewhat linked together, but they do not have to be used this way if you only want the group to consider a few of the topics.
   The identified topics are:
   - sexual identity
   - gender
   - gender identity
   - sexual practices
   - language
   - community
   - age
   - homophobia
   - mental health
   - ethnicity
   - religion

And the suggested groupings of these are:

- sexual identity, gender, gender identity, and sexual practices
- language, community, and age
- homophobia and mental health
- ethnicity and religion.

The topics can also be mixed into other groupings or used singly depending on what you have identified as useful to discuss.

5. Share with the groups the topics you would like them to discuss.
6. The first task for the groups is to identify and bullet point what they feel are the appropriate activities or issues attached to the topic/s you are using. An appropriate example given under the Sexual Practices headline could be 'blow jobs/fellatio' and under the Language headline the example could be 'sexualised or gendered language'.
7. The second task for the groups is to consider what their own experience (both personal and professional) has been around these issues and then to generate a list of answers to the questions:
   - "What would you like to experience within or from a service around these issues?"
   - "How would you like to be treated?"
   - "What would you want or expect the service to know?"
8. Inform the groups they have 40 minutes for these tasks – 20 mins for each task. Make sure you help the groups keep to their times.
9. When this time has elapsed, call for the groups' attention and tell them you would now like them to link their thoughts and suggestions across each topic, giving 1 example for each topic of what they would consider best practice with the issues they are considering. For example, with gender identity, how do you ensure and check that you are gendering the person correctly? What happens when someone asks about a sexual practice that you can't recognise, like 'felching'? How can we make sure that MSM of all ages can access and feel welcome at our services?

   Tell the groups they have 30 mins for this task – 15 mins per issue and ask them to bullet point their suggestions.

Facilitated Feedback: (30 mins)

When the time has elapsed ask the groups to feedback one at a time on their 'best practice' ideas for their topics, pointing out any similarities between the approaches for different topics.

Extra information:

It may be useful to refer to the following if the groups have any issues or difficulty with the exercise.

Cultural Competence in sexual health practice could be defined as:

- Creating a safe, non-judgemental environment.
- Considering, challenging and changing barriers to effective communication (knowledge about common words used by Gay and other MSM for sexual practices for example).
- Considered social-cultural history taking; gendering partnerships appropriately, acknowledging partnership and marriage status.
- Considered sexual history taking: the language used and the questions asked.
- Appropriate medical record documentation: who sees and has the right to see that documentation? Could this negatively affect the patient/client?

Other things to consider could include:

- What is and what is not LGBTQI+ friendly language (e.g. using LGBTQI+ instead of homosexual) and asking when not sure ("What term do you prefer me to use?").
- Information about LGBTQI+ mental health issues e.g. Non-heterosexual orientations are not pathological, although it is true that some LGBTQI+ people do experience depression or anxiety due to the heterosexism they face.

- Current issues important to the LGBTQI+ population that affect clients such as, incidence of 'gay bashing', political elections, same-sex marriage/adoption discussions, and what is in the media.
- Updates on clinical information about therapy with LGBTQI+ clients.
- Pro-active discussions about disrespect or discrimination incidents as they happen; how to handle them, and/or de-briefing discussions of recent difficult situations.
- Information on local and other services and resources useful to staff and clients.
- Examination of common myths and stereotypes, their deleterious effects on all of us, and how to dismantle or resist them.
- Information about human sexual development, sexuality, sexual orientation and gender identity.
- Information about the legal, religious and social pressures used to enforce heterosexuality, and the negative impact those forces have on everyone.
- Strategies on how to address the needs of, and contain the behaviour of, staff and clients who use their negative biases, beliefs and assumptions to inflict physical, psychological, social and/or economic harm on themselves and/or others.

Adapted from Rainbow Heights LGBT Project.

Online support materials

Knowing the Community you are working with (Cultural Competence)

Working across MSM Communities or Populations

"Cultural Competence refers to an ability to successfully negotiate cross-cultural differences in order to accomplish practical goals."[1]

The main goal may be:

- selfish, as in dating someone who speaks a different language
- socially responsible, as in trying to create a more inclusive society, or
- collaborative, as in working as a member of a cross-cultural team.

"Cultural competence has four main components: Awareness, Attitude, Knowledge and Skills.[2] [3]

Awareness:

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It is not enough for the healthcare provider to merely say they respect a client's values, beliefs, and practices or to go through the motions of providing a culturally specific intervention that the literature reports is effective with a particular group.

Focussing on Cultural Competence not only raises awareness about why learning to manage differences can pay off for everyone, but also takes the primary focus off social engineering and squarely places it where it rightfully belongs – on making people more competent in their cross-cultural interactions. In an organisation, this means finding ways to close competency gaps so that people can work more productively together.

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Working with Gay and other MSM Communities.

"Sexual orientation

- Is distinct from sexual behaviour. One's sexual behaviour may not match one's orientation e.g. celibacy, experimentation or prostitution.
- Is an inherent part of a person's core identity. Our society views heterosexuality as so normative that it is rarely even thought of as a sexual orientation, so that most heterosexuals experience their 'orientation' as a 'given', requiring little if any questioning or conscious thought. In contrast, much of our society views lesbian, gay and bisexual orientation as abnormal (and even immoral) causing many LGBTQI+ people to consciously think about and/or question this natural part of their core identity in ways that heterosexuals do not.
- Reflects the complexity of factors that determine to whom one is sexually attracted and with whom one falls in love. One's sexual orientation is not chosen but rather discovered as one moves from infancy through old age.
- Is not a 'lifestyle' (gay, lesbian and bisexual people are as varied as heterosexuals in the types of lives they lead) but a deep part of one's self. It can be something one becomes aware of gradually or has always been known.
- Is different from gender identity.
- Is a scientific mystery. Sexual orientation is a complex mix of biology, psychology, culture and many other factors. While there have been many theories and studies, we do not currently know why or how one person ends up identifying as heterosexual while another is bisexual or gay or lesbian.
- Is discriminate. Just as heterosexuals are not attracted to everyone of the other gender, lesbians and gay men are not attracted to everyone of the same gender nor are bisexuals attracted to everyone of 'both' genders.

- Is varied. Some people do not identify with the labels of straight, gay, lesbian, bi or queer. They may choose not to label themselves, or may have different ideas or terms. One person's experience of a given orientation may be quite different from another's experience. Sexual orientation can also grow and change over the lifespan.
- Is currently referred to as lesbian, gay, bisexual or heterosexual in common speech/language. 'Homosexual' is not commonly used in LGBTQI+ positive settings. Historically the word came into common usage/use as a psychiatric term of pathology, when 'homosexuality' was considered a mental illness. Therefore, its negative and judgemental connotations have led to it being disfavoured/disliked by LGBTQI+ communities.

Gender identity

- Refers to one's inner sense of being female, male, both or neither, which may or may not correspond with their biological gender.
- 'Transgender' is often used as an umbrella term to encompass a range of gender identities including; transgender, intersex, androgyne/androgynous, etc.
- People who identify as 'transgender' are as diverse as people whose biological or assigned gender coincides with their personal inner sense of gender identity.

Gender identity refers to one's inner sense of being female, male, both or neither. For many people this inner sense corresponds with their biological gender. However, this is not always the case. A person's biological sex can be defined in various ways (chromosomes, hormone patterns, internal reproductive organs, external genitalia and secondary sex characteristics) and these often, but not always, concur with each other. When one's biological or assigned gender does not coincide with one's personal inner sense of gender identity, the person may identify as transgender (or trans).

Transgender is often used as an umbrella term to encompass a range of gender identities. It may include transgender, intersex, androgyne/androgynous, etc. People who identify as transgender are as diverse as people whose biological or assigned gender coincides with their personal sense of gender identity.

Gender Identity refers to the gender one experiences oneself to be – an individual personal identity. Gender Identity is entirely different from sexual orientation – the interpersonal concept of the gender(s) of people one is attracted to or loves. Thus a given individual may embody any combination of gender identity (e.g. male, female, other genders) and sexual orientation (e.g. gay, lesbian, bisexual, heterosexual etc.) For example, it is incorrect to assume that all transgender people are gay or bisexual (although some are) or that lesbians all want to be men (although some may) – both are common myths borne from the confusion of gender identity and sexual orientation.

As a result of years of being misunderstood and mistreated, many transgender people have developed fear and/or mistrust of medical and mental health providers. For example, without their knowledge (or consent) many intersex people had 'corrective' surgery as children in order to 'fit' into one gender category or another. Another example: trans people often go through harsh medical and psychiatric assessments, and must be diagnosed with Gender Identity Disorder in order to receive hormonal and/or surgical procedures to change their bodies to more closely correspond to their gender identities. Such experiences tend to foster distrust or ambivalence about healthcare providers.

How one identifies one's own gender and sexual orientation are personal and complex matters. It is essential for mental health providers to be supportive and considerate of each individual, and to avoid conflating sexual orientation and gender identity. It is also important that providers avoid (covertly or overtly) pressuring people to label themselves in any particular direction. Societal, family, personal assumptions and judgements about sexual orientation and gender identity sometimes cause profound internal conflicts. Providers need to be cautious about aligning themselves with any 'side' of such conflicts. People and sexuality are always more nuanced and complex than any label.

'Queer'

In recent years, the term 'queer' has become commonly used by some LGBTQI+ people as a positive identity label. Individuals may call themselves queer, or refer to a 'queer community'. There are university based 'Queer Studies Programmes' in some places. At the same time, it is also still used as a violent epithet by those that are hostile to LGBTQI+ people.

In general, the reclaimed Queer is used:

- As a flexible umbrella term by some people to encompass a wide range of identities that would otherwise fall under LGBTQI+, transgender and 'not conventionally heterosexual'.
- To be more widely encompassing than any one of the other identity terms.
- To deliberately reclaim a hurtful word.
- More often by younger people, with whom the more firmly bounded categories of gay vs bisexual vs heterosexual (or male vs female vs intersex) do not resonate as well.
- Some older LGBTQI+ people cannot abide the use of the word because of their close associations between it and having experienced hatred.

Queer is also an 'in-house' word that may be used positively by queer people among themselves. Its use by someone outside the LGBTQI+ community is often experienced as hostility. Therefore, mental health and other health providers are wise to be cautious about using the word 'queer' unless a person or group clearly prefer it.

Similarly, other commonly insulting words such as 'dyke', 'fag' or 'tranny' are sometimes used 'in-house' in teasing or ironically affectionate ways among LGBTQI+ people. This does not mean that this language is appropriate for non-LGBTQI+ people to use casually.

Conversely, clinical-sounding words like homosexual and sexual minority may be experienced as cold or marginalising by LGBTQI+ individuals.

Ask about the language people feel comfortable hearing and would like you to use.

Staff training around Cultural Competence and working with gay and other MSM communities

Staff training is central/essential to achieve systemic change. Trainings, seminars, handouts, briefings and refreshers could include:

- What is and what is not LGBTQI+ friendly language (e.g. using LGBTQI+ instead of homosexual) and asking when not sure ("What term do you prefer me to use?").
- Information about LGBTQI+ mental health issues e.g. Non-heterosexual orientations are not pathological, although it is true that some LGBTQI+ people do experience depression or anxiety due to the heterosexism they face.
- Current issues important to the LGBTQI+ population that affects clients such as, incidence of 'gay bashing', political elections, same-sex marriage/adoption discussions, and what is in the media.
- Updates on clinical information about therapy with LGBTQI+ clients.
- Pro-active discussions about disrespect or discrimination incidents as they happen; how to handle them, and/or de-briefing discussions of recent difficult situations.
- Information on local and other services and resources useful to staff and clients.
- Examination of common myths and stereotypes, their deleterious effects on all of us, and how to dismantle or resist them.
- Information about human sexual development, sexuality, sexual orientation and gender identity.

- Information about the legal, religious and social pressures used to enforce heterosexuality, and the negative impact those forces have on everyone.
- Strategies on how to address the needs of and contain the behaviour of staff and clients who use their negative biases, beliefs and assumptions to inflict physical, psychological, social and/or economic harm on themselves and/or others.

It is also important to incorporate LGBTQI+ Awareness into all education and training programmes. For example, programmes on any topic should not assume heterosexuality among all staff or clients, should occasionally include LGBTQI+ people of various backgrounds in examples, and case studies and illustrations should acknowledge same-gender relationships.

Problem solving

Because LGBTQI+ bias occurs in organisations, problem solving should be explored. Daily practices that incorporate knowledge of LGBTQI+ people and issues result in an effective process that leads to constructive resolutions. Having policies and procedures in place before an incident occurs simplifies problem solving and makes it more effective. Examples include:

- Respectful resolution of problems creates enormous good will. Most LGBTQI+ people know that ignorance and bias are impossible to completely avoid, but they look closely at how such incidents are handled.
- Staff in all roles should use the same management tools to intervene when unfriendly behaviour towards LGBTQI+ clients or staff arises as they would towards any other clients or staff. For example: "We have a rule about no disrespectful language. That comment was disrespectful towards gay/LGBTQI+ people, so it's not acceptable here."
- Anti-LGBTQI+ comments or behaviours from other clients are often a problem for LGBTQI+ people attending services where clients spend time together e.g. waiting areas, groups, residential, inpatient and day programmes.
- Policies must apply equitably to lesbian, gay, bisexual, trans and heterosexual clients/users/staff such as the rules around relationships, visitors, displays of affection.

Common lapses in staff behaviour

It is common for staff in various roles to:

- Be unprepared and/or unable to have in-depth discussions with clients around/about gender and/or sexuality.
- Absorb and mistakenly apply stereotypes and prejudices in their work.
- Ignore that LGBTQI+ people are diverse regarding gender, race, culture, class, disabilities etc. and that all of these interact with sexual orientation and gender identities.
- Confuse sexual orientation and gender identity.
- Assume/believe that a person's LGBTQI+ identity is a symptom of mental illness, a mental illness per se, and/or as indicators of sub par development.
- Assume that sexual orientation/gender identity is a core problem for LGBTQI+ clients, but never presume so for heterosexual clients.
- Believe that being gay, lesbian or bisexual is 'no big deal' and that a client that wants to talk about it is using it to shy away from their 'real' issues.
- Constrain a client's exploration and self-discovery by jumping to their own conclusions about what the client's sexual orientation 'really is' or 'should be' and impressing this view on the client.
- Accept prejudices and misinformation, leading clinicians to advocate interventions designed to change the client's LGBTQI+ identity e.g. conversion or reparative 'therapies' which have been discredited by the major professional psychiatric organisations.
- Hold narrow views of how one 'should' be LGBTQI+, and overtly or covertly pressure clients to conform.

There are as many ways of being LGBTQI+ as there are of being heterosexual.

- Use heterosexual patterns as standards for healthy personal and relationship functioning, thereby perceiving LGBTQI+ people and relationships as de facto less healthy where they differ.
- Make unwarranted assumptions about a person's values or lifestyle based on myths or stereotypes about LGBTQI+ people.
- Positively stereotype LGBTQI+ people out of a fear of being called homophobic or due to romanticised views, which may pressure clients to hide their stress or pathology, and lead therapists/staff members to shy away from clients' problems.
- Inquire about clients' sexual lives and histories voyeuristically, as an erotic or exotic subject of education or titillation for themselves, rather than as being relevant to clients' issues.

Developing LGBTQI+ affirming provider-client relationships

Providers may want to know:

- That culturally competent practice (including LGBTQI+ affirmative) is an ongoing process, not something that is achieved and is then complete.
- About common prejudices, many of which come from historical and invalid assumptions within the mental health and other health professions and society at large.
- That LGBTQI+ affirmative staff need not be LGBTQI+ themselves to be well-informed and avoid heterosexism.
- That our society is heterosexist and heteronormative.
- That people, human sexuality and identities are much more complex than any of the labels we use.
- That even among staff and clients of similar identities, there may be misunderstandings and friction about LGBTQI+ and other issues, which can be food for fruitful discussions.
- That a LGBTQI+ identified or LGBTQI+ affirmative health worker may not be a good match for an LGBTQI+ client in other ways.
- That mental health and other health providers who are LGBTQI+ may be able to draw on this community in working with LGBTQI+ clients but may also face challenges such as higher expectations, conflicting views or identities, assumed agreement and common prejudices in some LGBTQI+ communities about each other.
- That due to the small size of many LGBTQI+ communities, an LGBTQI+ provider and an LGBTQI+ client may have overlapping social or cultural circles, and may be acquainted with more of each other's associates than an interaction between people with differing identities or one in which both are heterosexual.
- Of the tendency of some heathcare providers (and some consumers) to view LGBTQI+ identities as beleaguered or tragic because of the challenges of living as LGBTQI+ and thereby ignore or discount the positive aspects of these identities.

Providers may want to be aware that many people bring the following to their interactions:

- The effects of their interactions with previous health providers.
- Hyper-vigilance due to finely tuned self-protective abilities to read subtle signs of other's reactions to people's sexual orientations and/or gender identities. Such skills help people avoid or prepare for embarrassing or dangerous interactions.
- Wariness until they feel assured the clinician is both LGBTQI+ affirmative and able to work with them in other areas (focal problems, culture, class etc.)
- Reluctance to let a health provider know they are LGBTQI+ to avoid possible rejection or intolerant reactions, even if they are comfortable with their identity.

- Distress about the discord their identity creates with family members who are not LGBTQI+ affirmative, especially if: they rely on family support; come from a cultural or personal background that emphasises family harmony, honour, and/or filial loyalty and fear; they have experienced family conflict around other issues.
- A sense of isolation and a lack of comfortable community or social network; particularly if they are bisexual, transgender, people of colour, have other stigmatised 'differences' and/or don't live near a large metropolitan area.
- Conflict or distress about their sexual orientation, due to misinformation, cultural or religious values and/or internalised negative messages.
- A need to work actively to develop a positive identity. Heterosexuals usually do not have to engage so deliberately in their identity development, because they seldom encounter challenges to it.
- Concerns about stressors resulting from LGBTQI+ prejudice e.g. abuse, losing a job etc.
- A need to address substance abuse that may or may not be tied to social isolation, stress or personal conflict related to being LGBTQI+.
- Pressures and joys unique to same gender relationships in addition to all those common to all relationships. Pressures include a lack of social sanction, lack of relationship models, pathologisation of relationships and discrimination. Joys include deep degrees of friendship and flexibility, egalitarian roles, creative relationship models, profound intimacy and sexual communication.

Suggested strategies to stimulate individual and institutional change.

Personal/individual

- Clarify your own values, priorities and intentions. Passion is powerful.
- Focus on the fact that what you are seeking is a more just and humane world. You are in the right to be trying to change things.
- Look for and take advantage of everyday small opportunities to effect change. They add up and don't require as much risk.
- Accept where things are now, and reflect on where you can make changes and where you cannot. Channel your energy. "What can I do in this situation, or to move closer to this distant goal?"
- Don't shy away from failure; examine it and see what can be learnt. Be compassionate with yourself and with those that tried with you.
- Take responsibility for being personally offended at injustice when you see it happen, even if you are not a member of the group being mistreated at that moment.
- If you encounter negative reactions or hostility, acknowledge your feelings rather than deny them. Try not to retaliate but rather channel your anger or hurt into constructive actions.
- Recognise and conscientiously use the power sources and privileges you do have.
- Don't bang your head too much – acknowledge your own and the situation's limits.
- Be willing to step out of your comfort zone for the sake of change.
- Don't presume the worst – it rarely happens. Talk yourself out of 'catastrophising', and be alert to any real risks.
- Ask "What are the costs of not acting?" To one's self, conscience and others?
- Show acceptance to grow acceptance.
- Do what you need to strengthen and encourage yourself.

Interpersonal

- Find like-minded people and work together to help and support each other's efforts.
- Address problems when they are small rather than waiting for them to grow or explode.
- Hold others responsible for insensitive or unjust things they say or do, but be kind in doing so.
- Stay open to new ideas, strategies and creativity. Looking at a problem from different angles, trying different paths to the goal.
- Talk to someone outside the situation you are working on for a fresh perspective.
- Marshal resources: gather the information, allies and resources you need.
- Use a specific example (or one person's story) to show others the impact of the problem and the importance of the changes you are suggesting or working for.
- Think ahead of time about how you will give feedback or interrupt a negative incident.
- When attempting change that has real risks, talk to others about them ahead of time, especially those who may be implicated or end up involved.

Organisational

- Tie desired changes to your organisation's Mission Statement and Policies.
- Cultivate the involvement and endorsement of supervisors/managers and Board of Directors to make the changes agency wide.
- Consider hypothetical problems and make response/resolution plans before they actually happen. Examine standing policies and procedures for gaps.
- When a negative incident happens, address the acute situation at hand and also use it as an opportunity to later reflect on how it was able to happen, what could prevent it in the future, and whether the acute response was optimal.
- Examine what has worked or not in the past in similar change efforts. Consider how these lessons may apply to your current situation, or may be irrelevant.
- Try to institutionalise whatever change you are working for, get it encoded in your agency's policies and usual procedures so that it becomes 'the usual'.
- Provide staff with the information, training, coaching and supervision that encourages the skills you want to foster in your group/agency.
- Talk to other practices/agencies similar to yours regarding their efforts in this area. This gives you context, comparisons and can also show others who are sceptical that you are not the only person/agency who cares about LGBTQI+ issues. It can also generate new ideas, networks and resources.
- Ask clients and staff for feedback on changes.
- Join forces with self-help and advocacy groups wherever you can to share the resources, share work and share the joys.

Creating and sustaining LGBTQI+ affirming LGBTQI+ services

Individual/practitioner

Take initiative to examine one's own beliefs, attitudes and behaviours towards LGBTQI+ people, and LGBTQI+ clients in particular. Honestly decide to change through information, consultation, personal reflection and taking action.

Direct service level

Create daily procedures, tools and habits in order to deliver health services that are LGBTQI+ welcoming and respectful. Reinforce LGBTQI+ affirmative values in employee training, supervision and evaluation.

Agency level

Create agency-wide policies and practices that are non-discriminatory and openly welcome LGBTQI+ individuals.

Community level

Promote LGBTQI+ tolerance in one's community and speak out against intolerance or discrimination. Forge relationships with LGBTQI+ groups and resources by attending their events, meeting to discuss common interests, supporting their efforts and sharing resources.

Policy level

Support and advocate for LGBTQI+ positive legislation and candidates on local, state and national levels. Know the status of one's local and state non-discrimination statutes regarding their in/exclusion of sexual orientation and gender identity, support enforcement if they are included, and support their addition if they are not.

Cultural Competence in sexual health practice could be defined as:

- Creating a safe, non-judgemental environment.
- Considering, challenging and changing barriers to effective communication.
- Considered social–cultural history taking: gendering partnerships appropriately, acknowledging partnership and marriage status.
- Considered sexual history taking: the language used and the questions asked.
- Appropriate medical record documentation: who sees and has a right to see that documentation? Could this negatively affect the patient?"

Taken from: **Rainbow Heights LGBT Project (United States)**

Now you have read through that information, think about any changes you or your service could make to be more effective and inclusive of gay and other MSM around issues such as:

- Sexual identity (how do they identify?)
- Gender and gender identity (what gender do they identify as?)
- Sexual practices (what are gay and other MSM doing sexually?)
- Language (what language, especially around sexual practice are MSM using that you may not know?)
- Community (is there a 'community'? Are your users a part of it?)
- Age (do they experience problems around feeling 'too old' to be attractive?)
- Homophobia (how are they treated everyday? What is being said in the media about LGBTQI+/ MSM people?)
- Mental health (how are the issues they are facing affecting their mental health?)
- Ethnicity (are they in a minority group in your region? How does this affect their economic status and access to healthcare? How are they viewed by their community as a 'gay man' or MSM?)
- Religion (is religion important to them? How are they linked into the religious community they belong to and is it affecting them as a MSM?)

Consider the conversations you've already had, the gay and other MSM you've seen and worked with and see if you can identify any changes that you or the service you belong to could reach out to MSM who may be dealing with stigma and discrimination.

2.1.3 Challenging Stigma and Discrimination

Informal Exercise Title:
Vulnerable MSM groups and Their Sexual Health Needs

Study Area/Group:
Challenging Stigma and Discrimination

Exercise Aim and/or Purpose:
To be able to meet the specific needs of minority groups of MSM. The subgroups already identified as useful to discuss include, but are not restricted to:

- MSM youth
- MSM migrants
- Non Gay/Bi identified MSM
- MSM from ethnic or cultural minority groups
- Trans MSM
- MSM living with HIV
- MSM who do sex work
- MSM with drug (particularly ChemSex) and alcohol dependency needs
- MSM in Prison settings

This exercise allows participants to explore and examine the sexual health needs of vulnerable groups of MSM.

Expected exercise outcome:
Participants will have examined the topics faced by vulnerable groups of MSM and discussed and developed initiative/s that could lessen the negative impacts of the issues identified.

Materials Required:

- PowerPoint (PPT) slides.
- ASTOR sheets – one for each participant group.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:

- Decide which groups of MSM you would like to focus on, from the listing in the exercise aim. You may find it useful to identify information about vulnerable groups at your national or local level to help with the exercise.
- If you feel it could help you, read some of the ECDC data on vulnerable groups of MSM. The links are in the E-Learning module.

Helpful hints for facilitators:

- Don't get too ambitious and choose too many groups for the group to discuss; be informed by the Needs Assessment and the groups identified by the first discussions in the exercise.
- If you intend to discuss the 'MSM living with HIV' subgroup please consider also providing the exercise on 'Building Awareness on the Drivers of Stigma about HIV/AIDS and Sexuality' in your training session.
- It would be useful for you to familiarise yourself again with the data on MSM from EMIS 2010 and 2017.

Method: (60 mins)

1. Introduce the group to the subject and ask them:
   - "What do we mean when we say 'vulnerable groups' of MSM?"
   - "Can you identify any MSM groups you think of as 'vulnerable'?"
2. Note the subgroups identified on the flipchart.
3. Tell the group they are now going to consider some of those subgroups of MSM and think about what their sexual health needs might be. Mark out the subgroups on the board the group have just identified that link to the list you have decided upon, adding any missing subgroups so that you have the full list that you want them to discuss. You will need to identify at least 3 groups for discussion to allow a range of conversations to happen.
4. The subgroups already identified as useful to discuss include, but are not restricted to:
   - MSM Youth
   - MSM Migrants
   - Non Gay/Bi identified MSM
   - MSM from ethnic or cultural minority groups
   - Trans MSM
   - MSM living with HIV
   - MSM who do sexwork
   - MSM with Drug (particularly ChemSex) and alcohol dependency needs
   - MSM in Prison settings
5. Split the group into smaller groups of 3–5 people.
6. Each smaller group's task is to focus on the vulnerable subgroups they have chosen or been given and identify and discuss the probable/possible sexual health related issues faced by the subgroup. Useful prompt questions may be;
   - What are those issues and why could the subgroups be affected by them?
   - How are they affected – what effect do those issues have upon them?
   - What is the difference for these subgroups if they are living with HIV or face another issue such as being deaf or a wheelchair user? What are those differences?
7. Tell the smaller groups they have 30 mins for this task. Ask them to capture their discussions as bullet points on one piece of flipchart paper for each subgroup they discuss.
8. When the 30 mins is up, ask the smaller groups to put their flipchart sheets up on the wall of the training room. Ask them to take the larger group through their lists of issues faced by the MSM subgroups they focussed on. Give each group about 5 mins to do this.
9. Now the smaller groups have a list of issues faced by the MSM subgroups up, tell them their task is to develop interventions for a subgroup they focussed on around their sexual health; it could be working directly with that group, it could be working in a setting they use or occupy.
10. They are to develop their intervention using an ASTOR sheet, so take the group through the PPT slide outlining what an ASTOR is and then give each group their own ASTOR.

An ASTOR is a simple and useful project-building tool that helps identify some of the key elements you need for an intervention. It breaks down as:

AIM: What are you trying to do?

SETTING: Where are you doing what you are trying to do?

TARGET: Who is the intervention for?

OBJECTIVES: What are the steps needed to reach the AIM?

RESOURCES: What do you need to make the intervention happen?
For example: money, staff time, office space, any other resources?

11. Tell the smaller groups it's best to work on another sheet of flip chart paper as they roughly work out what they want to do during their discussion, and then transfer their decisions to the ASTOR sheet. Tell them they have 30 minutes for this task.

Facilitated Feedback:

- Facilitator asks each group to take turns to feed back on the subgroup they focussed on.
- Ask the groups to feedback on the ASTOR to outline their intervention and any additional thoughts they have as to how the intervention may work – it's intended outcome. What could it do?
- When all smaller groups have fed back, ask the larger group about the experience of developing these interventions:
  - How was it?
  - How does their intervention affect the sexual health needs of the subgroup they worked on?
  - Did they think the discussion helped identify the skills and approach they used to develop the initiative? Are they easy to use across the groups they all worked on?
  - Did the experience of developing an intervention for the subgroup they worked on give them any ideas or thoughts on interventions for other subgroups of MSM?
- If they are interested, refer the group to the E-Learning module for further information about vulnerable subgroups of MSM and links to data. Close the exercise.

Participant Worksheet: Challenging Stigma – Vulnerable Groups of MSM

ASTOR

Aim: what are you trying to do?	
Setting: where are you doing it?	
Target: who is the intervention for?	
Objectives: what are the steps needed to reach the aim?	
Resources: what do you need to make the intervention happen? For example: money, staff time, office space, any other resources?	

Informal Exercise Title:

Building Awareness of the Drivers of Stigma About HIV/AIDS and Sexuality.

Study Area/Group:

Challenging Stigma and Discrimination

Exercise Aim and/or Purpose:

To build knowledge on the drivers and impact of stigma around HIV/AIDS, STIs or sexuality on sexual health. This exercise allows participants to explore and examine the drivers of stigma around sexual orientation and HIV/AIDS.

Expected exercise outcome:

Participants will have thought through and become more aware of the drivers of stigma related to both sexuality and HIV/AIDS both within the MSM population and wider society. This exercise allows participants to examine the steps required to provide appropriate and acceptable services for gay and other MSM.

Materials Required:

- Printed 'issues' sheet. A3 size paper would be best, or you could replicate the sheets on flipchart paper.
- Flipchart easel, pad and pens
- Paper and pens for participants

Facilitator Preparation:

- Think about the three areas:
  - Lack of knowledge
  - Lack of visibility
  - Social norms

  and how they could affect the stigma and discrimination around HIV/AIDS and sexuality. For example, with lack of visibility, if you never see a 'gay' person on TV or in films it is easier to think they don't exist.

Helpful hints for facilitators:

- Think about the stigmatising statements you have heard or maybe even done work around, to help with the prompting of the group. When they are doing the exercise, encourage them to think about the things they've heard.

Method: (45 mins)

1. Introduce group to the subject and ask them to get into pairs or 3s and consider the question:
   - "How is HIV, living with HIV or being a man who has sex with men stigmatised?"
2. If you think it could be useful, capture some of the answers given on the flipchart. Take about 5 mins for this brainstorm.
3. When the brainstorm has completed, split the large group into 3 smaller groups. If there are too many participants to make the small groups workable, split the large group into 6 groups, and 2 groups will consider the same 'driver of stigma'.
4. Each group will consider one of the drivers of stigma we are concerned with:
   - Lack of Knowledge
   - Lack of Visibility
   - Social Norms related to Sex, Sexuality and Gender Identity.
5. The groups are to consider and note their thoughts on these drivers of stigma.
   Some useful prompt questions are:
   - What do we mean by a lack of knowledge? What are the knowledge gaps and how are they reflected in the stigmatisation of HIV, sexuality and gender identity?
   - What do we mean by a lack of visibility around HIV, sexuality and gender identity and how could this affect stigma and discrimination about them?
   - What are 'social norms' and how are these 'norms' around sex, sexuality and gender identity reflected in the stigma MSM experience?
6. If the groups need it, you can prompt them with some examples of the drivers of stigma such as;
   HIV:
   - Fear of becoming infected
   - Fear of death
   - Sexual taboos about anal sex
   - Being identified as gay/dirty/infected
   - Being a 'bad representation' of the LGBTQI+ community by being positive
   - Being a 'slut'.

   LGBTQI+:
   - Being considered 'unnatural'
   - There has been/is no representation of LGBTQI+ people
   - Challenging people's expectation of who you are
   - Religion/s and religious dogma
   - Being accused of having sex that won't lead to pregnancy or having children.
7. The groups are to consider these drivers for both HIV/AIDS and sexual orientation, and also to consider them in the context of both the MSM population/LGBTQI+ Community and the wider society.
8. Give each group enough copies of the issue sheet (see below) for them to complete. The examples filled out below are for information only; the groups will get clean sheets to fill out.

Issue: Lack of knowledge

HIV/AIDS		Sexuality	
MSM population	'Infectious slut'	MSM population	'Too camp'
	Example 2		Example 2
	Example 3 etc. etc.		Example 3 etc. etc.
Society	'Taboo around anal sex between men'	Society	'Unnatural'
	Example 2		Example 2
	Example 3 etc. etc.		Example 3 etc. etc.

9. Inform the groups they have 30 minutes for this task.

Facilitated Feedback: (30 mins)

- When the time has elapsed call the groups back into a large group. Each group will feedback on their discussion and share their 'final presentation' sheet with the larger group. After each group has completed their presentation, ask the other groups if they have any examples of 'drivers of stigma' they want to give.
- If there are 2 groups per driver, ask them to join up and build their 'final presentation sheet' together, 10 minutes before the end of the allotted time.
- When the groups have finished giving their feedback close the exercise.

Participant Worksheet: Challenging Stigma and Discrimination – Building Awareness of the Drivers of Stigma

<table>
<tr><td colspan="4">Issue:</td></tr>
<tr><td colspan="2">HIV/AIDS</td><td colspan="2">Sexuality</td></tr>
<tr><td rowspan="3">MSM population</td><td></td><td rowspan="3">MSM population</td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td rowspan="3">Society</td><td></td><td rowspan="3">Society</td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
</table>

Informal Exercise Title:

Creating a Non-Judgemental Service or Environment for Gay and other MSM

Study Area/Group:

Challenging Stigma and Discrimination

Exercise Aim and/or Purpose:

This exercise allows participants to examine the steps required to provide appropriate and acceptable services for gay and other MSM. Participants examine how to be more competent at engaging individuals or organisations on challenging HIV stigma and homophobia and to be able to use Cultural Competence with MSM populations to achieve better outcomes.

Expected exercise outcome:

Participants will have explored and assessed the steps needed in creating non-judgemental services and have a better idea of how to effect the changes they identify.

Materials Required:

- PowerPoint (PPT) slides.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:

- Read the PPT slides about the definition of stigma and the steps to challenging it.
- This is not an exercise to be negative about non-community based services, but to examine how all services could improve.
- Consider your own services as well as other local services when looking for examples to prompt/inform participants about.
- Think of both good and bad examples to use.
- Look at practical issues as well as policy level issues. Consider the information provided about the service as well as access to that service.
- Consider all aspects of non-discriminatory practice. Even simple things are important, like 'are the opening hours or times of groups appropriate for the people you are working with?'
- There are 2 methods outlined below; both have the same process in Facilitated Feedback. The second method is only to be used if you are providing training within your own service and all participants are from that same service. You will also need to read and understand all your service's policies and practical steps around anti-discriminatory practice.

Helpful hints for facilitators:

- Remember you don't have to have all the answers; let the knowledge and experience of the group members inform the discussions, helping and prompting if necessary.

Method One: (40 mins)

1. Introduce the group to the subject and ask the group:
   - "What do you think of when we talk about non-judgemental services?"

   and capture some of their thoughts on the flipchart if you think it could be useful. Only take about 5 mins (a maximum of 10) for this; it's a quick brainstorm not a discussion.
2. When that has been completed, share the information on the suggested steps to creating a non-judgemental service contained on the PPT slides.

Defining Stigma

- UNAIDS defines stigma and discrimination as: "…a 'process of devaluation' of people living with or associated with HIV and AIDS… Discrimination follows stigma and is the unfair or unjust treatment of an individual based on… perceived HIV status."

Reducing stigma in health facilities

- Increase awareness of what stigma is and the benefits of reducing it
- Fears and misconceptions around HIV transmission must be addressed
- Understand and confront the association of HIV and AIDS with assumed 'immoral' or 'improper' behaviours
- Develop and routinely monitor clear guidance or specific policies to challenge discriminatory behaviour

3. It is useful to link this to the four points around Cultural Competence, (Awareness, Attitude, Knowledge and Skills) by showing them the PPT slide and link the discussion from the 'When I Was Young… ' exercise, with creating non-judgemental environments/services if you ran the exercise with the group.

4.

Cultural Competence has four main components: Awareness, Attitude, Knowledge and Skills.

Awareness:
It is important to examine our own values and beliefs in order to recognise any deep-seated prejudices and stereotypes that can create barriers for our learning, personal development and work we are involved in. Many of us have blind spots when it comes to our beliefs and values; diversity training/education can be useful for uncovering them.

Attitude:
Values and beliefs impact effectiveness across cultural issues because they show the extent to which we are open to differing views and opinions. The stronger we feel our beliefs and values, the more likely we will react emotionally when they collide with cultural differences.

Knowledge:
The more knowledge we have about people from different cultures and backgrounds, the more likely we are able to avoid making mistakes. Knowing how culture impacts problem solving, managing people, asking for help etc. can help us remain aware when we are in cross-cultural interactions.

Skills:
One can have the 'right' attitude, considerable self-awareness and a lot of knowledge about cultural differences, yet still lack the ability to effectively manage differences. If we have not learnt skills or have had little opportunity to practice, our knowledge and awareness are insufficient to avoid and manage cross-cultural landmines.

5. Split the group into smaller groups of 3–5 members.

6. The task for the groups is to use a service or environment used in work with MSM that's either: part of their own services; or another community or clinical service that they know of. They are to consider any changes to that service that could be made using the information from the PPT slides and under the headings of Awareness, Attitude, Knowledge and Skills. Prompt questions are:
   - What would those changes look like? Think about small changes that could be made as well as large ones.
   - Who could you approach about making those changes and how could you build support both for themselves and for their suggested changes?
   - How could you ensure the services are 'culturally competent'? (work for the people using them).
   - How could you use networks that they could build (like the ones they are building at this training) or are already a part of, to support each other?
   - What would a 'perfect' service look like? Understand that there isn't a perfect service anywhere; this is about looking at how to be as good as a service can be.
7. Tell the groups they have 20 minutes for this task.

Method Two: (40 mins: only to be used in your own service)

Run the session as in Method One up to point 5.

5. The task for the groups is to use their service or environment used in work with MSM. They are to consider any changes to the service that could be made using the information from the PPT slides and under the headings of Awareness, Attitude, Knowledge and Skills. Prompt questions are:
   - What would those changes look like? Think about small changes that could be made as well as large ones.
   - What policies does your organisation have to help build non-judgemental services? Do all staff know about them? (Including Reception, cleaning and other auxiliary staff).
   - Do your clients know about the policies your service has? How do they know about them? How are you sure they know about them?
   - If you've identified any changes or additions to practical and policy issues, who could you approach about making those changes? How could you build support both for them and for the changes you could suggest?
   - What would a 'perfect' service look like? Understand that there isn't a perfect service anywhere; this is about looking at how to be as good as a service can be.
6. Tell the groups they have 20 minutes for this task.

Facilitated Feedback: (30 mins)

When the time is up, ask groups to feedback on their discussions. They have about 5 mins for each group and are to:

- Identify the service or type of service they considered.
- Suggest the 3 main changes they could make, both practical and policy level.
- How could they ensure transparency so that users know about policies that support them if they experience discrimination? How could the user know how to use these policies?
- How could they approach the changes they've identified?
- Who could be involved in the changes?
- What support do they feel these changes would need?

When the groups have fed back ask if there are any further points and refer the group to the E-Learning module for further information and support resources to help understand how to build policies to create a non-judgemental space/service. Close the exercise.

Extra Information:

The following will help you with the discussions or questions the group has. It's also available more fully in the Online Support Materials.

Defining stigma

- UNAIDS defines HIV-related stigma and discrimination as: "… a 'process of devaluation' of people either living with or associated with HIV and AIDS … Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status."
- "Stigma often heightens existing prejudices and inequalities. HIV-related stigma tends to be most debilitating for people who are already socially marginalised and closely associated with HIV and AIDS, such as sex workers, men who have sex with men, injecting drug users, and prisoners.
- There are many ways in which HIV-related stigma manifests in healthcare settings. A study in Tanzania documented a wide range of discriminatory and stigmatising practices and categorised them broadly into: neglect; differential treatment; denial of care; testing and disclosing HIV status without consent; and verbal abuse/gossip.
- Stigma and discrimination in the healthcare setting and elsewhere contribute to keeping people, including health providers, from adopting HIV preventive behaviours and accessing needed care and treatment. Fear of being identified as someone infected with HIV increases the likelihood that people will avoid testing for HIV, disclosing their HIV status to healthcare providers and family members, or seeking treatment and care, thus compromising their health and wellbeing.
- Stigma represents a major 'cost' for both individuals and public health. Research has demonstrated that the experience or fear of stigma often results in: postponing or rejecting care; seeking care far from home to protect confidentiality; and non-adherence to medication.
- Research conducted among general populations around the world has revealed three immediately actionable key causes of HIV-related stigma in the community setting:
  - Lack of awareness of what stigma looks like and why it is damaging;
  - Fear of casual contact stemming from incomplete knowledge about HIV transmission; and
  - Values linking people with HIV to improper or immoral behaviour.

Reducing stigma in health facilities

- A key lesson that has emerged from recent research and field experiences is that to combat stigma in the healthcare setting, interventions must focus on the individual, environmental and policy levels.

Individual level

- At the individual level, increasing awareness among health workers of what stigma is and the benefits of reducing it is critical. A better understanding of what stigma is, how it manifests and what the negative consequences are can help reduce stigma and discrimination and improve patient-provider interactions.
- Health workers' fears and misconceptions about HIV transmission must also be addressed. Programmes need to provide health workers with complete information about how HIV is and is not transmitted and how practicing universal precautions can allay their fears.
- Understanding the association of HIV and AIDS with assumed immoral and improper behaviours is essential to confronting perceptions that promote stigmatising attitudes toward individuals living with HIV.

Environmental level

- In the physical environment, programmes need to ensure that health workers have the information, supplies and equipment necessary to practice universal precautions and prevent occupational transmission of HIV.

Policy level

- The lack of specific policies or clear guidance related to the care of patients with HIV reinforces discriminatory behaviour among health workers. Health facilities need to enact policies that protect the safety and health of patients, as well as health workers, to prevent discrimination against people living with HIV. Such policies are most successful when developed in a participatory manner, clearly communicated to staff, and routinely monitored after implementation.

Suggestions include:

- Involve all staff members, not just health professionals, in training and in crafting policy.
- Use participatory methods such as games, small group work, exercises and group discussions to share experiences.
- Provide training on both stigma and universal precautions.
- Involve individuals living with HIV in building policy and developing training for staff.
- Periodically monitor stigma among health workers.
- Take advantage of existing tools.
- Address the needs of HIV-infected health workers by providing services including counselling, testing and support."

Taken from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2731724/

Online Support Materials

Challenging Stigma and Discrimination:

Creating a Non-Judgemental Service or Environment for Gay and other MSM

Defining stigma

UNAIDS defines HIV-related stigma and discrimination as: "... a 'process of devaluation' of people either living with or associated with HIV and AIDS ... Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status."

"Stigma often heightens existing prejudices and inequalities. HIV-related stigma tends to be most debilitating for people who are already socially marginalised and closely associated with HIV and AIDS, such as sex workers, men who have sex with men, injecting drug users, and prisoners.

There are many ways in which HIV-related stigma manifests in healthcare settings. A study in Tanzania documented a wide range of discriminatory and stigmatising practices, and categorised them broadly into: neglect; differential treatment; denial of care; testing and disclosing HIV status without consent; and verbal abuse/gossip.

Stigma and discrimination in the healthcare setting and elsewhere contribute to keeping people, including health providers, from adopting HIV preventive behaviours and accessing needed care and treatment. Fear of being identified as someone infected with HIV increases the likelihood that people will avoid testing for HIV, disclosing their HIV status to healthcare providers and family members, or seeking treatment and care, thus compromising their health and wellbeing.

Stigma represents a major 'cost' for both individuals and public health. Research has demonstrated that the experience or fear of stigma often results in: postponing or rejecting care; seeking care far from home to protect confidentiality; and non-adherence to medication.

Research conducted among general populations around the world has revealed three immediately actionable key causes of HIV-related stigma in the community setting:

- Lack of awareness of what stigma looks like and why it is damaging;
- Fear of casual contact stemming from incomplete knowledge about HIV transmission; and
- Values linking people with HIV to improper or immoral behaviour.

Reducing stigma in health facilities

A key lesson that has emerged from recent research and field experiences is that to combat stigma in the healthcare setting, interventions must focus on the individual, environmental and policy levels

Individual level

At the individual level, increasing awareness among health workers of what stigma is and the benefits of reducing it is critical. A better understanding of what stigma is, how it manifests and what the negative consequences are can help reduce stigma and discrimination and improve patient-provider interactions.

Health worker' fears and misconceptions about HIV transmission must also be addressed. Programmes need to provide health workers with complete information about how HIV is and is not transmitted and how practicing universal precautions can allay their fears.

Understanding the association of HIV and AIDS with assumed immoral and improper behaviours is essential to confronting perceptions that promote stigmatising attitudes toward individuals living with HIV.

Environmental level

In the physical environment, programmes need to ensure that health workers have the information, supplies and equipment necessary to practice universal precautions and prevent occupational transmission of HIV.

Policy level

The lack of specific policies or clear guidance related to the care of patients with HIV reinforces discriminatory behaviour among health workers. Health facilities need to enact policies that protect the safety and health of patients, as well as health workers, to prevent discrimination against people living with HIV. Such policies are most successful when developed in a participatory manner, clearly communicated to staff, and routinely monitored after implementation.

Suggestions include:

- Involve all staff members, not just health professionals, in training and in crafting policy.
- Use participatory methods such as games, role plays, exercises and group discussions to share experiences.
- Provide training on both stigma and universal precautions.
- Involve individuals living with HIV in building policy and developing training for staff.
- Periodically monitor stigma among health workers.
- Take advantage of existing tools.
- Address the needs of HIV-infected health workers by providing services including counselling, testing and support."

Taken from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2731724/

Creating a non-judgemental service or environment is strongly linked to the understanding and use of Cultural Competence. Cultural Competence refers to an ability to successfully negotiate cross-cultural differences in order to accomplish practical goals.

Cultural Competence has four main components: Awareness, Attitude, Knowledge and Skills.

Awareness:

"It is important to examine our own values and beliefs in order to recognise any deep- seated prejudices and stereotypes that can create barriers for our learning, personal development and work we are involved in. Many of us have blind spots when it comes to our beliefs and values; diversity training/education can be useful for uncovering them.

Attitude:

Values and beliefs impact effectiveness across cultural issues because they show the extent to which we are open to differing views and opinions. The stronger we feel our beliefs and values, the more likely we will react emotionally when they collide with cultural differences.

Knowledge:

The more knowledge we have about people from different cultures and backgrounds, the more likely we are able to avoid making mistakes. Knowing how culture impacts problem solving, managing people, asking for help etc. can help us remain aware when we are in cross-cultural interactions.

Skills:

One can have the 'right' attitude, considerable self-awareness and a lot of knowledge about cultural differences, yet still lack the ability to effectively manage differences. If we have not learnt skills or have had little opportunity to practice, our knowledge and awareness are insufficient to avoid and manage crosscultural landmines."

Adapted from **Rainbow Heights LGBT Project**.

There is an evaluative tool that you may find useful, which has been used to measure stigma within services. It is shown here as relating to both HIV stigma and stigma relating to LGBTQI+/MSM people.

Measuring HIV Stigma and Discrimination

Taken from: http://strive.lshtm.ac.uk/system/files/attachments/STRIVE_stigma%20brief-A4.pdf

"It is possible to measure the levels of stigma and discrimination around HIV/AIDS by using a set of questions aimed at the general population, healthcare workers and people living with HIV (PLWHIV) themselves. The following is an example of how such a measurement exercise might look:"

Illustrative questions by domain of HIV stigma and discrimination

	General Population	Healthcare workers	PLWHIV
Domain			
Fear of infection	Do you fear that you could contract HIV if you come into contact with the saliva of someone living with HIV?	How worried would you be of getting HIV if you did the following? • Took the temperature of a patient living with HIV • Etc. • Etc. Do you typically use any of the following measures when providing care or services for a patient living with HIV? • Avoiding physical contact • Etc. • Etc. How worried are you about assisting in labour and delivery if: The woman is living with HIV? The woman's HIV status is unknown?	N/A

Social Judgement	Do you agree or disagree with the following statement: *"I would be ashamed if someone in my family had HIV."*	Do you strongly agree, agree, disagree or strongly disagree with the following statements: *'People living with HIV could have avoided HIV if they wanted to.'* *'People living with HIV should feel ashamed of themselves.'* *'I would be ashamed if someone in my family were infected with HIV.'*	Do you agree or disagree with the following statement: *'People think that HIV is shameful and they should not be associated with me.'*
Legal and Policy environment	Further development needed.	Do you strongly agree, agree, disagree or strongly disagree with the following statements: *'My health facility has policies to protect patients living with HIV from discrimination.'* *'I will get into trouble at work if I do not follow the policies to protect patients living with HIV.'* *'Since I have been working at my institution, I have been trained in protecting the confidentiality of patients' HIV status.'*	Have you heard of *[insert the best known national law/policy or set of guidelines from your country]* which protect/s the rights of people living with HIV in this country? If yes, have you ever read or discussed the content of this law/ policy/set of guidelines? In the past 12 months have you been involved in any efforts to develop legislation, policies or guidelines related to HIV? Do you feel that you have the power to influence decisions in any of the following? • Legal/rights matters affecting people living with HIV • Local government policies affecting people living with HIV • National government policies affecting people living with HIV

Anticipated stigma	In your opinion, are people hesitant to take an HIV test due to people's reaction if the test result is positive for HIV?	In your opinion, how hesitant are healthcare workers in this facility to take an HIV test due to fear of other people's reaction if the test result is a positive result? How hesitant are healthcare workers in this facility to work alongside a co-worker living with HIV regardless of their duties?	Did fears about how other people (for example, your friends, family, employer or community) would respond if you were found to be living with HIV make you hesitate to get tested? Yes/No In the past 12 months, have you been fearful of any of the following things happening to you? • Being gossiped about • Being verbally insulted, harassed and/or threatened • Being physically harassed and/or threatened • Being physically assaulted
Internalised stigma	N/A	N/A	In the past 12 months, have you experienced any of the following feelings because of your HIV status? • I feel ashamed • I feel guilty • I blame myself • I blame others • I have low self-esteem • I feel I should be punished • I feel suicidal
Perceived stigma	Do people talk badly about people living with or thought to be living with HIV to others? Do people living with, or thought to be living with HIV lose respect or standing?	In the past 12 months, how often have you observed the following in your health facility? Healthcare workers talking badly about people living with or thought to be living with HIV	See parallel questions under 'experienced stigma'

Experienced stigma (outside legal purview)	Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	In the past 12 months how often have you: • Experienced people talking badly about you because you care for patients living with HIV • Been avoided by friends or family because you care for patients living with HIV • Been assumed to be living with HIV because you care for patients living with HIV	In the past 12 months, how often have you been aware of being gossiped about because of your HIV status? In the past 12 months, how often have you been excluded from social gatherings or activities?

Discrimination (inside legal purview)	Do you think children living with HIV should be able to attend school with children who are HIV negative? In your opinion, if a female teacher has HIV but is not sick, should she be allowed to continue teaching in the school?	Do you strongly agree, agree, disagree or strongly disagree with the following statements: *'I would never test a patient for HIV without informed consent'.* *'No matter my views or feelings, it is my professional responsibility to maintain the confidentiality of patients living with HIV.'* To assess key population stigma: *'I would prefer not to provide services to:* • *People who inject illicit drugs* • *Men who have sex with men* • *Sex workers* • *Transgender people* • *Women who have sex with women* • *Migrants'* For each of the populations listed there is a follow-up question: • I strongly agree/agree because of the following reasons: • 'They put me at higher risk for disease.' • 'This group engages in immoral behaviour.' • 'I have not received training to work with this group.' • 'I am worried people will think I am part of this group.'	In the last 12 months, how often have you been denied health services, including dental care, because of your HIV status? Was the decision to be tested for HIV up to you? • *'Yes, I took the decision myself to be tested.' (i.e. it was voluntary)* • *'I took the decision to be tested, but it was under pressure from others.'* • *'I was made to take an HIV test.' (coercion)* • *'I was tested without my knowledge.'* • *'I only found out after the test had been done.'* To assess key population stigma: If you experienced stigma and / or discrimination for reasons other than your HIV status, please choose one category that best explains why you were stigmatised and / or discriminated against. • Sexual orientation (men who have sex with men, gay or lesbian, transgender) • Sex worker • Injecting drug user • Refugee or asylum seeker • Internally displaced person • Member of an indigenous group • Migrant worker • Prisoner • None of the above – an(other) reason(s)

Resilience	N/A	In the past 12 months, how often have you observed the following in your health facility? • Healthcare workers confronting or educating someone who was mistreating or speaking badly about people living with HIV	In the past 12 months, have you confronted, challenged or educated someone who was stigmatising and / or discriminating against you? In the past 12 months, have you supported people living with HIV? If yes, what types of support did you provide? • Emotional support • Physical support • Referral to other services

This type of measurement tool can be adapted to measure stigma levels around other issues such as sexual orientation and HIV status. The following is a suggestion of how this may look:

	General Population	Healthcare workers	MSM/LGBTQI+
Domain			
Fear of infection	Do you fear that you could contract HIV if you come into contact with a gay man?	How worried would you be of getting HIV if you did the following? • Took the temperature of a patient living with HIV • Etc. • Etc. Do you typically use any of the following measures when providing care of services for a patient living with HIV? • Avoiding physical contact • Etc. • Etc. How worried are you about working with MSM who are living with HIV?	If you are a HIV negative man do you refuse to sleep with men living with HIV because you fear contracting HIV? Do you think men living with HIV should tell their sexual partners about their HIV status before they have sex? Do you think men living with HIV who don't tell their partners they are living with HIV before they have sex should be prosecuted?

Social Judgement	Do you agree or disagree with the following statement: *"I would be ashamed if someone in my family was gay/ LGBTQI+."*	Do you strongly agree, agree, disagree or strongly disagree with the following statements? *'MSM living with HIV could have avoided HIV if they wanted to.'* *'MSM could change their sexual orientation if they really wanted to.'* *'I would be ashamed if someone in my family were gay/LGBTQI+.'*	Do you agree or disagree with the following statement: *'People think that being gay/ LGBTQI+ is shameful and they should not be associated with me.'*
Legal & Policy environment	What legal rights and protections do MSM/ LGBTQI+ people have?	Do you strongly agree, agree, disagree or strongly disagree with the following statements? *'My health facility has policies to protect MSM/LGBTQI+ clients/ patients from discrimination.'* *'I will get into trouble at work if I do not follow the policies to protect patients who are MSM/LGBTQI+.'* *'Since I have been working at my institution, I have been trained in protecting the confidentiality of patients' HIV status.'*	Have you heard of *[insert the best known national law/policy or set of guidelines from your country]* which protect/s the rights of MSM/LGBTQI+ people in this country? If yes, have you ever read or discussed the content of this law/ policy/set of guidelines? In the past 12 months have you been involved in any efforts to develop legislation, policies or guidelines related to MSM/ LGBTQI+ rights? Do you feel that you have the power to influence decisions in any of the following: *Legal/rights matters affecting people who are MSM/LGBTQI+* *Local government policies affecting people who are MSM/ LGBTQI+* *National government policies affecting MSM/LGBTQI+ people living with HIV*

Anticipated stigma	In your opinion, are people hesitant to 'come out' as LGBTQI+ due to people's reaction?	In your opinion, how hesitant are healthcare workers in this facility to 'come out' as MSM/LGBTQI+ due to fear of other people's reaction? How hesitant are healthcare workers in this facility to work alongside a co-worker who is LGBTQI+ regardless of their duties?	Did fears about how other people (for example, your friends, family, employer or community) would respond if you told them you were LGBTQI+ make you hesitate to 'come out'? Yes/No In the past 12 months, have you been fearful of any of the following things happening to you? • Being gossiped about • Being verbally insulted, harassed and/or threatened • Being physically harassed and/or threatened • Being physically assaulted
Internalised stigma	N/A	N/A	In the past 12 months, have you experienced any of the following feelings because you are LGBTQI+? • I feel ashamed • I feel guilty • I blame myself • I blame others • I have low self-esteem • I feel I should be punished • I feel suicidal
Perceived stigma	Do people talk badly about LGBTQI+ people, or people thought to be LGBTQI+, to others? Do LGBTQI+ people, or people thought to be LGBTQI+, lose respect or standing?	In the past 12 months, how often have you observed the following in your health facility? Healthcare workers talking badly about LGBTQI+ people.	See parallel questions under 'experienced stigma'

Experienced stigma (outside legal purview)	Would you object to having neighbours who were LGBTQI+?	In the past 12 months how often have you: • Experienced people talking badly about you because you are LGBTQI+ • Been avoided by friends or family because you are living with HIV • Been assumed to be Living with HIV because you care for clients/patients living with HIV	In the past 12 months, how often have you been aware of being gossiped about because you are LGBTQI+? In the past 12 months, how often have you been excluded from social gatherings or activities?

Discrimination (inside legal purview)	Do you think children should learn about LGBTQI+ issues at school? In your opinion, if a teacher is LGBTQI+ should they be allowed to teach at a primary school?	Do you strongly agree, agree, disagree or strongly disagree with the following statements? *'I would never test a patient for HIV without informed consent.'* *'No matter my views or feelings, it is my professional responsibility to maintain the confidentiality of LGBTQI+ clients/patients and all patients living with HIV'.* To assess key population stigma: • 'I would prefer not to provide services to: • People who inject illicit drugs • Men who have sex with men • Sex workers • Transgender people • Women who have sex with women • Migrants.' For each of the populations listed there is a follow-up question. I strongly agree/disagree because of the following reasons: • *'They put me at higher risk of disease.'* • *'This group engages in immoral behaviour.'* • *'I have not received training to work with this group.'* • *'I am worried people will think I am part of this group.'*	In the last 12 months, how often have you been denied services, because you are or are thought to be LGBTQI+?If you have tested for HIV was the decision up to you? • 'Yes, I took the decision myself to be tested.' (i.e. it was voluntary) • 'I took the decision to be tested, but it was under pressure from others.' • 'I was made to take an HIV test.' (i.e. it was coercion) • 'I was tested without my knowledge.' • 'I only found out after the test had been done.' To assess key population stigma: If you experienced stigma and/ or discrimination for reasons other than your HIV status, please choose one category that best explains why you were stigmatised and/ or discriminated against. • Sexual orientation (men who have sex with men, gay or lesbian, transgender) • Sex worker • Injecting drug user • Refugee or asylum seeker • Internally displaced person • Member of an indigenous group • Migrant worker • Prisoner • None of the above – an(other) reason(s)

Resilience	N/A	In the past 12 months, how often have you observed the following in your health facility? • Healthcare workers confronting or educating someone who was mistreating or speaking badly about LGBTQI+ people	In the past 12 months, have you confronted, challenged or educated someone who was stigmatising and/or discriminating against you? In the past 12 months, have you supported LGBTQI+ people? If yes, what types of support did you provide? • Emotional support • Physical support • Referral to other services

You may find it useful to think about a service or environment that you know is used in work for MSM and consider any changes to that service that could be made using the information from the information about stigma and Cultural Competence, or by using the stigma index measuring tool shown here.

Please think about any changes under the headings of Awareness, Attitude, Knowledge and Skills. Consider these questions to help you:

- What would those changes look like? Think about small changes that could be made as well as large ones.
- Who could you approach about making those changes and how could you build support both for them and for their suggested changes?
- How could you ensure the services are 'culturally competent'? (work for the people using them).
- How could you use networks that they could build or are already a part of to support each other?
- What policies does your organisation have to help build non-judgemental services? Do all staff know about them? (Including Reception, cleaning and other anxilliery staff).
- Do your clients know about the policies your service has? How do they know about them? How are you sure they know about them?
- If you've identified any changes or additions to practical and policy issues, who could you approach about making those changes? How could you build support both for them and for the changes you could suggest?

What would a 'perfect' service look like? Understand that there isn't a perfect service anywhere; this is about looking at how to be as good as a service can be.

Are there any changes you could suggest in your working relationships? How could you take this work forward into practice?

Informal Exercise Title:
Engaging and Involving the Users of Your Service/s.

Study Area/Group:
Challenging Stigma and Discrimination

Exercise Aim and/or Purpose:
This exercise allows participants to explore how to engage their users in the services provided for them.

Expected exercise outcome:
Participants will have considered aspects of 'Patient' (User) Engagement and 'Patient' (User) Involvement and how they could affect and/or improve on them in their own practice.

Materials Required:
- PowerPoint (PPT) slides
- Flipchart easel, pad and pens
- Paper and pens for participants

Facilitator Preparation:

- ✓ The term 'Patient' in 'Patient Engagement' and 'Patient Involvement' has been replaced by 'Service User' or 'User' in the exercise as many people seen by Community Health Workers see aren't viewed as 'our' patients. If you are working with clinical staff you can use 'Patient' instead of 'Service User'.
- ✓ Read through the 5 Steps of Patient or Service User Engagement to understand how they work in engaging service users.
- ✓ Identify examples of services or projects that have engaged or involved service users either locally or nationally.
- ✓ Identify local examples of projects or services that could be improved by engaging or involving service users.

Helpful hints for facilitators:
- Let the experiences of the group inform the discussions; you don't have to know everything.
- Think about how to use the 5 steps with a project or service you are familiar with.
- It can be useful to link these discussion back to the four skills of Cultural Competence (Awareness, Attitude, Knowledge, Skills) and the discussions from When I Was Young… if you have run those exercises with the group.
- Don't forget that many community groups call for a 'nothing for me, without me' approach to projects and services – in other words, don't think you can produce anything effective for the service user without consulting with them or their being involved in some way.

Method: (45 mins)

1. Introduce subject to group and ask the group to brainstorm their thoughts to help build a definition of;
   - Service User Engagement ("What do we mean by Service User engagement? What levels of engagement within services do we mean?).
   - Service User Involvement (What do we mean by Service User Involvement? How is it different from User Engagement?).

   and also why Service user engagement or involvement is important.
2. Take the group through the PPT slide outlining the 5 Steps of Patient or Service User Engagement. These are:
   - Inform me
   - Engage me
   - Empower me
   - Partner with me
   - Support my (e)communication

The 5 Steps of Patient or Service User Engagement

- Inform me: Attracting new 'service users' with (online) information services
- Engage me: Attracting those 'users' to engage with you
- Empower me: Retaining those 'users' and partnering with them
- Partner with me: Creating interactions and collaborations between you
- Support my (e)communication: The 'user' defines their own (e)community

3. Explain these were developed to engage with 'users' via online settings and services and the headings can be utilised across a range of service user engagement initiatives.
4. Split the group into smaller groups of 3–5 members.
5. Their task in their groups is to consider:
   - What are the barriers you face with user engagement and user involvement?
   - What could help/facilitate better (or more) or begin user engagement and user involvement?
   - How could they use the 5 steps to better plan how to engage and involve the MSM they work with?
6. Participants should use their own experience to inform their discussions and decisions. The groups have 30 minutes for this task – 10 minutes for each question, noting their thoughts onto flip chart paper. Encourage the groups to consider what they believe would be the 'perfect' way of engaging and involving patients if there were no barriers and to use this to help build their scenarios.

Facilitated Feedback: (15–20 mins)

Ask the groups to feedback on their discussions, encouraging them to think and discuss how they would get over barriers, any thoughts on what they could do to facilitate engagement and involvement and their 'perfect' ideas if they have any.

When the groups have completed their feedback or the time is ended close the exercise.

Extra Information:

If you are involved in or participate in Participative Quality Development in HIV (PQHIV https://www.pq-hiv.de) or Quality Action (https://www.qualityaction.eu), the scale could indicate where you are with engagement and involvement. Ratings would be available on how you could improve your service level engagement and involvement by service users.

You can also find alternate models of participation here:
https://www.pq-hiv.de/en/chapter/levels-participation
https://www.pq-hiv.de/en/method/circles-influence

Informal Exercise Title:

Understanding Syndemic Production Models and how they Influence Our Work.

Study Area/Group:

Challenging Stigma and Discrimination

Exercise Aim and/or Purpose:

To build a good knowledge of the factors which influence poor sexual health for gay and other MSM. This exercise allows participants to build their knowledge around syndemic production models and how different factors in the lives of gay and other MSM impact upon their sexual health.

Expected exercise outcome:

Participants will have a better knowledge of what a syndemic production model is and how it can influence our understanding about the intertwining factors that can lead to poor sexual health for gay and other MSM.

Materials Required:

- PowerPoint (PPT) slides.
- Flipchart easel, pad and pens.
- Paper and/or card and pens for participants.

Facilitator Preparation:

- Identify some issues that could be linked together as a syndemic, use any local examples that you know of as well as general ones.
- Identify possible interventions that could link issues, using your own experience and thoughts. They don't have to be happening; what you feel would be a good intervention is valid.

Helpful hints for facilitators:

- Use the knowledge and experience of the group during the discussions they have; you don't have to know everything.
- Two methods for running the exercise are provided. Choose the one that best fits the group you are working with. Method One is quicker and more action orientated or practical; Method Two is more discussion-based.
- Read and work through the online support materials about Syndemics to help understand the concept.

Method:

1. Introduce the subject to the group and then take them through the PPT slide/s explaining what a 'Syndemic Production Model' is, and provide the example of the original syndemic model applied to HIV/AIDS

Understanding Syndemic Production Models

A syndemic is the presence of two or more disease states or issues that negatively interact with each other, affecting the course of each issue or disease, enhancing vulnerability to the disease, and which are worsened by any inequalities faced.

Identified in the 1990s, the notion of a syndemic was used to describe the interactions among Substance Abuse, Violence and AIDS (SAVA) that had become a full blown crisis in Hartford, USA.

In the years since SAVA was identified, there have been other syndemics described that include HIV/AIDS and sexual health as components.

Understanding Syndemic Production Models

Diagram – Basic Syndemics Model: the Lancet

Understanding Syndemic Production Models

Diagram: Syndemic Production Model – Gay and other MSM Health.
Adapted from Stall, Friedman and Catania 2008

2. Split the group into smaller groups of 3–5 people.
3. Their task is to work together to identify what they think are some of the common factors that may impact upon or have influence over gay and other MSM e.g. Homophobia/Internalised Homonegativity.
4. There are two ways of running the exercise, a shorter more 'practical' way, and a slightly longer more discussion-based way.

Method One

1. Tell the groups they have 10 mins to identify issues that they think affect gay and other MSM and write each of them down onto the cards/sheets of paper you have given them. Ask them to open up issues such as Mental Health into the factors that may have a negative impact on someone's mental health, such as loneliness or physical/mental abuse.
2. After 10 mins, ask the groups to put all their cards onto the floor, and then start suggesting how 3–5 of the issues could be linked. Encourage discussion between people while they are doing this:
   - Why do they feel those issues go together?
   - How do they negatively affect one another?
3. When you have the issues on the cards/paper linked together, point out to the group that they are syndemics, and ask them to start suggesting possible interventions for the syndemics they have built, such as drugs and alcohol services alongside STI testing and treatment services etc. etc.

Method Two

1. The groups have 15 minutes for this task, capturing their ideas on the flipchart sheets you will give them. Encourage them to unpack some of the larger factors, such as Mental Health, into what they feel may be the factors that may have a negative impact on someone's mental health, such as anxiety, depression, loneliness, physical or mental abuse. Encourage them to consider social (i.e. poor housing, lack of employment opportunities) as well as physical factors.
2. When the time has elapsed, ask the groups to see if they can link 3–5 of their suggested factors together to provide a syndemic (use the already identified model to prompt thoughts) and draw diagrams linking the factors. They have another 10 minutes for this part of the task. Ask them to discuss why they think they go together into a syndemic.
3. The final stage of the task is asking the groups to consider what they could do to intervene; either thinking of a new intervention or identifying an intervention they already know about or use. They have another 15 minutes for this part of the task.

Facilitated Feedback:

Facilitator asks each group to feedback on one syndemic model they have identified and any interventions they have identified.

Encourage the group to look at the E-Learning module if they are interested in more background on syndemics. Close the exercise.

Extra Information:

"The hallmark of a syndemic is the presence of two or more disease states that adversely interact with each other, negatively affecting the mutual course of each disease trajectory, enhancing vulnerability, and which are made more deleterious by experienced inequities.

Introduced in the 1990s by medical anthropologist Merrill Singer, the notion of a syndemic was used to describe the interactions among Substance Abuse, Violence and AIDS (SAVA) that had become a full-blown crisis among heterosexual women in Hartford CT, USA. Researchers noticed the constellation of elements that impinged on risk, structural factors such as lack of housing and poverty, and social aspects such as stigma and lack of support systems, all reinforcing the disease burden.

In the years since SAVA was identified, there have been other syndemics described that include HIV/AIDS as a component, such as the HIV malnutrition food insecurity syndemic in sub-Saharan Africa.

Rapid changes can precipitate or accelerate existing syndemics or provide conditions conducive to developing syndemics. For example, globalisation patterns have quickly and fundamentally changed dietary patterns in lower/middle income countries by increasing access to high calorie foods and processed carbohydrates, radically increasing the proportion of individuals with type 2 diabetes.

Changes in political and economic conditions, and relatedly the breakdown of protective health measures or infrastructure can induce different and extra detrimental effects on specific populations.

From a clinical perspective, applying a syndemic approach is novel and valuable for expanding the focus out from why a patient has a poor outcome (e.g. dysregulated blood sugar) to what other factors are contributing.

Although there may be little that clinical practitioners and public health interventionists can do about the presence of social and political circumstances that might negatively affect health, the syndemic framework allows for the potential to mitigate those effects by appreciating the complex nature of certain diseases and conditions and for addressing the array of factors that give rise to them. Syndemics suggest that context is key."

Taken from The Lancet Vol 389 March 4 2017 and Resilience, Syndemic Factors, and serosorting behaviours among HIV positive and HIV negative substance using MSM. AIDS Educ Prev. 2012 Jun; 24(3): 193-205. Steven Kurtz et al.

Online Support Materials

Challenging Stigma and Discrimination

Understanding Syndemic Production Models and how they Influence our Work.

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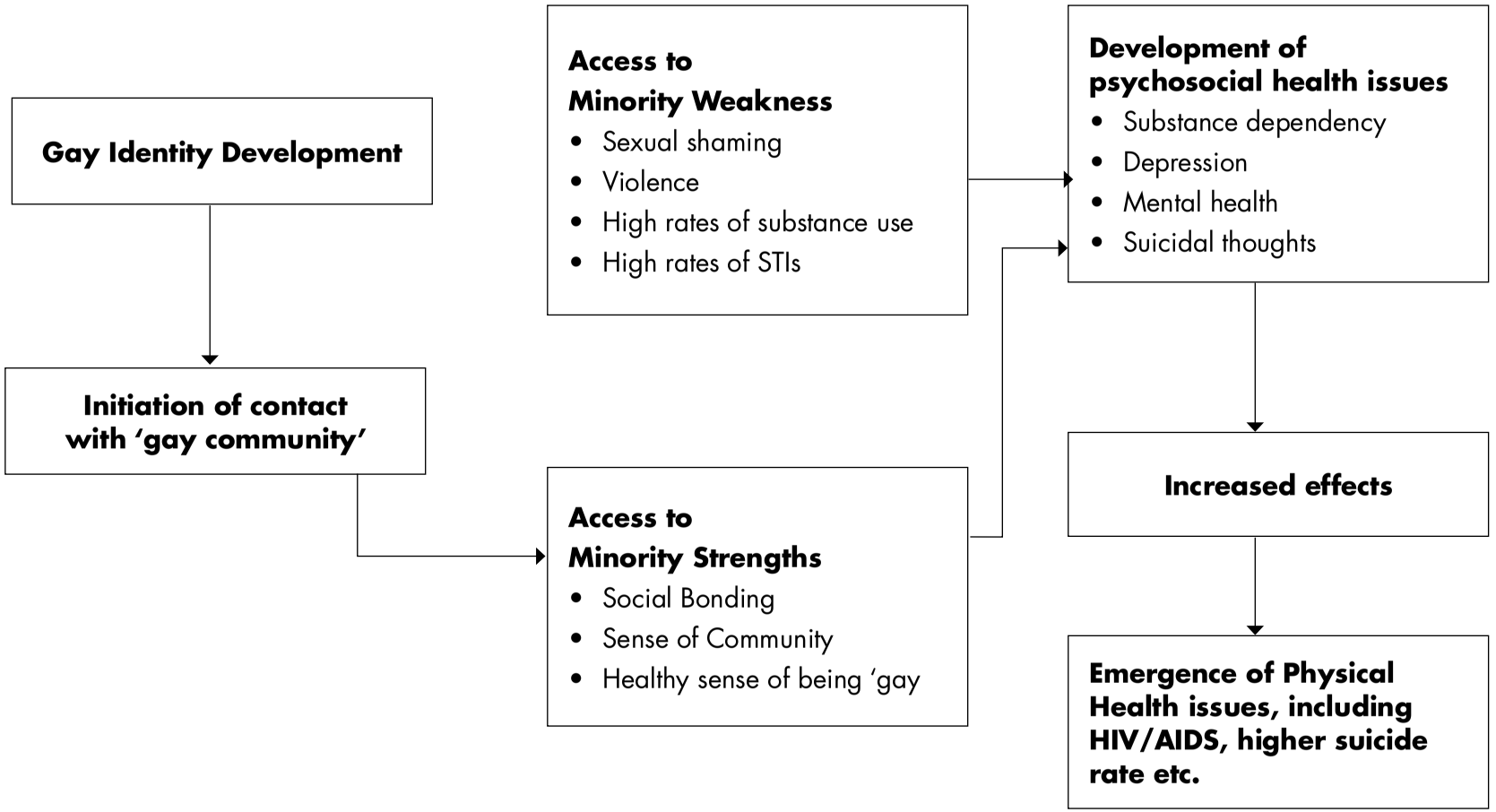
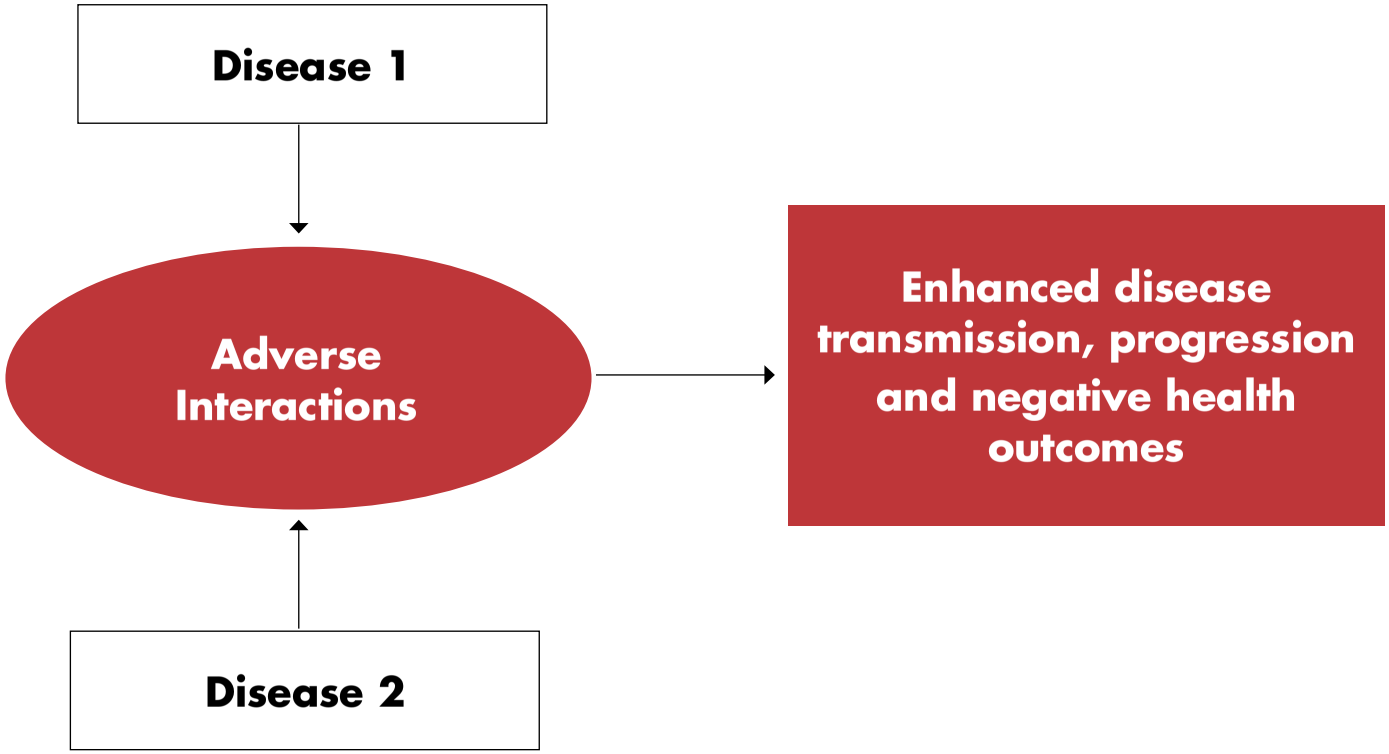
Syndemic Production Model – Gay and other MSM Health.

Adapted from Stall, Friedman and Catania 2008



Basic Syndemics Model

The Lancet



Now that you have read the information around syndemic production models and seen both the simple model and the specific model, your task is to identify what you think are some common factors that may impact on or have influence over MSM and to note them down e.g. Homophobia/Internalised Homonegativity. You are encouraged to 'unpack' some of the larger factors, such as Mental Health into what they feel may be the issues around mental health e.g. body dysmorphia etc. 15 minutes is a good amount of time for this.

When the 15 minutes is over, take some time to see if you can link your suggested factors together to build/provide a syndemic model (use the already identified model to prompt thoughts) and draw diagrams linking the factors. You have another 15 minutes for this part of the task.

The final stage of the task is for you to consider what could be done to intervene, either thinking of a new intervention or identifying an intervention you already know about or use. You have another 15 minutes for this part of the task.

Informal Exercise Title:

Recognising Complex Health Related Systems and how they Can Be Addressed.

Study Area/Group:

Challenging Stigma and Discrimination

Exercise Aim and/or Purpose:

Have a good knowledge of the factors that influence poor sexual health for gay and other MSM and be able to plan a whole systems approach to the health of these populations, using wider health, statutory and community services. This exercise allows participants to build their knowledge about what a 'whole systems approach' is, to explore aspects and fit the sexual health of gay and other MSM into a 'whole systems approach' appropriate for the target audience.

Expected exercise outcome:

Participants will have built their knowledge around a whole systems holistic approach and how to build interventions and initiatives that fit within that model.

Materials Required:

- PowerPoint (PPT) slides.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:

- Read and build knowledge about 'disease silos' and 'silo thinking' in the Extra information section and the online support materials.
- Identify concrete local or national examples of disease silos.
- Identify (if you can) any examples of joined up work or 'whole system approaches'.
- Read the EMIS 2010 information around 'Your Best Sex Life'.

Helpful hints for facilitators:

- Remember the links between this and the Stigma and Discrimination work. One of the reasons a whole system approach may not be thought of is because of traditional ways of working within that 'silo' i.e. that drugs services primarily deal with injecting opiate users and have little experience of other recreational drug use or gay and other MSM issues.

Method: (40 mins)

1. Introduce the subject of 'whole systems approaches' and take them through the information contained on the PPT slides around what is defined as a whole systems approach; the links between services and initiatives. Take them through the slides, explaining 'silo thinking' and 'disease silos'.

Definition of Whole Systems Approaches

Whole systems approaches involve identifying the various components of a system and assessing the nature of the links and relationships between each of them.

Silo Thinking

Diseases and health conditions are usually studied in separate silos.

This means they are thought about singularly and in a linear way rather than acknowledging possible overlaps that could affect change.

Health is not a stand-alone phenomenon with clear boundaries, it has individual, social, economic and environmental factors that influence it.

Disease Silos

Diseases and health conditions have multiple causes, including social, economic and environmental. They are interrelated with what you may be genetically predisposed to as well as the ability to look after your health, and both evolve over time.

Health systems defy simple representation. A holistic framework is needed to capture multiple diseases and health conditions and the way they interact into a unified approach. It is important not to concentrate on only one 'silo' i.e. behaviours.

2. Split the group into smaller groups of 3–5 members, and task them with coming up with a list of sexual health issues for men who have sex with men, capturing their suggestions upon a sheet of flip chart paper. They have 15 mins for this task
3. When this time has elapsed, call the groups back into the large group and take them through the information from EMIS 2010 around 'Your Best Sex Life' contained on the PPT slide/s. Remind the group about work around stigma and discrimination that could affect the ability of gay and other MSM to have the best sex life they have identified for themselves i.e. access to condoms or PrEP, substance use to overcome shame, ability to meet partners because of closure of venues/online apps.
4. Encourage the groups to also consider other issues some gay and other MSM face, such as problematic drug and alcohol use, loneliness etc. etc.

EMIS 2010: Components of a 'Best Sex Life' (for MSM)

- Relationship Formation
- Emotional/Sexual connection with sexual partner
- Volume and Variety (of sexual contact)
- Sexual Action / Behaviour (specific sexual acts)
- Free from physical harm
- Idealised physical attributes (of partner/s)
- Overcoming psychological and social barriers (To be confident and/or assertive; To enjoy sex without stress)
- Settings or physical spaces
- Don't know…

EMIS 2010

"The content of these answers may also reflect a widespread desire among single MSM for a steady partner, and the social and community needs that fuel this desire."

"Emotionally meaningful relationships are the most commonly valued feature. Therefore, programmes concerned with increasing the quality of MSM's sex lives should focus on emotional & interpersonal aspects and capacities alongside the more commonly addressed topics of safety and technique."

EMIS shows a country level average of 47% of MSM being unhappy with their sex lives.
The benefits:

- Reducing sexual unhappiness is itself a worthwhile goal.
- HIV prevention is strengthened if not in direct competition with what MSM seek from their sex life.
- A 'good' sex life is positively associated with effective treatment of HIV.

5. Ask the groups to reform back into the groups they were in. Ask them to consider this new information alongside the list of sexual health issues they have created and the information they were given around a whole systems approach. Remind them of the work around Syndemics if you have done that exercise with the group.
6. Their task is to identify areas in which they could intervene or support the use of services other than their own; to build a maximum of 2 initiatives (so 1 or 2) that could feed into a holistic whole systems approach e.g. providing drug support services/information around ChemSex dependency alongside sexual health and drug services.
7. Encourage the groups to discuss these issues on a personal as well as organisational level and also to consider developing one 'back to basics' initiative like condom provision/use as well as another issue and to think of services outside what may be the 'norm' for them, such as Prison Services. They have 20 mins for this task.

Facilitated Feedback:

Facilitator to ask each group in turn to go through one of their initiatives; what it is; how they hope to affect the health and/or behaviour of gay and other MSM; and how it fits within the whole systems approach.

Extra Information:

"Whole systems approaches involve identifying the various components of a system and assessing the nature of the links and relationships between each of them.

Whole systems approaches are a useful way of looking at participation because:

- Organisations must change at every level, from senior management to frontline staff, if they want to achieve meaningful participation.
- Participation should become part of daily practice, not a one-off activity.
- Participation operates at different levels. There are many ways to involve service users in different types of decisions. (Kirby et al., 2003b, p144-145).

Wright and colleagues (2006) suggest that different elements of participation can be brought together in a single framework, like a jigsaw puzzle. This is one example of a whole systems approach used to illustrate the concept, in the PRACTICE section 'children and young people' can be replaced by 'people' or 'clients' or 'users/service users' – anyone who could become involved."

Whole Systems Approaches and Health

From: Complex systems analysis: towards holistic approaches to health systems planning and policy
Babak Pourbohloul and Marie-Paule Kieny

"Diseases and health conditions are, by and large, studied in separate silos. Policies to reduce morbidity and mortality are developed within each 'disease silo'.[1] In many parts of the world, there is still no systematic evaluation of disease control or healthcare programmes, thus hampering efforts to efficiently allocate scarce resources. Health is not a stand-alone phenomenon with clear boundaries.

Diseases and health conditions have multiple causes, including social. They are interrelated with nature and nurture and evolve over time. Health systems defy simple representation. They call for novel ways of thinking to improve our ability to predict and control individual and population-based health outcomes. A holistic framework is needed to capture disparate diseases and health conditions and their intricate relationships into a unified platform. Such frameworks are developed using complex network analysis. Complex systems are composed of networks of interconnected components that influence each other, often in a nonlinear fashion. Whether we refer to an ecosystem or a healthcare system, we must acknowledge the interplay within and between such systems.

A health system consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health. Delivering optimal health services depends critically on the incidence and prevalence of infectious or chronic diseases, on social determinants and on resources available. As such, whether global or local, health systems are complex networks that permeate all dimensions of human health.

At the societal level, social interaction is the basis for the spread of pathogens, from influenza to HIV/AIDS, or individual behaviours, from obesity to illicit drug use.

At the institutional level, the complex interaction between national and international organisations is the basis for designing and implementing policy decisions on governance, allocation of workforce, services and technologies, sharing information and distributing resources.

At the molecular level, several diseases have a common genetic or functional origin. Hence a cooperative and collaborative approach to designing health interventions is required."

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[1]Silos and disease silos = thinking singularly and in a linear fashion rather than taking account of multiple agencies and agency approaches and disease issues and/or effects.'

Online Support Materials

Challenging Stigma and Discrimination

Recognising Complex Health Related Systems and how they Can Be Addressed. (Whole Systems Approaches)

Babak Pourbohloul and Marie-Paule Kieny

Whole systems approaches involve identifying the various components of a system and assessing the nature of the links and relationships between each of them.

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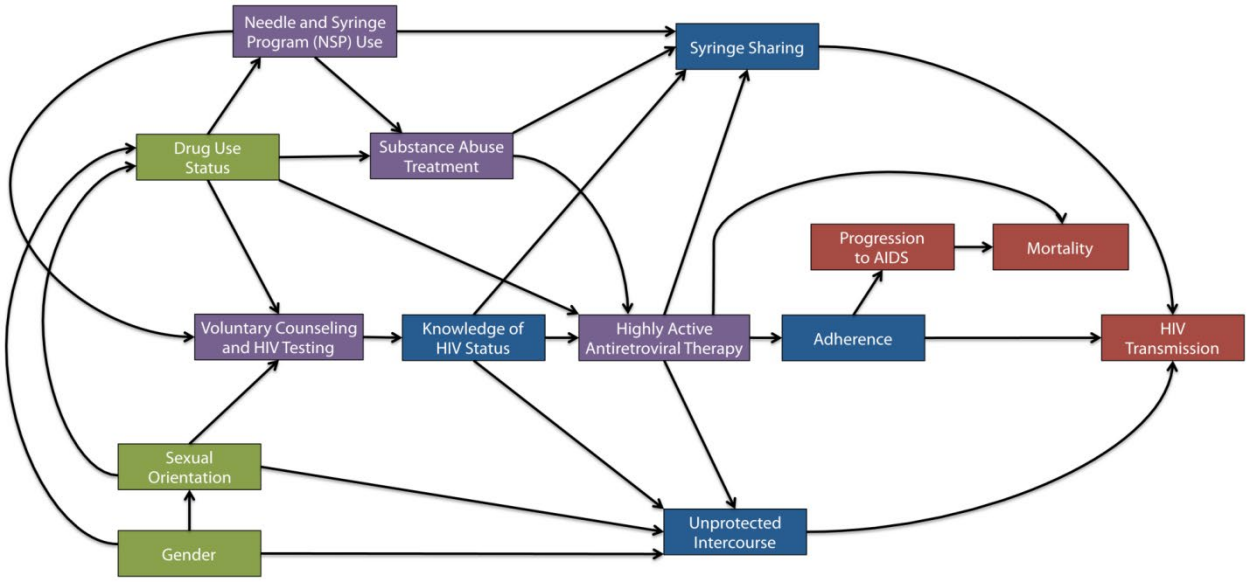
Model of a whole systems approach to HIV



Your task now that you have read this information, is to come up with a list of sexual health issues for men who have sex with men, writing your suggestions as notes on a sheet of paper. There is 15 mins for this task.

Now you have done that, please read the following information about what MSM consider is needed for a Best Sex Life taken from EMIS 2010.

EMIS 2010: Components of a 'Best Sex Life' (for MSM)

- Relationship Formation.
- Emotional/Sexual connection with sexual partner.
- Volume and Variety (of sexual contact).
- Sexual Action / Behaviour (specific sexual acts).
- Free from physical harm.
- Idealised physical attributes (of partner/s).
- Overcoming psychological and social barriers (To be confident and/or assertive; To enjoy sex without stress).
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The benefits…

- Reducing sexual unhappiness is itself a worthwhile goal.
- HIV prevention is strengthened if not in direct competition with what MSM seek from their sex life.
- A 'good' sex life is positively associated with effective treatment of HIV.

Now you have read this information from EMIS 2010, please consider it alongside the notes you have already made on sexual health issues for MSM and the information you read around a whole systems approach.

Now your task is to identify areas in which they could intervene or support the use of services other than their own; build a maximum of 2 initiatives (so 1 or 2) that could feed into a holistic whole systems approach e.g. providing drug support services/information around ChemSex within clinical GU services.

You are encouraged to think about these issues on a personal as well as organisational level. It may be useful to also consider developing one 'back to basics' initiative like condom provision/use as well as another issue and to think of services outside what may be the 'norm' for you, such as Prison Services.

2.1.4 Working in Partnerships

Informal Exercise Title:
Identifying and Building Good Practice for Partnership Work involving Statutory and Community Health Services.

Study Area/Group:
Working in Partnerships

Exercise Aim and/or Purpose:
Understanding and building participants' knowledge about partnerships between statutory and community services working with gay and other MSM.

Expected exercise outcome:
Participants will have identified some of the reasons for partnerships and the approaches, stages and practices needed to build successful partnerships.

Materials Required:
- PowerPoint (PPT) slides.
- Elements of Effective Partnerships sheet – one for each participant.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:
- Identify any local partnerships between statutory and community health services to use as examples if needed.
- Read the section on the benefits and risks of partnerships in the Extra information section below and in the Online Support Materials to help prompt the participant discussions.

Helpful hints for facilitators:
- Encourage the group to use their knowledge and experience around partnership working to help inform their discussions.
- Prepare the flipchart sheet with the 6 questions about partnership working before you start the exercise.
- Read the section in Extra information about Arnstein's Ladder of Participation to better understand the relationship between partnerships and power imbalances (See http://www.citizenshandbook.org/arnsteins_ladder.pdf for a high-resolution PDF illustration of the 'ladder'.)

Method: (40 mins)

1. Introduce the subject to the group and ask them to brainstorm possible answers to the question:
   - "When and why would you want a partnership between statutory and community health services?"
2. Facilitator to capture brainstorm suggestions on flipchart.
3. Facilitator shares the information on the PPT slide/s around partnerships, the suggested approaches and requirements for building a successful partnership.

Elements of Effective Partnerships

- *Leadership and vision* – the management and development of a shared, realistic vision for the partnership's work through the creation of common goals.
- *Organisation and involvement* – the participation of all key local players and particularly the involvement of communities as equal partners.
- *Strategy development and co-ordination* – the development of a clear, community focussed strategy covering the full range of issues supported by relevant policies, plans, objectives, targets, delivery mechanisms and processes. Development of local priorities for action will rely on the assessment of local needs, sharing of data, and a continuing dialogue between partners.

Elements of Effective Partnerships

- *Learning and development* – effective partnerships will not only invest in shared objectives and joint outcomes but will also add value through secondments. Willingness to listen and learn from each other builds trust.
- *Resources* – the contribution and shared utilisation of information, financial, human and technical resources.
- *Evaluation and review* – assessing the quality of the partnership process and measuring progress towards meeting objectives.

4. Split the group into smaller groups of around 5–6 members. If you think it helpful you could suggest that people who either work for the same organisation or in the same type of organisation work together for this task.
5. In their discussions ask the groups to:
   - Identify an idea for an intervention you feel is suitable for a piece of partnership working between a statutory health organisation and a community health organisation. What benefits are there in working in a partnership for your intervention idea?
   - How could the 'shared vision' for your intervention be developed?
   - What are the main stages your intervention would go through to ensure delivery?
   - How could you deal with any conflicts of interest that there may be between the audience for your intervention and the statutory or community health organisation involved in the project?
   - How would you keep the community the intervention is aimed at a 'key player' in the partnership work?
   - What 'risks' do you think could be associated with statutory and community health partnerships? How could you lessen these risks?
6. Tell the groups to take notes of their discussions around those 6 questions, paying particular note of the advantages and risks for both the organisations involved and the community the work is for. They have 20 minutes for these discussions.

Facilitated Feedback: (20 mins)

- Ask the groups one by one to feed back their key thoughts on their approaches and the issues involved in building their partnership/s.
- Highlight any differences in the approaches taken – ask the group why these differences may be necessary – who may have the most 'power' in the proposed partnership for example.
- Ask the group if they have any additional thoughts about partnership working, once they have heard all the groups' feedback. Once this feedback is over close the exercise.

Extra Information:

Effective partnerships:

"Partnerships come in all shapes, sizes and structures. There are no unique models for successful partnerships. Different kinds of partnerships will be effective under different conditions, according to local needs and circumstances, but there are factors that are common to all successful partnerships.

Analysis of effective partnership working (Audit Commission, 1998; Pratt et al., 1998) show that these factors are centred on the following elements:

- *Leadership and vision* – the management and development of a shared, realistic vision for the partnership's work through the creation of common goals. Effective leadership is demonstrated by influencing, communicating with and motivating others, so that responsibility for decision-making is shared between partners.
- *Organisation and involvement* – the participation of all key local players and, particularly the involvement of communities as equal partners. Not everyone can make the same contribution. Most voluntary organisations are small and locally based, with few staff. They may need resources and time to enable them to become fully engaged.
- *Strategy development and co-ordination* – the development of a clear, community focussed strategy covering the full range of issues supported by relevant policies, plans, objectives, targets, delivery mechanisms and processes. Development of local priorities for action will rely on the assessment of local needs, sharing of data, and a continuing dialogue between partners.
- *Learning and development* – effective partnerships will not only invest in shared objectives and joint outcomes but will also add value through secondments and other opportunities to share learning and contribute to professional and organisational development in partner organisations. Willingness to listen and learn from each other builds trust.
- *Resources* – the contribution and shared utilisation of information, financial, human and technical resources. The new freedoms to pool budgets and to provide integrated services, for example between primary care and social services, can remove some of the traditional barriers to joint working. Cooperation can start by resourcing what everyone wants, for example IT skills training.
- *Evaluation and review* – assessing the quality of the partnership process and measuring progress towards meeting objectives. Partnerships need to demonstrate that they are making a difference and that meetings are more than just talking shops. They must also be able to show that they are making real improvements to services.

  It is easy to underestimate the challenges of working together. Partnerships must establish legitimacy in the eyes of local people and enable voluntary sector, community and user groups to participate fully. They must also engage middle managers and frontline staff within statutory agencies.

  Partnerships must also devise effective cross-organisational arrangements that can cope with multiple lines of accountability to produce genuine collaborative working. They also need to generate meaningful yet realistic targets for change, and to demonstrate achievements and improvements."

Taken from 'Understanding Public Health: Health Promotion Theory. Edited by Maggie Davies and Wendy McDowell. Open University Press.

Arnstein's Ladder of Participation:

Sherry R. Arnstein: 'A Ladder of Citizen Participation' Journal of the American Planning Association, Vol 35, No. 4, July 1969, pp 216-224

"The ladder is a guide to seeing who has power when important decisions are being made. It has survived for so long because people continue to confront processes that refuse to consider anything beyond the bottom rungs. The ladder is read from the bottom up, starting with number 1 and rising through the stages to number 8 (see PDF). David Wilcox describes the 8 rungs of the ladder at www.partnerships.org.uk/part/arn.htm

1 **Manipulation and** 2 **Therapy**. Both are non-participative. The aim is to cure or educate the participants. The proposed plan is best and the job of participation is to achieve public support through public relations.

3 **Informing**. A most important first step to legitimate participation. But too frequently the emphasis is on a one-way flow of information with no channel for feedback.

4 **Consultation**. Again a legitimate step; including interventions such as attitude surveys, neighbourhood meetings and public enquiries. But Arnstein still feels this is just a window-dressing ritual.

5 **Placation**. For example, the co-option of hand-picked 'worthies' onto committees. It allows citizens to advise or plan ad infinitum but retains for 'power holders' the right to judge the legitimacy or feasibility of the advice.

6. **Partnership**. Power is in fact redistributed through negotiation between citizens and power holders. Planning and decision-making responsibilities are shared e.g. through joint committees.
7. **Delegation**. Citizens holding a clear majority of seats on committees with delegated powers to make decisions. Public now has the power to assure accountability of the programme to them.
8. **Citizen Control.** 'Have-nots' handle the entire job of planning, policy making and managing a programme e.g. neighbourhood corporation with no intermediaries between it and the source of funds."

Online Support Materials

Working in Partnerships

Identifying and Building Good Practice for Partnership Work Involving Statutory and Community Health Services

Taken from 'Understanding Public Health: Health Promotion Theory' Edited by Maggie Davies and Wendy McDowell. Open University Press. 'Social Capital and Health' Campbell, et al., Gender Institute, London School of Economics. Health Education Authority Report 1999.

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Another way of approaching those elements is:

Leadership

Effective leadership involves attention to:

- developing and communicating a shared *vision*
- embodying and promoting ownership of and *commitment* to the partnership and its goals
- being alert to factors and relationships in the external environment that might affect the partnership.

Organization

Clear and effective systems are need for:

- public *participation* in partnership processes and decision making.
- *flexibility* in working arrangements.
- transparent and *effective* management of the partnership.
- *communication* in ways and at times that can be easily understood, interpreted and acted upon.

Strategy

The partnership needs to implement its mission and vision via a clear strategy informed by local communities and other stakeholders which focuses on:

- *strategic development* to agree priorities and define outcome targets
- sharing *information and evaluation* of progress and achievements a continuous process of *action and review*.

Learning

Partner organisations need to attract, manage and develop people to release their full knowledge and potential by:

- *valuing people* as a primary resource
- development and application of *knowledge and skills*
- supporting *innovation*.

Resources

The contribution and shared utilization of resources, including

- building and strengthening *social capital**
- managing and pooling *financial resources*
- making *information* work
- using information and communication *technology* appropriately.

Programmes

Partners seek to develop coordinated programmes and integrated services that fit together well. This requires attention to:

- realising added value from joint *planning*
- focused *delivery*
- regular *monitoring* and review.

It is easy to underestimate the challenges of working together. Partnerships must establish legitimacy in the eyes of local people and enable voluntary sector, community and user groups to participate fully. They must also engage middle managers and frontline staff within statutory agencies.

Partnerships must also devise effective cross-organisational arrangements that can cope with multiple lines of accountability to produce genuine collaborative working. They also need to generate meaningful yet realistic targets for change, and to demonstrate achievements and improvements."

What is *social capital?

"Over the past 10 years, the notion that social, psychological, economic and contextual factors impact significantly on the health of individuals and communities has gained in currency as the evidence base has grown. At the same time, individual models of health behaviours and outcomes have declined in popularity and use within public health and health promotion. Within this context, the concept of social capital has emerged as having potential to further articulate the relationship between health and its broader determinants.

Social capital can be broadly described as the resources within a community that create family and social organisation. These resources, which arise out of activities such as civic engagement, social support or participation, benefit individuals, but are developed in relationship to and with others, for example within groups or communities. Key constructs within the concept, often – and variously – used as indicators, include social relationships, group membership, shared norms, trust, formal and informal social networks, reciprocity and civic engagement.

Campbell et al. (1999) give the following as examples of characteristics of communities where social capital is abundant:

- Individuals feel an obligation to help others and those in need, represented through dense personal networks of support that link individuals, households and peer groups.
- There is willingness and capacity to make use of community resources, notably those provided by the state, evidenced for example in use of institutionalized health service systems.
- Individuals exhibit more trust and less fear in interacting with others in the community, manifested for example in positive attitudes towards personal interactions, use of community facilities, sense of 'belonging' to the community.

The relationship between social capital and health (intersectionalities/syndemics)

But what is the link between social capital and health? In general, populations with high levels of material deprivation and poverty have worse health. For example, Kawachi (1996) found, in prospective studies of professional men in the US, that those with the lowest level of social networks were significantly more likely to die of cardiovascular disease. Cooper et al. (1999) found that women living in UK neighbourhoods which they perceived to be high in elements of social capital were less likely to smoke, after controlling for material deprivation and socio-economic factors.

Campbell et al. suggest that some elements of Putnam's original concept of social capital (particularly trust and civic engagement) might be more health enhancing than others. In this study, communities and networks were found to be more complex and multi-layered than those defined by geographical boundaries such as street or ward, and strong differences within communities were found in the way that elements of social capital were created, sustained and accessed. There were also clear differences in the types of community networks that men and women created and drew upon in their day-to-day lives, and in the type of support they gave and received from these networks. Individual constructions of health and relations to community appeared to vary according to gender, ethnicity and life-stage. These findings are congruent with broader work on health inequalities, where clear patterns of health outcomes and behaviours by gender, ethnicity, life-stage and income can be observed.

Campbell et al. (1999) have suggested that high levels of social capital may act as a buffer in deprived communities, serving to shield them from some of the worst effects of deprivation. Others have made the link between deprivation and health via the psychological constructs of self-efficacy and stress, with those lowest on socio-economic scales having least control over their life and work environments, more stress, and subsequently worse health."

Arnstein's Ladder of Participation:

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See http://www.citizenshandbook.org/arnsteins_ladder.pdf for a high resolution PDF illustration of the 'ladder'.

Your task now is to identify a partnership that your organisation is a part of, or a partnership that you know about between a statutory and community health organisation.

In considering that partnership, identify how you think each of the elements outlined previously have been established, and what you think is or could be missing. Identify a couple of these for each element you are considering. A maximum of 30 minutes working on this is recommended as the list could be extensive.

Think of how you could approach a partnership now, knowing about these elements and how they work together. How could you establish your approach to ensure the best possible partnership is built, both for the partners and the community you are working with?

Participant Worksheet: Working In Partnerships

The Elements of Effective Partnerships:

Taken from Understanding Public Health: Health Promotion Theory: Davies, M & McDowell, W. Open University Press.

"Partnerships come in all shapes, sizes and structures. There are no unique models for successful partnerships. Different kinds of partnerships will be effective under different conditions, according to local needs and circumstances, but there are factors that are common to all successful partnerships.

Analysis of effective partnership working (Audit Commission, 1998; Pratt et al., 1998) show that these factors are centred on the following elements:

- *Leadership and vision* – the management and development of a shared, realistic vision for the partnership's work through the creation of common goals. Effective leadership is demonstrated by influencing, communicating with and motivating others, so that responsibility for decision-making is shared between partners.
- *Organisation and involvement* – the participation of all key local players and, particularly the involvement of communities as equal partners. Not everyone can make the same contribution. Most voluntary organisations are small and locally based, with few staff. They may need resources and time to enable them to become fully engaged.
- *Strategy development and co-ordination* – the development of a clear, community focussed strategy covering the full range of issues supported by relevant policies, plans, objectives, targets, delivery mechanisms and processes. Development of local priorities for action will rely on the assessment of local needs, sharing of data, and a continuing dialogue between partners.
- *Learning and development* – effective partnerships will not only invest in shared objectives and joint outcomes but will also add value through secondments and other opportunities to share learning and contribute to professional and organisational development in partner organisations. Willingness to listen and learn from each other builds trust.
- *Resources* – the contribution and shared utilisation of information, financial, human and technical resources. The new freedoms to pool budgets and to provide integrated services for example between primary care and social services, can remove some of the traditional barriers to joint working. Cooperation can start by resourcing what everyone wants, for example IT skills training.
- *Evaluation and review* – assessing the quality of the partnership process and measuring progress towards meeting objectives. Partnerships need to demonstrate that they are making a difference and that meetings are more than just talking shops. They must also be able to show that they are making real improvements to services."

Informal Exercise Title:

Partnership Working With and Between LGBTQI+ Organisations and Other Services

Study Area/Group:

Working in Partnerships

Exercise Aim and/or Purpose:

This exercise allows participants to explore partnership working with and between LGBTQI+ organisations. To help reduce stigma and discrimination due to sexual orientation and of people living with HIV/AIDS in different healthcare settings and in the community.

Expected exercise outcome:

Participants will have a better understanding of how to establish partnerships with and between LGBTQI+ organisations. To identify any possible barriers such as power imbalances between partners as well as the benefits and support mechanisms needed to ensure successful partnership working.

Materials Required:

- PowerPoint (PPT) slides.
- 'Elements of Effective Partnerships' sheet – one for each participant.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:

- Identify any local partnerships between LGBTQI+ organisations and other providers of services to use as examples if needed.
- Read the section on the benefits and risks of partnerships in the Extra information section below and in the Online Support Materials.

Helpful hints for facilitators:

- Encourage the group to use their knowledge and experience around partnership working to help inform their discussions.

Method: (60 mins)

1. Introduce the subject to the group and ask them to brainstorm some ideas on
   - "When and why would you want to build a partnership between an LGBTQI+ organisation and another provider of services?"

   Capture their answers on the flipchart if you feel it would help the discussions further on in the exercise.
2. Then share the information on the PPT slides around building successful working partnerships with the group.

Elements of Effective Partnerships

- *Leadership and vision* – the management and development of a shared, realistic vision for the partnership's work through the creation of common goals.
- *Organisation and involvement* – the participation of all key local players and, particularly the involvement of communities as equal partners.
- *Strategy development and co-ordination* – the development of a clear, community focussed strategy covering the full range of issues supported by relevant policies, plans, objectives, targets, delivery mechanisms and processes. Development of local priorities for action will rely on the assessment of local needs, sharing of data, and a continuing dialogue between partners.

Elements of Effective Partnerships

- *Learning and development* – effective partnerships will not only invest in shared objectives and joint outcomes but will also add value through secondments. Willingness to listen and learn from each other builds trust.
- *Resources* – the contribution and shared utilisation of information, financial, human and technical resources.
- *Evaluation and review* – assessing the quality of the partnership process and measuring progress towards meeting objectives.

3. Ask the group to identify and share any examples of partnerships between LGBTQI+ organisations and other organisations that they know about or have been a part of. Capture their examples on the flipchart. You only need 1 or 2 examples, 3 at maximum.
4. Ask the group to share their knowledge about how useful or successful these examples of partnership working were:
   - What made them useful and successful?
   - Were there any difficulties the partnership/s faced?

   Bullet point these on the flipchart and link back to the points about effective elements of partnerships from the PPT slides if you can.
5. If you have run the exercise/s on Cultural Competence you can remind the group of the four elements of Awareness, Attitude, Knowledge and Skills that would be useful to consider when working with a marginalised group.
6. Split the group into smaller groups of 3–5 people. The task for the smaller groups is to discuss;
   - How could the 'shared vision' for the project be developed?
   - What does an understanding of the stigma and discrimination faced by gay and other MSM bring to the work of the partnership?
   - How could any differences in the size and economic status of the agencies involved affect the partnerships and its work?
   - How would partnership working with and between LGBTQI+ organisations, including the people working on the project, be supported effectively?
   - How could the evaluation and review process support the partnership and the continuation of the project?
   - What could help to deal with any conflicts that happen during the development or delivery stages of the project?
7. Inform the groups they have 30–40 minutes for their discussions. Ask them to notate their discussion points on flipchart paper and decide the 3 most important points on each question that they will feedback.

Facilitated Feedback: (30 mins)

When the time is up, call the groups back to the large group and ask the groups to feedback their 3 important points on each of the 6 questions, with you dealing with 1 question at a time. You can decide to either capture these on a flipchart (a separate sheet for each question) or ask the groups to put their sheets up in a space in the room.

We will then do the same with the second question, and then the third and so on until all questions have been covered. Then ask the large group to brainstorm what they think are the most important points raised by all the groups. Try to keep it to 1 or 2 points per question. All the points raised are valid, and there are some points that could be most useful to consider initially.

By the end of these discussion there should be some important points they can take away to use when discussing and developing partnerships. Inform the group there is further information about building partnerships and understanding 'social capital' and how that can affect partnerships between and with minority groups in the Online Support Materials. Close the exercise.

Extra Information:

Taken from 'Understanding Public Health: Health Promotion Theory' Edited by Maggie Davies and Wendy McDowell. Open University Press. 'Social Capital and Health' Campbell, et al., Gender Institute, London School of Economics. Health Education Authority Report 1999.

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It is easy to underestimate the challenges of working together. Partnerships must establish legitimacy in the eyes of local people and enable voluntary sector, community and user groups to participate fully. They must also engage middle managers and frontline staff within statutory agencies.

Partnerships must also devise effective cross-organisational arrangements that can cope with multiple lines of accountability to produce genuine collaborative working. They also need to generate meaningful yet realistic targets for change, and to demonstrate achievements and improvements."

What is social capital?

"Over the last ten years, the notion that social, psychological, economic and contextual factors impact significantly on the health of individuals and communities has gained in currency as the evidence base has grown. At the same time, individual models of health behaviours and outcomes have declined in popularity and use within public health and health promotion. Within this context, the concept of social capital has emerged as having potential to further articulate the relationship between health and its broader determinants.

Social capital can be broadly described as the resources within a community that create family and social organisation. These resources, which arise out of activities such as civic engagement, social support or participation, benefit individuals, but are developed in relationship to and with others, for example within groups or communities. Key constructs within the concept, often – and variously – used as indicators, include social relationships, group membership, shared norms, trust, formal and informal social networks, reciprocity and civic engagement.

Campbell et al. (1999) give the following as examples of characteristics of communities where social capital is abundant:

- Individuals feel an obligation to help others and those in need, represented through dense personal networks of support that link individuals, households and peer groups.
- There is willingness and capacity to make use of community resources, notably those provided by the state, evidenced for example in use of institutionalized health service systems.
- Individuals exhibit more trust and less fear in interacting with others in the community, manifested for example in positive attitudes towards personal interactions, use of community facilities, sense of 'belonging' to the community.

The relationship between social capital and health

But what is the link between social capital and health? In general, populations with high levels of material deprivation and poverty have worse health. For example, Kawachi (1996) found, in prospective studies of professional men in the US, that those with the lowest level of social networks were significantly more likely to die of cardiovascular disease. Cooper et al. (1999) found that women living in UK neighbourhoods which they perceived to be high in elements of social capital were less likely to smoke, after controlling for material deprivation and socio-economic factors.

Campbell et al. (1999) suggest that some elements of Putnam's original concept of social capital (particularly trust and civic engagement) might be more health enhancing than others. In this study, communities and networks were found to be more complex and multi-layered than those defined by geographical boundaries such as street or ward, and strong differences within communities were found in the way that elements of social capital were created, sustained and accessed. There were also clear differences in the types of community networks that men and women created and drew upon in their day-to-day lives, and in the type of support they gave and received from these networks. Individual constructions of health and relations to community appeared to vary according to gender, ethnicity and life-stage. These findings are congruent with broader work on health inequalities, where clear patterns of health outcomes and behaviours by gender, ethnicity, life-stage and income can be observed.

Campbell et al. (1999) have suggested that high levels of social capital may act as a buffer in deprived communities, serving to shield them from some of the worst effects of deprivation. Others have made the link between deprivation and health via the psychological constructs of self-efficacy and stress, with those lowest on socio-economic scales having least control over their life and work environments, more stress, and subsequently worse health."

Taken from: Understanding Public Health: Health Promotion Theory. Davies & McDowell. Open University Press.

Online Support Materials

Working in Partnerships

Partnership working with and between LGBTQI+ organisations and other services.

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Key elements for successful partnership

Leadership

Effective leadership involves attention to:

- developing and communicating a shared *vision*
- embodying and promoting ownership of and *commitment* to the partnership and its goals
- being alert to factors and *relationships* in the external environment that might affect the partnership

Organization

Clear and effective systems are need for:

- public *participation* in partnership processes and decision making
- *flexibility* in working arrangements
- transparent and effective *management* of the partnership
- *communication* in ways and at times that can be easily understood, interpreted and acted upon

Strategy

The partnership needs to implement its mission and vision via a clear strategy informed by local communities and other stakeholders which focuses on:

- *strategic development* to agree priorities and define outcome targets
- sharing *information and evaluation* of progress and achievements
- a continuous process of *action and review*

Learning

Partner organisations need to attract, manage and develop people to release their full knowledge and potential by:

- *valuing people* as a primary resource
- development and application of *knowledge and skills*
- supporting *innovation*

Resources

The contribution and shared utilization of resources, including

- building and strengthening **social capital*
- managing and pooling *financial resources*
- making *information* work
- using information and communication *technology* appropriately

Programmes

Partners seek to develop coordinated programmes and integrated services that fit together well. This requires attention to:

- realizing added value from joint *planning*
- focused *delivery*
- regular *monitoring* and review

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The relationship between social capital and health (intersectionalities/syndemics)

But what is the link between social capital and health? In general, populations with high levels of material deprivation and poverty have worse health. For example, Kawachi (1996) found, in prospective studies of professional men in the US, that those with the lowest level of social networks were significantly more likely to die of cardiovascular disease. Cooper et al. (1999) found that women living in UK neighbourhoods which they perceived to be high in elements of social capital were less likely to smoke, after controlling for material deprivation and socio-economic factors.

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Do you know of partnerships between statutory agencies and LGBTQI+ organisations? Or between LGBTQI+ organisations themselves? Make notes on what you know about those partnerships and about how useful or successful these examples of partnership working were.

How was the 'shared vision' for the project developed?

- What does an understanding of the stigma and discrimination faced by gay and other MSM bring to the work of the partnership?
- How could any differences in the size and economic status of the agencies involved affect the partnerships and it's work?
- How would partnership working with and between MSM/LGBTQI+ organisations, including the people working on the project, be supported effectively?
- How could the evaluation and review process support the partnership and the continuation of the project?
- What could help to deal with any conflicts that happen during the development or delivery stages of the project?

It is suggested you take 30 minutes to make notes and capture your ideas around these questions. When the time is complete spend some time identifying the points you consider to be key in establishing good partnerships with and between LGBTQI+/MSM organisations and other services.

Participant Worksheet: Working In Partnerships

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Informal Exercise Title:
Using Motivational Interviewing Techniques in your Work

Study Area/Group:
Prevention

Exercise Aim and/or Purpose:
This exercise allows participants to explore and improve their understanding of the use of Motivational Interviewing (MI) techniques to better engage with gay and other MSM.

Expected exercise outcome:
Participants will have practised and gained a better understanding of MI techniques and have explored the use of MI with gay and other MSM.

Materials Required:
- PowerPoint (PPT) slides.
- 'Initiator' script pages – one for every participant.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:
- Read over the information about MI and the two techniques outlined – OARS and LURE
- Read over the Initiator scripts to check that they are appropriate for your group. It can be useful to write your own scripts based on local issues or your experiences of working with the local gay and other MSM populations. You could ask the pairs to come up with their own script or just improvise on a theme like 'condom use difficulties' or 'being drunk and out of control'
- An E-Learning tool for MI with a target group of family doctors is available at http://equip-eLearning.woncaeurope.org/ which includes two useful examples of MI interactions, one around excessive alcohol use and the other on starting long-term medication. It may be useful to work through these if you yourself have little experience of MI.

Helpful hints for facilitators:
- This is about the participants practicing MI, not talking about what they could or would do. Encourage them to use their time for practice; even when experienced, we all benefit from more practice.
- When you are observing and helping with the participants practices remind them of OARS and LURE, without insisting they have to follow them exactly. Tell them that usually if you can remember the first instruction of the acronym then the others follow on naturally.

Method: (40 mins)

1. Tell the group that we are now going to consider and practice Motivational Interviewing (MI) and how we can best use it in our work.
2. Share the PPT slide definition of MI with the group.

Motivational Interviewing (MI)

- Is a guided and client based communication strategy.
- Helps clients explore and resolve feelings in order to amend or change problem behaviours.
- Offers specific, re-enforcing steps to help the client.

3. Share and take the group through the PPT slide around MI tools OARS and LURE.

Motivational Interviewing Tools – OARS

OPEN (rather than closed) questions
"How do you feel about that?" (open) versus "Did that make you angry?" (closed).

AFFIRMATIONS (for positive re-enforcement)
"Congratulations on taking you medications regularly, that can be difficult for many people."

REFLECTIONS (repeat, rephrase, paraphrase)
"Are you are saying you find it difficult to ask your partners to use condoms?"

SUMMARY (2 or 3 key points raised by the person)
"So the main things you want to do today are see your test results and find out about the support group?"

Motivational Interviewing Tools – LURE

LISTEN to the person.
MI involves as much listening as informing, and you can only understand someone's motivation by listening.

UNDERSTAND their motivations.
Their reasons for change, rather than yours, are more likely to help behaviour change.

RESIST the urge to 'correct' the person you are talking with.
It's their conversation, not yours.

EMPOWER the person you are talking with.
Health outcomes are better when someone takes an interest in and plays an active role in their own care.

4. Ask the group to raise their hand if they use MI in their current work; if none respond then just put them into pairs; if some people respond then pair experienced with inexperienced; if all respond then just pair people together and tell the group that practice is good for us all, no matter what our level of experience. Practice is always useful, and these suggested techniques may be new to people.
5. Inform the group that now they are paired together they will be practicing MI around 3 'issues':
   - Testing for HIV.
   - Adherence to medications.
   - Substance Use (alcohol and recreational drugs).
6. Inform the group they will base their practice conversations on the Initiator scripts on the sheets you give them. The point here is to practice in their pairs; not to talk about how they *might* approach different situations but to practice. It's also important to let them know that they are not being trained to be counsellors – the time and resources are not available for that to happen here. This practice is about understanding a good basic level of MI conversation.

MI – Initiator Scripts

Script One
"I'm feeling quite low today. I was out all weekend again… and it was fun, I ended up not sleeping though and having sex and taking drugs all weekend and missed work on Monday. I've got to go to this birthday party next weekend. I'm worried the same thing is going to happen again. I don't really think I can get out of going."

Script Two
"I've been such an idiot the last few weeks with everything that's been going on. I've had lots of sex without a condom with different partners. I know the risks but in the moment I just don't care. Then after I feel so stupid. I'm sorry. I don't really know why I'm here."

Script Three
"I don't know whether to be concerned or not, but I get so out of it at the weekends that I keep missing taking my meds. I take them when I remember and sometimes, I've taken two doses just to be sure, but I just can't seem to get my head around getting into a routine to take them."

7. Start the group off on their practice, telling them they have 10 minutes each (so a total of 20 mins) to practice, with one person being a service user and the other being the CHW.
8. Go around all the groups helping/reminding them about OARS and LURE guidelines. Again, if needed, remind them the time is to practice in and not to talk about what they would or could do. Practice, practice, practice…
9. After the first 10 minutes inform the group it is time to change over; the second person using a different issue and Initiator script from the first person. Again, go around the groups helping with OARS and LURE guidelines and reminding them to practice rather than talk.
10. When this second 10 minutes is over, call the group back to the large group.

Facilitated Feedback: (15–20 mins)

Ask the group to feedback on their practices
- Did OARS and LURE help?
- If they are experienced in MI, had they used OARS and LURE before?
- How were their conversations?
- What was the outcome?

Take short feedback examples from the pairs around these questions.

When the group has finished their short feedback (or the time has ended) close the exercise.

Extra Information:

"Research has shown that:

- MI enhances change for a range of behaviours, including diet, exercise, medication adherence, reducing the use of alcohol and illicit drugs, safer sex practices, and medication adherence (Burke et al., 2003; Hettema et al., 2005; Rubak et al., 2005).
- MI also works for smoking cessation, although its effects are less dramatic than for other health behaviours (Hettema & Hendricks, 2010). MI does work as well as other smoking cessation methods, potentially in a shorter amount of time.
- Adding MI to other active treatments improves outcomes.
- When MI is compared to other established counselling methods, outcomes are similar despite the lower intensity of MI. MI produces positive oncomes at lower cost and effort.
- MI works well with clients/patients who are angry, resistant, or less ready to change. One of the original studies offered a 'drinker's check-up' to patients with unacknowledged alcoholism. MI helped these patients change their drinking, without first requiring them to admit to having a problem (Miller & Rose, 2009).
- MI is less effective with clients/patients who are already clearly committed to change and ready for action. These patients may benefit from more active problem-solving support instead.
- MI works well with minority populations. It has characteristics that fit with the Latino cultural values of respecto and personalismo (Anez, Silba, Paris, & Bedregal, 2008), and has larger effects with African American patients than with White patients (Miller & Rose, 2009). MI has also been adapted specifically for Native American patients (Tomlin, Walker, Grover, Arquette & Stewart, n.d.; Venner et al., 2006).
- MI has been tested primarily in adults, but it is also effective in changing behaviours for adolescents (Berg-Smith et al., 1999) and children (Lozano et al., 2010; Resnicow, Davis, & Rollnick, 2006; Schwartz et al., 2007; Suarez & Mullins, 2008; Weinstein, Harrison, & Benton, 2006).
- MI has also been adapted for use in palliative care (Pollak, Childers, & Arnold, 2011).
- MI works quickly; you get results from your efforts right away (Rollnick, et al., 2008).
- Training in MI improves client/patient communication and lifestyle counselling behaviours (Söderlund, Madson, Rubak, & Nilsen, 2011). Primary healthcare providers report that using MI improves and enriches their practice (Brobeck, Bergh, Odencrants, & Hildingh)."

Taken from Motivational Interviewing & HIV: Reducing Risk, Inspiring Change. Mountain Plains AIDS Education and Training Centre.

Participant Worksheet

Prevention – Using Motivational Interviewing techniques

MI – Initiator Scripts

Script One

"I'm feeling quite low today, I was out all weekend again… and it was fun, I ended up not sleeping though and having sex and taking drugs all weekend and missed work on Monday. I've got to go to this birthday party next weekend. I'm worried the same thing is going to happen again. I don't really think I can get out of going."

Script Two

"I've been such a idiot the last few weeks with everything that's been going on. I've had lots of sex without a condom with different partners. I know the risks but in the moment I just don't care. Then after I feel so stupid. I'm sorry. I don't really know why I'm here."

Script Three

"I don't know whether to be concerned or not, but I get so out of it at the weekends that I keep missing taking my meds. I take them when I remember and sometimes I've taken two doses just to be sure, but I just cant seem to get my head around getting into a routine to take them."

Online Support Materials

Prevention

Using Motivational Interviewing techniques in your work.

"To start – Motivational Interviewing (MI) is a communication strategy that is a guided and client based communication strategy. It is not Counselling, although it can be used as part of a therapeutic session.

The goal of MI is to help the person you are working with explore and resolve ambivalence in order to change unhealthy or problematic behaviours. The heart of MI is a spirit of empathy, acceptance, respect, honesty, and caring (Moyers, Miller, & Hendrickson, 2005).

MI offers specific reinforcing manoeuvres for every step of the way as the client advances, often in a spiralling fashion, toward change.

It is a stage-based model, and is a person-centred, goal-oriented approach for facilitating change through exploring and resolving ambivalence. Pragmatic strategies are tailored to the client's level of willingness to adjust his or her behaviour.

Originally published in 1991 for substance abuse counselling, the MI approach has been studied in more than 200 randomized controlled trials for various health behaviours (Miller & Rollnick, 1991; Rollnick, Miller, & Butler, 2008).

So what is the evidence of the effectiveness of MI as an intervention?

Research has shown that:

- MI enhances change for a range of behaviours, including diet, exercise, medication adherence, reducing the use of alcohol and illicit drugs, safer sex practices, and medication adherence (Burke et al., 2003; Hettema et al., 2005; Rubak et al., 2005).
- Adding MI to other active treatments improves outcomes.
- When MI is compared to other established counselling methods, outcomes are similar despite the lower intensity of MI. MI produces positive oncomes at lower cost and effort.
- MI works well with clients/patients who are angry, resistant, or less ready to change. One of the original studies offered a 'drinker's check-up' to patients with unacknowledged alcoholism. MI helped these patients change their drinking, without first requiring them to admit to having a problem (Miller & Rose, 2009).
- MI is less effective with clients/patients who are already clearly committed to change and ready for action. These patients may benefit from more active problem-solving support instead.
- MI works well with minority populations. It has characteristics that fit with the Latino cultural values of respecto and personalismo (Anez, Silba, Paris, & Bedregal, 2008), and has larger effects with African American patients than with White patients (Miller & Rose, 2009). MI has also been adapted specifically for Native American patients (Tomlin, Walker, Grover, Arquette, & Stewart, n.d.; Venner et al., 2006).
- MI works quickly; you get results from your efforts right away (Rollnick, et al., 2008).
- Training in MI improves client/patient communication and lifestyle counselling behaviours (Söderlund, Madson, Rubak, & Nilsen, 2011). Primary healthcare providers report that using MI improves and enriches their practice (Brobeck, Bergh, Odencrants, & Hildingh).

Although MI has traditionally been delivered in a One-to-One in-person format, research suggests that it is also effective when delivered in a group setting (Santa Ana, Wulfert, & Nietert, 2007), or by telephone (Cook, 2006).

Ongoing studies will help to determine whether MI can be effectively delivered via email, text messaging, or social networking. Current data suggest that MI messages delivered in an electronic format work as an addition to telephonic MI counselling (Battaglia, Benson, Cook, & Prochazka, in press).

Research also shows that MI can be used by a range of health educators and can be delivered successfully by client/patient counsellors from many different professional backgrounds, including:

- nurses (Cook & Sakraida, 2006),
- paediatricians (Lozano et al., 2010),
- dentists (Weinstein et al., 2006),
- patient educators (Cook, Bremer, Ayala, & Kahook, 2010),
- pharmacists (Basiago, 2007),
- school nurses (Robbins, Pfeiffer, Maier, LaDrig, & Berg-Smith, 2012),
- teachers (Cook, Richardson, & Wilson, 2012), and
- mental health and substance abuse professionals (Miller & Rollnick, 1991).

So, now we've looked at what MI is and what research says about it, lets move onto how we can best engage with MI and use the some tools that may be useful when using MI in a variety of situations.

There are a couple of useful tools that we can use to guide the conversations we have when using MI – OARS and LURE.

OARS.

One easy way to start using MI is to apply the acronym OARS (Miller & Rollnick, 1991). You are practicing MI when you use:

Open (rather than closed) questions

- "How do you feel about that?" (open) versus "Did that make you mad?" (closed)
- "Tell me about the last time you used meth." (open) versus "You quit using drugs – right?" (closed and leading)

Affirmations (for positive reinforcement)

- "You're doing a good job of keeping your appointments."
- "Congratulations on taking your medications regularly – that can be difficult for some people!"

Reflections (repeat, rephrase, paraphrase)

- "It sounds like you are worried about your headaches."
- "Are you saying that you are afraid to ask your partner to use condoms?"

Summary (2 or 3 key points raised by the patient)

- "So the main things you want to do today are to see your test results and find out about the support group."
- "It looks like we have your new exercise plan in place and you will start with Step 1 tomorrow."

LURE.

This is another way to approach an MI conversation with someone.

LURE has been rearranged from the originally published RULE (Rollnick et al. 2008) to help avoid unhelpful communication patterns that may happen and because listening to a patient/client/person before making a suggestion is the most useful practice.

LISTEN to your client/patient:

- MI involves at least as much listening as informing, and you can only understand your client/patient's motivation by listening.
- Good quality listening is part of good general healthcare.
- Listening is a display of empathy that shows your client/patient you are really interested in them.

UNDERSTAND your client/patient's motivations:

- The client/patient's reasons, rather than the provider's, are more likely to trigger behaviour change.
- The provider helps by expressing interest in the client/patient's values, concerns, motivations, and life context.

RESIST the urge to correct the client/patient. Rollnick and colleagues (2008) refer to this as the "righting reflex." Care providers have a powerful desire to heal, prevent harm, and 'set the patient straight,' but this can have a paradoxical effect because people don't like to be told what to do.

The MI practitioner resists the righting reflex through the use of reflective listening:

- "You're saying that if you tell your partner you want to use condoms, he will become angry at you."
- "You don't want to take antiretroviral medications because they will place an extra burden on your liver on top of your current alcohol consumption."

EMPOWER your client/patient:

- Health outcomes are better when clients/patients take an interest in and play an active role in their care.
- You empower your clients/patients when you help them explore the ways they can take control of their health.
- Clients/patients are essential consultants on their own lives and on the ways in which they can successfully build behaviour change into their daily routines.
- Empowered clients/patients are more likely to sustain changes that sacrifice short-term convenience for long-term risk reduction.
- Practitioners empower clients/patients by soliciting options from them, and by maintaining a balance of power in the healthcare relationship. Options and solutions generated by the client/patient are more likely to be successful than options generated by the provider. Clients/patients do best when they take an active role in their care.

MI can also be seen to work when using an approach like the Stages of Change Model.

The Stages of Change Model (Prochaska & Velicer, 1997) provides a framework you can use to help your clients/patients make positive health changes at every level of readiness. Understanding these stages will help you determine their readiness to change and provide appropriate guidance.

People may be more or less ready to change their behaviours at any given point in time, and different messages are appropriate for people at different stages of readiness for change.

Here, the goal is to identify where the person you are working with is in the change process in order to determine what interventions might work best.

As ever, start with an open-ended question or statement:

- "I see your nurse practitioner recommended that you start taking ART. Tell me what you think about that."
- "What's been happening with your plan to quit smoking?"

The questions in the following sections are intended to be examples or conversation starters to help you and your clients/patients have a discussion about change.

They are not a script to follow or a research survey.
Several of them or none of them can be used in any given encounter. Remember that making an authentic connection with the person you are working with and trying to truly understand their perspective is the key to success in MI.

PRECONTEMPLATION STAGE

Clients/Patients in the Precontemplation Stage of readiness may not realize there is a problem and have not yet thought about changing.

Goals are to:

- **bring awareness of the problem to the surface so the client/patient can start *thinking about it, and***
- **keep the client/patient engaged in the process.**

It is easy to turn these 'uncommitted' people off during this stage, so choose appropriate messages. Remember that you want to keep the door open for future discussions.

LISTEN to concerns

Reflect content:

- "It sounds like you want to be sure that our discussion here is confidential."
- "I heard you say that you have a cough but don't think you can stop smoking."
- "You would like your partner to stop nagging you."

Reflect emotion:

- "So you feel overwhelmed?"
- "It sounds like you're feeling depressed."

Summarize:

- "You really enjoy smoking."
- "It seems that you don't think you can say no when your partner wants to have sex."

ELICIT more information

Past experiences:

- "Tell me about when you tried to quit smoking before."
- "What happened when you asked him to use condoms?"

Current strengths:

- "How do you manage to exercise so consistently?"
- "You're so good about coming in for your appointments. What helps you remember?

Current attitudes:

- "What do you think about changing your medicines?"
- "How do you feel about using condoms when you have sex with new partners?"
- "More and more people are hooking up online. What do you think about that?"

COMMUNICATE caring

Empathy:

- "That sounds really hard. How did you handle it?"

Honesty:

- "I might be scared too if my CD4 count were dropping."

Acceptance:

- "You get to decide; it's your health."
- "You're the only one who can make these decisions, but I can help you look at the issue and explore your options."

CONTEMPLATION STAGE

Clients/Patients in the Contemplation Stage are willing to think about making a change, but not yet ready to do something about it.

The goal is to move the person you are working with toward action by:

- **keeping them talking about change,**
- **boosting their awareness of change options, and**
- **increasing the perceived benefits of change.**

DEVELOP discrepancy

Reflect ambivalence:

- "You see benefits to changing, and also some drawbacks."
- "It sounds like you feel stuck."

Explore concerns:

- "How do you think using condoms would affect your sex life?"
- "What concerns you about going on ART?"

Explore values and goals:

- "What are you hoping to gain from treatment?"
- "Tell me how protecting your partner would make a difference."

Reflect intention:

- "It sounds like you want to be safer in your drug use, but you aren't sure how."
- "So you're thinking about creating a plan to take your medications consistently."

Explore context:

- "What has changed in your life that makes now a good time to stop using drugs?"
- "How did your partner's concerns make you decide to use condoms?"
- "Has something changed that is encouraging you to start ART?"

Give feedback:

"Your doctor will tell you why she thinks you need to start ART. I can tell you what others have said, and give you a brochure if you like."

ROLL with resistance. Resistance means that it's time for the provider to change tactics. Try precontemplation strategies instead of arguing or trying to persuade the client/patient.

Apologize:

- "I'm sorry; maybe I misunderstood. Let's go back."

Affirm:

- "I hear your concern about the side effects of the drugs, and it's valid. Let's talk about it."

Accept:

- "Maybe using that herbal remedy wasn't the best idea. If it isn't working for you, we can explore some other options."

Reflect others' concerns:

- "You're not worried, but your partner is. What are his concerns?"

Reframe "yes but" as "yes and":

- "It sounds like you want your plan to work, and you also have some reservations about it."

Clarify:

- "What do you need to move your plan forward?" "How can I help you?"

Amplified reflection: (If you use this strategy, be careful that your tone isn't dismissive or pejorative. If this is said respectfully, most patients will respond with reasons they are ready to change.)

- "Maybe you aren't ready to start ART now."
- "It could be that using condoms is not for you."

SUPPORT self-efficacy

Self-Monitoring:

- "Would you be willing to keep track of how you take your medications for a week? This will help us see any patterns that could indicate when you have trouble remembering your pills."

Past Successes:

- "What strategies have worked for you in the past?"
- "Tell me about the last time you were able to use a condom."

Optimism:

- "What is different now that makes change possible?"

Explore Extremes:

- "What is the best/worst thing that might happen when you start using this plan? What's the likelihood it will happen?"

Commitment:

- "Where do you stand on this issue, at least for today?"

Decision Making:

- "Which of those ideas might you be ready to try?"
- "Do any of these ideas to decrease your alcohol use sound possible for you?"

Autonomy:

- "You are in charge – no one is going to go home with you to check on your progress."
- "You can decide whether you want to do this."

ACTION STAGE

People in the Action Stage are ready to make an initial attempt to change behaviours, but may not be confident yet about their abilities to succeed.

The goal is to decrease the barriers to change.

ENCOURAGE progress

- "I'm impressed with what you've been able to achieve."
- Ask the patient to help you "scale" change:
  - "On a scale of 1-10, where were you before? And where are you today?"
  - "A 7 is great. You've come a long way compared to the 2 where you were at when you started."
  - "Is a 7 where you want to be right now? If not, what would it take to get you to an 8?"

REDUCE barriers

- "What has worked best so far?"
- "What other actions would make that strategy work even better?"
- "Here are some resources that might help you (plan nutritious meals, develop a schedule for taking your medication, etc.)."
- "How can I help you get past this?"

RESTRAIN excessive change

- "It's better not to change too many things all at once. How can you take a small step in this direction?"
- "Where is the best place to start?"
- "What do you think you can do to improve your health this week?"

MAINTENANCE STAGE

People in the Maintenance Stage have succeeded in changing a behaviour, and have sustained the change for at least 6 months.

The goals are to:

- help the patient stay focused, and
- anticipate and reduce the chance of a relapse.

NORMALIZE ups and downs and offer ENCOURAGEMENT

- "It is not unusual for people who have changed a behaviour to occasionally move backward; it is normal. If you know this can happen, you can be prepared to deal with it."
- "A lapse is not a relapse."
- "You did it before and you can do it again. I believe in you."

ENLIST support

- "Is there anyone who can remind you to take your meds?"
- "What other activities could help you stay away from the bars?"
- "Are you ready to share your success with others?"

PLAN ahead

- "What situations may make it hard to maintain your new behaviour? How do you think you will handle those situations?"
- Set a follow-up: "When can we meet again to talk about how things are going?"

RELAPSE

Relapses are a normal and expected part of the process of change. When one occurs, you have an opportunity to help the patient step back and re-assess personal goals, readiness, and the strategies used so far.

The goals are to:

- help them avoid becoming discouraged and
- help them re-engage in the change process.

Use all of your MI skills to help the patient discuss these issues. Some questions that might help start this conversation:

- "Did something trigger your drug use this time?"
- "What affected your ability to take your medications?"
- "You can be proud of not smoking/using/drinking for the last 14 months. That was a big success."
- "Tell me what happened. What do you make of this?"
- "It can be very helpful to know what didn't work. What can you learn from this relapse?"
- "What might you do differently next time?"
- "You have the skills to make this change; you've done it before and you can do it again."
- "Where do we go from here?"
- "A relapse is not a collapse."

Taken from 'Motivational Interviewing & HIV: Reducing Risk, Inspiring Change. Mountain Plains AIDS Education and Training Centre and the Terrence Higgins Trust 'Motivational Interviewing: Tools and Techniques' training course.

Informal Exercise Title:

Awareness about and the use of Treatment as Prevention (TasP or U=U), PrEP, PEP and Self-Testing or Self-Sampling for gay and other MSM.

Study Area/Group:
Prevention

Exercise Aim and/or Purpose:
To increase the access to prevention, including testing services, for HIV, STIs and Viral Hepatitis among MSM and priority subgroups. This exercise allows participants to find out about new prevention technologies and how they can apply them within interventions aimed at gay and other MSM.

Expected exercise outcome:
Participants will have examined and explored the new prevention technologies (TasP or U=U), PrEP, PEP and Self-Testing/Sampling) and planned how to inform gay and other MSM about them.

Materials Required:
- PowerPoint (PPT) slides.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:
- Read up about what are known as 'new technologies' – TasP (U=U), PrEP, PEP and Self-Testing / Self-Sampling – and take into account what will be available locally, what the legal status and economic barriers could be for their use.
- Decide on which 'technologies' to use for the exercise; you can use all 4 covered here or decide to concentrate on 1.
- Be aware of and prepare to deal with questions about the efficacy or ethics around these new technologies and remember that this training is about both providing information about these 'technologies' and challenging stigma and misconceptions about their use and who uses them. For example, many people have an issue with PrEP as it provides no protection against any other STIs apart from HIV, whereas condoms are seen as providing some protection. The basic answer is that this is the case, however if an appropriate protocol is put into place, testing and treatment for STIs is increased as users are linked into care and are more likely to test and treat and be informed about what to look for.
- Read through the 7 A's of Accessibility to familiarise yourself with the process.

Helpful hints for facilitators:
- Let the knowledge, experience and opinions of the participants inform the discussion while keeping in mind your role in providing current and up-to-date information, correcting wrong information and challenging stigma. At the core, the choice the person makes to use the 'technology' is theirs and not ours. Our role is to inform them about how to access and use their choice of 'technology' so that they can be as safe as they want to be.

Method: (40 mins)

1. Ask the group their thoughts on:
   - "What do we mean when we talk about 'New Prevention Technologies'? Which of them are available for us to use/provide here locally?"
2. You are hopefully going to get answers that contain – TasP, PrEP, PEP and Self-Testing and Self-Sampling.
3. Share the PPT slides with the group, taking them through each of the new technologies that you have chosen to use and how they can interlink and support each other i.e. PrEP and TasP link together to prevent HIV… Also take them through the slide on the 7 A's of Accessibility.

Treatment as Prevention (TasP)

- Also known as U=U or Undetectable = Untransmittable
- When people with HIV are on effective treatment and have an undetectable viral load, they cannot pass HIV onto someone else during sex. We do not have enough data yet to be sure that this is also the case for injecting drug users who may share equipment/needles.
- HIV treatment stops the virus from reproducing and reduces the amount of HIV in the blood. The amount of HIV is measured by a blood test called a viral load test.
- When someone has an undetectable viral load this means that there is hardly any HIV in their bodily fluids.
- When there is hardly any HIV in semen, HIV cannot be passed on during sex – even if condoms aren't used.
- Not everyone taking treatment has an undetectable viral load, particularly if they have started treatment within the past six months or if they often take their treatment late or miss doses.

PrEP – or pre-exposure prophylaxis

- PrEP is a pill taken to protect the person from HIV. It is extremely effective when taken properly. PrEP only protects you against HIV.
- One of the main drugs approved for use as PrEP is the branded drug Truvada. PrEP is also available in generic, sometimes unbranded forms which contain the same ingredients as Truvada and work in the same way, both contain 2 active drugs: Tenofovir and Emtricitabine.
- On Demand dosing (or Event Based Dosing) and 4 pills per week are methods suitable only for anal sex.
- Daily PrEP and Holiday PrEP are the only methods of taking PrEP that are suitable for both anal and vaginal or frontal sex and are the recommended methods for both trans people or people with chronic Hepatitis B.

PEP

- A month-long course of HIV treatment taken within 72 hours maximum of supposed infection risk.
- Recommended that PEP be started as soon as possible after supposed exposure to risk, ideally within 24 hours.
- Mainly used for occupational needle stick injuries, and when a condom breaks or is not used with a sexual partner of unknown or different HIV status.

Self-Testing and Self-Sampling

- HIV self-sampling: a kit that allows a user to take a blood spot or saliva sample, post it to a testing lab and receive the results by phone, text or email.
- HIV self-testing: a kit to obtain a blood or saliva sample, test this sample themselves using the test and then gain the result.
- Many countries have approved the use of self-sampling and self-testing kits.
- Self-testing or self-sampling kits for certain STIs are also available in some countries.

The 7 A's of Accessibility

- Awareness: of the 'product' and any associated issues; and of the agencies and services involved in the provision of both information about the product and the product itself.
- Accessibility: to the 'product'; and also to the associated agencies, services and advocates involved.
- Affordability: of the product; both to the supplier and to the user; and of any associated services.
- Appropriateness: of a product in the situation for the client, based on discussion with clients on whether their needs would be or are being met.
- Adequacy: are the client's needs being met?
- Acceptability: is the product acceptable to the client, based on their physical, emotional, psychological and cultural needs?
- Availability: is the product available to the supplier/client? Are there financial or legal barriers?

4. Inform the group that they will now be developing an information intervention around a new technology.
5. Split the people into groups of 3–5 participants.
6. Share the task with the groups; "You have to get information about your chosen technology – TasP, PrEP, PEP or Self-Testing or Self-Sampling to an MSM audience". Encourage them to use the 7 A's of Accessibility to help consider questions such as:
   - What information do you want to get across to gay and other MSM about that technology?
   - What is the best setting or format to use to get information across to your audience? Think about what you know about MSM locally and what works with them.
   - How can you refer men onto appropriate services or signpost to more information? Can you provide them with information or access to the 'technology' via your organisation?
   - How would you deal with any risks around misinformation or stigma about that 'technology' that MSM may hear from friends or other sources?
   - Helping MSM to incorporate the technology into their sexual strategy/strategies. What are the practical ways in which we can help MSM?
7. Depending on whether you have decided to concentrate on one 'technology' or multiples, you can assign each group to work on them or ask the groups to choose a 'technology' to use, ensuring that each of the technologies is covered by the groups.
8. Tell the group they have 40–50 minutes to complete the task.

Facilitated Feedback: (30 mins)

When the allotted time has finished (or before if all groups have completed the task) ask the groups to share their ideas and discussions.

Encourage the groups to feedback using the 7 A's of Acceptability and to include:
- What choices did they make in settings, information given and onward referrals?
- Why they made the choices they did?
- What problems or difficulties did they identify?
- What was easy, or easier than they first thought it may be?

Encourage the group to read the Online Support Materials module of the exercise if they want more background information on these 'technologies' and then close the exercise.

Online Support Materials

Prevention

Awareness about, and the use of, TasP (U=U), PrEP, PEP and Self Testing or Self Sampling for MSM.

We will now be considering what are sometimes known as new prevention technologies – they are Treatment as Prevention (TasP), Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP) and Self-Testing/ Self-Sampling

Treatment as Prevention (TasP)

"HIV treatment has been shown to be beneficial both to individual health and in decreasing the risk of transmission to the individual's partner(s).

The sexual transmission of HIV from an HIV-positive person to their partner is correlated with concentrations of HIV in the genital tract and genital fluids, which is the mechanism for how combination antiretroviral treatment (ART) reduces sexual transmission of HIV.

Studies evaluating HIV transmission were carried out mostly on heterosexual HIV-discordant couples and have shown that treatment of persons with HIV can reduce the risk of sexual transmission of HIV to their partner by over 90%.

The results of the PARTNER study, which included MSM discordant couples, have confirmed these findings for the MSM population by not detecting any episodes of linked HIV transmission from men infected with HIV and a viral load below the limit of detection. It has been estimated that the majority of HIV transmissions among MSM in UK settings occur before the positive partner is diagnosed. Therefore, the main efforts for effective HIV prevention and care programmes in EU/EEA settings will be focused on achieving high and regular testing frequency for those MSM most at-risk and facilitating treatment access and adherence to treatment among those who are tested positive.

New data from the Partner II study, which concentrated on sero-discordant MSM couples support the findings of the orginal PARTNER study. Neither of these studies observed any genetically linked infections while the partner living with HIV was virally suppressed and the couples were engaging in condomless sex and not using PrEP. In these studies, viral suppression was defined as less than 200 copies of HIV RNA per millilitre of blood; most participants living with HIV had less than 50 copies of HIV RNA per millilitre of blood. Couples in both studies engaged in over 100,000 sex acts without a condom or PrEP – and the transmission risk estimates and their corresponding 95% confidence levels are reported as a 0.00 risk (0.00-0.24) per 100 couple years. This is why we can now say with confidence that Undetectable equals Untransmittable and that partners living with HIV on effective treatment cannot pass on their HIV."

Taken from the National Centre for HIV/AIDS, Viral Hepatitis, STI and TB Prevention. USA – December 2018

"A simple explanation which may be useful for explaining Treatment as Prevention is:

- When people with HIV are taking anti-HIV drugs and have an undetectable viral load, it is extremely unlikely they will pass HIV onto someone else.
- HIV treatment stops the virus from reproducing and reduces the amount of HIV in the blood. The amount of HIV is measured by a blood test called a viral load test.
- When someone has an undetectable viral load this means that there is hardly any HIV in their bodily fluids.
- When there is hardly any HIV in semen (and vaginal fluids) it is extremely unlikely that HIV will be passed on during sex – even if condoms aren't used.
- Not everyone taking treatment has an undetectable viral load, particularly if they have started treatment within the past few months or if they often take their treatment late or miss doses."

Pre-exposure prophylaxis (PrEP)

"PrEP is a method to reduce the risk of HIV infection in HIV-negative adults who are at high risk of HIV exposure. The treatment includes the use of oral antiretrovirals in order to prevent the virus from establishing a permanent infection. Detectable drug levels in the blood strongly correlated with the prophylactic effect, emphasising the importance of adherence to PrEP.

The final results of the extension of a large clinical trial (iPrEX OLE) conducted among MSM and transgender women showed that good adherence to PrEP was associated with a risk reduction of 84% for HIV infection.

While it was expected that open-label, non-trial use of PrEP might result in lower efficacy, the UK PROUD trial of 545 MSM randomised to immediate or deferred daily PrEP arms, found an 86% reduction among men in the immediate PrEP arm, and equal rates of rectal STIs and high condom use in both groups throughout the course of the trial, indicating that men had incorporated PrEP into existing risk-reduction strategies.

The French IPERGAY study carried out on 400 MSM, also demonstrated an 86% reduction in HIV infection among MSM taking intermittent PrEP (two tablets 2–24 hours before sex, one tablet 24 hours later, and one tablet 48 hours subsequent to the first dose) as compared to the placebo arm. High efficacy was achieved despite the fact that only 43% of MSM reported taking PrEP optimally during their last intercourse.

These studies provide strong evidence on the efficacy of PrEP and indicate that serious consideration should be given to its inclusion in the 'HIV prevention toolbox', especially for those MSM most at risk of acquiring infection.

WHO has included a new recommendation on the use of PrEP in MSM as an additional prevention choice within a comprehensive HIV prevention package, in the consolidated guidelines for HIV prevention, released in July 2014. The US has recommended it since 2012, although implementation in many areas has been slower than anticipated.

The high efficacy of PrEP in reducing the risk of sexually acquired HIV infection has recently been shown in a number of randomized controlled trials, including two conducted among MSM in Europe. In July 2016 the European Medicines Agency recommended granting market authorisation for the use of antiretroviral medication for PrEP, and this recommendation was approved by the European Commission in August 2016.

Currently two countries in Europe, France and Norway, provide PrEP through their public health services. However, there is not yet clear consensus across Europe with regard to how to implement PrEP."

Post-exposure prophylaxis (PEP)

"Post-exposure ARV-based prophylaxis is approved for use in Europe and should be started as soon as possible after HIV risk exposure, but always within 48–72 hours. Treatment should be continued for 28 days, unless the source individual is determined to be HIV negative.

PEP has consistently been shown to reduce HIV transmission in animal studies and was originally introduced to reduce transmission following needle stick injuries. For ethical reasons no randomised controlled trial has been conducted. Observational studies show consistent protection, but of various degrees.

Apart from occupational PEP and PEP in situations of sexual assault, in most countries PEP is also recommended to individuals having had anal intercourse without a condom with partner of unknown HIV serostatus, seeking care within 48–72 hours.

The most common use of non-occupational PEP is in discordant couples (where the index partner is not on ART) due to condom breakage or failure. US and most European guidelines also specifically include individuals having had unprotected receptive anal intercourse with a homosexual or bisexual man of unknown HIV-status as eligible for PEP.

Since antiretroviral medication also carries a risk of adverse events, individual benefit of PEP needs to be weighed against risks, and in countries where PEP is available, it is a clinical decision based on individual benefit, rather than a strict guideline-based measure.

PEP has not been associated with an increase in high-risk sexual behaviour among MSM, and has rarely been promoted as a main prevention method to the MSM population. Awareness of PEP and perceived access to PEP is low among MSM in most European countries, indicating that PEP is not a first-line prevention intervention.

A Danish study showed only a modest increase in requests for PEP despite having a PEP knowledgeable MSM population and easy access to the treatment. A study evaluating Amsterdam's PEP programme found a similar trend of a very modest increase in PEP requests, however 75% of requests were from MSM.

In EMIS 2010, less than 2% of respondents in 26 of the 38 countries included reported ever having accessed PEP; the remaining countries reported slightly higher use, with respondents in France reporting the highest use, although still only 9%.

The low use of PEP in most European settings could be explained by low awareness or low perceived needs of or for the intervention. Access is also an important issue and in the 2010 EMIS survey, about one-third of European countries reported that PEP could not be accessed for free.

There is a large variation across Europe with respect to how often PEP is considered and prescribed for HIV prevention. MSM who are exposed to HIV – regardless of the reason for exposure – have a right to be informed about all potential interventions, including knowledge about what PEP is and where it can be obtained. EMIS 2010 findings suggest that condom accidents and a consistent lack of knowledge on how to use condoms correctly, rather than carelessness, are associated with exposure to HIV and related experience of PEP.

It has been strongly suggested by authorities such as ECDC that knowledge about PEP should be promoted to MSM and PEP should be provided at clinics targeting MSM or sexual health where feasible. PEP should be offered to MSM having had sex without a condom with a partner living with HIV of unknown viral load status, and additionally to MSM who have had receptive anal sex with a partner of unknown HIV status and who seek care within 48–72 hours."

HIV self-sampling and self-testing

"HIV self-sampling consists of a kit that allows a user to take a blood or saliva sample from themselves, post it to a testing lab and receive the result by phone, text or email.

HIV self-testing implies that the patient would obtain a sample at his own convenience, such as an oral fluid swab, self-administer the test and then interpret the result. Some countries have approved or are in the process of approving the sale of self-testing kits for HIV.

The UK became the first country to initiate the sale of tests for home testing in April 2015. These kits will permit the individual to produce their own sample and run the test in their own home, with a result in 15–40 minutes.

Self-testing might increase testing frequency due to test availability and easy access, but it requires careful quality assurance to minimise false negative and false positive results as well as well-defined pathways for accessing confirmatory testing and counselling in order to ensure linkage to care, and access to prevention and support.

New WHO guidelines recommend that countries should increase the available range of innovative HIV self-testing strategies in order to increase testing uptake. To date, the implementation of self-sampling and self-testing is relatively limited in Europe.

According to the Barring the Way to Health database, HIV self-sampling (i.e. taking a sample at home and posting it to a laboratory where testing is performed) is legal in 5 of the countries which were included in EMIS 2010, including Belgium, Ireland, the Netherlands, Switzerland and the UK.

HIV self-testing (i.e. taking a sample and conducting the test at home) is legalized in France and an approved product is available for purchase. In the UK, self-testing was legalized in April 2014, and the first HIV self-testing kit was released to the market in April 2015. Initial results show that 75% of tests have been sold to people living outside urban areas, and that half of users purchasing the test had not tested for HIV before.

Test orders were closely tied to external influences (e.g. World AIDS Day, National AIDS Week), with increases in orders when HIV was in the press and/or when the kit was advertised through social networks.

Qualitative research among MSM in the UK reported that the primary perceived benefit of self-testing (and to a lesser extent self-sampling) was increased anonymity for individuals who were concerned about privacy and confidentiality when testing Face-to-Face. Self-testing was also perceived to be potentially beneficial for those that were not yet out about their sexuality, such as young men, those who also had relationships with women, men living in rural areas, and those from ethnic and cultural communities where disclosure of homosexual activity remained taboo. Perceived drawbacks of self-testing included fear of having a reactive result without any immediate personal support, mens' concerns about their ability to perform the test, and cost (self-testing kits must be purchased in the UK), given that tests are available free of charge in other settings, including self-sampling.

Outside of France and the UK, the legalization and availability of HIV self-testing is limited in Europe. In Belgium the sale of self-testing kits is permitted, but as of mid to late 2016 no products were officially available for sale on the market, and under current policies Belgian health insurance does not cover the cost of the test. In the Netherlands guidelines on the use of self-tests have been published but no public policy has been established, and no tests have been approved for the Dutch market. In Germany current legislative provisions do not permit the sale of self-tests and they are considered 'medical devices' which must be administered by a health professional. Spain is currently considering the inclusion of HIV self-tests, but no kit has yet been authorized for sale. According to the Barring the Way to Health database, self-testing is legal in a number of Eastern European countries (Czech Republic, Estonia, Moldova, Poland, Romania, Russia, Ukraine), however the accuracy of these data were not verified with country contacts."

Taken from ECDC: HIV and STI prevention among men who have sex with men. Stockholm: ECDC 2015 and the Terrence Higgins Trust website.

Informal Exercise Title:

Frontline Interventions' – working with MSM using One-to- One and Group advice, Counselling and Therapy and Community HIV and STI testing Interventions.

Study Area/Group:
Prevention

Exercise Aim and/or Purpose:
This exercise allows participants to explore and increase their knowledge around One- to-One and group advice and information giving (including outreach work carried out online), MI and therapeutic change (counselling) and Community HIV and STI testing.

Expected exercise outcome:
Participants will have explored the range of prevention frontline interventions, and the groups experience of providing them.

Materials Required:
- PowerPoint (PPT) slides.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:
- Decide if you want to concentrate on one of the interventions or a couple. It is not worth covering Motivational Interviewing (MI) if you have already done the practical session that covers the skills. The discussion here is more about the differences between counselling and MI.
- Identify examples of work for your chosen intervention/s, including online examples.
- If there are any local guidelines, protocols or boundaries on the interventions you have chosen, inform yourself of what they are and how they affect the work.
- Read through the 5 'C's for HIV Testing Services and think about whether they are still relevant for all MSM, especially in community settings.

Helpful hints for facilitators:
- This exercise is more suitable for people who are new to the work done with gay and other MSM around HIV and sexual health, rather than experienced workers.
- These exercises help share experience and skills across the people within the group you are working with, so it's more about talking around what happens, what could happen and what is the best practice in your local area, rather than 'this is the only way to do this'.

Exercise: Exploring giving information or advice either One-to-One or in/at a group and including online outreach.

Method: (30 mins)

1. Inform the group that we will now be considering information and advice giving both in One-to-One and group situations and also including work carried out online.
2. Ask the group to share their thoughts and experience around what is meant by One-to-One or group advice or information giving.
3. Capture the definitions as bullet points on a flipchart.
4. If you think it's useful show the PPT slide/s containing information around base definitions.

One-to-One or Group – Information and/or Advice

- To give information or advice to a person or a group of people on a range of social or personal issues.
- Online Outreach: To perform this task in an online forum via a website or online app.
- They are usually a one-off intervention.

5. Ask the group to share examples of a typical One-to-One or group advice or information intervention
   - What kind of information or advice? (advice about what?)
   - Where do you provide these interventions? What settings?
   - What resources do you/will you need to help?
   - How could we improve on what we do already? Have you seen examples of work from other places?
6. Ask the group if any of them have experience of carrying out online advice or information work.
7. If so, can they share how they do it and how it is different from Face-to-Face work?
8. If not, how do they think it would be different to Face-to-Face work?
9. For both questions you are looking for issues such as:
   - You cannot see the person you are talking with so can't read facial expressions and body language.
   - The person you are chatting with could think that you are telling them what to do.
   - It can be more difficult to ask and answer questions when you are typing/texting rather than just talking with someone.
10. Inform the group there is more information about One-to-One and group advice and information on the Online Support Materials of this exercise.

Exercise: Exploring Motivational Interviewing, One-to-One or group therapeutic change (Counselling/Groups)

Method: (30 mins)

1. Inform the group that we will now consider Motivational Interviewing (MI), and therapeutic work both in One-to-One and group situations.
2. Ask the group to share their ideas of what MI is and capture those on a flipchart. These can be quite loose definitions; they don't have to fit exactly what the flipchart says.
3. Ask the group to share their ideas of what One-to-One and group therapeutic change is and capture those on a flipchart. Again these can be quite loose ideas/thoughts.
4. Share the PPT slide/s containing information around definitions.

Motivational Interviewing (MI)

Motivational Interviewing is a brief treatment model designed to help clients low in motivation to change and realise the need for change with self-identified risk behaviours.

- One-to-One Therapeutic work (Counselling)

Assisting and guiding clients/people, especially by a trained person on a professional basis, to resolve personal, social or psychological issues, problems or difficulties. Usually a multiple session intervention, although single sessions of counselling usually given alongside HIV testing.

- Group Therapeutic work (Groupwork)

Groupwork describes a variety of interventions, delivered to a collection of people with a common interest and can have a number of functions including the imparting of information, building of skills, social capacity and knowledge and the resolution of psychosocial conflicts.

5. Ask the group for any examples of work they know or carry out using MI or therapeutic change either One-to-One or in groups.
   - How and where does it happen?
   - What is the difference between working One-to-One and working in groups?
   - How is it different from advice or information giving work? Do the two approaches mix? Could you use MI when outreach working?
6. More on MI can be found in the Quality Action Training and links to the website will be available on the Online Support Materials of this exercise. You could link the participants there if they have any further questions.

Exercise: Exploring Community HIV and STI testing

Method: (30 mins)

1. Inform the group that we will consider Community HIV and STI testing
2. Share the information around Community HIV and STI testing via the PPT slides

Community Testing: HIV and STIs

- Usually carried out within Checkpoints or other community settings (CBVCT), MSM can be checked for both HIV and a range of STIs using rapid and lab sample tests (blood, saliva and urine)
- Community Testing can be seen to have an advantage over clinical based testing because of its link to the community it serves. Issues of identification, homophobia and being 'outed' are lessened within community contexts.
- Information and a toolkit around Checkpoints has been developed by Euro HIV EDAT https://eurohivedat.eu/
  or www.msm-checkpoints.eu
- Information and tools to challenge barriers to testing and linkage to care have been developed by OptTEST www.opttest.eu

The WHO 5 'C's for HIV Testing Services

1. Consent
2. Confidentiality
3. Counselling
4. Correct Results
5. Connection

Guidance available at: https://apps.who.int/iris/handle/10665/179870

3. Show the PPT slide and introduce the group to the idea of the 5 'C's introduced by WHO in 2015. According to WHO, the 5 C's are principles that apply to all HIV Testing Services (HTS) and in 'all circumstances'.
   - **Consent**: People receiving HTS must give informed consent to be tested and counselled. (Verbal consent is sufficient; written consent is not required.) They should be informed of the process for HIV testing and counselling and of their right to decline testing.
   - **Confidentiality**: HTS must be confidential, meaning that what the HTS provider and the client discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Confidentiality should be respected, but it should not be allowed to reinforce secrecy, stigma or shame. Counsellors should discuss, among other issues, whom the person may wish to inform and how they would like this to be done. Shared confidentiality with a partner or family members – trusted others – and healthcare providers is often highly beneficial.
   - **Counselling**: Pre-test information can be provided in a group setting, but all people should have the opportunity to ask questions in a private setting if they request it. All HIV testing must be accompanied by appropriate and high-quality post-test counselling, based on the specific HIV test result and HIV status reported. Quality assurance (QA) mechanisms as well as supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counselling.
   - **Correct**: Providers of HIV testing should strive to provide high-quality testing services, and QA mechanisms should ensure that people receive a correct diagnosis. QA may include both internal and external measures and should receive support from the national reference laboratory. All people who receive a positive HIV diagnosis should be retested to verify their diagnosis before initiation of HIV care or treatment.
   - **Connection**: Linkage to prevention, treatment and care services should include effective and appropriate follow-up, including long-term prevention and treatment support. Providing HTS where there is no access to care, or poor linkage to care, including antiretroviral treatment (ART), has limited benefit for those with HIV.

4. Ask the group if anyone has any experience of working on or providing community HIV or STI testing.
5. If yes, ask a few participants if they still use all of the 5 C's and if they consider them enablers or barriers. For example, do all gay and other MSM need pre- and post-test 'counselling'? Has it become a barrier to accessing the test itself? Could participants share 3 learning points they feel are important from the experience of providing community based testing. If not, end the discussion, or use your own experiences if relevant.

   At the end of the session/s you have chosen, close the exercise.

Online Support Materials

Prevention

'Frontline Interventions': working with MSM using One-to-One and group advice and information interventions; Motivational Interviewing and Counselling and Community HIV and STI testing.

Now you are going to consider the interventions that are used at the frontline of prevention. We will consider giving information or advice, both Face-to-Face (F2F) (or One-to-One), in groups and online; then looking at behavioural or therapeutic change including Motivational Interviewing (MI), again in F2F and group situations.

We will also explore Community HIV/STI Testing and finally other media such as print and broadcast.

Thinking about giving information and advice, I'd like you to think about and make note of interventions that either use One-to-One or group settings to give information or advice, or situations and settings you are in when people approach you (as a representative of your organisation) to ask for information or advice. Think about the range of information or advice that is chosen to be given to an MSM audience as well as the range of situations and settings you are in when you are approached for information or advice. It may also help to think about the resources you need to help you.

You have 10 minutes to do this task.

Now we are going to think about online settings. In giving advice or information in an online setting what are the issues that you will need to remember?

Suggestions/ideas?

- Removed from visual signals
- Issues with being perceived as 'directive'
- Phrasing answers in a way that is satisfactory to both sides
- Etc.

Now that you have thought about that, can you identify and note down any examples that you know of that use online settings to give advice or information? (Do we consider organisational websites aimed at MSM as portals of information or advice as well as 'chatroom' settings?)

Now onto therapeutic behaviour change. Firstly what do we mean by therapeutic behaviour change? A basic definition says that all behaviour is learned so can be 'unlearned' or behaviours felt to be 'unhealthy', changed.

Therapeutic Behaviour Change does this by using a range of therapies such as Cognitive Behavioural Therapy to help people identify the issues that are stopping the desired change and develop solutions to bypass those issues and get to the desired behaviour. Motivational Interviewing is a talking or conversational tool that uses a formula to help clients/people identify their issues and think about and identify their own solutions.

Now that we've gone through the definition, can you identify and note down examples of One-to-One and group therapeutic interventions; the issues they can cover, the forms that they take, and if you know of any, the models (such as CBT) that they use? Again, you have 10 minutes for this exercise.

Quality Action Training: www.qualityaction.eu

Community HIV/STI Testing

Usually carried out within Checkpoints or other community settings (CBVCT), MSM can be checked for both HIV and a range of STIs using rapid and lab sample tests (blood, saliva and urine).

Community Testing can be seen to have an advantage over clinical-based testing because of its link to the community it serves. Issues of identification, homophobia and being outed are lessened within community contexts.

The World Health Organisation built guidance around HIV Testing Services in 2015 that incorporated the idea of 5 'C's. The 5 C's are principles that apply to all HIV Testing Services (HTS) and in 'all circumstances'.

- **Consent**: People receiving HTS must give informed consent to be tested and counselled. (Verbal consent is sufficient; written consent is not required.) They should be informed of the process for HIV testing and counselling and of their right to decline testing.
- **Confidentiality**: HTS must be confidential, meaning that what the HTS provider and the client discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Confidentiality should be respected, but it should not be allowed to reinforce secrecy, stigma or shame. Counsellors should discuss, among other issues, whom the person may wish to inform and how they would like this to be done. Shared confidentiality with a partner or family members – trusted others – and healthcare providers is often highly beneficial.
- **Counselling**: Pre-test information can be provided in a group setting, but all people should have the opportunity to ask questions in a private setting if they request it. All HIV testing must be accompanied by appropriate and high-quality post-test counselling, based on the specific HIV test result and HIV status reported. Quality assurance (QA) mechanisms as well as supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counselling.
- **Correct**: Providers of HIV testing should strive to provide high-quality testing services, and QA mechanisms should ensure that people receive a correct diagnosis. QA may include both internal and external measures and should receive support from the national reference laboratory. All people who receive a positive HIV diagnosis should be retested to **verify** their diagnosis before initiation of HIV care or treatment.
- **Connection**: Linkage to prevention, treatment and care services should include effective and appropriate follow-up, including long-term prevention and treatment support. **Providing HTS where there is no access to care, or poor linkage to care, including ART, has limited benefit for those with HIV**.

Information and a toolkit around Checkpoints has been developed by Euro HIV EDAT https://eurohivedat.eu/

Information and tools to challenge barriers to testing and linkage to care have been developed by OptTEST www.opttest.eu

Read through the WHO 5 'C's and the toolkit at Euro HIV EDAT and answer the following questions:

- What is the collective level impact community based voluntary counselling and testing (VCT) can have?
- What could you do to reach at-risk and hard to reach MSM?
- How do you make it easy to use community based testing centres?
- What are the best ways to build a comprehensive and positive approach to sexual health for MSM?
- What are the best ways to keep community based testing services running?
- Are there advantages of one setting over another for community based testing services?
- What are the comparative benefits of traditional versus rapid tests?
- What are the best ways to ensure proper monitoring and evaluation of the service?
- How do you make the service acceptable to your target audience?
- How do you ensure confidentiality and appropriate and acceptable counselling services at a community setting? When could counselling become a barrier rather than an enabler?

"In developing and providing information across a number of interventions, whether in print or online, there are some recommendations you can follow to help them be as effective and acceptable as possible to your target audience, including the barriers and facilitators to communication.

They are:

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.

Facilitator: Giving accurate information.

Barrier: Giving too much information in too complex language.

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.

Facilitator: Relationship between provider of information and recipient.

Barrier: No knowledge of, or trust of information provider by recipient.

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.

Facilitator: Useful accurate information that enables self-respect, and the recipient to use the knowledge.

Barrier: Confusing the audience/recipients.

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.

Facilitator: Enabling recipients to be a part of the process of development and engaged with the information.

Barrier: Telling people what you think they should do.

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.

Facilitator: Using language and imagery familiar to the recipients in the right context.

Barrier: Using over complicated language and inappropriate imagery."

Further information about this is available in the ECDC Technical document, 'Communication strategies for the prevention of HIV, STI and hepatitis among MSM in Europe'.

2.2 Face-to-Face and E-Learning Material

Prevention 2.2.1

- STIs – Symptoms and Treatments
- ChemSex – Sexualised Substance Use
- What is Safer Sex Now?
- Understanding the epidemiological dynamics of HIV infection in MSM in Europe

The E-Learning material can be accessed via the ESTICOM training platform www.msm-trainings.org.

Informal Exercise Title:

Informal Exercise Title: STIs, Symptoms and Treatments

Study Area/Group:
Prevention

Exercise Aim and/or Purpose:
This exercise allows participants to build their knowledge around the symptoms and treatments around STIs including HIV for gay and other MSM.

Expected exercise outcome:
Participants will have a better understanding of STI epidemiology, transmission risks, prevention options, resistance, symptoms and treatments.

Materials Required:
- PowerPoint (PPT) slides.
- Print outs of STI Exposure: tell-tale symptoms – one for each participant OR
- Kahoot! format for STI symptoms.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:
- You can decide to run this as a general exercise using most or all of the identified STIs or concentrate on one STI that may be of local interest such as hepatitis. Think about the local situation and need.
- You may find it useful to read the information in the E-Learning module component of this exercise for further information around STIs and treatments.

Helpful hints for facilitators:
- As well as running this exercise using the paper forms, you could always develop/use the Kahoot! game platform to get your answers from the group. www.kahoot.com
- Use the knowledge of the group as well as your own to get answers; you don't have to know everything.
- The STI symptoms form shown in the method section is filled out for illustration purposes only – the forms the participants get are blank. You will have a completely filled form to use to check their answers against.

Method: (40 mins)

1. Tell the group we are now going to explore the range of STIs that MSM may encounter while sexually active, identifying their symptoms and treatments.
2. Explain that there are 2 parts to the exercise; first we will look at the types of STIs MSM might encounter, and then they will undertake an activity in small groups that is about them identifying symptoms and treatment options for a number of STIs.
3. Firstly take the group through the PPT slides on the grouping of STIs and which ones are bacterial, fungal, viral or parasitic.

STI Information

There are four different groups of infections which can be transmitted sexually:
Bacterial, Viral, Parasitic and Fungal.

- **Viruses** are capsules of genetic material (DNA or RNA) surrounded by a protective coat of protein. They can't multiply on their own, so they have to invade a 'host' cell and take over its machinery in order to be able to make more virus particles. The cells of the mucous membranes, such as those in your arse, throat and urethra (piss tube) are particularly open to attacks because they are not covered by protective skin.
- **Bacteria** are organisms made up of just one cell. They are capable of multiplying by themselves, as they have the ability to divide. Bacteria exist everywhere, inside and outside of our bodies. Most bacteria are completely harmless, some of them are useful and some cause diseases. Some bacteria cause disease because they end up in the wrong part of the body or because they are evolved to invade us.
- **Parasites** are minute creatures that live on or inside another creature (the host) and takes their nourishment from the host. A parasite cannot live independently though they can survive for a while without the host.
- **Fungus/Fungi** are plant-like organisms that lack chlorophyll. Since fungi do not have chlorophyll, they must absorb food from other organisms. Fungi like warm, dark and damp places to live.

STI Information

Bacteria	Virus	Parasitic	Fungal
Gonorrhoea NSU Chlamydia Syphilis Gut infections	Hep A Hep B Hep C Herpes Warts HIV	Crabs Scabies	Thrush

4. Explain that now they will work in pairs or groups of 3 to identify some of the more common symptoms for a range of STIs. Make it clear that these are recognised symptoms and many people are 'asymptomatic' or don't show any symptoms. It's important that they make this clear to the MSM they work with. A person may also show symptoms of an infection in the genital area and not in their throat or anus. Remind the group that good practice for testing STIs is to swab the throat and anus as well as taking urethral swabs and blood for testing.
5. Split the group into pairs or 3s.
6. Tell the participants to look at the STI worksheet and they are to look over the symptoms and place an X next to the ones they think are relevant for each of the STIs. Tell them that a couple of the columns are already filled in to give them an idea of what to do.
7. They have 10 mins for this task.
8. When the time has elapsed call them back to the large group.
9. Facilitator to ask the groups to go through their answers, for each STI in turn (e.g. all answers for gonorrhoea before moving onto syphilis). Groups to help inform and challenge any answers alongside the facilitator. Ask them if they identified any 'missed' symptoms and what they are.
   The answers should be along these lines:

STI Exposure – Tell-Tale Signs – Possible Symptoms

SYMPTOMS	GONORRHOEA	CHLAMYDIA	SYPHILIS
Discharge from cock	X	X	
Pain when pissing	X	X	
Sore or blister on cock			X
Itching in or on cock			
Small growths on cock			
Discharge from arse	X	X	
Pain in arse or when shitting	X	X	
Sore or blister in or around arse			X
Itching in or around arse			
Small growths in or around arse			X
Sore throat	X		
Sore or blister in or around mouth or throat			X
Rash			X
Swollen glands			X
Flu-like symptoms			X
Diarrhoea			
Losing weight			
Extreme tiredness			X
Yellowness in skin and white of eyes			
Pale shit or dark piss			
Itching on body			
White patches in mouth			

10 When you have completed answering all symptoms with the group, share the information on the PPT slide around treatment for each of the groups of STIs, informing the group this is a simple format to enable this information to be shared with MSM they encounter/work with.

STI Treatment Options – a simple approach

Bacterial

- Bacterial infections can be quickly treated with antibiotics.

Viral

- Generally, there are no treatments for viruses; they generally have to run their own course. However, there are treatments to keep the virus suppressed. There are vaccines for Hepatitis A and B, individually or together. However there is currently no vaccine for Hepatitis C although drug treatment is available and known as direct acting antivirals (DAAs).
- There is no vaccine for HIV yet there are treatments that can suppress the virus.

Parasitical

- Parasitic skin infections can be relieved and treated with creams and lotions which can be purchased over the counter at the chemist. For parasitic gut infections, a doctor can prescribe specific antibiotic medications that can help.

Fungal

- Fungal infections can be relieved and treated with creams and lotions which can be purchased over the counter.

STIs that present symptoms within 3 days are normally bacterial infections. Viral infections have longer incubation periods. Sometimes they only manifest when the immune system is impaired or run down.

11. Then ask the group to go back into their pairs or 3s and consider the question;
    - "How could you help gay and other MSM feel less guilt around having an STI?"
12. Prompt the group to think of their own experience; have they encountered stigmatising attitudes from doctors and healthcare workers? In the information that is disseminated around STIs?
13. Tell the group they have 15 minutes to discuss this and come up with a suggestion for how they could combat guilt and stigma around STIs for gay and other MSM.

When the time has elapsed get the pairs/3s to feedback on their suggestions. When complete close the exercise.

Participant Worksheet: Prevention – STIs: Symptoms and Treatments

STI exposure – Tell Tale Signs – Possible symptoms

SYMPTOMS	GONORRHOEA	CRABS/ SCABIES	CHLAMYDIA	HIV	HEPATITIS C	HEPATITIS B	HEPATITIS A	HERPES	WARTS	NSP	NSU	THRUSH	SYPHILIS
Discharge from cock											X		
Pain when pissing								X			X	X	
Sore or blister on cock								X					
Itching in or on cock		X						X				X	
Small growths on cock									X				
Discharge from arse								X		X			
Pain in arse or when shitting								X		X			
Sore or blister in or around arse								X					
Itching in or around arse		X						X				X	
Small growths in or around arse									X				
Sore throat													
Sore or blister in or around mouth or throat								X					
Rash		X		X									
Swollen glands				X						X	X		
Flu-like symptoms				X	X	X	X	X					
Diarrhoea/nausea				X	X	X	X						
Losing weight				X	X	X	X						
Extreme tiredness				X	X	X	X						
Yellowness in skin and white of eyes					X	X	X						
Pale shit or dark piss					X	X	X						
Itching on body		X											
White patches in mouth				X								X	

Informal Exercise Title:
ChemSex: Sexualised Substance Use.

Study Area/Group:
Prevention

Exercise Aim and/or Purpose:
To improve the understanding of sexualised substance use among gay and other MSM.

Expected exercise outcome:
Participants will have discussed sexualised substance use, the drugs involved and identified appropriate services for referral.

Materials Required:
- PowerPoint (PPT) slides.
- 'Let's Talk about Drugs' cards printouts.
- 'I'm looking for help and advice' prompts printouts.
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:
- Read through the drug-related information in the E-Learning module
- Identify local services around drug use and specifically any work about ChemSex that happens in your local area. You may want to share information and figures with the group if they are available and you can add that information to the talk during the PPT slides section in the Method section.
- Prepare enough of the cards for the "Let's Talk About Drugs" game and the prompts for the 'I'm looking for help and advice' small group practice for the numbers of participants attending.

Helpful hints for facilitators:
- As there are only 14 cards for the 'Let's Talk About Drugs' exercise it will depend on the number of participants as to how the game plays. If you have more than 14 people, encourage others apart from the person who has chosen the card to talk about the substance/drug. If you have less than 14 participants, they can pick up more than one card. Information on the drugs on the cards is contained in the E-Learning module – other information on substances like nicotine and caffeine are easily found online.
- This exercise can be linked to other exercises around Stigma and Discrimination, like Vulnerable MSM Subgroups or Populations and Creating Non-Judgemental Services, and skills like Motivational Interviewing.

Method: (40 mins)

1. Ask the group:
   - "What do you understand by the term ChemSex?"
   - They are to brainstorm their answers to the question; you can write a few of these suggestions onto the flipchart if you wish, but it's not essential.
2. Tell the group that they are going to play a game called 'Let's Talk About Drugs'.
   - Tell them you are going to place a series of cards onto the floor, facedown, and in turn they will pick up a card and read it out.
   - They are to talk about what it says on the card, what they know about the drug or substance written on the card, including the name it's commonly called (e.g. Crystal Meth is commonly known as Tina, although names can vary according to region and subgroup of users.)
   - If they feel comfortable enough it would be good to hear if they have personal experience of using the drug or substance. Do not force people to share anything they do not want to.
   - Drugs and substances on the cards are:

Poppers	Cocaine
GHB/GBL	Crystal Meth
Ketamine	Marijuana
Caffeine	Nicotine
Alcohol	Sugar
Mephedrone	MDMA
Speed	Acid

   - Place the cards so that the words face the floor and without letting the participants see what the cards say and ask a participant to volunteer to be the first one to pick up a card.
   - Encourage them and the group to fill in any gaps and use your own knowledge from your reading to help.
3. When all the cards have been used, ask the group to get into pairs and discuss
   - "What's the difference between drug use and drug dependency?"
   - Tell them they have 5 minutes for this chat.
   - When 5 minutes has ended ask the pairs to feedback to the larger group on their thoughts and encourage the group to discuss them. Remind the group of the Harm Reduction approach and model, which is to lessen the possible harmful impact of potentially dangerous actions. Harm Reduction and Safer Use initiatives related to drug use include needle exchange programmes for example.
4. Show the PPT slides to the group outlining:
   - Main drugs used in ChemSex
   - How those drugs are used and their effects
   - EMIS 2017 data on number of users of ChemSex drugs

ChemSex: Main drugs used: GHB/GBL

- Also known as G or Gina.
- Depressant drugs or 'downers'.
- Have a sedative and euphoric effect similar to being drunk.
- Overdoses can be common as it's hard to know what is a 'safe dose'.
- Is used as 'knock out drops' in people's drinks at bars and parties.

ChemSex: Main drugs used: Methamphetamine

- Also known as Crystal Meth, T or Tina.
- Super strength stimulant drug.
- Releases 'stress' hormone Norepinephrine and 'feel good' hormones Dopamine and Serotonin into the blood stream.
- Increases body temperature, heartbeat and blood pressure so increases risk of heart attack, stroke or comas.

ChemSex: Main drugs used: Mephedrone

- Also known as Meow Meow.
- Stimulant drug similar to amphetamines.
- Induces euphoria, alertness, confidence, feelings of empathy to people around you as well as making you feel horny and talkative.
- Powerful comedown, with tiredness, depression and no ability to concentrate for a few days after taking it. Mixing it with alcohol causes problems.

ChemSex: Main drugs used: Ketamine

- Also known as K or Special K.
- An anaesthetic drug, also known as a horse tranquiliser.
- Users feel 'high', numb, have 'out of body' experiences (known as k-holes).
- K-Holes can lead to swallowing and breathing difficulties and sexual and physical assaults can happen while under the effects of K.

ChemSex: How the drugs are used: Injection

- Also known as 'slamming'.
- Carries risk of HIV and Hep C transmission if needles, spoons, filters or water are shared.
- Use own syringe and utensils – a new syringe for every shot.

ChemSex: How the drugs are used: Snorting

- Cocaine, Crystal Meth, Mephedrone, Speed and Heroin are all snorted.
- Carries risk of Hep C and HIV transmission if tubes shared.
- Use own tube, never use banknotes.

ChemSex: How the drugs are used: Smoking

- Cocaine, Crystal Meth and Heroin are all smoked.
- Carries risk of Hep C if pipes shared because of high temperatures causing mouth blisters.
- Use own pipe, don't share with anyone else.

ChemSex: How the drugs used: Swallowing and anal ingestion

- Pill and liquid forms of many drugs are swallowed.
- Anal use (booty bumping) can irritate the anal lining, cause bleeds and increase risk of HIV and Hep C transmission.
- Less control over amounts taken and their effects, but less damage caused to the body i.e. nose, lungs and veins. Measure out amounts taken carefully and remember how much taken to avoid overdosing.

EMIS 2017 data on ChemSex in Europe

This is the section where you can share any information about local work or numbers that you have sourced.

5 Tell the group that they are now going to do a small group practice of a few situations to examine what it's like to try and access services as an MSM. They are to get into pairs, each pair will take a turn in being the person trying to access a service while the other person takes the role of the service provider, whether that is a Doctor, Nurse, outreach worker etc. They will each get to play both roles – as the person trying to access a service, they will be given a short outline of what they are trying to get help with. Each person in the pair will have a different outline.

The outlines are:

You got a bit drunker than you normally do and can't remember if you took some drugs as well. You woke up in some guy's bed and can't remember much about what happened, so you are here to ask for PEP.
You have been using drugs at the weekends to relax and chill for years, recently you've started using meth as it helps you enjoy sex, but you are worried about becoming HIV positive so want to start taking PrEP and are here to talk to the staff about it.
You have been having sex without condoms on and off for a while now but can't access PrEP or afford to buy it for yourself online and want to know how to avoid STIs.
You are worried about getting Hep C because your sex life sometimes includes being fisted and you have heard that this is linked to Hep C. You want advice on how to 'play safer' to help avoid Hep C
You were recently diagnosed with syphilis and can't understand why as you always use condoms when having anal sex. The last STI you had was oral gonorrhoea about 8 months ago. You want to know why it happened and what your treatment options are.
Although you have been taking meth for a year or so with no problems you have recently started slamming which you really enjoy, but you are starting to notice that it's affecting your job. Also you are starting to take more Tina which is costing a lot and so you've started to ask for money in exchange for sex and got arrested recently. You'd like some advice.
You have always used condoms as you are afraid of getting infected with HIV. Now you've started to have sex without condoms with your new boyfriend. You really love him but you also feel insecure and afraid and have problems talking about it with him. You'd like some advice.

6. Ask the group to get into pairs and decide who is the 'patient' and who is the service provider, and then give the 'patient' one of the outlines, making sure they know to not show it to their partner. The person who is the service provider is encouraged to think of someone they know who may be a bit judgemental around these issues and use them for their practice. Once you have done this with all the pairs tell them they have 5 minutes for each practice, so a total of about 10 minutes. Remind them that this is a time to practice, not discuss what they could, would or should do between them.
7. Start the small group practices and go around the pairs encouraging them to really engage with each other in the practice. Once 5 minutes has ended, get the pairs to swap roles and give the new 'patient' a different outline, and start them practicing, again encouraging the service provider to use a person who may be judgemental as their inspiration.
8. When the time has finished, ask the pairs to feed back to the large group on the following questions:
   - "How did this experience feel as the 'patient'? What made the situation and conversation easy and what made it difficult?"
   - "What do you think could help make this situation less intimidating for the person accessing the service, and lessen any shame they may feel?"
   - "Was there any point in your practices as the 'patient' that you felt accepted, and at what points did you notice any stigma or discrimination?"
9. When you are taking feedback remind the group that we are working to reduce stigma and discrimination around the work we do and not to stigmatise people for their choices. Doing so can be a barrier for the work we are doing, leading to people not coming to us at all. If we provide help and 'neutral', scientific-based information that helps people to take their own, informed decisions that is less stigmatising and allows people to engage with us. Not everyone who uses drugs develops a dependency or has a problem, and there are many reasons for drug use that we have to respect – i.e. fun, adaptive behaviours like dealing with minority stress or feelings of inferiority etc.
10. When you have done that, ask the group to share any experiences they have of working with Gay and MSM who report ChemSex use. How do they help them and which services do they provide or refer to?
11. Show the last PPT slide to refer onto 'How to Help' – this includes details of David Stuart's ChemSex Care Plan and ChemSex First Aid, the 56 Dean Street ChemSex pages and the THT fridaymonday website.

ChemSex: How to help

- Refer to appropriate local services
- Read the E-Learning module to find out more about the drugs used and their safer use
- David Stuarts ChemSex Care Plan – www.davidstuart.org/care-plan
- David Stuarts ChemSex First Aid – www.davidstuart.org/chemsex-first-aid
- 56 Dean Street ChemSex pages – www.dean.st/chemsex-support
- THT fridaymonday – www.fridaymonday.org.uk

When you have shown the last slide, close the exercise.

ChemSex: Let's Talk about Drugs – Cards for the exercise

Poppers	Cocaine
GHB/GBL	Crystal Meth
Ketamine	Marijuana
Caffeine	Nicotine
Alcohol	Sugar
Mephedrone	MDMA
Speed	Acid

ChemSex: 'I'm looking for help and advice' – situation prompts for the exercise

To be used for the small group practice.

You got a bit drunker than you normally do and can't remember if you took some drugs as well. You woke up in some guy's bed and can't remember much about what happened, so you are here to ask for PEP.
You have been using drugs at the weekends to relax and chill for years, recently you've started using meth as it helps you enjoy sex, but you are worried about becoming HIV positive so want to start taking PrEP and are here to talk to the staff about it.
You have been having sex without condoms on and off for a while now but can't access PrEP or afford to buy it for yourself online and want to know how to avoid STIs.
You are worried about getting Hep C because your sex life sometimes includes being fisted and you have heard that this is linked to Hep C. You want advice on how to 'play safer' to help avoid Hep C.
You were recently diagnosed with syphilis and can't understand why as you always use condoms when having anal sex. The last STI you had was oral gonorrhoea about 8 months ago. You want to know why it happened and what your treatment options are.
Although you have been taking meth for a year or so with no problems you have recently started slamming which you really enjoy, but you are starting to notice that it's affecting your job. Also you are starting to take more Tina which is costing a lot and so you've started to ask for money in exchange for sex and got arrested recently. You'd like some advice.
You have always used condoms as you are afraid of getting infected with HIV. Now you started to have sex without condoms with your new boyfriend. You really love him but you also feel insecure and afraid and have problems talking about it with him. You'd like some advice.

Informal Exercise Title:
What is Safer Sex now?

Study Area/Group:
Prevention

Exercise Aim and/or Purpose:
This exercise allows participants to examine and discuss the current responses to HIV, STIs and Viral Hepatitis.

Expected exercise outcome:
Participants will have a better understanding of what the current responses to HIV, STIs and Viral Hepatitis are.

Materials Required:
- Flipchart easel, pad and pens.
- Paper and pens for participants.

Facilitator Preparation:
- Update yourself on all of the tools now available to MSM to protect themselves against HIV, STI and Viral Hepatitis infection including vaccinations, treatments and prevention tools by reading the E-Learning module of this exercise.
- The current guidance used for this exercise and in the E-Learning component may not be up to date at the time of your use of the exercise, so please check to see if more current evidence or data is available to use.
- At the time this session was written the evidence says that Treatment as Prevention (TasP or U=U) is only effective for preventing HIV infection via sexual routes and vertical transmission (mother to baby) routes, as other possible routes have ethical issues attached to evaluating them. New evidence may be available on this when you are running the session so please check.

Helpful hints for facilitators:
- Allow your experience and the experience of the group to inform their discussions.

Method: (20 mins)

1. Tell the group we are going to look at the current responses to
   - HIV
   - STIs and
   - Viral Hepatitis (Hepatitis A, B and C).
2. Split the people into groups of 3–5. Ask these groups to discuss "What is safer sex now?" asking them to take notes on their discussions. Give the group 15 mins for this discussion
3. If the group has questions about what is meant by this prompt them with;
   - "Is it just about using condoms?"
   - "What other things could be seen as making the sex MSM have safer?"
   - "What about hepatitis?"

Facilitated Feedback: (30–40 mins)

1. Ask the groups to feedback on their discussions. It's likely that the groups will have come up with things like
   - Condoms
   - Testing for both HIV, STIs and Hepatitis A, B and C
   - TasP or U=U (Undetectable = Untransmittable)
   - PrEP
   - PEP
   - Self-Testing/Self-Sampling.

   Encourage the groups to expand those 'headlines' out in their discussions i.e.
   - Testing regularly, for both HIV and STIs
   - Being vaccinated against Hepatitis A and B
   - Being on treatments for HIV
   - Getting STIs treated quickly and informing partners
   - Getting tested and treated for Hepatitis C
   - Using PEP or PrEP if its available
   - Measuring viral load if living with HIV to ensure they are undetectable – as detectable viral load means the person could be infectious.
2. As the groups feedback, take notes, using one flipchart sheet for each 'tool' (so one for PrEP, one for condoms etc.). Encourage the groups to share all the points they made about each 'topic' and ask if there are local influences that affect whether MSM can access that intervention – is PrEP legal to obtain? is it free?; are a variety of condoms and lube freely available? etc.
3. When that discussion has closed, ask the group if they have tips they can share about helping MSM use these tools i.e. any tips they share with men about easier use of condoms etc. This is to share experience across the group; if they are an experienced group this is a less important discussion to have.
4. Inform the group that the E-Learning module contains much more information on each of these components and the evidence used of their effectiveness and encourage them to read it in their own time. Close the exercise.

Informal Exercise Title:

Epidemiology: Supporting the understanding of the role and usefulness of data in the work of Community Health Workers.

Study Area/Group:
Prevention

Exercise Aim and/or Purpose:
To improve the understanding about the usefulness and importance of data related to the work carried out by CHW aimed at MSM.

Expected exercise outcome:
Participants will have examined and discussed the use of data and how it underpins their work.

Materials Required:
- Flipchart easel, pads and pens
- Paper and pens for participants
- Copies of the data you have identified for use by the participants

Facilitator Preparation:
- Identify and source recent data on a specific issue such as HIV or Gonorrhoea incidence from a source such as ECDC or EMIS (2010/2017) i.e. https://ecdc.europa.eu/en/publications-data-gonorrhoea-annual-epidemiological-report-2017 and familiarise yourself with it.
- Source local data on the issue you have identified to help localise the discussion.
- Prepare prompt questions and reminders around how data can be used to help challenge barriers to access and decrease stigmatisation of disease acquisition.

Helpful hints for facilitators:
- This exercise can be linked to the other modules in 'Challenging Stigma and Discrimination' and 'Knowing The Community You Are Working With'.
- Consider how data from sources such as EMIS (2010/2017) have impacted upon the work carried out with and for MSM, and bring that understanding to this exercise.

Method: (35 mins)

1. Inform the group that they will be looking at some epidemiological data to consider both the data itself and the trends that the data indicates around the issue/s covered.
2. They will be looking at the data and considering two questions about the trends they have identified in the data:
   - "What are their thoughts on the reasons for the trend?"
   - "What do they think are the 'influencers' upon the trend?"
3. Tell the group they will be working in small groups of between 3 and 5 people, and during their discussions they are to use those two questions to consider as many factors associated with the data/trend under consideration. Ask them to please make notes of their discussions – they can either use a sheet of flipchart paper or an ordinary sheet of paper to do this.
4. When they have discussed these questions, they are to consider, discuss and identify a couple of ways this data can be used to either influence ongoing work or develop new work.
5. Ask them to get into groups of between a 3 and 5 people (or put them into such groups yourself) and tell them they have 20 minutes for their discussion. You can allow them to go up to 30 minutes if they are really involved in their conversations. Start the groups working.

Facilitated Feedback: (25-30 mins)

1. When the time you have given them for discussion is ended, call the small groups back and ask each group to feedback to the larger group on their thoughts around the questions on the data and ideas of how it could influence their work. As the facilitator use your knowledge and the prompt questions you have developed to get the groups to expand on how the data can inform the work done, but can also sometimes be used to stigmatise the MSM we are working with.
2. Take around 25 – 30 minutes for this feedback from all the small groups, encouraging discussion after each group has fed back ("Do other groups think that?" etc.)
3. When the discussions have finished refer the group to the E-Learning module on Epidemiology.
4. Close the group.

E-Learning material

Prevention

- Using Health Promotion Models to aid behaviour change

Settings and Interventions

- Useful settings for interventions aimed at MSM
- Improving linkage and retention in care
- Anti-Stigma campaigns: learning from HIV/AIDS and MSM/LGBTIQ+ interventions

Skills Building

- Using Social Marketing to engage with MSM
- Building tailored training for specialised services

The E-Learning material can be accessed via the ESTICOM training platform www.msm-trainings.org.

Prevention

'HIV 90-90-90' – what are the targets?

This module was developed as part of the training programme. It was decided not to include it in the final training material. The treatment cascade 90-90-90 remains relevant for policy and the planning of health interventions, but it is less of practical use for CHW. Therefore, the module has not been finalised, but can be adapted, updated, and used as needed. It can be found in the Annex as a draft document.

E-Learning: Prevention.

STI's: symptoms and treatments:

Information used has been taken from ECDC (see links) and WHO 'Growing antibiotic resistance forces updates to recommended treatment for sexually transmitted infection' News. August 2016.

General overview – trends in bacterial STIs

"Across European countries, there is currently large variability with regard to the extent and frequency of diagnostic procedures to detect sexually transmitted co-infections amongst MSM treated for HIV. The conditions allowing for STI outbreaks or epidemic spread, in terms of the numbers of individuals involved in high-risk sexual networks, also vary considerably between countries.

In some Central and Eastern European countries increases in the incidence of STIs (particularly syphilis) occurred among the general population during the 1990s. Data on the prevalence and incidence of bacterial STIs among MSM in many Eastern European countries are sparse, largely due to high stigmatization of homosexual behaviour."

Gonorrhoea and chlamydia

"From very low levels in the mid-1990s, incidence of gonorrhoea and chlamydia increased among MSM in Western Europe in the late 1990s and early 2000s. This may have been partly due to improved sensitivity of diagnostic tests and the expanded use of combination diagnostic tests, in addition to behavioural changes such as increases in partner numbers and declines in condom use.

Many studies conducted in the last decade have convincingly demonstrated that the usual standard testing of urogenital sites for gonorrhoea and chlamydia misses most infections in MSM, which occur at extra-genital sites in the pharynx and rectum, and are mostly asymptomatic. While pharyngeal infections are self-limiting and usually clear within two to three weeks even without treatment, rectal infections can persist over longer periods, often without severe symptoms.

Few European countries provide an infrastructure for routine screening of MSM in dedicated low-threshold testing sites, thus many MSM rely on general practitioners (GPs) for sexual healthcare, where they do not disclose their sexual preference and will therefore not be offered comprehensive three-site screening, even if this is recommended by guidelines. Even if sexual preference is disclosed, comprehensive screening is less frequently initiated by GPs compared to at dedicated STI clinics, for various reasons. This results in very high levels of undiagnosed asymptomatic extra-genital infections among MSM.

As a result, data on trends in gonorrhoea and chlamydia diagnoses are difficult to interpret without additional information on testing frequency, as well as on testing policies and practices, such as the anatomical sites tested, and whether testing was part of routine screening or was symptom-driven."

Estimates of prevalence of gonorrhoea among MSM

"Studies conducted in Western European countries have reported the following pharyngeal prevalences of gonorrhoea: 4.2% among MSM attending an STI clinic in the Hague, 5.5% among MSM attending sentinel STI sites (local health offices, STI clinics, private practitioners) in 16 German cities, and 9.5% among HIV-positive MSM attending a university hospital outpatient clinic in Madrid. The studies in the Hague and Germany reported rectal prevalence of gonorrhoea to be 6% and 4.6% respectively, while the study in the Hague reported urethral prevalence to be 2.8%. One study among MSM attending a genitourinary medicine (GUM) clinic in inner London between 1999 and 2001 reported urethral, pharyngeal and rectal prevalence of gonorrhoea to be similar at 7.2%, 7.3% and 7.3% respectively."

Gonorrhoea: Epidemiology across all populations – 2017 figures

"In 2017, 89 239 confirmed gonorrhoea cases were reported in 27 countries, an increase of 17% compared with 2016. One country less (Greece) reported data for 2017 compared with 2016. The United Kingdom reported 55% of all cases reported in 2017. The crude notification rate in 2017 was 22.2 per 100 000 population for countries with comprehensive surveillance systems, an increase of 22% compared with 2016. The highest rates in 2017 (>25/100 000 population) were observed in the United Kingdom (75 per 100 000), Ireland (47 per 100 000), Denmark (33 per 100 000), Iceland (29 per 100 000), Norway (27 per 100 000) and Sweden (25 per 100 000). The lowest notification rates (<1 per 100 000) were observed in Bulgaria, Croatia, Cyprus, Poland and Romania."

For more information and the latest figures around Gonorrhoea epidemiology
https://ecdc.europa.eu/sites/portal/files/documents/gonorrhoea-annual-epidemiological-report-2017.pdf

For the facts around gonorrhoea https://ecdc.europa.eu/en/gonorrhoea/facts

Chlamydia: Epidemiology across all populaions – 2017 figures

"In 2017, 26 countries reported 409 646 chlamydia infections. The crude notification rate for the 22 EU/EEA countries with comprehensive surveillance systems was 146 per 100 000 population. The United Kingdom accounted for 56% of all reported cases in 2017, while the combined case numbers of Denmark, Norway and Sweden, and the United Kingdom amount to 79% of all cases reported in 2017. The disproportionate contribution of the United Kingdom is due to its inclusion of data from a successful screening programme targeted at 15–24-year-olds in England that has been in operation since 2008. This programme offers community-based testing services outside of sexually transmitted infection (STI) clinics and resulted in a large increase of chlamydia diagnoses from 2008 onwards.

In 2017, notification rates higher than 200 cases per 100 000 were observed in Iceland (650 per 100 000), Denmark (573), Norway (478), the United Kingdom (350), Sweden (337) and Finland (263). All countries reporting rates above 200 per 100 000 had chlamydia control strategies recommending either active screening (UK–England) or widespread opportunistic testing (Denmark, Finland, Iceland, Norway, Sweden and the rest of the United Kingdom). Rates below 10 per 100 000 were reported by eight countries (Bulgaria, Croatia, Cyprus, Hungary, Luxembourg, Poland, Portugal and Romania)."

For more information and the latest figures around Chlamydia epidemiology
https://ecdc.europa.eu/en/publications-data/chlamydia-infection-annual-epidemiological-report-2017

For the facts around Chlamydia https://ecdc.europa.eu/en/chlamydia/facts

Syphilis incidence among MSM

"Syphilis transmission is most effective in the presence of primary syphilitic ulcers and secondary mucocutaneous lesions. Early diagnosis is facilitated by the visibility of lesions in the genital area. While oral and perioral lesions can be relatively easily recognized (but also easily mis-diagnosed), typically painless intra-rectal lesions usually remain unnoticed. Thus, infections transmitted to insertive partners during oral and anal intercourse may be diagnosed as penile ulcers earlier than infections transmitted to receptive partners, particularly to anal receptive partners. Condomless anal intercourse is therefore associated with an increased risk for syphilis transmission, particularly within sexual networks where condomless anal sex with multiple partners is common.

On the other hand, new infections can be detected by regular serological screening if people are in medical care, such as for HIV treatment, even if they cause no characteristic symptoms. Onward transmission of syphilis to new partners can be effectively reduced if screening frequency is adapted to risk behaviour and partner numbers.

By sharing common modes of transmission, the prevalence and incidence of syphilis and HIV among MSM are highly associated. This association is further strengthened by immunological and biological factors. A recent history of syphilis is a strong independent risk factor for acquiring HIV infection, just as being diagnosed with HIV is a strong independent risk factor for syphilis infection.

Syphilis incidence among MSM declined to an all-time low in Western Europe in the mid-1990s, although localized outbreaks still occurred in larger cities in the late 1990s (such as in Hamburg in 1997), and the proportion of HIV-positive men among syphilis patients was very high.

More generalized spread of syphilis among MSM started from about 2000 onwards, fuelled by increases in partner numbers, and larger sexual networks facilitated by online social and sexual networking websites. After a four-to-five-year period of increasing syphilis incidence, this levelled off in many countries in the mid-2000s, as increasing awareness and improved testing strategies helped to control further spread.

Increases in syphilis incidence among MSM in the UK and Germany from about 2010 onwards appear to be fuelled by increasing diversification of HIV risk reduction strategies, such as HIV serosorting, and declining rates of consistent condom use. These behavioural changes have been mitigated, although not fully matched, by expansions and intensifications of testing policies. While syphilis screening rates among MSM treated for HIV infection have increased in recent years, several modelling studies suggest that screening intervals would need to be shortened to six or even three months among groups with high partner numbers to have an impact on the epidemic."

Syphilis prevalence

"Among an HIV-negative cohort of MSM recruited in Lisbon between 2011 and 2014, self-reported lifetime prevalence of syphilis infection was 7%.

In the Sialon II study, syphilis markers were investigated in four European cities; the prevalence of active syphilis was 9.7% in Bucharest, 5.1% in Verona, 1.4% in Bratislava and 0.1% in Vilnius. In the same study, markers of prior syphilis infection were highest in Vilnius (10.5%) and lowest in Bratislava (3.3%).

A study in Germany among 1 052 MSM seroconverting for HIV between 1996 and 2007 reported an overall syphilis prevalence of 26%, increasing from 10% between 1996-1999 to 35% in 2005. Co-incident syphilis infection at HIV diagnosis increased significantly ($p<0.001$) from 2.3% in 2000 to 16.9% in 2003, declining thereafter to 4.3% in 2007. Another cohort study among HIV-positive MSM in Germany which collected data between 1996 and 2012 reported that syphilis prevalence at HIV-seroconversion was 27.1%."

Epidemiology across all populations – 2017 figures

"In 2017, 33 189 confirmed syphilis cases were reported in 28 countries, giving a crude notification rate of 7.1 cases per 100 000 population for countries with comprehensive surveillance systems. The highest rate was observed in Iceland (15.4 cases per 100 000 population), followed by Malta (13.5 per 100 000), the United Kingdom (11.8 per 100 000) and Spain (10.3 per 100 000). Low rates below 3 cases per 100 000 population were observed in Croatia, Cyprus, Estonia, Italy, Portugal and Slovenia."

For more information and the latest figures around Syphilis epidemiology
https://ecdc.europa.eu/sites/portal/files/documents/syphilis-annual-epidemiological-report-2017.pdf

For the facts around Syphilis https://ecdc.europa.eu/en/syphilis/facts

STI Antibiotic Resistance – World Health Organisation recommendations

"New guidelines for the treatment of 3 common sexually transmitted infections (STIs) have been issued by WHO in response to the growing threat of antibiotic resistance.

Chlamydia, gonorrhoea and syphilis are all caused by bacteria and are generally curable with antibiotics. However, these STIs often go undiagnosed and are becoming more difficult to treat, with some antibiotics now failing as a result of misuse and overuse. It is estimated that, each year, 131 million people are infected with chlamydia, 78 million with gonorrhoea, and 5.6 million with syphilis.

Resistance of these STIs to the effect of antibiotics has increased rapidly in recent years and has reduced treatment options. Of the 3 STIs, gonorrhoea has developed the strongest resistance to antibiotics. Strains of multidrug-resistant gonorrhoea that do not respond to any available antibiotics have already been detected. Antibiotic resistance in chlamydia and syphilis, though less common, also exists, making prevention and prompt treatment critical.

When left undiagnosed and untreated, these STIs can result in serious complications and untreated gonorrhoea and chlamydia can cause infertility in both men and women. Infection with chlamydia, gonorrhoea and syphilis can also increase a person's risk of being infected with HIV two- to three-fold.

Chlamydia, gonorrhoea and syphilis are major public health problems worldwide, affecting millions of peoples' quality of life, causing serious illness and sometimes death. The new WHO guidelines reinforce the need to treat these STIs with the right antibiotic, at the right dose, and the right time to reduce their spread and improve sexual and reproductive health. To do that, national health services need to monitor the patterns of antibiotic resistance in these infections within their countries.

The new recommendations are based on the latest available evidence on the most effective treatments for these 3 sexually transmitted infections.

Gonorrhoea

Gonorrhoea is a common STI that can cause infection in the genitals, rectum, and throat. Antimicrobial resistance has appeared and expanded with every release of new classes of antibiotics for the treatment of gonorrhoea. Because of widespread resistance, older and cheaper antibiotics have lost their effectiveness in treatment of the infection.

WHO guidelines for the treatment of Neisseria gonorrhoeae

WHO urges countries to update their national gonorrhoea treatment guidelines in response to the growing threat of antibiotic resistance. National health authorities should track the prevalence of resistance to different antibiotics in the strains of gonorrhoea circulating among their population. The new guideline calls on health authorities to advise doctors to prescribe whichever antibiotic would be most effective, based on local resistance patterns. The new WHO guidelines do not recommend quinolones (a class of antibiotic) for the treatment of gonorrhoea due to widespread high levels of resistance.

Syphilis

Syphilis is spread by contact with a sore on the genitals, anus, rectum, lips or mouth.

WHO guidelines for the treatment of Treponema pallidum (syphilis)

To cure syphilis, the new WHO guidelines strongly recommend a single dose of benzathine penicillin – a form of the antibiotic that is injected by a doctor or nurse into the infected patient's buttock or thigh muscle. This is the most effective treatment for syphilis, as it is more effective and cheaper than oral antibiotics.

Benzathine penicillin was recognized by the Sixty-ninth World Health Assembly in May 2016 as an essential medicine which has been in short supply for several years. Reports of stock outs have been received by WHO from antenatal care representatives and providers in countries with high burdens of syphilis from 3 WHO Regions. WHO is working with partners to identify countries with shortages and help monitor global availability of benzathine penicillin to close the gap between national needs and supply of the antibiotic.

Chlamydia

Chlamydia is the most common bacterial STI and people with this infection are frequently co-infected with gonorrhoea. Symptoms of chlamydia include discharge and a burning feeling when urinating, but most people who are infected have no symptoms. Even when chlamydia is asymptomatic, it can damage the reproductive system.

WHO guidelines for the treatment of Chlamydia trachomatis

WHO is calling on countries to start using the updated guidelines immediately, as recommended in the 'Global Health Sector Strategy for Sexually Transmitted Infections (2016-2021)' endorsed by governments at the World Health Assembly in May 2016. The new guidelines are also in-line with the 'Global Action Plan on Antimicrobial Resistance', adopted by governments at the World Health Assembly in May 2015."

Other main STI's that affect MSM: Hepatitis A, B and C; Lymphogranuloma Venereum (LGV) and Human Papillomavirus (HPV).

Hepatitis A: Epidemiology across all populations – 2016 figures

"In 2016, 29 EU/EEA countries reported 12 502 cases of hepatitis A, 12 429 (99.4%) of which were confirmed.

2016 was the year with the lowest number of confirmed cases for the period 2012–2016.

Eighteen countries reported fewer than 100 confirmed cases, while nine countries reported more than 500 cases. Romania reported 25.7% of all confirmed cases. Compared with the four-year average from 2012–2015, nine countries reported increases of over 50% in the number of confirmed cases (Austria, Croatia, the Czech Republic, Greece, Luxembourg, Malta, Portugal, Slovakia and Spain) in 2016, while three countries (Estonia, Finland and Lithuania) reported decreases of more than 50%.

In the 25 countries reporting information on travel history for all or part of their cases, 813 of 5 968 cases (13.6%) with available information were travel-associated. France (n=307) and Germany (n=151) accounted for more than half (56.3%) of all travel-associated cases.

In 2016, the EU/EEA notification rate was 2.4 cases per 100 000 population, ranging from 0 in Iceland to 25.0 in Slovakia (Table 1). About two-thirds of the EU/EEA countries (18/29) had notification rates below one confirmed case per 100 000 population (Figure 1). In addition to Slovakia (25.0 cases per 100 000 population), high notification rates were reported in Bulgaria (22.7 cases) and Romania (16.1 cases)."

For more information and the latest figures around Hepatitis A epidemiology
https://ecdc.europa.eu/sites/portal/files/documents/AER_for_2016-hepatitis-A_0.pdf

For the facts around Hepatitis A https://ecdc.europa.eu/en/hepatitis-A/facts

Hepatitis B: Epidemiology across all populations – 2017 figures

"For 2017, 30 EU/EEA Member States reported 26 907 cases of hepatitis B virus (HBV) infection. Excluding the five countries that only reported acute cases, the number of cases, 26 262, corresponds to a crude rate of 6.7 cases per 100 000 population. No data were reported from Liechtenstein. Of all cases, 2 486 (9%)

were reported as acute, 15 472 (58%) as chronic, 8 607 (32%) as 'unknown' and 342 cases (1%) could not be classified due to an incompatible data format.

Twenty-six countries were able to provide data on acute cases. The overall rate of acute cases was 0.6 per 100 000 population, ranging from no cases in Luxembourg to 2.2 cases per 100 000 population in Latvia. When restricting the analysis to the 19 countries that reported consistently from 2008–2017, the rate for acute cases showed a steady decline from 1.1 cases per 100 000 population in 2008 to 0.6 in 2017. Not all countries share in this trend, however: the rate of acute cases reported by Portugal has shown a steady increase since 2012, when the country started to report.

Twenty countries submitted data on chronic infections. The overall notification rate was 7.2 cases per 100 000 population, ranging from <0.1 in Romania to 18.0 in Iceland. The United Kingdom reported 62% of all chronic cases reported in 2017. Among the 13 countries that reported consistently between 2008 and 2017, the rate of reported chronic cases increased from 6.7 cases per 100 000 population in 2008 to 10.2 in 2017."

For more information and the latest figures around Hepatitis B epidemiology
https://ecdc.europa.eu/sites/portal/files/documents/hepatitis-B-annual-epidemiological-report-2017.pdf

For the facts around Hepatitis B https://ecdc.europa.eu/en/hepatitis-b/facts

Hepatitis C: Epidemiology across all populations – 2017 figures

"For 2017, 29 EU/EEA Member States reported 31 273 cases of HCV infection.

Excluding the three countries that only report acute cases (Hungary, Lithuania and the Netherlands), the total number of cases (31 178) represents a decrease of 9.8% over the previous year. No data were reported from France or Liechtenstein. Of all cases reported, 861 (2.8%) were reported as acute, 6 805 (21.8%) as chronic, 23 311 (74.8%) as 'unknown' and 296 cases (0.9%) could not be classified due to an incompatible data format. Excluding countries that only reported acute cases, the crude rate of HCV infection was 7.3 per 100 000 population in 2017. From 2008–2017, the overall number of cases diagnosed and reported across the 22 EU/EEA Member States that reported data consistently over this time, excluding those who only reported acute cases, showed year-to-year fluctuations, increasing from 2010–2014 to a high of 9.8 cases per 100 000 population and decreasing again slightly since then.

Country-specific rates ranged from 0.3 cases per 100 000 population in Italy to 71.5 cases per 100 000 population in Latvia. The United Kingdom accounted for 34% of all reported cases.

Twenty countries were able to provide data on acute cases. The rate of reported acute cases was 0.3 per 100 000 population, ranging from <0.1 in Greece, Poland and the United Kingdom to 2.1 per 100 000 in Latvia. Nineteen countries submitted data on chronic infections. The notification rate of chronic cases was 2.8 cases per 100 000 population, ranging from <0.1 in Luxembourg and Romania to 69.4 in Latvia. The rate of cases classified as unknown ranged from <0.1 cases per 100 000 population in Cyprus and Denmark to 20.3 in Finland. Overall notification rates were mostly higher in northern and western European countries than in southern European countries."

For more information and the latest figures around Hepatitis C epidemiology
https://ecdc.europa.eu/sites/portal/files/documents/AER_for_2017-hepatitis-C.pdf

For the facts around Hepatitis C https://ecdc.europa.eu/en/hepatitis-c/facts

For more on epidemiology of Hepatitis B and C in selected populations (including MSM) in Europe
https://ecdc.europa.eu/sites/portal/files/documents/Hepatitis-B-C-epidemiology-in-selected-populations-in-the-EU.pdf

Lymphogranuloma Venereum (LGV): Epidemiology across all populations – 2017 figures

"In 2017, 24 countries provided LGV surveillance data. Fifteen countries reported a total of 1 989 cases, while the remaining nine reported no cases. Spain reported LGV surveillance data for the first time in the 2018 data collection and provided data for 2016 and 2017. Four countries (France, the Netherlands, Spain and the United Kingdom) accounted for 86% of all notified cases. Croatia reported the first two LGV cases in 2017.

Compared with 2016, the number of cases reported in 2017 decreased by 13%. The largest decreases were reported by the two countries reporting the largest numbers of cases: the United Kingdom (-30%) and France (-23%), but Denmark, Finland, Ireland and Italy also reported fewer cases. On the other hand, increased numbers of cases were reported by eight countries, with increases of 50% or more in Hungary (57%), Norway (74%), Portugal (300%) and Slovenia (100%), although many of these countries reported small numbers of cases.

Transmission category was reported for 1 377 cases in 2017 (69% of all reported cases). All but 12 cases were reported among men who have sex with men (MSM). Age was reported for 95% of cases, with the large majority of cases distributed evenly among 25–34-year-olds (31%), 35–44-year-olds (31%) and those aged 45 years or over (32%)."

For more information and the latest figures around LGV epidemiology
https://ecdc.europa.eu/en/publications-data/lymphogranuloma-venereum-annual-epidemiological-report-2017

For the facts around LGV https://ecdc.europa.eu/en/lymphogranuloma-venereum/facts

Human Papillomavirus (HPV)

There is no current epidemiological data available about HPV, for the facts about the infection
https://ecdc.europa.eu/en/human-papillomavirus/factsheet

STI Treatment Options – a simple approach

Bacterial

- Bacterial infections can be quickly treated with antibiotics.

Viral

- Generally, there are no treatments for viruses; they generally have to run their own course. However, we could loosely group them into three categories:
  9. Can be cured (like Hepatitis C) but there is no vaccine as yet
  10. There is a vaccine available (as with Hepatitis A & B), but there is no cure as yet.
  11. Treatable but not curable, and no vaccine available as yet (HIV).

Parasitical

- Parasitic skin infections can be relieved and treated with creams and lotions which can be purchased over the counter at the chemist. For parasitic gut infections, a doctor can prescribe specific antibiotic medications that can help.

Fungal

- Fungal infections can be relieved and treated with creams and lotions which can be purchased over the counter.

STIs that present symptoms within three days are normally bacterial infections. Viral infections have longer incubation periods. Sometimes they only manifest when the immune system is impaired or run down.

ChemSex: base information

Information taken from the THT site www.fridaymonday.org.uk and drugscouts.de

"The use of drugs is never without risk. Among other things, there is a danger of becoming dependent on the drug being used. Also, it may be harder for the user to keep to their safer sex strategy.

The term 'ChemSex' can be used differently by different people. In general it means sexual activity performed while under the influence of psychoactive drugs, in some definitions limited to specific substances, in particular Crystal Meth, GHB/GBL, Poppers, Mephedrone and Ketamine. Substances used in ChemSex are often called 'chems'.

ChemSex use is happening at some level across most of Europe. Even if the number of gay and other MSM engaged in ChemSex is quite small (see EMIS2017 data), it is important for the work of Community Health Workers to know about what is happening and how to provide important information to support men who engage in ChemSex.

Many ChemSex users are able to control their consumption. But there are also a high number of chems users whose substance use gets problematic. Many chems carry a high risk of dependency developing in the user, which means that it is not always easy to control the consumption. Knowledge about risk reduction around drug use and 'Safer Use' of drugs is not widely-spread among gay and other MSM. It may become difficult for the user to keep to their Safer Sex or risk reduction strategy when under the influence of chems (being 'high').

Forms of consumption and their risks

Snorting

Drugs like cocaine, Crystal Meth, Mephedrone, Speed and Heroin can be sniffed or snorted through a tube into the nose. The risks of overdosing and any risks of picking up or passing on any infections are reduced when snorting.

Tiny nasal mucosal lesions that are easily formed by snorting drugs can allow hepatitis or HIV in blood to be transferred to the tubes being used and then transferred to others. A user should only use their own tube when snorting drugs and banknotes should never be used.

Smoking

Smoking Crack Cocaine or Metamphetamine creates high temperatures in the pipe being used that can cause lip and mucous membrane damage in the mouth. Due to the numbing effect of the drugs the user often only feels these injuries much later on in their use, and can therefore be transferring blood between users without knowing about it. In order to avoid Hepatitis C infections it is important not to share the pipe with others.

Injecting (slamming)

Because of the inevitable contact with blood, intravenous use (called 'slamming') is the most risky form of consumption in regards of HIV and Hepatitis C.

Blood residues on and in the needle as well as in the syringe and other user items such as spoons, filters or water can contain HIV and other viruses as well as bacteria in high concentrations, even if the blood is not visible to the naked eye.

This is why it is strongly recommended for users to only use their own syringe and own utensils and never share these things. Ideally, a new syringe should be used for each "shot".

In many cities, there are facilities where sterile syringes can be acquired for free or for a very low price or where you can trade old syringes for new ones.

Other forms of consumption

Pills and some liquids are swallowed. The main risks here are irritation to the lining of the mouth, esophagus and stomach. Swallowing drugs in drinks or food can mean users have less control over the amount taken, but much of the damage caused by taking drugs in other ways, such as through the nose, lungs or veins is avoided.

Sometimes other forms of consumption are used such as anal ingestions also known as a "booty bump". This means injecting the substance (in liquid form or dissolved in water) via a syringe without needle up into the rectum. Drugs taken anally are absorbed faster than if swallowed and tend to have a stronger effect. This form of consumption tends to cause small injuries, irritations and bleeding and the risk of HIV, Hepatitis C or STI infections rises significantly.

Safer Use

When injecting, snorting and smoking drugs, Hepatitis viruses can be transmitted, as well as HIV. To minimize the risk, its best to advise users to always only use their own items such as syringes, pipes or tubes. Used utensils, including water and filters should never be shared.

Risk Reduction

It is not possible to use drugs without their being some level of risk. However many things can be done to minimize the risks: providing accurate information about the effects and interactions of the substances, suggesting that users avoid using new substances whilst on their own and advising them to be careful around dosing and supplementing their doses.

This information could look something like this:

Use substances only when you are in a good mood and with people you trust. When using chems at a party or in a group, there should be someone around who stays sober. Tell each other what you swallow, sniff or squirt – in an emergency this helps a lot. And when going to a party together, it is also recommended that you leave together. Do not leave anyone behind if they have used drugs. If you have not seen a friend for a long time, look for them – they may need help.

Preparation: good preparation helps to support low-risk consumption: a personal tube and sterile syringes, and possibly filters and water for intravenous use. GHB/GBL rations should be put into small syringes or other containers whilst you are at home and sober, to avoid overdosing later when you are 'high'. If you are taking HIV treatment or PReP, you should take enough medication with you to last a while longer than you think you'll be partying as it could be that you'll be there longer than you planned for.

Breaks between use: it is important to plan your breaks between each dose of the drug or drugs you are taking. The effect of the drugs may come on later than expected and may differ, depending on the how your body is dealing with things that day. For example, there should be a minimum break of two hours between any two doses of GHB/GBL you are using.

Setting: the reaction you have to the drugs you are using can differ a lot in different settings. A downer, like GHB/GBL or Ketamine used in a Sauna can cause problems much faster than if you are using them in a private setting, because of the heat of the sauna and the drugs effects on your body. It is always important to remember to drink water and to have eaten beforehand, as drugs often mask any feelings of thirst and/or appetite and therefore the risk of dehydration or energy loss is higher.

Safer way home: You should never drive a car or bike when high – even if you think you are able to. You also need sufficient recovery time after partying as the drugs can be hard on your body.

Safer Sex

When under the influence of any substances that affect your ability to think clearly whether its drugs or alcohol, things can often happen that would not normally happen when you are sober.

Clarify to yourself and with any sexual partners beforehand what you want to do or not want to do and which safer sex method you want to use.

It might be difficult for you to use a condom properly when being 'high' so a useful Safer Sex strategy should be discussed and agreed on beforehand.

Information about major substances used for ChemSex:

Crystal meth

AKA: crystal, Tina, T, methamphetamine or meth (not to be confused with meph – mephedrone).

Crystal meth is a super-strength amphetamine stimulant. Industrial chemicals and cleaning products which can be toxic often go into making it.

Used in chillouts, sex parties and during sex or clubbing, crystal releases the brain's stress hormone norepinephrine and 'feel good' chemicals dopamine and serotonin.

Meth comes as white or colourless crystals which can be crushed to make a powder. It can also come as a pill.

How it's used

Meth in its crystalline form can be smoked through a glass pipe.

Crystal as a powder is usually snorted, but can be mixed with water and injected. It can also be injected up the arse with a syringe with the needle taken off – this is known as a 'booty bump'.

Using meth is called 'tweaking' and injecting it is called 'slamming'.

Highs and lows of crystal meth

Meth is used for energy during non-stop sex or dancing sessions. It can make users feel high, euphoric, wide awake, self-confident, invincible, impulsive, less likely to feel pain and very horny with fewer inhibitions.

Crystal increases body temperature, heart beat and blood pressure – possibly to dangerous levels – increasing the risk of heart attack, stroke, coma or death.

Users may go for days without eating or sleeping because crystal meth suppresses the appetite and keeps them wide awake.

The comedown can leave people feeling exhausted, aggressive and paranoid, in some cases even suicidal. They can also develop stomach problems such as acid reflux or gastritis due to not eating for a long period of time. Many users develop bad teeth and gum problems due to their regular use of Crystal and their disinterest in their personal hygiene. Dehydration is also a common problem, as using 'Tina' masks feelings of thirst and hunger.

Depending on how Crystal is taken, it might also damage the lungs, nose and mouth.

The drug's bad reputation is warranted by the many casualties it's caused on the gay scene around the world, although not everybody who uses it develops problems. As with any drug use there is problematic and non-problematic usage, with some users being able to control their consumption and some not. It's also thought that the risks of dependency on Crystal may be linked to the way that it's been taken.

Sex on crystal meth

Crystal can make the user feel very horny, even sexually compulsive with a stamina during sex not felt when not using the drug. It can also stop them cumming or even getting a hard-on in the first place. Being on crystal for some guys means they take sexual risks that they normally wouldn't.

Long or rough crystal-fuelled sex sessions can cause a sore or bleeding arse, dick and mouth. These might not be noticed at the time but they mean that there's more risk of HIV, hepatitis C and other STIs being passed on.

Condoms are more likely to break after about half an hour of fucking. During long sex sessions on crystal, use plenty of silicon or water-based lube, check the condom remains intact and put a fresh one on after 30 minutes.

Sex on crystal has been described by regular users of the drug as 'the best sex in the world', 'intense' but also as cold, aggressive or disconnected.

A long-term relationship?

Tolerance to crystal meth builds up quickly and users need to take more to get the same high. The drug has a reputation for being quickly addictive, especially when 'slammed' or 'booty bumped'.

Even hardened gay scene party animals who can control their use of other drugs have found themselves out of their depth with crystal. It can become hard to think of having sex without being on meth and – like G and mephedrone – it can have a big impact on peoples ability to have sex sober.

People who were addicted and are now sober say that it is hard to deal with sex afterwards, often for many years. Problematic use of Crystal can cause severe negative effects, including job loss, financial problems and health issues including psychosis or lasting mental health problems, even after quitting the drug.

Quitting problematic use of Crystal can be very hard. Its effects on the brain can last long after giving the drug up, but users can turn this relationship around.

Tips to share with users about consuming Meth

- Consume only when they feel comfortable and it's best done when someone you trust is with you and who knows about your (mixed) consumption and could get help in an emergency.
- You can't always tell with the naked eye what drug that line in front of you is. If something is offered to you, ask what that substance is.
- Think about how long you want to stay awake. Do not take anymore when the party is over or you want to go home. It's not good to be exhausted and unable to sleep.
- Using Crystal leads to increased facial motor skills in many users (teeth grinding). Chewing gum can help to protect teeth, gums and cheeks, but this does not help against developing sore muscles in your face from the chewing. Some users recommend magnesium and calcium for muscle relaxation.
- Take rest breaks during your drug 'bumps' to avoid overheating and over-exertion. When dancing in the club, give yourself a little break and go out into the fresh air for a while.
- Even if you feel fit and alert: do not drive a car under the influence of Crystal or perform other dangerous activities (such as operate heavy machinery for example) Do not underestimate how the drug can still be affecting you.
- Using Crystal deprives your body of fluids, essential minerals and vitamins; therefore always drink enough water or vitamin-rich fruit juices. You can compensate for calcium deficiency by eating dairy products or beans. Vitamin and mineral drinks and tablets, as well as fruits, vegetables and nuts can be helpful during or after Crystal use in the short term.

- Crystal is not a suitable diet. You can lose a lot of weight in a short time, but it's in a very unhealthy way.
- If you consume Crystal on a regular basis, your tolerance to the substance increases really quickly meaning your body builds a tolerance and you have to take more to get the same high. This will mean that the nutrient and power reserves in your body continue to decrease. Therefore its highly recommended to take longer breaks between uses of Crystal, and it's really important to get sufficient sleep and a healthy diet. It also helps you to take care of your personal hygiene (which can be lost over long weekends of partying) and it's especially recommended to pay close attention to your teeth, gums and nose. A break of a couple of weeks between uses is recommended so that your body and mind can recover and regenerate sufficiently.

Crystal with other drugs

HIV drugs/PrEP

Protease inhibitors – especially ritonavir, but also some other drugs in this class – could cause a big, possibly fatal rise in levels of Crystal in the body. This is because ritonavir slows down the metabolisation of Crystal which leads to high levels of the drug in the bloodstream, making overdose more likely. If users are on these treatments it's recommended to start with low doses of all chems, not only Crystal.

If someone is partying the weekend away on crystal, they are more likely to be late with their meds or miss them entirely, so it may be useful to set alarms on clocks and phones as reminders of when to take meds.

Crystal also damages the immune system, as does going without food or sleep when you're on it.

Ecstasy, cocaine, poppers and Viagra-type drugs

All of these drugs put the heart under strain. If people are using crystal too they are pushing their heart even harder. Mixing those drugs can lead to:

- sudden spikes in blood pressure
- chest pains
- heart attack
- strokes.

Anti-depressants

Taking crystal while on antidepressants can make life-threatening reactions more likely, including dangerously high blood pressure and increased risk of serotonin syndrome (the levels of serotonin in your blood becoming too high). Users should check with their doctor before using antidepressants and crystal at the same time.

Useful information to know and share

It's recommended that users avoid injecting, as it's the quickest way to getting addicted and runs the risk of serious health problems including skin abscesses, collapsed veins, blood poisoning and heart infections. There are other ways of using Crystal that are less problematic.

Sharing injecting equipment puts the user at a high risk of getting or passing on HIV, hepatitis C and other infections. Using hot pipes can injure the lips and lining of the mouth and if pipes are shared it risks passing on – through tiny amounts of blood – infections such as hepatitis C and HIV.

GBL/GHB

GBL and GHB are also known as G or Gina.

GBL (gamma butyrolactone) and GHB (gamma hydroxybutyrate) are chems used during sex, often in chillouts, sex parties or when clubbing. They're depressant drugs ('downers'), which means they have a sedative and euphoric effect, similar to being drunk.

Both types of G can be used legitimately as industrial solvent and paint stripper-type chemicals. In most cases GBL is in the market as it's much cheaper and easier to buy than GHB.

How it's used

GBL is the most common form of G now and is a clear liquid that has a strong chemical smell and taste.

GHB is a clear, salty liquid with no smell. Sometimes it comes as a powder that's added to a drink. Both are usually mixed with a soft drink, but never alcohol.

Because GBL turns into GHB inside the body, the effects of GBL can be stronger or more unpredictable.

The strength of G varies a lot so it's hard to know what a safe dose is.

Highs and lows of G

With G the high comes after about 20 minutes, lasting about one hour. But it may last up to four hours.

A dose of G can make users feel chilled out, horny or mildly high. It's often used with other chems like mephedrone or crystal meth.

Too much G leaves users dizzy, confused, drowsy or vomiting – which could cause death from choking if G has knocked them out. The worst case scenarios with G are seizures, coma and death. G usage is thought to be linked to a number of deaths which have taken place in saunas in recent years.

Overdoses tend to happen when:

- People take a second dose before the first kicks in – always give it two hours before second dosing.
- The G is stronger than expected.
- They've been drinking alcohol.

Dosing

The strength of G varies a lot, so it's hard to know what a safe dose is. A little 'Gina' goes a long way, with a typical dose varying from 0.5ml to 1.5ml.

There's not much difference (less then a millilitre) between the dose that gets people high and one that has them hitting the floor. Overdosing is easy to do and comes on with little warning.

Doses need to be precise, so they're often measured with a syringe with the needle removed. An additional danger comes when someone takes a dose and thinks nothing's happening, so they take more.

Waiting at least two hours before taking a second dose makes overdosing less likely. Taking another shot of G within an hour makes overdosing likely as the body hasn't processed the first shot yet.

G should never be used at the same time as alcohol as this is likely to be life threatening. G and alcohol affect the same mechanism in the body and therefore the effect of G is increased greatly leading to overdose levels being present in the blood. If someone has already drunk some alcohol it's advised that they wait at least two hours before taking any G and then it should only be a small amount.

Sex on G

The drug has a reputation for making people horny. Its relaxing effect can be used to help take things up the arse.

Less welcome is that it can make it harder to come or can lower peoples inhibitions, making unsafe sex more likely – and with it passing on infections such as HIV, Syphilis or Hep C. If someone is a bit out of it – or totally dead to the world – it'll be hard to control what's happening or even remember what had happened when (or if) they come round. Guys have reported being sexually assaulted or raped while unconscious on G.

A long term relationship?

Regular users often build up a tolerance to G, needing more to get the same buzz.

It's possible to become physically dependent on G with regular usage. The best way to avoid developing tolerance and dependence is not to take G for more than 2 days in a row.

Withdrawal from G, if someone is addicted, can be very dangerous without medical support — so advise against people withdrawing on their own.

G is often thought of as the most dangerous ChemSex drug and is linked to the most deaths. It is famous as "K.O. drops" as it is used to knock people out in bars or clubs, so the advice is for people to never leave their drinks alone. The difference between a dose that has the desired effect and a dose that will kill is very small, and the advice is to never use G at saunas or whilst alone.

G with other drugs

Depressants

It's very risky to mix G with other depressant drugs (downers) such as alcohol and tranquilisers – but also ketamine or antihistamines (used in allergy medicines). Their combined action can dangerously slow down a persons breathing or cause a long 'G sleep'.

Also known as 'going under', G sleep isn't sleep at all but a state of unconsciousness. A fit, coma or death can possibly follow. Even drinking booze a few hours earlier can leave enough of it in someones system to risk a collapse.

HIV drugs

G can also interact with some HIV meds, causing dangerously high levels of GHB and a bigger risk of collapsing.

Useful information to know and share

If someone's getting drowsy from GHB/GBL, don't let them fall into G sleep – they're not 'sleeping', they're unconscious and may not wake up. Try to keep them awake and moving until the effects wear off or medical help arrives.

If G knocks someone out, to stop them choking on their own vomit they should be laid on their side, in the recovery position, not on their back.

If someone isn't feeling well or can't be woken up, get medical help straight away. There's always a risk of sudden death if someone's unconscious. You'll be in a lot more trouble if you don't get help and then have a dead body on your hands.

If you're not going to get medical help put the person in the recovery position, sit with them and regularly monitor their pulse and breathing.

G should definitely be avoided if you have:

- high or low blood pressure
- epilepsy
- convulsions
- heart or breathing problems.

Mephedrone

AKA: meph, drone, m-cat, MCAT, meow, meow meow, plant food/feeder, bath salts

Mephedrone is a stimulant drug, chemically similar to amphetamines and derived from cathinone – also found in the drug khat. Another cathinone is known as MDPV (methylenedioxypyrovalerone) or Monkey Dust.

Mephedrone is now commonly cut with other substances and the quality of the drug can vary greatly. What someone may think is meph, may be something else entirely as very similar substances are called 'Mephedrone'.

How it's used

Mephedrone is a white, cream or yellow coloured powder. Usually when first received, it comes as a coarse powder made of tiny crystals. These can then be crushed into a finer powder for use.

Mephedrone can be snorted or swallowed in 'bombs' (wraps of paper) or dissolved in water and 'slammed' (injected) or 'booty bumped' (injected with a syringe into the arse).

It sometimes comes as a capsule or pill.

Highs and lows of mephedrone

Highs

For about an hour after taking mephedrone users may feel euphoric, horny, alert, empathic to those around them, confident and talkative. Some people describe it as being like a mixture of MDMA (ecstasy) and cocaine.

Lows

After using mephedrone, people can experience a powerful comedown: feeling tired, depressed and finding it difficult to concentrate for a few days. The strength and duration of the comedown will be worse if more mephedrone has been used for longer periods.

Mouth ulcers and sores are also common as mephedrone can cause people to grind their teeth or bite their tongue or mouth and not notice.

Although there hasn't been much research into mephedrone, medics think it's more dangerous to mix it with alcohol as this seems to increase the chances of it causing breathing problems.

Sex on mephedrone

Mephedrone can make users feel more alert, euphoric and horny.

It's often taken with GHB to keep people awake and offset the drowsy aspect of G.

Mephedrone can make it harder for users to maintain an erection and to cum, so Viagra is often taken alongside it to offset this side effect.

Mixing mephedrone with other drugs can cause unpredictable reactions and seriously reduce your inhibitions. This means users may have sex with people, or in situations, where they may feel uncomfortable afterwards.

A long-term relationship?

Because the effects wear off quite quickly, it's easy to become dependent on mephedrone and to keep using more. Users may find it hard to stop once they've started a session on the drug.

Getting hooked on mephedrone carries several risks:

- If it's snorted it can cause soreness in the nose and nosebleeds.
- It also has an effect on the heart, with the risk of palpitations and an irregular heartbeat.
- Mephedrone can cause grinding of the teeth and excessive chewing, which can damage teeth and gums, the tongue or the lining of the mouth.
- It can also cause fits because of the way it stimulates the nervous system.
- Regular users report low mood, sleep problems and fatigue.
- Recently some guys have started 'slamming' (injecting) mephedrone. This is especially dangerous as the drug gets into the bodies system much quicker.

It can be easy to make a mistake while slamming. If the veins are damaged when injecting mephedrone, it can lead to ulcers or gangrene.

Injecting mephedrone may act as a gateway to injecting other drugs such as crystal meth too. Infections such as HIV and hep C can be passed on easily by sharing injecting equipment.

Useful information to know and share

Less is known about mephedrone than about most other drugs, as it's relatively new and many drugs with different effects on peoples systems are sold as mephedrone. It's clear that it stimulates the heart, causing a rapid heartbeat. Some people have also experienced their fingers being cold or turning blue.

Reported side-effects are similar to amphetamines, such as teeth grinding, anxiety, paranoia, short-term memory loss and changes in body temperature.

The lack of research means it's hard to know the effect mephedrone has on other drugs such as HIV meds, but it's best to be cautious if someone is using it. The advice is for them to talk to their doctor about how it might affect their other pills.

Cocaine

AKA: coke, Charlie, C, snow, blow, a toot, Bolivian/Peruvian/Colombian marching powder

Coke is a powerful stimulant made from the leaves of the South American coca shrub. It makes the brain release its natural 'feel good' chemical dopamine.

Coke usually comes as a powder. It's often cut with impurities such as baking soda, sugar, amphetamines or painkillers.

Freebase and crack, also known as rocks or stones, are types of cocaine which have been treated to make them smokeable. Crack cocaine is a less pure version of freebase cocaine and comes as small, dirty white/light brown rock-like pieces. Crack has a more powerful high than cocaine and is even more addictive.

How it's used

Coke is normally divided into lines on a smooth surface, then snorted through a straw or rolled up banknote (which is not recommended at all). Other ways of taking it are smoking it or rubbing it into the gums or arsehole.

Crack is smoked in a pipe, glass tube, plastic bottle, or from foil.

Highs and lows of cocaine

A hit with either coke or crack comes on fast, usually within a minute, making the user feel exhilarated, alert, full of energy, confident, sociable, talkative and physically strong. It stops people feeling hungry or tired and kills pain.

Effects last for up to approximately half an hour if it's snorted and less if its smoked or injected.

The drug pushes up body temperature, blood pressure and heart rate and can cause chest pain and an irregular heartbeat even in healthy people. People who use coke or crack are much more likely to have a heart attack than people who don't use them.

Cocaine and crack use is also linked to strokes and seizures.

Comedown symptoms include:

- feeling down, rough and tired
- agitatation
- craving for more of the drug.
- Sudden death is more likely with large doses but smaller doses can kill, especially if someone has sensitivity to the drug.

Sex on cocaine (and crack)

Both drugs can make users feel physically strong, horny, more sexually aggressive or confident and with more stamina for longer sessions. Peoples sense of touch can be heightened, and they might get longer, stronger orgasms.

As inhibitions are lowered, it might be more likely that users will have unsafe sex.

Cocaine's painkilling effects can lead to rougher sex, making the cock and arse sore or bleed. This damage might not be noticed but it makes it easier for HIV, hepatitis C and other infections to be passed on.

Problems getting a hard-on, difficulty cumming and a lower sex drive can be other side effects, especially if the dose is big or it is taken for a long time.

A long term relationship?

When someone takes a lot of cocaine or crack, they build up tolerance and they're likely to start taking higher doses to achieve the same high. Coke has a reputation for being more addictive than most chems and crack is even more addictive.

The drugs can cause lasting damage to how the brain works and, given the drug's price, becoming addicted can ruin users financially.

Using cocaine or crack for a long time, or taking large doses, can cause panic attacks, hallucinations, depression, paranoia and psychosis.

Snorting coke can, over time, destroy the lining of the nose and the septum (the wall between the nostrils made from thin cartilage).

Coke/crack with other drugs

Alcohol

Using booze together with coke or crack makes the bad effects of both worse and can give people the illusion of being sober when they're drunk. These drugs mix together in the body with alcohol to make cocaethylene, a toxin that damages the brain, liver and heart. This is the reason for the bigger risk of sudden death in people using alcohol and coke or crack together.

Speed, crystal meth, mephedrone, ecstasy, or Viagra

Mixing these drugs with coke or crack means even more pressure on the heart and circulatory system, with a bigger risk of stroke and heart attack.

Anti-depressants

Taking cocaine or crack when on some antidepressants can cause 'serotonin syndrome'. This could be dangerous and causes symptoms such as a fast heart beat, sweating, muscle spasms and not being able to sleep. Users need to seek urgent medical help if this happens to them. If someone is on antidepressants the advice is to check with a doctor before using these drugs.

HIV drugs

As the body uses different pathways to processes these two drugs, there are no known dangerous interactions. However, regular use of cocaine has been linked to poor adherence to HIV treatment.

Useful information to know and share

- If users share straws or banknotes to snort coke, tiny amounts of blood could go from the lining of one person's nose to another's. This might spread blood-borne viruses such as hepatitis C. The same could happen if crack pipes are passed from a mouth with ulcers or burns to another person's mouth.
- Rubbing coke into the arsehole will make it numb and irritate the skin. This makes it more likely someone will pick up or pass on infections, including HIV.
- Rougher, longer sex sessions mean there is more risk of condoms breaking, so putting a fresh one on after fucking for about 30 minutes is recommended.
- These drugs make the heart beat harder and push up the blood pressure so should be avoided if the user has high blood pressure or a heart condition. They should be avoided by people with a history of mental health problems too.

MDMA (Ecstasy)

AKA: Mandy, Molly, E, ecstasy, pills.

MDMA is a derivative of amphetamine. It used to be better known as ecstasy, E or pills, and was more commonly found in tablet form.

As with all powdered drugs, MDMA is often cut with other substances.

How it's used

MDMA tends to come as slightly off-white (yellow or brown) crystals, which can be crushed into a powder.

The powder can be snorted, wrapped in tissue and swallowed (bombed) or dabbed on the gums. If it's a tablet, it's likely to be swallowed.

Highs and lows of MDMA

Highs

About half an hour after taking MDMA – or longer, depending on how much has been eaten – the user will start to 'come up'. It's now that their brain releases its 'feel good' chemicals dopamine and serotonin.

For up to four hours they might be buzzing with energy and feeling less uptight.

They may feel high and 'loved up'. Sounds and lights can be enhanced, which is another reason for MDMA's popularity with clubbers.

Lows

Jaw clenching, teeth grinding and sweating while high on MDMA are also common.

MDMA can sometimes cause anxiety or panic attacks, and leave people feeling disorientated or confused.

The drug can push up body temperature to what could be life-threatening levels, which is made worse by hot clubs and dancing.

MDMA-related deaths are often due to heatstroke, heart failure or drinking too little or too much water.

Once the brain's 'feel good' chemicals have been used up they take a few days to be replaced – so there's little point taking more MDMA. Any extra buzz that might be achieved will come from whatever the drug's been cut with, and it's often cut with things like speed, aspirin, caffeine or ketamine.

Sex on MDMA

MDMA can make people horny, with an increased sense of touch. But it can also make it difficult to get a hard-on or to cum. As the drug lowers inhibitions it can make some people more likely to risk getting or passing on HIV.

MDMA is often taken with Viagra. This combination is used to get around the problem of getting and keeping a hard-on, however, this can be dangerous and lead to an erection that will not subside for more than four hours. If this happens, users need to seek urgent medical help.

A long-term relationship?

Tolerance to MDMA can build up quickly, with more needed to get the same high.

Although MDMA has not been shown to be highly addictive, some people come to rely on the drug and can't imagine clubbing without it. Some research suggests that prolonged MDMA use can cause long term memory loss, depression, anxiety, and cognitive problems.

MDMA with other drugs

Alcohol

Alcohol can deaden the effects of MDMA while MDMA masks the effects of the booze, making it difficult for someone to tell how drunk they are.

Both dehydrate the body, put strain on the liver and kidneys, and raise body temperature. MDMA-related deaths often involve booze.

HIV drugs

Some of these – especially protease inhibitors such as ritonavir – could increase levels of MDMA to life-threatening levels in the body as they prevent it from being broken down in the liver. The advice is for users to check with their HIV doctor before getting high.

Antidepressants

Taking MDMA when on a course of some antidepressants can be fatal, as it increases the risk of 'serotonin syndrome'. This is a dangerous reaction with symptoms of agitation, sleeplessness, sweating, faster heartbeat and muscle spasms.

If this happens, the user needs to seek urgent medical help.

The advice is that if a user is on antidepressants they should get medical advice before taking MDMA. An older type of antidepressants called monoamine oxidase inhibitors (MAOIs) mix particularly badly with MDMA.

Cocaine, speed, mephedrone, crystal meth

These stimulant drugs taken with MDMA can put the heart under a dangerous level of stress, leading to a risk of heart attack.

Viagra-type drugs

As well as possible extra stress on the heart, there have been a few reports of this combination possibly leading to erections that won't go down for over four hours. If medical help isn't found quickly, this can cause lasting damage to the users cock.

Useful information to know and share

Users can avoid overheating and dehydration by drinking a pint of water for every hour that they're dancing, and by taking breaks. But drinking too much water can be dangerous, so try not to exceed that amount. Drinks that contain minerals are also recommended.

If they're hyperactive or dancing, take regular breaks to bring their body temperature down.

MDMA should be avoided by people with a history of mental illness or depression as it can trigger depression or make it worse if you have it already.

As MDMA pushes up blood pressure and heart rate, it should be avoided if you've got any of the following:

- high blood pressure
- heart, liver, or kidney problems
- the eye condition glaucoma
- a history of stroke.

Ketamine

AKA: K, Special K, vitamin K

K is an anaesthetic and is sometimes referred to as 'horse tranquiliser'. It's one of the chems used in dance clubs or during sex.

Ketamine can come as a powder or a liquid that's dried to make the powder.

How it's used

As a powder, K can be snorted, which is known as a bump, or added to drinks.

K should never be mixed with alcohol or GBL as the drugs can greatly amplify the effects of one another.

K can be smoked if the powder's mixed in a joint with cannabis and tobacco. Ketamine powder can also be mixed with water and injected into a muscle, but never a vein. The powder can also be snorted or sprayed up the nose. K can also come as a pill.

Highs and lows of ketamine

Ketamine can boost energy levels in small doses or make users feel high, numb, cut off from their body or in a dreamy, floating state.

K can cause hallucinations and an out-of-body experience that can feel like the user is entering a different reality, meeting God or aliens.

The effects last 45-90 minutes if snorted, and up to three hours if injected or swallowed.

The side effects of K can include:

- dizziness
- feeling sick and throwing up, which is risky as the user might choke on their vomit if they've passed out
- feeling disorientated and detached from reality
- racing heartbeat and shallow breath
- blurred sight and speech
- bladder dysfunction – in extreme cases even peeing 'jelly'
- urinary tract infections like cystitis
- waking up with bruises and injuries – K numbs the body, so it's easy for users to injure themselves without feeling pain.
- A large enough dose can cut people off from their surroundings and sense of self. This is called a 'K hole' and can last for up to 90 minutes. Users might find it hard or impossible to move or talk in this state and swallowing or breathing can be difficult.

Sex on ketamine

Although ketamine can make users feel horny, it can make it difficult to get a hard-on or cum.

K can be used by guys who are into getting fisted as it relaxes the arse muscles.

As the drug makes people feel pain less, rough sex can lead to damage inside a users arse or cuts and bleeding that aren't noticed. This may mean more risk of HIV, hepatitis C and other infections being passed on.

Ketamine can lower inhibitions, which might lead to unsafe sex.

A long-term relationship?

Overdose deaths are rare, but people can build up a tolerance to K with more needed to get the same result. Some people become dependent on it.

Using ketamine long term might cause mental health problems such as:

- anxiety
- depression
- suicidal thoughts
- memory loss.

If someone uses ketamine often they might end up with:

- bladder problems
- kidney or liver damage
- stomach pains and blood in the urine.

Ketamine and the bladder

Ketamine can cause scarring and inflammation of the bladder, making the user unable to hold much urine and causing them to need to piss very often. These symptoms often lessen when ketamine use is stopped, but in some cases surgery is needed.

Some people have had to have their bladder taken out and be fitted with a bag that collects their urine.

Ketamine with other drugs

Depressants

This includes 'downers' like alcohol, GHB/GBL, Valium and barbiturates. As K and other depressants slow the body and its functions down, the combined effect can knock the user out and/or slow their breathing and pulse to dangerous levels.

HIV drugs

Some of these, especially protease inhibitors, could theoretically raise the levels of ketamine in the body. If the user is taking protease inhibitors such as ritonavir, they should be very cautious when taking K, as they might affect ketamine metabolism in their body.

MDMA

Mixing K with MDMA is not a good idea as the user can end up with dangerously high blood pressure.

Tobacco/cannabis

Smoking cigarettes or joints when using K carries a risk of fires, as K can make people unable to move. There is also a risk of burns as K's anaesthetic effect can stop the feeling of pain.

Useful information to know and share

- K is usually snorted in its powder form although some people add it to drinks. However, K should never be mixed with alcohol.
- Sometimes people smoke K mixed with cannabis in a joint, but smoking it is unpleasant and can damage the lungs.
- If users share their injecting equipment there's a real risk of getting or passing on infections such as HIV or hepatitis C. Injecting can also cause skin abscesses, blood poisoning, life-threatening blood clots or heart infections.

- Someone in a K hole should be taken away from music and bright lights and reassured that it'll be over soon and they will be OK. It can take minutes or hours to come out of a K hole, depending on how much has been taken.
- K should be avoided by people who have fits, high blood pressure or heart or liver problems.

Speed

AKA: amphetamine, uppers, sulphate or whizz

Speed is the street name for amphetamine sulphate, a stimulant drug.

How it's used

Although it might come as a pill, speed usually comes as a white-ish powder, often cut with other things such as caffeine or talc.

It makes the brain release its 'feel good' chemicals, dopamine and serotonin, and the stress hormone norepinephrine.

There are several ways of taking speed. It can be:

- snorted through a straw or rolled up banknote
- put on the tongue
- rubbed on the gums
- mixed in a drink
- wrapped in cigarette paper then swallowed (bombing)
- smoked from a pipe or foil or mixed with water then injected.

Effects of speed can last from three to six hours.

Highs and lows of speed

Speed can lower inhibitions and raise the users mood making them feel energetic, confident, alert, talkative and sociable. It can allow them to go without sleep or food.

Common side effects of speed are:

- an increased heartbeat
- sweating
- teeth grinding
- jaw clenching
- being unable to sleep.

After using speed users can feel depressed, anxious and tired.

Sex on speed

Speed often causes problems getting erections. It can make the dick feel less sensitive and make it harder to cum.

This can lead to longer, rougher fucking sessions and sore or bleeding dicks and arses, with a greater risk of HIV, hepatitis C and other sexually transmitted infections (STIs) being passed on.

Long-term relationship?

People can become dependent on the drug, with larger doses needed to get the same effect and withdrawal symptoms if they stop.

Withdrawal symptoms can include:

- exhaustion
- insomnia
- depression
- feeling irritable.

Long-term use of speed can cause:

- damage to the heart, liver, kidneys and lungs
- premature ageing of skin and heart
- aggression
- 'speed psychosis', which can include violent behaviour, paranoia and hallucinations.

Speed with other drugs

HIV drugs

Protease inhibitors, particularly ritonavir, can cause a big increase in the amount of speed in the body, leading to overdose.

Cocaine, crystal meth, Ecstasy, MDMA, poppers

Mixing these drugs with speed risks a dangerous strain on the heart.

Anti-depressants

Taking speed when on these drugs can cause a life-threatening rise in blood pressure.

Alcohol

Speed masks the effects of booze, leading people to drink more without realising how drunk or over the limit they are.

Viagra-type drugs

Speed causes loss of erections, but taking Viagra to combat this puts even more stress on the heart.

Useful information to know and share

Swallowing the drug wrapped in a cigarette paper (a speed bomb) or mixing it with water is less harmful than snorting which can damage the nose. Though it's always a good idea to know what, and how much is being swallowed.

When snorting there's less damage to the nose if:

- the powder's fine, so make sure to chop it well
- the user alternates nostrils
- the user rinses their nostrils out after snorting.

The advice is for users to always use their own snorting equipment as hep C can be passed on from tiny particles of infected blood. If they're with a group of friends who are all snorting, tag their own stuff with a Post-it note with their name on it.

Injecting is best avoided as this is more likely to lead to addiction. Also, speed deaths are linked to taking the drug this way, and it can cause skin abscesses, damaged veins, blood poisoning and heart infections.

Sharing injecting equipment can pass on HIV and hepatitis B and C.

Speed should be avoided by people with high blood pressure or heart conditions."

ChemSex: How to help

Now you know about the drugs and how they are used, here are a few links and suggestions about how to usefully help any service users who talk with you and want some advice or information about their ChemSex drug use:

- Find out about and refer people onto appropriate local services
- Read and refer users onto David Stuarts ChemSex Care Plan – www.davidstuart.org/care-plan
- Read and use David Stuarts ChemSex First Aid – www.davidstuart.org/ChemSex-first-aid
- Find out how a large London clinic provides ChemSex services
- 56 Dean St ChemSex pages – www.dean.st/ChemSex-support
- Have a look at the Terrence Higgins Trust online resource fridaymonday – www.fridaymonday.org.uk

E-Learning: Prevention

What is Safer Sex now?

Safer sex is now a combination of preventative methods, which for many years focussed on condom use only. In many countries condoms, PrEP, TasP (U=U) and PEP are considered equally effective interventions against onward transmission of the virus.

HIV

The following are the recommended responses from the ECDC 2015 Guidance: HIV and STI Prevention among men who have sex with men. Information on TasP (U=U) has been taken from the National Centre for HIV/AIDS, Viral Hepatitis, STI and TB Prevention. USA – December 2018.

It is recommended that you check online at ECDC and other sources such as PrEP In Europe to see if more up to date guidance has been published recently.

Condoms and condom-compatible lubricant use

"Condom use when having anal sex with a partner of unknown viral burden or infection status is a core component of HIV and STI prevention. Condoms prevent contact between semen and rectal mucosa, as well as between rectal fluid and the penile mucosa, thereby preventing the transmission of HIV.

Operational research also emphasises the importance of condom-compatible lubricant use (water- or silicon-based) during anal sex. Lubricant use facilitates entry and prevents micro-tears in the rectum during anal sex as well as decreasing rates of condom breakage. Oil-based lubricants increase the risk of latex condom breakage and are not recommended in combination with condoms for anal sex. The importance of condom-compatible lubricant use needs to be taken into account as a part of condom promotion interventions for MSM, and preferably distributed through the same programmes. Sub-optimal lubricant use is common among MSM, and correct use of lubricant should be included in prevention messages."

HIV testing

"Provide voluntary and confidential HIV counselling and testing through a variety of ways that are easy to access for the target group, including outreach to the community, and routine offering of tests in clinics and community-based settings.

It is suggested that individual counselling and mapping of risk behaviour should be used for individual recommendations around frequency of testing for HIV (and other STIs), but that annual testing for sexually active MSM would be a minimum suggested interval for testing."

Community-based testing

"Rapid HIV testing and counselling in community settings delivered by trained staff or peers can increase the uptake of HIV testing among MSM and can reach populations of men that have previously not accessed HIV testing. MSM have also expressed preference for rapid testing over conventional testing in some European settings. Testing done in community settings such as testing centres located in easily accessible areas and at easily accessible times of day, or through outreach or mobile services, can allow easier access to and uptake of HIV testing services. Community-based testing services provide testing that is free or low-cost in an environment that is comfortable for difficult-to-reach groups. Community based testing services can be delivered by trained peers, which can improve the uptake and acceptability of services for some MSM."

HIV self-sampling and self-testing

"HIV self-sampling consists of a kit that allows a user to take a blood or saliva sample from themselves, post it to a testing lab and receive the result by phone, text or email. HIV self-testing implies that the patient would obtain a sample at his own convenience, such as an oral fluid swab, self administer the test and then interpret the result. Some countries have approved or are in the process of approving the sale of self-testing kits for HIV. The United Kingdom became the first country to initiate sale of tests for home testing in April 2015. These kits will permit the individual to produce their own sample and run the test in their own home, with a result in 15 to 40 minutes. Self-testing might increase testing frequency due to test availability and easy access, but it requires careful quality assurance to minimise false negative and false positive results as well as well-defined pathways for accessing confirmatory testing and counselling in order to ensure linkage to care, and access to prevention and support."

Pre-exposure prophylaxis (PrEP)

"PrEP is a method to reduce the risk of HIV infection in HIV-negative adults who are at high risk of HIV exposure. The treatment includes the use of oral antiretrovirals in order to prevent the virus from establishing a permanent infection. Detectable drug levels in the blood strongly correlated with the prophylactic effect, emphasising the importance of adherence to PrEP.

While it was expected that open-label, non-trial use of PrEP might result in lower efficacy, the 2014 UK PROUD trial of 545 MSM randomised to immediate or deferred daily PrEP arms, found an 86% reduction among men in the immediate PrEP arm, and equal rates of rectal STIs and high condom use in both groups throughout the course of the trial, indicating that men had incorporated PrEP into existing risk reduction strategies. The 2014 French Ipergay study carried out on 400 MSM, also demonstrated an 86% reduction in HIV infection among MSM taking intermittent PrEP (two tablets 2–24 hours before sex, one tablet 24 hours later, and one tablet 48 hours subsequent to the first dose) as compared to the placebo arm. High efficacy was achieved despite the fact that only 43% of MSM reported taking PrEP optimally during their last intercourse.

These studies provide strong evidence on the efficacy of PrEP and indicate that serious consideration should be given to its inclusion in the 'HIV prevention toolbox', especially for those MSM most at risk of acquiring infection."

Post-exposure prophylaxis (PEP)

"Post-exposure ARV-based prophylaxis is approved for use in Europe and should be started as soon as possible after HIV risk exposure, but always within 48–72 hours. Treatment should be continued for 28 days, unless the source individual is determined to be HIV negative.

PEP has consistently been shown to reduce HIV transmission in animal studies and was originally introduced to reduce transmission following needle stick injuries. For ethical reasons no RCT has been conducted. Observational studies show consistent protection, but of various degrees. Apart from occupational PEP and PEP in situations of sexual assault, in most countries PEP is also recommended to individuals having had anal intercourse without a condom with partner of unknown HIV serostatus, seeking care within 48–72 hours. The most common use of non-occupational PEP is in discordant couples (where the index partner is not on ART) due to condom breakage or failure. United States and most European guidelines also specifically include individuals having had unprotected receptive anal intercourse with a homosexual or bisexual man of unknown HIV-status as eligible for PEP. Since antiretroviral medication also carries a risk of adverse events, individual benefit of PEP needs to be weighed against risks, and in countries where PEP is available, it is a clinical decision based on individual benefit, rather than a strict guideline-based measure.

PEP has not been associated with an increase in high-risk sexual behaviour among MSM, and has rarely been promoted as a main prevention method to the MSM population. Awareness of PEP and perceived access to PEP is low among MSM in most European countries, indicating that PEP is not a first-line prevention intervention.

In EMIS 2010, less than 2% of respondents in 26 of the 38 countries included reported ever having accessed PEP; the remaining countries reported slightly higher use, with respondents in France reporting the highest use, still only 9%. The low use of PEP in most European settings could be explained by low awareness or low perceived needs. Access is also an important issue and in the 2010 EMIS survey, about one-third of European countries reported that PEP could not be accessed for free."

Treatment as Prevention (TasP)

"HIV treatment has been shown to be beneficial both to individual health and in decreasing the risk of transmission to the individual's partner(s). The sexual transmission of HIV from an HIV-positive person to their partner is correlated with concentrations of HIV in the genital tract and genital fluids, which is the mechanism for how combination antiretroviral treatment (ART) reduces sexual transmission of HIV.

Studies evaluating HIV transmission were carried out mostly on heterosexual HIV-discordant couples and have shown that treatment of persons with HIV can reduce the risk of sexual transmission of HIV to their partner by over 90%.

The results of the PARTNER study, which included MSM discordant couples, have confirmed these findings for the MSM population by not detecting any episodes of linked HIV transmission from men infected with HIV and a viral load below the limit of detection. It has been estimated that the majority of HIV transmissions among MSM in UK settings occur before the positive partner is diagnosed. Therefore, the main efforts for effective HIV prevention and care programmes in EU/EEA settings will be focused on achieving high and regular testing frequency for those MSM most at-risk and facilitating treatment access and adherence to treatment among those who are tested positive."

"New data from the Partner II study, which concentrated on sero-discordant MSM couples support the findings of the original Partner study. Neither of these studies observed any genetically linked infections while the HIV positive partner was virally suppressed and the couples were engaging in condomless sex and not using pre-exposure prophylaxis (PrEP). In these studies, viral suppression was defined as less than 200 copies of HIV RNA per millilitre of blood; most HIV positive participants had less than 50 copies of HIV RNA per millilitre of blood. Couples in both studies engaged in over 100,000 sex acts without a condom or PrEP – and the transmission risk estimates and their corresponding 95% confidence levels are reported as a 0.00 risk (0.00-0.24) per 100 couple years. This is why we can now say with confidence that Undetectable equals Untransmissible and that HIV positive partners on effective treatment cannot pass on their HIV."

(taken from the National Centre for HIV/AIDS, Viral Hepatitis, STI and TB Prevention. USA – December 2018)

STI's

Comprehensive screening for STIs

"Regular comprehensive screening offered to asymptomatic MSM includes anal/penile inspection and sampling of the urethra, pharynx, rectum and blood for syphilis, gonorrhoea, chlamydia (and LGV if positive for chlamydia).

Testing for Herpes simplex virus type 2 (HSV-2) should also be performed if clinically indicated. These tests should preferably be performed in combination with HIV testing for men not yet diagnosed. MSM living with HIV should be offered voluntary screening for hepatitis C and other STIs annually or more often if clinically indicated.

Routine STI screening of asymptomatic individuals will reduce the period in which infected individuals might remain both untreated and unknowingly able to transmit the infection to others. Screening frequency for STIs should be decided according to individual risk assessment and local epidemiological circumstances. The use of rapid tests, which are progressively becoming widely available for some infections can increase test uptake, including among MSM, but quality standards for their use must be ensured. Adequate treatment according to national, regional or WHO guidelines should be offered to persons testing positive."

Treatment for STI's

"Bacterial STIs should be treated with targeted antibiotic treatment in accordance with national clinical guidelines. Due to widespread availability of diagnostic tools including rapid tests and in order to reduce drug resistance, syndromic management is not recommended for STI treatment. National treatment guidelines, particularly for gonorrhoea, should be reviewed regularly due to changing resistance patterns. The IUSTI treatment guidelines are regularly updated based on the latest epidemiological and microbiological data.

Topical lotions for treatment of infections such as pubic lice (crabs) or Scabies are available via pharmacies."

Viral Hepatitis (A, B & C)

Testing

"Testing protocol for Viral Hepatitis should follow the suggestions made for STI testing, so regular comprehensive screening offered to asymptomatic MSM includes anal/penile inspection and sampling of the urethra, pharynx, rectum and blood for syphilis, gonorrhoea, chlamydia (and LGV if positive for chlamydia). Hepatitis B (for unvaccinated men) and C screening is performed as indicated by the individual risk or local epidemiological circumstances."

Vaccination/s

Hepatitis A and B vaccination

"A three-dose course of hepatitis B vaccination (at 0, 1 and 6 months) provides 95% long-term protection against hepatitis B and is recommended by WHO to be part of child vaccination programmes. According to self-reported data from EMIS 2010, 40% of MSM in Europe are in need of hepatitis B vaccination, largely irrespective of age. In many countries the proportion is substantially higher. Therefore, better access to hepatitis B vaccination is a crucial prevention measure for MSM in Europe.

Outbreaks of hepatitis A have occurred among MSM within the EU, associated with faecal-oral contact during sex and also with sex at saunas. Given this, a combination vaccine for both hepatitis A and B is suggested for adults as a catch-up vaccination for MSM in need. Vaccination against both hepatitis A and B has been shown to be safe and have a high efficacy. Information on vaccine availability should be included in health promotion programmes targeting MSM."

Treatment

"Antiviral treatment for hepatitis C or herpes simplex virus should also be provided as per national or regional (EASL and IUSTI) clinical guidelines. There is good evidence that early treatment of hepatitis C is more desirable, and new direct-acting antiviral treatment regimens are highly effective.

Timely provision of antiviral treatment of HIV, hepatitis B and C according to individual needs and national or international clinical guidelines should be ensured.

Provide targeted antibiotic treatment for other STIs.

The preventive benefits of treatment are significant. STI, HIV and hepatitis treatment should be offered following a positive diagnosis based on an appropriate test, and in relation to clinical guidelines. In the absence of national guidelines, regional guidelines produced by IUSTI, the European Association on the Study of the Liver (EASL), and the European AIDS Clinical Society (EACS) [54] or global guidelines could be useful. Correct and specific treatment is crucial to benefit the health of the individual and to hinder further transmission."

Interventions reviewed which were not included due to strength of evidence and expert opinion

Intervention	Outcome	Strength of Evidence	Expert Opinion
Voluntary medical male circumcision	HIV Incidence	Possible (2b) *evidence of reduced incidence for MSM who are only or mostly insertive during intercourse	Not recommended due to lack of evidence for efficacy for receptive anal sex; perceived unacceptability to the target group.
Avoid semen in the mouth/unprotected oral sex	HIV Incidence	Insufficient (3)	Not recommended
Avoiding nitrate inhalants/poppers during intercourse	No studies retrieved	Insufficient (3)	No recommendation made due to insufficient evidence for reduction of HIV transmission. Members of the expert group noted that use of stimulants affect individuals decision making capacity with regard to sexual risk taking.
Serosorting	HIV Incidence	Insufficient (3)	Not recommended
Interventions to reduce alcohol binge drinking	UAI	Insufficient (3)	No recommendation made due to insufficient evidence for reduced HIV/ STI transmission; members of the expert group noted that alcohol affects individuals decision making capacity with regard to sexual risk taking.
Female condom for anal sex	Condom failure	Pending (2c)	While biologically possible, it was deemed that the product needed to be adjusted for anal sex in order to be used by MSM. It was the opinion of the expert group that this intervention is rarely used among MSM.

E-Learning: Prevention

Understanding the epidemiological dynamics of HIV infection in MSM in Europe.

Information taken from the ECDC: HIV/AIDS surveillance in Europe 2018 (2017 data). Copenhagen: WHO Regional Office for Europe; 2018 & the Review of HIV and Sexually Transmitted Infections among men who have sex with men (MSM) in Europe. (WP1 ESTICOM) RKI March 2017.

Why is understanding and using data around epidemiology and behaviour important for the work with MSM?

Data gives us a starting point to understand where the epidemic is within both the larger and regional contexts for the community/ies you work with.

Knowing levels of prevalence and incidence in the populations you are working with is key to knowing the needs of that community. It is also key is assessing the provision of services and ensuring that they are appropriate to, and meet the needs of, those population/s.

Understanding where the epidemic started in your region and how it has developed within the population ensures you are able to shape the services to the needs of the people infected and affected. It will affect which services are provided, and how changes in behaviours and incidence are reflected in service provision.

This approach is generally known as 'evidence into practice'.

Historical trends in HIV incidence among MSM in Europe

"HIV started to spread among gay and bisexual men in Europe at different time periods in different geographical regions.

In Northern and Western European countries (Scandinavian countries, UK, France, the Netherlands, Belgium, Western Germany, Switzerland, Austria) HIV started to spread largely unrecognized in metropolitan gay communities in the late 1970s and early 1980s, fueled by repeated importations from North America. Peak incidences were reached around 1985/1986, when the first diagnostic tests became widely available. Spontaneous and promoted behaviour changes, such as reductions in numbers of anal intercourse partners and increasing condom use, contributed to declining incidence of new HIV and STI infections in the late 1980s and early 1990s. However, incidence increased again in the late 1990s/ early 2000s.

In Southern Europe (Spain, Portugal, Italy), HIV initially spread mainly among IDUs, while transmission among gay and bisexual men increased gradually from the late 1990s onwards. In Eastern Europe, explosive HIV epidemics developed among IDUs from the mid-1990s, followed by increasing incidence of sexual transmission.

In Central and Eastern Europe HIV started to spread among MSM from the early 1990s, with incidence initially increasing slowly but then accelerating from the early 2000s onwards. In Eastern Europe heterosexual contact and IDU remain the main modes of HIV transmission, although the epidemic among MSM remains masked and often invisible because detailed information on mode of transmission is either unavailable or unreliable, due to high stigmatization of homosexual behaviour."

Overview: What does the most recent data tell us?

"Sex between men remains the predominant mode of HIV transmission reported in the EU/EEA, accounting for 38% (9694) of all new HIV diagnoses in 2017 and half (50%) of diagnoses where the route of transmission was known.

Among those with known route of HIV transmission, sex between men was the most commonly reported and accounted for more than 60% of new HIV diagnoses in 10 countries (Austria, Croatia, the Czech Republic, Hungary, Ireland, the Netherlands, Poland, Slovakia, Slovenia and Spain)

The trend in reported HIV diagnoses declined slightly between 2008 and 2017. In the earlier part of this period, rates were 6.9 per 100,000, decreasing slightly to 6.5 in more recent years, and 6.2 in 2017. While the overall EU/EEA trend appears to have declined slightly during the last decade, contrasting trends are seen at national level.

Several countries, including Austria, Belgium, Denmark, Estonia, the Netherlands, Norway, Spain and the United Kingdom, have reported a decline in rates of new diagnosis in recent years, even after adjusting for reporting delay.

Conversely, since 2008, and taking reporting delay into account, rates of HIV diagnoses have more than doubled in Bulgaria, Cyprus and Lithuania, and have increased by over 50% in the Czech Republic, Hungary, Malta and Poland."

HIV diagnoses

"In 2017, 25, 353 new HIV diagnoses were reported in the 30 countries of the EU/EEA, with a rate of 6.2 per 100, 000 when adjusted for reporting delay.

The highest rates were reported by Latvia (18.8; 371 cases) and Estonia (16.6; 219 cases), and the lowest by Slovakia (1.3; 70 cases) and Slovenia (1.9; 39 cases).

More men than women were diagnosed with HIV in 2017 (19, 032 and 6178, respectively), resulting in an overall male–female ratio of 3:1).

This ratio was highest in Croatia (20.2) and Slovenia (18.5) and was above 1 in all countries in the EU/EEA. The predominant mode of transmission in these countries was sex between men. The overall rate of new diagnoses in men was 9.0 per 100, 000 population and for women 2.8 per 100 000 population.

Men had higher age-specific rates than women in all age groups except among people under 15 years, where age-specific rates were similar. The highest overall age-specific rate of HIV diagnoses was observed among 25–29-year-olds (14.4 per 100, 000 population), largely because this age group has the highest age-specific rate for men at 22.2 per 100 000 population, while rates for women were highest in the 30–39 age group (6.9 per 100, 000 population).

The median age at diagnosis was lower for MSM (34 years) than for cases attributed to injecting drug use (37 years) or heterosexual transmission (39 years overall, 37 in women and 41 in men). The 30–39 age group accounted for most HIV diagnoses overall (32%) and in all transmission groups. Thirty-four per cent of cases attributed to sex between men are diagnosed before age 30, while half (48%) of HIV infections due to sex between men and women are diagnosed at 40 years or above, and nearly one quarter (24%) at 50 or above.

Sex between men remains the predominant mode of HIV transmission reported in the EU/EEA, accounting for 38% (9694) of all new HIV diagnoses in 2017 and half (50%) of diagnoses where the route of transmission was known.

Sex between men was the most commonly reported route of transmission among those for whom route of transmission was known, accounting for more than 60% of new HIV diagnoses in 10 countries (Austria, Croatia, the Czech Republic, Hungary, Ireland, the Netherlands, Poland, Slovakia, Slovenia and Spain)."

Trends in HIV diagnoses

"As reported by the ECDC and WHO Regional Office for Europe, the number of HIV diagnoses among MSM in the European region increased from 8,244 cases in 2006 to 10,849 cases in 2014. While fewer cases were reported in 2015 (10,274), a decrease in diagnoses is less evident when delays in reporting are accounted for. HIV diagnosis trends among MSM in Western Europe were largely stable between 2006 and 2015.

In contrast, trends in rates of new HIV diagnoses among MSM in Central Europe (Bulgaria, Croatia, Hungary, Romania and others) increased almost universally between 2006 and 2015, with particularly large increases in Cyprus in recent years. There is high variability in the completeness of reporting of transmission risk group for Poland and Turkey, and increases in these two countries may be due primarily to improved reporting of transmission category (and also in Turkey, due to increased rates of testing).

In some countries, such as Romania, HIV diagnoses among MSM may still be underreported due to the high stigma associated with homosexuality. In interpreting the increasing numbers of new diagnoses in Central European countries, it is important to consider that historically there has been a much higher proportion of undiagnosed HIV among MSM in Central compared to Western Europe (in part because the epidemic is younger in the former region). Therefore, improvements in testing uptake may partly explain increases in rates of new diagnoses.

While the overall rates of new HIV diagnoses among MSM were lower in many Eastern European countries (e.g.Turkmenistan, Uzbekistan, Tajikistan, Azerbaijan) compared to Central and Western European countries, rates generally increased between 2006 and 2015. In Eastern European countries overall, the officially reported number of new HIV diagnoses among MSM increased ten-fold from 80 in 2006 to 799 in 2015. This increase may be explained by improvements in ascertainment of transmission group, as well as improved targeting of testing by projects implemented and funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. In other countries however, such as Russia, the social recognition of MSM has deteriorated and underreporting and under-ascertainment of transmission among MSM is likely increasing.

The trend in reported HIV diagnoses for the period 2008–2017 has declined slightly in recent years. Rates in the earlier part of this period were 6.9 per 100, 000, decreasing slightly to 6.5 in more recent years, and 6.2 in 2017 (27, 055 cases when adjusted for reporting delay.

While the overall EU/EEA trend appears to have declined slightly during the last decade, trends at national level are contrasting. Several countries, including Austria, Belgium, Denmark, Estonia, the Netherlands, Norway, Spain and the United Kingdom, have reported a decline in rates of new diagnoses, even after adjusting for reporting delay.

Conversely, since 2008, and taking reporting delay into account, rates of HIV diagnoses have more than doubled in Bulgaria, Cyprus and Lithuania, and have increased by over 50% in the Czech Republic, Hungary, Malta and Poland.

Reporting delay affects some countries more than others: decreases in the rates of new HIV diagnoses may therefore be overestimated and increases in rates underestimated.

HIV diagnoses among people born outside of the reporting country comprised 44% of all new diagnoses in 2008, decreasing slightly to 37% in 2013 and increasing to 41% in 2017. New diagnoses among people originating from sub-Saharan Africa decreased from 24% of all new diagnoses in 2008 to 18% in 2017, while new diagnoses among people originating from other countries in central and eastern Europe increased from 4% to 6% of all new diagnoses. The proportion of people originating from other regions has remained stable.

The proportion of all HIV diagnoses attributed to sex between men increased from 34% of cases in 2008 to 41% in 2014 and 2015, then decreased to 37% in 2017.

The number of HIV diagnoses reported among MSM in countries reporting consistently increased from 7369 cases in 2008 and peaked at 8297 in 2013. Although fewer cases were reported in 2017 (6294), reporting delay probably plays a partial role in this decline.

Most of the decline appears to be due to fewer diagnoses among MSM in Belgium, Greece, the Netherlands, Spain and the United Kingdom. Increases were observed in many EU/EEA countries between 2008 and 2017, with substantial increases noted in Bulgaria, Cyprus, Ireland, Malta, Poland and Romania in recent years.

Cases attributed to MSM born outside of the reporting country increased over the period, declining slightly between 2015 and 2017 but not to the same extent as observed in EU/EEA-native MSM."

90-90-90: Why is understanding the Continuum of Care important?

We now have overwhelming evidence via research such as the Partner Studies that getting people tested, and if positive onto effective treatments, not only affects their disease progression but also means they cannot pass on HIV to sexual partners or via the Mother to Child route (there is insufficient evidence to show that it is effective with intravenous drug use as of August 2019).

So getting people tested, onto treatments and virally suppressed is a major part of a combination prevention approach, which has led to the adoption of the 90-90-90 targets.

What are the targets?

THE TREATMENT TARGET

90% diagnosed: Diagnosis is dependant on testing technologies, now improving with rapid tests, and self sampling and self testing kits.

90% on treatment: Treatment is dependant on economics and access to treatments – costs of effective first line treatments and use of effective generics and ability to access treatment regimes.

90% virally suppressed (= 73% of all PLHIV will have a durable viral suppression): Viral suppression is dependant on effective treatment, treatment adherence and support for it and access to viral load testing.

"When this three-part target is achieved, at least 73% of all people living with HIV worldwide will be virally suppressed – a two- to three-fold increase over current rough estimates of viral suppression. Modelling suggests that achieving these targets by 2020 will enable the world to end the AIDS epidemic by 2030, which in turn will generate profound health and economic benefits.

HIV treatment is a critical tool towards ending the AIDS epidemic, but it is not the only one.

While taking action to maximize the prevention effects of HIV treatment, urgent efforts are similarly needed to scale up other core prevention strategies, including elimination of mother-to-child transmission, condom programming, pre-exposure antiretroviral prophylaxis, voluntary medical male circumcision in priority countries, harm reduction services for people who inject drugs, and focused prevention programming for other key populations. To put in place a comprehensive response to end the epidemic, concerted efforts will be needed to eliminate stigma, discrimination and social exclusion.

HIV treatment averts AIDS-related deaths: Whereas someone who acquired HIV in the pre-treatment era could expect to live only 12.5 years, a young person in industrialized countries who becomes infected today can expect to live a near normal lifespan (or an additional five decades) with the use of lifelong, uninterrupted HIV treatment. A rapidly expanding body of evidence indicates that comparable results are achievable in resource-limited settings.

HIV treatment prevents new HIV infections: Among prevention interventions evaluated to date in randomized, controlled trials, HIV treatment has demonstrated by far the most substantial effect on HIV incidence.

Interim findings from the PARTNER study indicate that among 767 serodiscordant couples, no case of HIV transmission occurred when the person living with HIV had suppressed virus – after an estimated 40 000 instances of sexual intercourse. As a prevention tool, HIV treatment should be seen as a critical component of a combination of evidence based approaches (known as 'combination prevention')."

Further evidence can be found at http://www.aidsmap.com/Zero-transmissions-mean-zero-risk-PARTNER-2-study-results-announced/page/3311249/

"HIV treatment saves money: Early initiation of treatment enhances both health and economic gains. According to another modelling exercise, investments in HIV treatment scale-up generate returns more than two-fold greater when averted medical costs, averted orphan care and labour productivity gains are taken into account. Nor will it be necessary to wait decades to see the economic benefits of early investments in rapid treatment scale-up. In some countries, savings from investments in HIV treatment scale-up would be immediately felt. Actual costs savings would emerge somewhat later in countries with high HIV prevalence."

Conclusions

"HIV surveillance data for 2017 contribute to demonstrating important changes in the epidemiology of HIV in EU/EEA countries over the past decade. Rates of AIDS and AIDS-related deaths in the EU/EEA as a whole have decreased significantly over the past decade, reflecting greater access to treatment and better case management, and sustained progress towards the SDG of ending the AIDS epidemic and decreasing AIDS-related deaths.

There is a clear decline in the rate of new HIV diagnoses per 100, 000 population, with an adjusted rate of 6.2 reported in 2017. While the notification rate is lower than in previous years, it is expected to be revised upwards in future reporting cycles due to reporting delay, which is common for HIV generally and for certain countries in the EU/EEA in particular.

Despite the evidence of some progress in reducing the number of new HIV diagnoses in the EU/EEA overall, rates continue to increase in about one third of EU/EEA countries.

There appears to be evidence of a true decrease in HIV diagnoses among MSM in select EU/EEA countries that seems to be driving the overall decline observed in the EU/EEA. This is significant because MSM still account for the largest number of new HIV diagnoses in the EU/EEA; until recently, this was the only population in the EU/EEA in which HIV cases were increasing during most of the last decade. The decline at EU/EEA level is driven by substantial declines in specific EU/EEA countries – Austria, Belgium, Denmark, Estonia, the Netherlands, Norway, Spain and the United Kingdom.

Reasons for the decrease may include successful programmes to offer more frequent and targeted HIV testing to promote earlier diagnosis, rapid linkage to care and immediate initiation of ART for those found to be positive, which results in higher rates of viral suppression and a decline in HIV incidence.

A trend toward earlier diagnosis is evident in the mean CD4 count data at diagnosis, which has increased significantly over the last decade in all people diagnosed, including MSM; this indicates improvements in case ascertainment, which could be a result of more effective testing policies. In addition to more frequent testing and linkage to care, the use of formal and informal PrEP may also have played a role in the decline of HIV diagnoses observed in at least some of these settings. The positive trend described above is countered, however, by the prevailing situation in other EU/EEA countries where HIV continues to increase among MSM.

Overall in the EU/EEA and even in some settings with declines in rates among MSM, new HIV diagnoses in migrant MSM have not declined at the same rate as those who are not foreign-born. There is an urgent need

for significant scaling up of more effective combination prevention programmes for this at-risk population. This includes promoting the uptake of regular, easy-to-access HIV testing, accompanied by immediate linkage to care and treatment for those found positive, and condoms, peer support and possible PrEP for some populations of high-risk HIV-negative men."

Information contained in this module was correct at April 2019 and taken from:
https://ecdc.europa.eu/sites/portal/files/documents/hiv-aids-surveillance-europe-2018.pdf

You can find associated information and links to service providers at:

- Cobatest: https://www.cobatest.org/
- EuroHIVEdat https://eurohivedat.eu/
- Integrate Joint Action: https://integrateja.eu/
- EMIS 2010: http://www.emis-project.eu/final-report.html
- EMIS 2017: https://www.esticom.eu/Webs/ESTICOM/EN/emis-2017/emis-2017-node.html

Now that you have read the information, please think about a few issues:

- How has the epidemic changed in the Eastern regions of the EU?
- What is the general trend in the Western areas of the EU and what is this linked to? How could this be further enhanced?
- How could you increase your use of data to inform the work you carry out?
- How could you use data to initiate new initiatives?
- What do you think the next 90-90-90 type initiative could be?
- What makes it complicated to compare data?

E-Learning: Prevention

Using Health Promotion Models to aid behaviour change.

Information taken from a variety of sources; see Bibliography for full listing.

You are now going to consider the behaviour change models that have been most consistently used in HIV, STI and Viral Hepatitis prevention programmes. Follow along and it may help to make notes on interventions that you know about or have developed that use any of the behaviour change models that are covered.

After you have finished reading, identify the models used in an intervention aimed at MSM that you are familiar with. See if you can identify how that intervention and others are linked and if you are interested, see where they fit in a final overarching model at the end of the module.

Harm Reduction

Harm Reduction is the attempt to reduce or mitigate the harm from a particular behaviour through a process of behavioural change. It is a strategy, service or product that is designed to modify causes, consumption and/or consequences of risky behaviour.

It was developed for and used mainly and extensively in Drug Treatment programmes where harm reduction measures include needle exchanges, drug replacement and drug withdrawal.

Sexual Harm Reduction is an offshoot of this methodology and seeks to reduce the risk of HIV transmission during sexual encounters.

Some principles of Harm Reduction Practice, amended from https://harmreduction.org/about-us/principles-of-harm-reduction/:

- Accepts, for better and or worse, that risk behaviours form part of our world and chooses to work to minimize harmful effects rather than simply ignore or condemn them.
- Understands behaviour as a complex, multi-faceted phenomenon that encompasses a continuum of behaviours, and acknowledges that some ways of behaving are clearly safer than others.
- Establishes quality of individual and community life and well-being–not necessarily cessation of all potentially harmful behaviour–as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people at risk from harmful behaviours and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that the communities the work is aimed at routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms the people at risk from harmful behaviours as the primary agents of reducing the harms of their behaviour/s, and seeks to empower them to share information and support each other in strategies which meet their actual needs.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with risk behaviours.

A Harm Reduction strategy around condoms could involve their use with people who you do not know well and do not know their HIV status, at the same time as having condomless sex with people who's status you know to be the same as your own.

Harm Reduction is different to Harm Elimination, which is an attempt, usually imposed upon a person or group of people, to eliminate harm from their behaviours. Attempting to eliminate harm rather than reduce harm could lead to interventions such as; suggesting changing sexual behaviour by abstaining from sex altogether, separating out 'infected' people from 'uninfected' and segregating them or making certain behaviours or activities illegal and imprisoning people who engage in those behaviours.

Harm Reduction measures attempt to persuade people to reduce harm by providing strategies or tools to help enable safer behaviours to be enacted. Harm Elimination measures attempt to eliminate the behaviour by measures that restrict peoples in that behaviour, many times by using legal restrictions and separation policies (imprisoning positive people who have sex with negative people). As such they disable people rather than enabling them to be safer in their choices and behaviours.

Health belief model

"The Health belief model, developed in the 1950s, holds that health behaviour is a function of individual's socio-demographic characteristics, knowledge and attitudes. According to this model, a person must hold the following beliefs in order to be able to change behaviour:

- Perceived susceptibility to a particular health problem: "Am I at risk for HIV?"
- Perceived seriousness of the condition: "How serious is AIDS; how hard would my life be if I got it?"
- Belief in effectiveness of the new behaviour: "Condoms are effective against HIV transmission"
- Cues to action: "Witnessing the illness or death of a close friend or relative due to AIDS"
- Perceived benefits of preventive action: "If I start using condoms, I can avoid HIV infection"
- Barriers to taking action: "I don't like using condoms"

In this model, promoting action to change behaviour includes changing individual personal beliefs. Individuals weigh the benefits against the perceived costs and barriers to change. For change to occur, benefits must outweigh costs. With respect to HIV, interventions often target perception of risk, beliefs in severity of AIDS ("there is no cure"), beliefs in effectiveness of condom use and benefits of condom use or delaying onset of sexual relations."

Theory of reasoned action and Theory of Planned Behaviour

"The theory of reasoned action, advanced in the mid-1960s by Fishbein and Ajzen, is based on the assumptions that human beings are usually quite rational and make systematic use of the information available to them.

People consider the implications of their actions in a given context at a given time before they decide to engage or not engage in a given behaviour, and that most actions of social relevance are under volitional control (Ajzen, 1980).

The theory of reasoned action is conceptually similar to the health belief model but adds the construct of behavioural intention as a determinant of health behaviour. Both theories focus on perceived susceptibility, perceived benefits and constraints to changing behaviour.

The theory of reasoned action specifically focuses on the role of personal intention in determining whether a behaviour will occur. A person's intention is a function of 2 basic determinants:

- Their attitude toward the behaviour, and
- The prevailing 'subjective norms', i.e. any social influence upon them

'Normative' beliefs play a central role in the theory, and generally focus on what an individual believes other people, especially influential people, would expect him/her to do.

For example, for a person to start using condoms, their attitude might be "having sex with condoms is just as

good as having sex without condoms" and subjective norms (or the normative belief) could be "most of my peers are using condoms, they would expect me to do so as well".

Interventions using this theory to guide activities focus on attitudes about risk-reduction, response to social norms, and intentions to change risky behaviours.

The Theory of Planned Behaviour built further on this framework. Its design and dissemination followed Bandura's work on self-efficacy and the publication of his Social Cognitive Theory in 1986 (Ajzen 1985, 1988).

It is differentiated from the Theory of Reasoned Action, by the additional dimension of Perceived Behavioural Control (PBC), which is defined as the product of the control beliefs and self-efficacy. PBC is seen as acting as a determinant of intentions alongside subjective norms and behavioural attitude, and also as a direct influence on behaviour additional to intention."

Stages of change model

"This model, developed early in the 1990s specifically for smoking cessation by Prochaska, DiClemente and colleagues, posits 6 stages that individuals or groups pass through when changing behaviour:

- pre-contemplation,
- contemplation,
- preparation,
- action,
- maintenance and
- relapse.

With respect to condom use, the stages could be described as:

- pre-contemplation: has not considered using condoms
- contemplation: recognizes the need to use condoms
- preparation: thinking about using condoms in the next months
- action: using condoms consistently for less than 6 months
- maintenance: using condoms consistently for 6 months or more
- relapse: slipping-up with respect to consistent condom use

In order for an intervention to be successful it must target the appropriate stage of the individual or group. For example, awareness raising between stage one and two. Groups and individuals pass through all stages, but do not necessarily move in a linear fashion (Prochaska, 1992). As with previous theories, the stages of change model emphasizes the importance of cognitive processes and uses Bandura's concept of self-efficacy. Movement between stages depends on cognitive-behavioural processes."

Social cognitive (or learning) theory

"The premise of the social cognitive or social learning theory (SCT) states that new behaviours are learned either by modelling the behaviour of others or by direct experience. Social learning theory focuses on the important roles played by vicarious, symbolic, and self-regulatory processes in psychological functioning and looks at human behaviour as a continuous interaction between cognitive, behavioural and environmental determinants (Bandura, 1977).

Central tenets of the social cognitive theory are:

- self-efficacy: the belief in the ability to implement the necessary behaviour:
  - "I know I can insist on condom use with my partner"

- outcome expectancies: beliefs about outcomes:
  - "I believe that if I use condoms correctly that will prevent HIV infection."

Programmes built on SCT integrate information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy. Specifically, activities focus on the experience people have in talking to their partners about sex and condom use, the positive and negative beliefs about adopting condom use, and the types of environmental barriers to risk reduction."

Now we will move on to look at models built on social interaction, and how people interact and could be influenced by those they come into contact with. They are:

Diffusion of innovation theory

"The diffusion of innovation theory (Rogers, 1983) describes the process of how an idea is disseminated throughout a community. According to the theory, there are four essential elements: the innovation, its communication, the social system and time.

People's exposure to a new idea, which takes place within a social network or through the media, will determine the rate at which various people adopt a new behaviour. The theory posits that people are most likely to adopt new behaviours based on favourable evaluations of the idea communicated to them by other members whom they respect (Kegeles, 1996).

Kelly explains that when the diffusion theory is applied to HIV risk reduction, normative and risk behavioural changes can be initiated when enough key opinion leaders adopt and endorse behavioural changes, influence others to do the same and eventually diffuse the new norm widely within peer networks. When beneficial prevention beliefs are instilled and widely held within one's immediate social network, individuals' behaviour is more likely to be consistent with the perceived social norms (Kelly, 1995).

Interventions using this theory generally investigate the best method to disperse messages within a community and who are the leaders able to act as role models to change community norms.

So if we look at this theory around condom use; at the start of the HIV epidemic condom use among gay and other MSM was low, they were viewed as something to stop pregnancy. As the leaders in the LGBTQI+ community identified that barrier methods were a probable protective method of avoiding infection community leaders began to use them and advocate their use with sexual partners. This grew to be a 'norm'.

At the same time community based publications provided both evidence and information about condoms as protection against HIV infection to help spread the message, and community based organisations began providing and distributing condoms via bars and other places gay and other MSM met for sex to enable men to access the 'tools for safer sex'."

Now that we have covered the most popular theories, here's a table that shows how the models fit within the areas they change/affect, so read down the table to see where the models we've covered fit in.

Areas of change and the theories and models that underpin them

Areas of change	Theories or models
Theories that explain health behaviour and health behaviour change by focussing on the individual	• Health Belief Model • Theory of Reasoned Action • Trans theoretical (stages of change) model • Social Learning Theory
Theories that explain change in communities and community action for health	• Community Mobilisation — Social Planning — Social Action — Community Development • Diffusion of Innovation

Now that we have gone through the table, I'd like you to take some time to develop a small intervention of your choice that uses one of the models we've covered. If you'd prefer, try and identify a couple of interventions you have seen or worked on that use one or more of the models. See if you can identify separate interventions that have used models from the individual, the social and then the structural or environmental areas.

You have about 15 minutes to complete the task/s.

How was that? Now that you maybe know more about the models, did it make it easier to think of or identify an intervention?

E-Learning: Settings and Interventions

Useful settings for interventions aimed at MSM

Information used is taken from 'HIV and STI Prevention among men who have sex with men. Stockholm: ECDC; 2015'

Welcome to the section on settings appropriate for interventions aimed at MSM. In this section you will consider both the physical and online settings that can be utilised. You will also be considering the Quality Standards around working with MSM across these spaces, what they do to make the work the best it can be as well as protecting both you as the provider of the intervention, and the person you are working with as the user of the intervention.

To begin with, please make a list of the physical spaces or settings you can think of that are appropriate for interventions for MSM.

At the same time as doing this please consider and note what interventions you know about would work best in that setting, or be appropriate for that setting. Give yourself 10 minutes to do this.

Compare your list to the information below, did you consider all the suggestions? Did you think of anything else that is not suggested?

Physical:

Sex venues

"Sex venues include commercial venues such as saunas, sex clubs, night clubs, health clubs, adult movie houses, adult bookstores, backrooms of bars, etc. They can also include places within the public space, 'cruising zones', such as certain parks, beaches, alleys, restrooms or private venue sex parties.

A combination of interventions at these venues should offer one or all of the following services: health promotion, condoms and lubricant provision, and HIV/STI-testing, hepatitis A and B vaccination. Key programmatic considerations include building alliances with community agencies and strong relationship between owners of the commercial sex venues and implementers of the intervention.

Sex venue-based interventions have been effective in reaching MSM with high sexual risk and in testing men who have previously not been tested for HIV/STIs. High acceptability rates have been reported among MSM in different contexts. Sex venues are an important environment to provide services to hard-to-reach MSM who may have a particularly high risk of HIV and STI acquisition and transmission."

Other venues

"Healthcare, Clinical, Community settings, Bars and clubs can all provide a useful setting for working with gay and other MSM. These are the traditional settings for this type of outreach contact."

Online:

Now make a list of the online settings you can think of and the interventions that are appropriate to use via that setting. You have 10 minutes for this. Now compare what you have considered and noted with the information below. Did you think about smartphone apps? Are you aware of any interventions that use smartphone apps?

Internet and mobile phone-based interventions

"While the internet or mobile-phone based applications are not physical intervention 'settings' they are increasingly important for HIV and STI prevention.

The internet is now the most popular tool used by MSM to meet sexual partners. It is increasingly common for MSM to meet their sexual partners online and available data indicate that persons with more use of online platforms tended to have higher partner numbers and more unprotected anal intercourse (UAI).

While the internet and mobile apps are increasingly key modalities through which to reach MSM, a 2015 ECDC/Terrence Higgins Trust project entitled 'Understanding the impact of smart phone applications on MSM sexual health and HIV/STI prevention in Europe' found that although the majority of HIV prevention organisations surveyed reported that they are doing prevention work online, only half reported that they are doing prevention work through mobile phone apps."

Examples of ways of using internet or mobile phone based interventions

		Examples of types of tools/interventions
Examples of internet sites where interventions could take place	• Traditional webpages: from NGO's, public health orgs, health care clinics, news, club owners etc. • Facebook/other social media sites like Pinterest • Wikipedia and forums • General dating sites • LGBTQ/MSM community sites and forums • Porn sites	• Banners • Sponsored content • Pop-ups or push messages (informing about testing services, outbreaks in specific areas) • Testing location services • Editorial messages • Peer to Peer chat • Chat with Health Providers • Hashtags • Provision of content to feed social media (infographics, blogs, photos, meme's, video's, playlists etc.) • Monitoring of social media, Wikipedia, news etc.
Examples of mobile based locations where interventions might take place	• Twitter/Instagram • Mobile adjusted webpages • Apps like Grindr/Scruff • SMS – reminder • SMS – chat • GPS/Maps interventions	

Adapted with permission from: Niklas Dennermalm, Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights, Sweden.

"Delivering an effective intervention via the web or via a mobile application has many advantages. Importantly, it makes it possible to reach more people potentially increasing access to some populations of MSM who do not access other services. Moreover, it affords individuals the opportunity to access the intervention confidentially, and potentially at critical moments when one is looking for new partners online. Some web- or mobile-based interventions require minimal staffing and can be easily replicated after development, while others require significant human resources and up-keep. Mobile-based HIV or STI testing reminder services, for example, are becoming more widely used by sexual health services in many countries. The internet and smart phone applications allow asynchronous communication, multiple ways to communicate, interactivity, customisation of contents, and flexibility. Mobile phones or 'push notifications' can also be used to provide information or alerts to MSM about ongoing outbreaks in MSM in a specific geographic area (e.g. for a local cluster of syphilis).

Interactive interventions can promote sexual health and provide individualised feedback while promoting active learning. These programmes should be available directly to users and allow independent access without needing expert facilitation.

Internet- and mobile phone-based interventions are a promising way in which to encourage and promote sexual health. However, so far efficacy data has been unclear, largely due to the lack of evaluation research carried out using internet- and mobile-phone based interventions. Different modes of internet and mobile-based interventions should be developed and evaluated for MSM in Europe."

There is further reading about online settings and smartphone apps at:

- **Smartphone apps versus other MSM spaces** (Understanding the impact of smartphone applications on STI/HIV Prevention among men who have sex with men in the EU/EEA. THT. 2015) http://ecdc.europa.eu/en/publications/Publications/impact-smartphone-applications-sti-hiv-prevention-among-men-who-have-sex-with-men.pdf
- **"Reaching Out Online"** University of Sussex & THT 2014 http://www.sussex.ac.uk/rcmdc/projects/reachingoutonline www.communitiesandculture.org/files/2013/.../Reaching-Out-Online-Final-Report.pdf

Online Outreach

- **ECDC: Use of Online outreach for HIV Prevention among men who have sex wit men in the EU/EEA – An ECDC guide to effective use of digital platforms for HIV Prevention. Stockholm: ECDC; 2017.** https://ecdc.europa.eu/sites/portal/files/documents/Online%20outreach%20-%20final%20with%20cover%20for%20web.pdf
- **"The Cruising Counts Guide" GMSH, Ontario. 2016** www.gmsh.ca/aids-service-organizations/publications.../cruising-counts-guide.pdf_2
- **"We are the Sexperts" RFSL Stockholm 2009** https://www.kennisplein.be/Documents/outreach/RFSL_sexperterna_rapport.pdf

Quality Standards

Quality Standards are defined as documents that provide Requirements, Specifications, Guidelines or Characteristics that be used consistently to ensure that materials, products, processes, interventions and services are fit for their purpose.

So what does this mean for the work done with gay and other MSM in these settings?

Please think about any policies or documentation you have or use at your service that guide the work you do with gay and other MSM. Does it cover issues such as:

- Personal Safety – for both the worker and the user
- Sexual Boundaries – between worker and user
- Data Security – how do we collect data in a legal manner?
- Confidentiality – the MSM you are working with may not be 'out', how do you keep their confidentiality?
- Providing accurate and up to date information

Work through what you know about each of the policies your service has around these issues.

- What can you recall about them?
- Did you have training to support your learning about them?
- How often are they updated? Are they 'fit for purpose'?
- Do you think anything needs to be added to the current Standards?

E-Learning: Settings and Interventions

Improving Linkage and Retention in Care

Information is taken from two interventions that deal with linkage and retention into care; the Euro HIV EDAT Project and the OptTest Project (www.eurohivedat.eu / www.opttest.eu)

The recommendations in the Euro HIV EDAT document "Optimal Linkage to care among MSM: a practical guide for CBVCT's and Points of Care" (https://bit.ly/2TOFVBL) outlines the following recommendations:

The test situation

"The success of linkage to care starts in the test situation. The following aspects should be taken into account:

1. A welcoming and non-judgmental attitude of the staff is important
2. Knowledge on sex life and sex practices of MSM is important
3. Knowledge on HIV and STIs (including risk of transmission, symptoms and treatments) are important
4. In settings where Chemsex is a practice of some MSM, knowledge on this issue is important
5. Some CBVCTs have good experience with having health staff from the HIV-unit working in the CBVCTs as testers. This can contribute to ensure a good cooperation between CBVCT and HIV-unit
6. Some CBVCTs have good experience with having HIV-positive people working as staff at the CBVCT, so clients with a reactive test result can immediately be referred to talk with a peer"

If confirmatory test is not taken at the CBVCT

"If a laboratory / STI-clinic is performing the confirmatory test, close cooperation with the laboratory / STI-clinic is recommended.

1. This could e.g. be making a specific appointment for the client with the laboratory / STI-clinic for the confirmatory test
2. If the laboratory / STI-clinic refer the client to HIV-unit / doctor for treatment in case of a reactive test result, it is advisable that the laboratory / STI-clinic make a specific appointment for the client with the HIV-unit / doctor for treatment
3. If the laboratory / STI-clinic is informing the CBVCT (and not the client) of the result of the confirmatory test, it is advisable to make a specific appointment with the client at the time the person is referred to laboratory / STI-clinic for the confirmatory test

If a HIV-unit is performing the confirmatory test, close cooperation with the HIV-unit is recommended.

1. Close cooperation (and advisably personal cooperation) between the CBVCT staff and the HIV-unit(s) is strongly recommended
2. It is recommended that the HIV-unit has in-depth knowledge about how the CBVCT operates and the procedures in referrals to confirmatory testing
3. It is recommended that the CBVCT staff makes a specific appointment for the client for the first visit at the HIV-unit
4. Clients should be offered to be accompanied at the first visit at the HIV-unit if the assessment is that this would be beneficial for the client.

If a GP is performing the confirmatory test, close cooperation with the GP(s) is recommended.

In countries where HIV-treatment is offered by GPs, the CBVCT is typically not allowed to refer to specific doctors. This makes it impossible to be make specific appointments for the clients – and they are often left with the only solution of giving the client a list of the relevant doctors. It is the experience that being linked to care (following the HIV diagnosis) contributes to the likelihood of attending the first visit. It is therefore recommended that CBVCTs in this situation start negotiations with the doctors about this problem."

If confirmatory test is taken at the CBVCT

"1. Close cooperation (and advisably personal cooperation) with the HIV-unit(s) is strongly recommended
2. It is recommended that the HIV-unit has in-depth knowledge about how the CBVCT operates and the procedures in referrals to care
3. It is recommended to make a specific appointment for the client for the first visit at the HIV-unit
4. Clients should be offered to be accompanied at the first visit at the HIV-unit if the assessment is that this would be beneficial for the client"

Documentation of linkage to care

"It is suggested to use the following definition of linkage to care in the future: 'Linkage to health care is defined as entry into health care or follow-up by an HIV specialist or in an HIV- unit after a reactive or confirmatory HIV-test at a CBVCT facility.

In many CBVCTs informal information from the HIV-unit or random knowledge from clients are the basis of data on linkage to care. Documentation of linkage to care are crucial to monitor and evaluate the effectiveness and success of CBVCTs.

A system of unique identifiers to track patients from a CBVCT testing-site to HIV-care should be developed. There are issues of privacy and data protection though, that has to be taken into account. Before a more formalized system is developed, a simple system (e.g. having the client consent to communication between HIV-unit and CBVCT with a signature on a document) might be useful. When making systems to document linkage to care it is important to respect the data protection law in the respective countries.

To document the success of linkage to care from CBVCTs it is recommended to collect information and prioritise publishing scientific papers."

Barriers to linkage to care which are not specifically related to the MSM group

"A number of barriers to linkage to care are not specifically related to the MSM group. This can e.g. be:

- Patients are referred to a HIV-unit far away from where they live
- Underage young people who cannot have access to HIV-test or HIV-treatment without their parents' knowledge and accept
- HIV-units refuse to accept HIV-positive patients because the hospital department are overcrowded
- Undocumented migrants do not have access to HIV-treatment in some countries
- Language problems if the client do not speak the local language

These problems are not unique to the CBVCTs but apply to all HIV testing in the specific country whether this is done at a hospital, a clinic, a CBVCT or with a doctor. It is recommended that this kind of problems are raised with relevant bodies."

Information of the support from the CBVCT

"Before the clients leave the CBVCT for further care at a HIV-unit or GP they should be informed on the support that the CBVCT is offering to people living with HIV, whether this is support groups; peer-to-peer support; counselling or psychological, social or medical support."

More data and information can be found at www.eurohivedat.eu or www.msm-checkpoints.eu

OptTest (www.opttest.eu) has the following tools available to help improve linkage and retention into care:

"Implementing Indicator Condition (IC) Guided Testing

- Online Training Module: Staff Training on IC Guided Testing
- Online Tool: How to set up IC Guided Testing
- Policy Briefing: Scaling up early diagnosis for HIV through expanded implementation of provider initiated HIV testing.

Improving Linkage To Care

- How to measure Linkage to Care
- Improving National Data: Stakeholder meetings
- Assessment Method of Continuum of Care

Addressing Legal and Regulatory Barriers to Testing

- Overview on Legal and Regulatory Barriers
- Challenging and Changing Regulatory Restrictions to Testing
- Challenging and Changing Legal and Regulatory Barriers
- Challenging and Changing Barriers to Prevention and Treatment
- Tips for Advocacy for Legal and Regulatory Changes (How To guides)

Addressing Stigma

- Stigma Index Database (http://www.stigmaindex.org/)
- Best Practice Manual with National Case Studies

Assessing Cost Effectiveness of Testing

- Methodology
- Examples of Heat Maps
- Article with Results
- National Reports"

Using the information from Euro HIV EDAT and OptTest projects please move on to consider these four areas:

- Technology and Online Tools
- MSM Networks
- Peer Led Services
- Cultural Competence

You may find it useful to make a quick noted description for and examples of work for each of these.

You are to consider two of the areas e.g. MSM Networks and Peer Led Services, to get a better overall understanding of linkage and retention.

It may help you to read and consider the modules in the face-to-face training about Cultural Competence (called Knowing the Community you are working with) as well as the E-Learning module on the use of Social Media. Additional searches on the ECDC website https://ecdc.europa.eu/en/home may help to expand the knowledge you already have. Please read carefully both the OptTest and the Euro HIV Edat websites to assess how the interventions built a 'best practice' scenario for each issue you are working with for both linkage to care and retention in care.

You will have 60 minutes for each area you are working with, so will have 120 minutes in total for this task.

Please make notes for yourself on your thoughts.

Some questions you may find useful in their process are:

- What functions and what needs improvement in the case study intervention they were using?
- What could improve the initiative?
- What did they learn, if anything?
- Could they replicate the initiative or their improved version in their region/area/work? What may be some of the barriers they may face and how could they try to overcome them? What could it mean for their work if they did replicate the work?

E-Learning: Settings and Interventions

Building an understanding of anti stigma campaigns

For this session you will be considering and analysing a number of examples of anti stigma interventions, either relating to HIV or LGBT issues.

This is a chance to really dissect and pull apart some interventions, looking for what you think are good practices and learning from any mistakes that have been identified.

The description of and links to the intervention examples are:

Ukraine:

- HIV Prevention and Psychosocial support for men in prisons
  https://www.amfar.org/content.aspx?id=9281

Germany:

- Acceptance on the Gay Scene: IWWIT
  https://www.iwwit.de/akzeptanz
- Stigmatisation of PLWHIV: IWWIT
  https://www.iwwit.de/HIV-Positiv
- Test and Testing Awareness: IWWIT
  https://www.iwwit.de/geschlechtskrankheiten
- HIV and Buddies: Sprungbrett
  https://buddy.hiv/
- Enough is Enough: Challenging Stigma and Discrimination
  https://www.enough-is-enough.eu/
- HIV information in Sign Language: Gehoerlosen
  https://www.gehoerlosen-aids-info.de/

Austria

- Smartphone/Web App/Social Media initiative to meet MSM not linked to services: Quickiecheck
  http://www.quickiecheck.at/

UK

- Rainbow Laces: Kicking Homophobia Out of Football: Stonewall
  https://www.stonewall.org.uk/our-work/campaigns/rainbow-laces
- Stamp It Out: Ending discrimination in Football
  http://www.stamp-it-out.co.uk/

Sweden

- O=O (U=U) a YouTube intervention: RFSL, Swedish Federation for LGBTQ Rights
  https://www.youtube.com/watch?v=r3Gy86TNYp8

Switzerland

- Break The Chains: Staying HIV Negative: Swiss AIDS Federation
  https://www.drgay.ch/de/kampagne/break-the-chains

- Dr Gay: Online advice tool for gay and other MSM: Swiss AIDS Federation
  https://www.drgay.ch/de/

Worldwide

- GAYISOK: Lush Cosmetics
  https://shortyawards.com/8th/gayisok

Canada

- This is Our Community: Bisexual anti stigma poster campaign
  https://www.lgbtqhealth.ca/community/bisexualantistigmacampaign.php

USA

- DailyBlue Campaign: Combating PrEP Related Stigma: Human Rights Campaign
  https://www.hrc.org/blog/hrc-launches-dailyblue-campaign-combatting-prep-related-stigma

- U=U: Undetectable = Untransmittable: Prevention Access Campaign
  https://www.preventionaccess.org/

To help you analyse the studies the following questions may help:

- What are the interventions good points?
- Are there any 'weak' points with the intervention?
- Are there main themes or steps the interventions share? If so, what are they?
- Where do they intervene? (what is the setting)
- Who do they intervene with? Why that audience?
- Are there transferable or replicable points with the interventions?
- Considering each intervention, could that intervention be reproduced by your own organisation or within your region if not appropriate for your organisation?
- If so, are there any changes they would have to or would like to make?
- What are the facilitators and barriers involved in reproducing that intervention or building an intervention along similar lines.

You have up to two hours to analyse as many of the case studies as attract you.

When the time is up, spend some time going through your notes, identifying the key points you think are important in building effective and appropriate anti stigma interventions. It may help to develop your notes on one HIV stigma campaign and one LGBT stigma campaign that you would be interested to replicate in your work or region.

E-Learning: Skills Building

Using Social Marketing to engage with MSM.

You are now going to be exploring the use of social marketing such as digital and social media, 'influencers' and print and broadcast media in work aimed at MSM.

It is important to remember that in the 'world' of Social Media things can change fast and platforms can gain and lose popularity. All the information here is useful across a range of platforms although it is specific to the one being examined. It's recommended that you check the current situation regarding the use and popularity of the social media platform you are thinking of using to make sure you are using your resources to gain the most impact.

Please read through the following sets of information about social marketing about YouTube, Facebook, Twitter, Online Outreach and Social Influencers gathering information and making notes. Each 'set' explains the basic information around and steps related to working in these settings.

You have a form to help you gather this information that asks a series of basic who, where, what types of questions. You are encouraged to also think along these lines but asking your own questions of the information, such as:

What:
Platform has the most 'members'?

Who:
Are social influencers?

Where:
Would you best do online outreach – Facebook, Twitter, GayRomeo etc.?

When:
Would you use YouTube rather than Twitter?

Social Marketing Data Collection Form

WHO: Does this platform attract?

Three pieces of demographic info, from the information here and your own knowledge

-
-
-

HOW: Could you engage with your audience?

Three points you need to know to use this platform

-
-
-

WHY: Would you use this platform instead of another?

Three advantages this platform gives you, from the information here and own knowledge

-
-
-

WHAT: Intervention/s could you develop for use on this platform?

Three types of intervention

-
-
-

Any additional thoughts or notes?

When you have read the information about all the settings you are to choose one of the areas, and your task to plan an intervention.

You are encouraged to consider:

- Who are you targeting?
- What intervention? What does it need for it to take place?
- Why that intervention in that setting?
- How will it work?
- Is there something similar another organisation has done that you might learn from?

Use the notes you made to help with the task and also make notes plans. You have around 60 mins for this task. If you would find it useful you could try and do a similar campaign using a different setting, or develop and 'enhanced' campaign using more than one setting.

FACEBOOK

Go to https://ecdc.europa.eu/sites/portal/files/documents/Facebook%20-%20%20final%20with%20cover%20for%20web.pdf for the full document on using Facebook from ECDC, from which the following information is taken.

"With 1.23 billion active users, Facebook is one of the cheapest and most efficient platforms for HIV prevention, but it is also one of the most competitive. This means that having an understanding of how to best optimise content and target key MSM populations is crucial to the success of any organic or monetised Facebook campaign.

Getting Started

Facebook's Business Manager is the system that will allow you to create and manage your campaigns. Once your Business Manager account is set up then it's time to create your first campaign, but before you get started it's important to first understand exactly what objective you are trying to achieve. There are three different objective types Facebook outlines and each requires a different plan of action.

— **Awareness**: Designed to encourage engagement, promote key messages and increase knowledge. This can include boosting a post to generate conversations around sexual health or the service you provide, or encouraging users to become a fan of your page for future updates.

— **Consideration**: Designed to raise awareness of the services you provide and encourage future action. This can include getting people to watch a promotional video or sending people to your website to view information or consider taking action.

— **Conversion**: Designed to promote direct action, e.g., finding a testing centre or ordering a postal test. By setting up a pixel within your website Facebook will be able to track the number of people engaging with your services and use this to optimise your campaign to increase the number of conversions.

Determining your core objective before beginning your campaign is vital as it will heavily influence the way you design and measure your campaign and the way Facebook distributes and optimises it. If one singular objective is not clear then consider multiple campaigns with their own individual objectives.

Creating Content

It's important to remember that any social media campaign you create will be directly competing for space in a person's timeline alongside updates from their family, friends, and other brands and organisations they love. For this reason any traditional advertisements will stand out and a softer approach is often necessary.

The aim is to make your advert fit seamlessly into a person's timeline while simultaneously promoting your message.

The first step in creating an engaging piece of content is to decide what kind of content will best convey your message. There are four different types of content currently available on Facebook, including:

- **Text**: A simple text update with no embedded links, images, videos or graphics.
- **Image**: An image usually accompanied by text and a link if applicable
- **Video**: A video usually accompanied by text and a link if applicable
- **Link**: A clickable post usually including an image and a call to action

Images are the most versatile type of content and are compatible with all of Facebook's different advert types and placements but it's still recommended that you experiment with video and links to see what your audience engage with most.

Creating Engaging Content

When creating content, ensuring that it is engaging should be your top priority. Before you send out your first post or advert it's worth considering the following:

- **Be consistent**: being consistent in the quality and types of posts you create will help to establish your brand voice and message and give your audience a clear understanding of your intentions and objectives and what to expect from you in future.
- **Be brief**: try to keep your posts between 100 and 250 characters to get more engagement. Shorter, succinct posts with a clear call to action are much better received.
- **Be timely**: be reactive and create content related to breaking news and current events. Plan ahead to take advantage of relevant tent pole occasions like World AIDS Day, Sexual Health Week, National HIV Testing Week, and Valentine's Day.
- **Utilise links:** even if there is no direct call to action, always give your audience the option to get involved and find out more by including a relevant link to your own or a partner's website.
- **Use engaging images and videos**: invest the extra time and money into curating and creating high quality photos and videos. Higher quality content means higher engagement.
- **Create a two way dialogue**: social media is designed to encourage conversation. Make sure you're engaging your audience in conversation and responding to comments. Including a question in your content where relevant is proven to massively increase engagement.
- **Keep it simple**: Don't overwhelm your audience with too much information or multiple different call to actions. Keep it clear and make it as easy as possible for your audience to engage.

Consider your audience

Identifying the audience you are targeting is also extremely important when creating content. From choosing the models you use in your campaign to establishing a tone of voice, it's important to ensure that your content appeals to your target demographic. Pre-testing different campaign materials before launching is often advised and can help to determine which adverts will perform best.

Advert placements

Adverts placed in Facebook's Business Manager can appear in multiple places including Facebook itself (in the desktop feed, mobile feed, and right column), Instagram, and the Audience Network. Different marketing objectives work best with different placements, and Facebook recommends the following:

Brand awareness: Facebook & Instagram
Engagement: Facebook & Instagram
Video views: Facebook, Instagram, and Audience Network
Website Referrals: Facebook & Audience Network
Conversions: Facebook and Audience Network

Facebook also has an in built "Automatic Placements" feature that will optimise your placements in order to get the best results at the cheapest cost. Taking advantage of this feature is recommended but it's important to first ensure that your content is optimised for each individual placement.

Targeting

Targeted adverts are the key to any successful Facebook campaign. With effective targeting it's possible to make a lasting impact with even the smallest budget. Targeting options include location, age, gender, languages, interests, and connections. Being as specific as possible with the available targeting methods is crucial to the success of your campaign.

Demographic based targeting:

- **Age**: your call to action should be relevant to the age group you're targeting. Are some age groups more at risk in the areas you're targeting? Are some age groups more likely to engage with your call to action? Effectively narrowing your age group by relevance will increase the success of your campaign and lower your cost per conversion.
- **Gender**: Facebook's gender based targeting is binary and doesn't allow trans based targeting. Using interest based targeting is currently the only way to specifically target trans individuals.
- **Languages**: Consider including only those who speak the language your advert is written in.
- **Connections**: Consider excluding those who like your page if you're seeking a new audience, or target friends of people that like the page already.
- **Location**: Only include people in locations that can access your service, and consider exclusively targeting areas that are highly populated with MSM or are most prevalent for HIV.

Interest based targeting:

Sexuality based targeting is not always reliable and is no longer available in many areas. MSM can instead be identified through interest based targeting. This will never be 100% accurate so some trial and error is always necessary to produce the best possible results.

Interest targeting can also be used to refine your audience even further. For example:

- **Trans individuals**: consider targeting trans specific pages such as Trans Pride.
- **Ethnic minorities**: consider targeting pages specific to ethnic minorities such as Black Gay Pride.
- **High risk individuals**: consider targeting sex clubs or other high risk areas such as Circuit Festival.
- **Different age groups**: consider targeting or excluding age based pages such as Gay Mature Dating.
- **Affluence**: consider targeting or excluding luxury purchases such as European Gay Ski Week.

Summary

Before starting your Facebook campaign, you should have done the following:

1. Chosen your campaign objective and outlined your goals
2. Created a selection of highly engaging content that is suitable for your target audience
3. Selected the best placements for your adverts to appear
4. Created at least one target group based on both demographic and interest based targeting
5. Allocated a budget and distribution plan and outlined achievable realistic targets
6. Set holistic goals to measure the overall success of your campaign and determined a plan to measure and act upon your on-going progress, successes, and failures

Once you've completed these tasks you're ready to start your first campaign. The success of any campaign will always rely on a certain degree of trial and error so remember to follow your campaign through every stage and be prepared to optimise and make changes as you go."

TWITTER

Go to https://ecdc.europa.eu/sites/portal/files/documents/Twitter%20-%20final%20with%20cover%20for%20web.pdf for the full document from ECDC on using Twitter, from which the following information is taken.

"With 313 million monthly active users, Twitter is the 4th largest social media platform after Facebook, YouTube and Instagram. Both organic and paid for content thrive on Twitter and can be used together or independently as part of a successful social media strategy.

Getting Started

Before you begin, it's advised that you familiarise yourself with Twitter's interface and adverts manager. Twitter's adverts manager gives exclusive access to certain tools and functionalities which are invaluable for both organic and paid campaigns. Once you've familiarised yourself with Twitter's interface, then it's time to decide which campaign type will best help you to reach your objective.

Twitter offers the following campaign types:

- **Website clicks or conversions**: Designed to push people towards your website and encourage them to take action. The campaign will optimise for link clicks and you'll only be charged for every person who visits your website.
- **Follower growth**: Designed to build and grow your audience. If the majority of your campaigns are organic, investing a small amount into building an initial following could be beneficial. You only pay for the followers you gain and can set the parameters for how much you want to pay.
- **Awareness**: Designed to spread awareness and increase knowledge. You pay for every impression but can often reach a higher quantity of people for a significantly lower price.
- **Tweet engagements**: Designed to increase engagement on your tweets. You only pay for the first engagement a person makes which can be effectively used to encourage people to retweet, reply, or actively engage with your content.
- **Video views**: Designed to increase the number of views on a Twitter video. You pay for every video view. This should only be used for videos uploaded directly to Twitter. Opt for an awareness or tweet engagement campaign instead for YouTube or other third party video views.

Determining your core objective before beginning your campaign is vital as it will heavily influence the way you design and measure your campaign and the way Twitter distributes and optimises it. If one singular objective is not clear then consider multiple campaigns with their own individual objectives.

Creating Content

Unlike other social media platforms, Twitter is much more conversational and runs in real time. This means that establishing yourself through frequent conversational content is crucial. Even though there is a limitation of 140 characters, there are many components that make up a tweet, and deciding how to best use them to spark conversation and action is the key to engaging your audience:

- **Text**: What is your message and what kind of language should you use to best convey that? Consider using engaging questions or direct calls to action to encourage your audience to engage with your tools and services.
- **Link**: Clickable cards with a clear call to action can be used to make your advert stand out, or you can include a link within the body of a regular tweet for a more conversational feel.
- **Video**: Videos can be directly uploaded to Twitter and will automatically play in a user's timeline. Alternatively videos can be embedded from YouTube and other third party websites.
- **Hashtag**: Hashtags enable you to start or join a conversation with other Twitter users and have your tweets appear in search. This can be incredibly effective for capitalising upon trending events like National HIV Testing Week or World AIDS Day.
- **Image**: Using an appropriate image can help catch your audience's attention, but not every tweet will require one. Use images often but only where necessary and frequently rotate creatives to keep your campaign looking fresh and compelling.
- **Tags**: Does your tweet relate to another organisation or individual? Tags (@ with username) can amplify your reach by encouraging influential people & organisations to share and engage with your content.

Creating Engaging Content

When creating content, ensuring that it is engaging should be your top priority. Before you send out your first post or advert it's worth considering the following:

- **Be consistent**: being consistent in the quality and types of posts you create will help to establish your brand voice and message and give your audience a clear understanding of your intentions and objectives and what to expect from you in future.
- **Be brief:** even with Twitter's 140 character count limitation, it's still good practise to keep your content as brief and to the point as possible.
- **Be timely**: be reactive and create content related to breaking news and current events. Plan ahead to take advantage of relevant tent pole occasions like World AIDS Day, Sexual Health Week, National HIV Testing Week, and Valentine's Day.
- **Use links**: For awareness and engagement posts a link may not always be necessary, but always consider your objectives before posting and use links where applicable.
- **Use engaging images and videos**: invest the extra time and money into curating and creating high quality photos and videos. Higher quality content means higher engagement.
- **Create a two way dialogue**: social media is designed to encourage conversation. Make sure you're engaging your audience in conversation and responding to their comments. Including a question in your content where relevant is proven to massively increase engagement.
- **Keep it simple**: Don't overwhelm your audience with too much information or multiple different call to actions. Keep it clear and make it as easy as possible for your audience to engage.

Targeting

The success of an advertising campaign on Twitter heavily relies on effective targeting. Twitter's targeting approach is unique and in addition to offering demographic and interest based targeting, it also offers keyword and behaviour based targeting.

Demographic based targeting:

- **Age**: your call to action should be relevant to the age group you're targeting. Are some age groups more at risk in the areas you're targeting? Are some age groups more likely to engage with your call to action? Effectively narrowing your age group by relevance will increase the success of your campaign and lower your cost per conversion.
- **Gender**: Twitter's gender based targeting is binary and doesn't allow trans based targeting. Using interest based targeting is currently the only way to reach trans individuals.
- **Languages**: Consider including only those who speak the language your advert is written in.
- **Location**: Only include people in locations that can access your service, and consider exclusively targeting areas that are highly populated with MSM or are most prevalent for HIV.

Interest based targeting:

Sexuality based targeting isn't available but it's still possible to target MSM based on their interests or the people they follow. This will never be 100% accurate so some trial and error is always necessary to produce the best possible results. Some examples of pages MSM may follow include targeting LGBT+ celebrities and influencers; adult websites, entertainers and performers; gay media; and gay community groups and organisations.

Keyword & behaviour targeting:

It's also possible to target people based on the keywords they use in their tweets or based on their lifestyle patterns and behaviours. Keywords surrounding high risk activity can be used to pinpoint higher risk individuals and certain behaviour categories like "nightlife enthusiasts" and "alcoholic drink buyers" can help to narrow down and target specific subgroups of MSM.

A combination of the above targeting methods will produce the best results, and experimenting with different subgroups is the key to reaching the most at risk individuals for the lowest price.

Summary

Before starting your Twitter campaign, you should have done the following:

1. Chosen your campaign objective and outlined your goals.
2. Created a selection of highly engaging content that is suitable for your target audience.
3. Created at least one target group based on a combination of targeting methods.
4. Allocated a budget and distribution plan and outlined achievable realistic targets.
5. Set holistic goals to measure the overall success of your campaign and determined a plan to measure and act upon your on-going progress, successes, and failures.

Once you've completed these tasks you're ready to start your first campaign. The success of any campaign will always rely on a certain degree of trial and error so remember to follow your campaign through every stage and be prepared to optimise and make changes as you go."

YOUTUBE

Go to https://ecdc.europa.eu/sites/portal/files/documents/YouTube-HIV-prevention-2017.pdf for the full document from ECDC on using YouTube, from which the following information is taken.

"With over a billion active users, YouTube is the second largest search engine in the world, reaching more 18 to 49-year-olds than any cable network in the U.S. Using YouTube for HIV prevention allows global access to MSM and gives the unique opportunity to reach people who may not be reachable through more traditional social media platforms.

Getting Started

YouTube is a highly competitive platform with 300 hours of content uploaded every single minute, so even with a large established following or a highly engaging video, it can still be difficult to get your content seen. To remedy this, it's advised that you take advantage of YouTube's advertising platform.

Once you've familiarised yourself with YouTube and have an understanding of how you want to advertise on the platform, then it's time to create your first campaign. Before you get started it's important to first understand exactly what objective you are trying to achieve. There are three core objectives when it comes to advertising on YouTube and each has a slightly different plan of action.

- **Video views**: unsurprisingly, getting your content seen is one of the key reasons people come to YouTube. Whether you're trying to build awareness around a campaign or help spread a particular message, this is most likely the objective you will be trying to achieve on YouTube.
- **Clicks**: the number of times a user clicks your advert or clicks through to your website. Due to the nature of YouTube as a video streaming service, a lower click through rate (CTR) can be expected in comparison to other platforms like Facebook and Twitter.
- **Conversions**: the number of times a user takes action on your website by engaging with one of your tools or services. Google analytics and Google AdWords must be linked up and connected to your website in order for conversions to track correctly.
  Determining your core objective before beginning your campaign is vital as it will heavily influence the way you design and measure your campaign. Most YouTube campaigns will optimise for video views and awareness – so consider using an alternative platform if clicks and conversions are your core objectives.

Creating Content

On YouTube, video is king, so deciding how best to convey your message through this medium is the key to campaign success. Before creating your content, consider who is going to be watching it, and how your video is going to be displayed. Different audiences respond differently to different content types, so it's recommended that alternate videos are created for a wide range of audiences.

Before creating your content it's also worth considering how it will be displayed on the platform. There are two ways your adverts can be seen, and they may both influence the type of content you create.

- **In stream adverts**: in-stream adverts are video adverts that play before – or during – a YouTube video of the advertiser's choice. It's worth considering the types of videos your adverts will be displayed on before deciding the type of content you're going to create. These adverts are skippable after just a few seconds, so it's important to either hook your audience's attention early on, or incorporate your key messaging into the first few seconds of the advert.
- **Video discovery**: video discovery adverts will appear in search and as recommended videos in the side-bar of selected videos. In order for these videos to be seen, the user will have to actively click on them, so highly clickable content is a must. It's important to think about both the title and thumbnail of these videos to entice people into watching them.

Creating Engaging Content

When creating content, ensuring that it is engaging should be your top priority. Before you publish your first video it's worth considering the following:

- **Be brief**: try to keep your videos short and to the point. Looking at your video analytics can show the watch time of your videos and where your audience are dropping off. Experiment with different video lengths to see what works best for them.
- **Be timely**: be reactive and create content related to breaking news and current events. Plan ahead to take advantage of relevant tent pole occasions like World AIDS Day, Sexual Health Week, National HIV Testing Week, and Valentine's Day.
- **Utilise links**: even though link clicks may not be your core objective, always give your audience the option to get involved and find out more by including a link to a relevant website. Overlaying video annotations can be beneficial but these aren't always compatible with mobile.
- **Create quality content**: invest the extra time and money into curating and creating high quality material. Higher quality content means higher engagement.
- **Create a two way dialogue**: YouTube may be a video search engine but it's also a social media platform. Encourage your audience to share your content and engage in conversation.
- **Keep it simple**: Don't overwhelm your audience with too much information or multiple different call to actions. Keep it clear and make it as easy as possible for your audience to engage.

Targeting

The success of an advertising campaign on YouTube heavily relies on effective targeting. YouTube offers multiple different targeting options including demographic, interest and placement based targeting.

Demographic based targeting:

Demographic based targeting allows you to target your audience based on gender, age, parental status and household income. YouTube determines this information based on a user's Google account or behaviours inferred from their browser activity. This will not always be 100% accurate so it's important to further narrow down your target audience with other targeting methods.

Interest based targeting:

Sexuality based targeting isn't available but it's still possible to target MSM based on their interests. It's also possible to narrow this down further into subgroups of MSM who may be at higher risk. By utilising the interests, keywords, and topics targeting options you're able to create a clear picture of the people you are trying to reach and tailor individual adverts for them.

Placement based targeting:

The third, and often most successful, method of targeting is placement based targeting. This option allows you to place your adverts on specific videos and channels. Identifying channels and videos with a large MSM viewership is relatively easy through search. Searching for relevant keywords highly used by MSM can quickly identify which channels and videos are trending and most popular amongst MSM. YouTube will prioritise new content so it's important to update this at least once per campaign cycle.

Examples of highly viewed YouTube videos that are likely to be popular amongst MSM:

- The Hottest Gay Sex – 31 million views
- How To Have Gay Sex – 5.8 million views
- Gay Guy Shows Lesbian His Penis – 3 million views
- Gay Guys React To Gay Porn – 1.2 million views
- Our Best Gay Sex Tips – 1.1 million views
- 10 Reasons Gay Sex is better – 900,000 views.
- Gay Couple Tries Sex Toys – 600,000 views
- Reacting To Gay Porn – 300,000 views

Examples of popular YouTube channels that are likely to be viewed by MSM:

- Tyler Oakley: World's most popular gay male YouTuber with over 8,000,000 subscribers.
- Willam Belli: One of YouTube's most successful drag queen channels with over 700,000 subscribers
- Mark & Ethan: One of YouTube's most successful gay couples with over 600,000 subscribers.
- Tom Daley: LGBT+ sports person with over 350,000 subscribers

A combination of the above targeting methods will produce the best results, and experimenting with different subgroups is the key to reaching the most at-risk individuals for the lowest price.

Summary

Before starting your YouTube campaign, you should have done the following:

1. Chosen your campaign objective and outlined your goals.
2. Created at least one engaging video that is optimised and suitable for your target audience.
3. Created at least one target group based on a combination of targeting methods.
4. Allocated a budget and distribution plan and outlined achievable realistic targets.
5. Set holistic goals to measure the overall success of your campaign and determined a plan to measure and act upon your on-going progress, successes, and failures.

Once you've completed these tasks you're ready to start your first campaign. The success of any campaign will always rely on a certain degree of trial and error so remember to follow your campaign through every stage and be prepared to optimise and make changes as you go."

SOCIAL 'INFLUENCERS'

Social 'Influencers' are people across the range of platforms like Facebook, YouTube and Twitter who have an audience they talk to and have some 'influence' over. Key people identified as 'influences' include the Kardashians, Tyler Oakley, Willam Belli, Tom Daley etc.

Getting started:

You will first need to work out your campaign parameters, the audience, the message, what the campaign will look like and if the campaign will have any resources attached (such as condom packs etc.) When you have these resources settled then you will need to identify which platform you want to use and therefore what 'influencers' you will be trying to contact and partner with for the campaign. Remember that nearly everyone that has a consistent presence on social media will have a profile on multiple platforms.

Key questions you might want to consider include:

- Who could you work with?
- Who would be the best 'influencer' for that particular campaign?
- The types of campaigns to use particular influencers with.

Content:

Once you have created your campaign then it's time to consider using 'influencers'. People are far more likely to become involved with your campaign when you have your campaign messages, images and any resources you are developing ready. People like to see things, so they can make a decision about whether they want to become involved with that campaign.

- Identify key players who are talking about the subject you want to cover – on Twitter and YouTube you can search for people talking about the subject
- There are people creating content/tweeting about nearly everything, so there is no restriction on the types of issues or interventions influencers could help with
- Key players are identifiable by number of followers/views they have on videos around that subject
- Get one or two key ambassadors on board who can then reach out and attract other key players

Engaging content:

How much you can help your chosen 'influencers' impact upon the campaign will depend on the information and resources you provide them with to use.

Understand that there is an incentive for people to get involved, sometimes it's altruistic/philanthropic, maybe it's to get more views, re-tweets or followers – you may be helping their 'brand' giving them a chance to be involved in the intervention. You can also help by offering support and information, space to film videos, support in filming videos, maybe helping content creators to collaborate with each other on content

Providing branded goods for the creators to use (and keep) such as 'influencer packs' that contain things like flashcards, tee-shirts, condom packs etc. would be useful to keep content 'on brand'. Asking your key influencers what they would find useful for your campaign/intervention may be a start in building the pack. Provide them with links to the online presence for the campaign if there is one, or your organisations website if not. At the least you could be linking to relevant online resources like the European Test Finder.

Consider your audience:

Who are you trying to reach? What message are you trying to get across to them? Questions such as these will help you identify both your audience and the 'influencers' that you contact. Who are the 'influencers' audience? On platforms such as YouTube it's very easy to search by subject to see what people talk about.

Typing things such as 'condom use' into the search bar will bring up a number of videos you can search and people who talk about these issues to enable you to identify who you will use. What age is your intended audience? Is that the audience the 'influencer' has? You may not reach an audience of older MSM who wear leather and are into fetish play if you work with an 'influencer' under 20 who gives make up demonstrations for young MSM. You can also use the comments on the videos, who re-tweets comments and who their followers are to help identify the best 'influencer' to try and work with.

Consider the 'influencers' you contact to be part of your audience for the campaign; the more information they have and the more engaged they are the better they will be about talking about the subject and your campaign.

- Start with one or two creators/influencers only to begin with and build from there, if your campaign has multiple or ongoing iterations then supporting key creators will help build momentum
- Momentum will also be built by keeping the campaign something that creators will want to be involved with; 'cool and trendy' are keywords here, and this will help attract other creators/influencers to want to be involved
- Build and maintain your relationships with influencers, send Xmas cards, comment on videos, keep in contact, re-tweet their other comments outside the campaign you are working on. Such things keep a relationship ongoing and happy

Summary:

Before you approach 'influencers' you should have done the following:

1. Chosen campaign objectives and outlined goals
2. Created some content, imagery and resources for the campaign
3. Created a list of your target group/s or audience/s you want to reach
4. Created an 'influencer' pack
5. Set holistic goals to measure the success of your campaign and the impact of the influencers you work with, act upon your ongoing progress, successes and failures.

Online Outreach

Go to https://ecdc.europa.eu/sites/portal/files/documents/Online%20outreach%20-%20final%20with%20cover%20for%20web.pdf for the full document from ECDC from which the following information is taken.

Getting Started:

"Reaching out to communities in digital spaces is also known as online outreach or online fieldwork.

The purpose of online outreach is to provide an array of services in digital meeting places where men who have sex with men (MSM) commonly spend time.

- Health messages are primarily delivered to individuals (via personal profiles on websites or dating applications) and sometimes to groups of people (for instance via chatrooms or bulletin boards websites)
- Online outreach may include education, risk-reduction counselling and provider-based referrals to reliable information sources and other resources including testing and treatment locations.

Outreach work in digital communities can be effective in:

- Reaching MSM typically considered at risk, invisible or hard to reach
- Identifying previously unidentified communities
- Providing contextually-relevant information to 'gated' communities based on their sexual practices, identities and HIV status.

For projects with limited resources (budget, time and/or trained staff), advertising may be more cost effective than online outreach provided by paid staff members.

Differences between online outreach and advertising on dating platforms

	Online outreach	**Advertising**
Provider	Staff member	Automated algorithm
Target	Individual profilee	Groups of users
Interaction	Personal, tailored, agile, real-time	Mass-medial, targeted, determined in advance, asynchronous
Scale and reach	Small scale, depending on staff time	Large scale, depending on budget
Required resources	Staff, time, training	Promotion budget, visual and/or animated materials, mobile-optimised online content
Expenses determined by	Time and costs of staff members	Total number of clicks or impressions

Active versus passive outreach

You can decide between two types of one-on-one interactions: an 'active' versus 'passive' approach. Which approach is suited best depends on the objectives of your outreach activity.

Approach	Active	Passive
Description	Provider takes the initiative to message one user within a group of users	Provides waits until a user takes the initiative to send a message
Objectives	Increasing awareness and use of services Sharing information with target populations Partner notification	Offering online counselling, tailored and/or in-depth information Stimulating communication about sexual health
Use	Provision-centred	Needs-centred
Activities	Sending health-related messages to individual profiles Posting messages in discussions or chatroom sessions with multiple users Sending invitations to multiple users on bulletin boards, forums or chatrooms to join one-on-one conversations	Answering direct messages of individual users/profiles Answering questions in discussion threads on bulletin boards/forums Sharing information or dispelling myths in publically visible profile texts
Advantages	Large output in a short amount of time Greater visibility Targeting populations with filters Incidental or irregular activity is possible	Clients' needs central Greater acceptability among users Less likely to be blocked or reported Multi-tasking is possible In-depth
Disadvantages	First message needs to be concise and effective Less focused on needs of clients Can be considered 'spam' by users Terms of services (conditions of use) may not allow active outreach May compete or interfere with automated broadcast messages May cause lasting effects to provider's reputation	Time and labour intensive Fast and adequate answers required Unpredictable and variable output Regular presence is needed Demands comprehensive knowledge and skills Difficult to reach users with low awareness or engagement Sensitive to abuse of service and privacy concerns

Meeting the needs of your target population

Health promotion should always meet the needs of your target populations. Based on international literature, the following objectives match the needs of MSM related to HIV, sexual health and online prevention. Depending on your country's context, issues of homophobia, stigma and discrimination may require equal attention in your outreach work. ILGA's Rainbow Europe resources and the European Commission's Eurobarometer on Discrimination provide up-to-date information on discrimination and human rights in your region.

- Potential objectives of online HIV prevention and sexual health promotion
- Increase awareness and perceptions of risks relating to HIV and STIs
- Increase basic knowledge and dispel myths about HIV and STIs (transmission, symptoms)
- Increase knowledge of local or online services for HIV and STI testing and prevention
- Increase knowledge of safe and pleasurable sex
- Recruit MSM for online or offline HIV prevention interventions
- Improve knowledge about consistent and correct condom use
- Increase communication about protective behaviours and HIV and STI testing
- Increase awareness and knowledge of new biomedical prevention strategies, including pre- and post-exposure prophylaxis (PEP/PrEP)
- Increase awareness and knowledge of HIV viral load and risk reduction strategies
- Promote harm reduction in relation to sex-related alcohol and drug use
- Promote information-seeking behaviour
- Support meaningful and fulfilling sexual and intimate relationships
- Stimulate open communication about sexuality
- Decrease HIV-related stigma and support respectful communication about HIV
- Support partner notification

Guiding principles for online outreach:

Client-centred approach

A client-centred approach means providing an environment of empathy and openness, free of judgement. Negative experiences and long waiting times are the primary reasons why MSM who have experience with online prevention work would not use them again. Confidentiality concerns stop some MSM from accessing online prevention. It is necessary to always uphold a client-centred approach that is sensitive to your clients' needs, expectations and interests including their right to privacy.

Positive approach to sex and relationships

Gay culture is often considered as highly sexualised, but when European MSM are asked individually what they consider to be the best sex life, most of them formulate this in terms of desire for relationships and intimate connections [12]. A positive approach to sex and relationships is necessary to create engaging and holistic HIV prevention work.

Greater involvement and meaningful engagement of people living with HIV

Meaningful engagement and greater involvement of people living with HIV are important principles for any prevention activity. This included involving HIV-positive MSM in activities that aim to prevent new HIV infections as well as activities involving STI prevention, including Hepatitis C.

Participatory quality development

Participatory quality development strives for continuous improvement of health promotion projects. It is characterised by the optimal participation of stakeholders (target populations, service providers, funding bodies and other important parties). The needs and insights in the local situation of your 'front line' outreach workers and target populations are key to the success of the activity. As part of the Quality Action project, a handbook on participatory quality development has been developed in 5 languages.

Protecting privacy and confidentiality

Online outreach work provides a level of anonymity not found in many other types of interventions. However, concerns of confidentiality and privacy are common among MSM. During the design and implementation of online outreach work, two aspects require your attention: security and confidentiality.

Secure software

Always discuss software and security issues with your IT department or IT support prior to starting online fieldwork. Some sexual networking platforms may confront you with malware or malevolent software hidden inside advertising banners. Avoid security issues by:

- Installing recommended updates to your operating system, applications and web browsers
- By installing security software on computers, laptops and mobile devices
- Working on private, password-protected Wi-Fi networks. Third parties can easily scan unprotected or public Wi-Fi traffic and steal sensitive data.

Privacy and confidentiality

Organisations that conduct online outreach should have policies in place that explicitly cover online interactions and registration of information that could be used to identify clients. Ensure that:

- All staff members (outreach, IT, support staff and volunteers) have signed confidentiality agreements
- Access to sensitive data remains limited. Avoid registering names, e-mail addresses, phone numbers, IP addresses, geo-location data, profile names and other information that can be used to identify individuals.

Collaborating with dating platforms

Endorsement from sexual networking platforms helps to build trust in your online outreach activities. Unfortunately, only a few platforms openly support and facilitate online outreach activities on their platforms. Contact the platform you wish to do outreach on in advance to discuss your objectives and how they can be achieved.

Targeting:

Targeting specific populations with your intervention means you can better tailor your activity to their needs and change your message accordingly. Targeting your outreach work can be done in two distinct ways:

- Choosing specific platforms
- Using filters within platforms to reach specific groups of users.

By choosing the right platform and by filtering users, you can improve the effectiveness and reach of your work and prevent negative feedback from users for whom your message is less relevant.

Which apps and websites are most popular among subgroups of MSM differs per country and often per region. In most countries popular platforms exist that are only available in their country or native language. Moreover, there are apps and websites that specialise in specific subcultures or sexual practices.

In order to choose the best platforms in your region, you should first assess two things:

1. Find out which platforms are most popular in your region. Contact the platform and ask how many users they have in your region or conduct a local community assessment to find out which platforms are most popular.
2. Assess the possibilities and limitations of the platform.

Using filters to reach specific groups

Many platforms provide possibilities to selectively show users based on physical, demographic or sexual characteristics. These filters are especially useful for active outreach work, because it allows you to send tailored messages to different subgroups.

Filters also allow you to reach more users in applications that limit the number of users visible in the grid. Use filters to send messages to narrow subsets of users, change the filter to another subset, send messages etc., thereby expanding your reach significantly in a short amount of time.

Creating Content:

In terms of online outreach, MSM voice concerns over privacy, confidentiality and trustworthiness of online service provision. Because some dating platforms do not officially allow health promotion, it is important not to be careful not to violate their terms and conditions of use.

The most important contents you need to consider in advance are:

— Information on your website

— Profile description

— Message (when conducting active outreach).

Profile description

It is crucial for your profile to be as authentic and professional as possible. Your profile description should include enough information for users to easily identify your organisation. You may choose to develop a mascot or persona to improve your visibility and recognisability, or connect your online presence to a campaign.

Adding a picture to your profile will attract more attention and personalise your service:

— You may choose to use images of your organisation, project staff, events or campaign pictures, or stock images bought via stock image websites

— Consider using stock photograph instead of a profile picture if all outreach workers are female, or if male workers want to remain anonymous

— Make sure your organisation owns the copyrights of each image you use to avoid legal issues

However, too much information about your offers or services could violate the terms and conditions of the platform. Always review the terms and conditions of each platform prior to drafting your profile name and description:

Recommendations for profiles

Do:	Don't:
• Create a unique and recognisable username • Use the name of the organisation • Include basic information and a profile picture • Include contact information for the organisation (work-related-e-mail address and/or phone number) • Include social media connections (work-related Facebook, Twitter or Instagram)	• Use personal email address • Link to personal social media accounts • Use personal phone numbers • List sexual preferences or sexual statistics about the outreach worker • Explicitly mention services or offers Link to paid websites or services

Message

Users may consider personal messages actively sent out by healthcare workers to be intrusive. Make sure your message is as inviting and acceptable as possible, be careful with the tone of voice used, and ensure all essential information is given up front. Your objectives should be transparent and it should be easy for the user to find more information or share their questions and comments.

Pre-testing and improving your message

To make sure your message is of the best quality, always pre-test your message with your target population. In order to pre-test your message you should:

— Invite MSM who already use your services to give feedback on your message

— Develop two or three versions of a message and let users chose their favourite

— Improve your message based on their feedback and share your learnings

It is often necessary to change your message regularly to catch the attention of your audience. Before changing your message, always evaluate your previous message and improve your message according to learnings from past interventions.

Resources required for online outreach

Online interventions are at the crossroads of classic prevention work and online education and counselling. They require time and perseverance:

— Individual conversations between users and professionals often entail complex questions, requiring more than only medical knowledge of HIV and STIs

— Training is necessary to ensure staff members have adequate knowledge and skill to perform high-quality outreach work

— Beneficial personality traits include empathy, respect, authenticity, concreteness, directness, commitment, discipline, identification and open-mindedness.

Budgeting and costs:

Calculating staff time

No standard calculations for the time it takes to do online outreach can be given. Passive outreach work generally takes more time than active outreach work, but this largely depends on frequency and duration, scale and reach, and the worker's scope for multi-tasking.

Regarding staff time, make sure that staff members with a medical, IT and communication background are available to provide technical support and feedback. If your financial resources are insufficient, consider working with volunteers to expand your reach.

Membership costs

Memberships and subscriptions are not always necessary for your online outreach. Many platforms offer many options for free. Others limit the number of users they show and the filtering options they provide to non-paying users. Due to the relatively low costs of monthly subscriptions, their benefits may outweigh their costs.

Professional knowledge and skills

Users can disclose many questions and complex issues in a short period of time. Next to a knowledge base in HIV and STI transmission and prevention work care, providers should possess the following professional skills to do online outreach work:

- Written communication
- Knowledge management and self-reflection
- Referral knowledge: when and where to refer users to other support services

Written communication

Text-based communication lacks non-verbal communication such as body language and intonation. This means you should write textual responses consciously and carefully and check if your responses match the user's needs.

For practical suggestions on managing conversations during online outreach we refer to the chapters on 'Troubleshooting—Tips and tricks' in The Cruising Counts Guide and 'Prolonging and ending conversations' in the manual 'We are the Sexperts!'.

Knowledge management and self-reflection

To tackle questions effectively you require in-depth knowledge of topics ranging from basic HIV and STI transmission; available services; specific sexual practices and risks; and broader sexual health-related themes. It is important that outreach workers have the ability to listen, reflect and learn.

Outreach workers themselves can also use online resources to find answers to uncommon questions. This information should always be translated to the individual's needs and capacities. Additional training may be necessary to ensure that prevention workers have sufficient knowledge and skills to provide the right information and support.

Referral knowledge

The following online resources should be available at hand for online outreach workers:

- HIV and STI information including viral hepatitis
- Testing and treatment locations
- Safe sex and sexual risk reduction information

— Sexual health information and resources
— Mental health and substance abuse resources and counselling services
— Domestic and sexual violence information and resources
— Information and resources specifically for youth
— Information and resources specifically for transgender people.

Cultural communication

Outreach workers need to have sufficient understanding of vernaculars and cultural values to communicate effectively. Online communication between MSM is saturated with euphemisms, abbreviations and acronyms. The perceived anonymity of dating platforms allows MSM to interact in more open and sexually direct ways and express specific interests and fantasies. Prevention workers need to remain cautious when drawing inferences solely based on profile descriptions such as sexual identity and risky behaviour. The importance of sexual fantasy and gratification in online communication between MSM should not be underestimated.

Spending time on digital platforms will help you to learn about the target population and convey messages in your own words

Summary

Before starting your campaign, you should have done the following:

- Understood the opportunities and limitations of online outreach
- Selected the platform(s) that is/are most appropriate for your work
- Understood the needs of your target audience and adopted a plan for targeting them
- Created a realistic trustworthy profile for your outreach interventions
- Implemented a plan for each intervention and a strategy to avoid risks
- Understood all the associated costs and developed a plan for any necessary funding
- Outlined your key performance indicators and set clear goals and targets

Once you've completed these tasks you're ready to start your first campaign. The success of any campaign will always rely on a certain degree of trial and error so remember to follow your campaign through every stage and be prepared to optimise and make changes as you go."

There are also ECDC documents on the use of:

Smartphone applications
(https://ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/impact-smartphone-applications-sti-hiv-prevention-among-men-who-have-sex-with-men.pdf)

Google AdWords
(https://ecdc.europa.eu/sites/portal/files/documents/Google-Adwords-HIV-prevention-2017.pdf)

that will help provide information about their use in working with MSM. In addition there is an ECD Technical Document: **Utilising social media to support HIV/STI prevention: evidence to inform a handbook for public health programme managers** (https://ecdc.europa.eu/sites/portal/files/documents/social-media-use-to-support%20HIV-STI-prevention-evidence-for-public-health_0.pdf) that may provide useful evidence for starting to use these platforms to engage with MSM.

E-Learning: Skills Building

Building tailored training for specialised services

What this session will be helping you to do, is develop a series of identified training needs for the services in question.

In one session you will be unable to cover all the services, so it's suggested that you work on the services you work most closely with, or that you are trying to build relationships with.

The services have been grouped together into three groups containing two services. These groupings are:

- Group One: Mainstream Sexual Health & Mental Health Services
- Group Two: Primary Care Doctors & Healthcare Assistants
- Group Three: Drug and Alcohol & Prison Services

Use a search engine such as Google to look for information and articles around these services and their work with MSM in Europe and your region. You may already have access to some knowledge and information around your own local services that will be useful for this exercise. Below are some links to information and guidance around these services that you may find useful from places like ECDC:

Sexual Health Services:

- Places and people: the perceptions of men who have sex with men concerning STI testing: a qualitative study. Sexually Transmitted Infections.
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5800331/
- Sexual health of ethnic minority MSM in Britain (MESH project): design and methods. BMC Public Health.
  https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-10-419
- Setting the standards for sexual health support for MSM - Community Health Work in Slovenia. AIDS Action Europe.
  https://www.aidsactioneurope.org/en/news/setting-standards-sexual-health-support-msm-community-health-work-slovenia

Mental Health Services:

- Journal of Gay and Lesbian Mental Health
  https://www.tandfonline.com/toc/wglm20/current
- Promoting the health and wellbeing of gay, bisexual and other men who have sex with men: Public Health England
  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/339041/MSM_Initial_Findings__GW2014194.pdf
- Promoting the sexual health of MSM in the context of comorbid mental health problems. Europe PMC.
  https://europepmc.org/articles/pmc3610408#S4title

Primary Care Services:

- Public health guidance in brief on HIV, hepatitis B and C testing in the EU/EEA: ECDC
  https://ecdc.europa.eu/sites/portal/files/documents/hiv-hep-guidance-brief-6-december.pdf
- Full report
  https://ecdc.europa.eu/sites/portal/files/documents/hiv-hep-testing-guidance_0.pdf

Drug and Alcohol Services:

- Drug use among men who have sex with men: Implications for Harm Reduction. Sigma Research. http://sigmaresearch.org.uk/files/Chapter_3.3_MSM_.pdf
- Joining up sexual health and drug services to better meet client needs. European Monitoring Centre for Drugs and Drug Addiction. https://core.ac.uk/download/pdf/132547534.pdf

Prison Services:

- ECDC: Guidance on Prevention and Control of Blood Bourne Viruses in Prison Settings 2018 https://ecdc.europa.eu/sites/portal/files/documents/Guidance-on-BBV-in-prisons.pdf
- ECDC: Guidance on active case finding of communicable diseases in prison settings 2018 https://ecdc.europa.eu/sites/portal/files/documents/Active-case-finding-communicable-diseases-in-prisons.pdf
- ECDC: Thematic Report 2014: Prisoners https://www.ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/dublin-declaration-prisoners-2014.pdf

There are also a number of other reports that may be useful in helping your understanding of the situations faced by gay and other MSM across services. Some of them are a few years old, and still contain relevant insights although data figures may have changed.

ECDC

- Evidence Brief: HIV and Laws and Policies in Europe [30/05/17] https://ecdc.europa.eu/sites/portal/files/documents/Dublin-EB-HIV%20and%20laws%20and%20policies%202017%20final.pdf=
- Evidence Brief: Impact of Stigma and Discrimination on access to HIV services in Europe [30/05/17] https://ecdc.europa.eu/sites/portal/files/documents/Dublin-EB-Stigma%20and%20discrimination%202017_final.pdf
- Thematic Report: HIV and Men who have sex with Men [25/04/17] https://ecdc.europa.eu/sites/portal/files/documents/HIV%20and%20men%20who%20have%20sex%20with%20men.pdf
- Thematic Report: HIV Treatments and Care [25/04/17] https://ecdc.europa.eu/sites/portal/files/documents/HIV%20treatment%20and%20care.pdf
- Thematic Report: HIV and Migrants [25/04/17] https://ecdc.europa.eu/sites/portal/files/documents/HIV%20and%20migrants.pdf
- Thematic Report: Sex Workers: 2014 Progress Report [07/09/15] https://www.ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/dublin-declaration-sex-workers-2014.pdf

Please study this information and use it to identify the issues MSM face within these services:

— What are the gaps in their services?

— What and where are the barriers for gay and other MSM wanting to access them?

It would be best if you could concentrate on identifying, selecting and prioritising issues into areas for training. Use the knowledge you have as well as the information you have found to identify these gaps, which in effect, are the 'needs' of the service around this work.

You could consider grouping them as 'Knowledge', Cultural Competency, Service Restrictions, Economic Restrictions, Legal Restrictions for example.

Please make notes on the information, providing examples and priority areas for training.

It is likely that you will need at least 60 mins for this task.

By the end of this time you should have a series of identified training needs and issues for the services you were working on. It may also be useful to carry out a Needs Assessment with the service you are working with – use the ESTICOM Needs Assessment as a base to work from as it covers attitudes as well as skills and add in the needs you have identified in this exercise. [internal document link back to ESTICOM Needs Assessment]

There are other modules within this ESTICOM training and also ECDC provide a number of modules that could be a good basis for training.

ECDC Training: https://www.ecdc.europa.eu/en/training

ESTICOM Face to Face modules **here**

If you have time or want to re-do the session looking at other services it may be helpful to spend some time making notes on the areas you didn't work on to help start the process and act as a reminder.

2.4 Communication and Interpersonal Skills

- Back to Back Communication, and participant worksheet
- Body Language and Exploring Relative Distance
- Communication Origami
- Follow All Instructions, and participant worksheet
- Going to a Party
- Listen Without Speaking
- Samaritans
- Situational Awareness

Informal Exercise Title:
Back to Back Communication

Study Area/Group:
Communication and Interpersonal Skills

Exercise Aim and/or Purpose:
To explore the complexity of communication between people.

Expected exercise outcome:
By the end of the exercise participants will have explored and experienced complex communication strategies to obtain their goal.

Materials Required:
- Copies of the diagram and instruction sheet – one for each pair of participants.
- Paper and pens for participants.

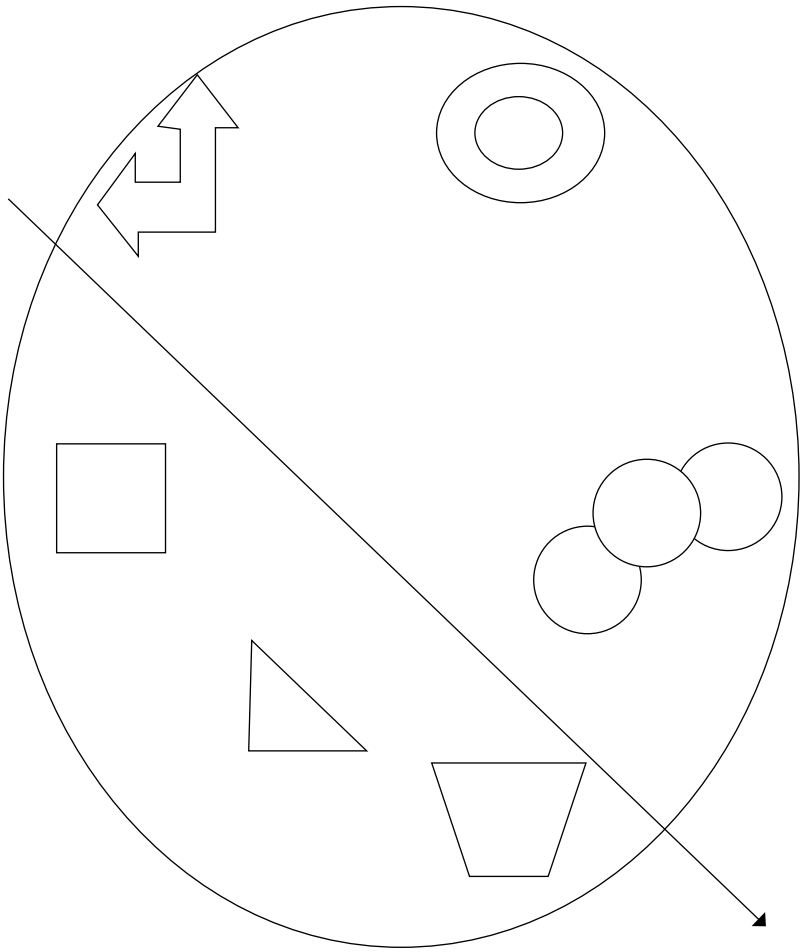
Facilitator Preparation:
- Read through the exercise to help understand how to prepare and run it.

Helpful hints for facilitators:
- This is a useful exercise to run if participants deal with difficult communication issues during their work. Can be especially useful for those engaged in outreach work in noisy and dark spaces like clubs and saunas.

Method: (40 mins)

1. Ask the group to get into pairs and have each pair adjust their chairs and sit back to back.
2. Give a copy of the diagram in the figure below to 1 of each pair of participants
3. Explain to the group that the person holding the diagram is tasked to explain the drawing to his/her partner. The listener must not see the diagram and should draw it based on their partner's description and directions. They have 10 minutes for this.
4. After 10 minutes call the activity to a stop and ask each pair to compare the outcome and how close to the original diagram is the listener's drawing.

Suggested diagram and instruction sheet



Sit back to back with your partner
One person will describe what to draw
The other person draws what is being described
The drawer should ask questions if they don't understand the instruction

Facilitated Feedback: (10 mins)

1. Ask the participants what they learnt about communication from this simple activity.
2. Ask participants how this could be helpful during their everyday communications on the job.
3. When the feedback is complete or the time ended close the exercise.

Extra Information:

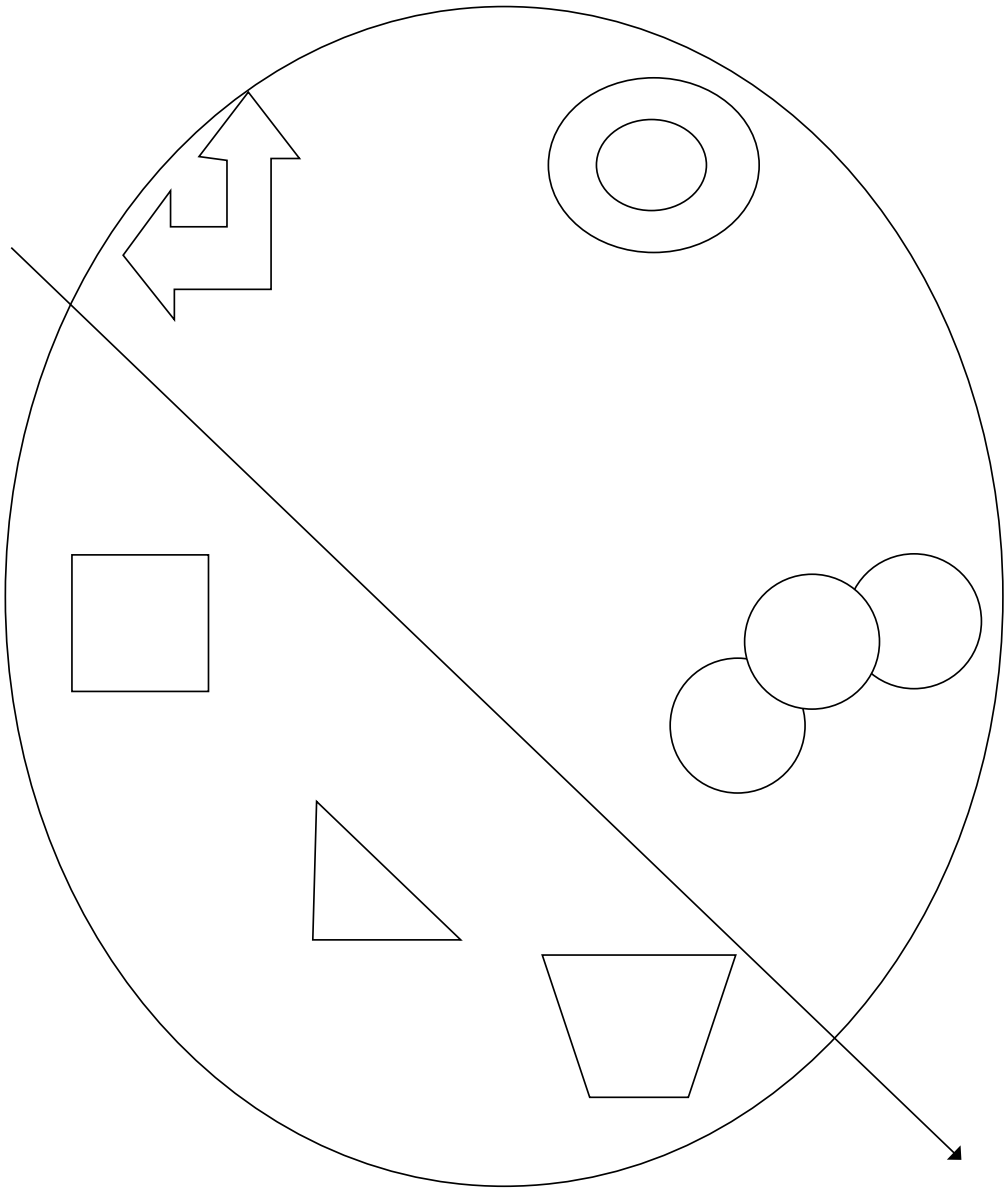
- You can run the activity more than once. The first time do not allow listeners to ask any questions; the second time allow listeners to ask questions and for clarifications. Then compare the outcomes. Here you can stress the importance of asking questions to confirm understanding and ensure the accuracy of communication.
- You can debrief the group by asking questions such as "how difficult it was for the person doing the drawing when they were not allowed to ask questions?"
- You can also switch roles, allowing both participants to be a listener and a chance to describe the diagram.

Participants Worksheet: Communication & Interpersonal Skills –

Back to Back Communication

This is the diagram you will be describing – good luck!

Suggested diagram and instruction sheet



Sit back to back with your partner
One person will describe what to draw
The other person draws what is being described
The drawer should ask questions if they don't understand the instruction

Informal Exercise Title:

Body language and Exploring Relative Distance and Position

Study Area/Group:

Communication and Interpersonal Skills

Exercise Aim and/or Purpose:

This exercise allows participants to experience their own feelings around body language, eye contact and personal space issues, to help them better understand these issues for the MSM they work with.

Expected exercise outcome:

Participants will have built a variety of experiences and understanding around the importance of body language, respecting people's personal 'comfort zone' and how eye contact and body language interact to affect interactions between people and how this understanding can be utilised in their work with MSM.

Materials Required:

- None.

Facilitator Preparation:

- Read through the exercise so you understand how it works and decide if you would like to add the optional extra activities in the Extra Information section.

Helpful hints for facilitators:

- This is a useful exercise to run when providing training around communication with others, Motivational Interviewing and/or Counselling.
- You will need a clear space in the training room to allow participants to be able to get up and move.
- If you are working with people of different physical abilities (i.e. a person who is a wheelchair user) – encourage them to speak from their experience of body language and eye contact.

Method: (5 mins)

Tell the group: "Body language speaks louder than any words you can ever utter. Whether you're telling people that you love them, you're angry with them, or don't care less about them, your body movements reveal your thoughts, moods, and attitudes. Both consciously and sub-consciously your body tells observers what's really going on with you."

1. Explain to the group that you are going to give them a series of instructions, which you would like them to copy as fast as they can
2. State the following actions as YOU do them:
   - Put your hand to your nose
   - Clap your hands
   - Stand up
   - Touch your shoulder
   - Sit down
   - Stamp your foot
   - Cross your arms
   - Put your hand to your mouth – BUT WHILE SAYING THIS PUT YOUR HAND TO YOUR NOSE
3. Observe the number of group members who copy what you did rather than what you said.

Facilitated Feedback: (5 mins)

1. Ask the group: "Why do you think you/some of you followed what I did rather than what I said?"
2. Inform the group that body language can reinforce verbal communication, however it can also be stronger than verbal communication – it is important that we are aware of our body language to ensure we are projecting the right message.
3. Now move onto explore relative distance and eye contact.

Method: (20 mins)

The safe distance between pairs of people is very culture dependent as is the degree of eye contact which is permitted and certainly the amount of touch. What is explored here is the simultaneous meeting of eyes and the aware adjustment of distance between partners who face each other.

This activity needs only a simple introduction. Participants are asked to find a comfortable distance and explore their feelings and thoughts at that position, as they moved from a distance towards each other, what is their 'comfort zone' and how they were affected as they moved towards each other. A demonstration is generally unnecessary. Participants are taken into the exercise quickly enough to prevent any resistance building up. Prepare the room by clearing sufficient space for the whole class.

1. Inform the group that the idea is to be sensitive to your own reaction and that of your partner as you move slowly closer to each other.
2. Ask the participants to identify a partner and tell them that, in pairs, they will move from the edges of the room to the centre, walking towards each other.
3. Tell the pairs to start against the walls of the room and walk towards each other slowly in silence. Ask them to note their experience at each point and continue to make the best eye contact they can while slowly walking towards each other.
4. They are to continue moving towards each other until they almost touch and move apart to a comfortable distance by non-verbal negotiation. Once at a mutually agreed distance they share their experience and how they felt.

The laughter of embarrassment is encouraged. Many may well experience embarrassment as they conduct the non-verbal negotiation and review the experiences at each significant point.

Facilitated Feedback: (10 mins)

When they have done this a couple of times ask them to review their experience. You can use either of the following methods:

- Pair Review: Pairs talk briefly (a couple of minutes, more if your eavesdropping shows continued talk to be productive) about the experience, how their feelings changed as they moved, critical points, and how they found a comfortable compromise.
- Whole Group Review: Participants are asked to remain standing and share with the whole group any aspect of their own experience. Facilitator/s may guide the responses so the participants report experiences rather than judgements about the experience or the exercise. Nor do they report what their partner said. You can counter the 'artificiality' argument ("but this is an artificial situation") by saying the exercise only exposes what happens normally or is ignored to the detriment of some relationships.
- When the feedback is complete or the time ended close the exercise.

Extra Information:

You have the option of adding more practice for the group using one or more of the following activities: (5 mins each)

Practical activity 1: On proximity with other partners: Since the experience is dependent on many factors, not least the gender of partners and how well they know each other, as well as the heights of the individuals, it is vital to repeat the exercise with 2 or 3 new partners in turn. If the class is managing the activity well, there is no need to have a whole class review after each new pair's activity and review. The task is to amass data from many interactions before the review.

Whole Group Review: This brings out the variables as well as the experiences. Participants are asked to reform the group circle and invited again to share their experiences, this time relating the differences and similarities between different partners, without any hint of judgement of their various partners. Conclusions are drawn about the negotiation of the comfort zone and the different occasions and relationships where the distances are different.

Practical activity 2: Relative position: Pairs are invited to set up their own experiments where relative position includes height and body angles or postures. This readily mimics professional-client norms such as a nurse with a patient in bed, or a doctor behind a desk. The role reversals created by participants can be very instructive if they are encouraged to reflect on the experience as if they are the client and think about the question "How can I improve conditions for my client so they can put the problem to me as they see it and disclose all relevant information about their situation?" Carry out a short whole group review.

Informal Exercise Title:
Communication Origami

Study Area/Group:
Communication and Interpersonal Skills

Exercise Aim and/or Purpose:
To explore and experience communication issues using a practical exercise.

Expected exercise outcome:
By the end of the exercise participants will have explored and experienced the complexity of communication issues.

Materials Required:
- Paper for participants.
- Scissors are optional for one of the alternative exercise suggestions.

Facilitator Preparation:
- Read through the exercise to understand how to run it effectively.
- Decide if you want to run the suggested exercise or use one of the alternative methods.

Helpful hints for facilitators:
- This is a useful exercise for anyone who does Face-to-Face work with gay and other MSM. It helps explore the complexities of communication skills and how one person can say something that another person hears differently.
- This is a quick and easy activity that shows how the same instructions are interpreted differently by different people and highlights the importance of clear communication.

Method: (10 mins)

1. Give one sheet of letter size/A4 paper to each person in the group.
2. Then tell the group that you will start giving them all instructions on how to fold the paper to create an origami shape.
3. Tell the group that while you give them the instructions, they must keep their eyes closed and cannot ask any questions.
4. Start giving the group several instructions to fold and rip their paper several times then ask them to unfold their paper and compare how it looks with others.
5. Use your own instructions – they can be things like 'fold the paper twice', 'fold one of these folds back on itself' etc. etc. See the alternative versions in the Extra Information section for more suggestions.

Facilitated Feedback: (10 mins)

1. After the group has unfolded and compared their papers you can make the point that each paper looks different even though you have given the same instructions to everybody. What does this mean?
2. Ask the group if you think the results would have been better if they kept their eyes open or were allowed to ask questions. Communicating clearly is not easy as we all interpret the information we get differently. That is why it's very important to ask questions and confirm your understanding to ensure that the communicated message is not distorted.
3. When the group has finished their feedback or the time has ended close the exercise.

Extra Information:

Alternative version 1: paper folding
Method: (10 mins)

1. Give everyone a sheet of paper. Tell everyone to close their eyes and follow your instructions.
2. Start giving instructions about what to do with the piece of paper, for example:
   - Fold it in half
   - Fold the lower left corner over the upper right corner
   - Turn it 90 degrees to the left
   - Fold it again
   - Rip a half-circle in the middle of the right side
   - etc.
3. Once you have given quite a few instructions (at least 10 is ideal), tell everyone to open their eyes and unfold their piece of paper.
4. Even though they all received the same instructions and had the same starting material, pretty much everyone will have a different result.

Facilitated feedback: (10 mins)

- Ask the group their thoughts on why there were differences. The following points are useful prompts/answers:
  - We don't all start with the same base – some held their piece of paper vertically others horizontally – so we don't all have the same results.
  - Some interpreted the ripping of a piece of paper as removing a big piece, some as a small piece.
  - Having eyes closed = not receiving feedback on our performance.
  - Some instructions appear vague to some and clear to others.
- When the feedback has finished or time ended, close the exercise.

Alternative version 2: paper cut
Method (10 mins)

This is a 5–10 mins highly effective activity on the importance of perception and asking questions in communication process. The exercise illustrates the importance of giving meaningful instructions to others and expecting feedback for correct execution of those instructions. It is fun and quickly makes a point.

1. Explain to participants that you are about to give them instructions and they must follow these instructions as given to them.
2. They must follow these quietly and are not allowed to ask any questions. They should not get help from others around them or even look at other people's work.
3. If anyone asks questions, simply tell them to follow the instructions as they see fit.
4. Give the group these instructions:
   - Hold up the papers please.
   - Fold the paper in half.
   - Cut (or neatly tear) off the top right corner of the folded paper.
   - Fold in half again.
   - Cut off the top left corner of the paper.
   - Fold in half again.
   - Cut off the bottom right corner of the paper.
   - Fold in half.
   - Cut off the bottom left corner of the paper.
   - Unfold the paper.
   - Ask delegates to show off their unfolded papers to each other and examine similarities or differences.

Facilitated feedback: (10 mins)

When you have reached the end of the instructions ask the group:

- Did you end up with similar patterns or is everyone's pattern different?
- Why could that be?
- Were the instructions clear enough? What was missing?
- Why is feedback so critical in communication? What happens if feedback is missing?
- What lessons do we take from this?

When feedback has finished or time ended, close the exercise.

Informal Exercise Title:
Follow All Instructions

Study Area/Group:
Communication and Interpersonal Skills

Exercise Aim and/or Purpose:
This exercise allows participants to build their listening skills and also can be used as an Energiser exercise (helping to build energy in the group after a long period of listening, or a lunch break for example).

Expected exercise outcome:
Participants will have experienced a quick (possible Energiser) exercise to help them improve their listening skills.

Materials Required:
- Printouts of the instructions for the participants – one for each participant.

Facilitator Preparation:
- Read through the instructions so you know how to run the exercise, without giving the point of the exercise away.

Helpful hints for facilitators:
- This exercise is useful to run when you want to talk about any Face-to-Face work with gay or other MSM as it's about Active Listening.
- This is a fun exercise about how we can fall into patterns of behaviour around communication, so avoid language that could be felt as accusing a player of the game of being stupid. It's about awareness raising not checking levels of intelligence.

Method: (10 mins)

This is a quick fun activity with a little trick to see how many of the participants will actively listen and follow the one single instruction you will give them to "Read all instructions first" and how many will rush and start doing each instruction one by one.

Make sure before the course starts that you have a copy/photocopy of the Instructions Sheet from the following page for each of the participants on the course.

1. Split participants into 3 or 4 teams and give each participant a copy of the Instruction Sheet (as below).
2. Tell the teams that this is a competition and that the first person in any of the teams to finish will be declared the winner. Start the teams off by giving one single instruction to "read all instructions first" (without over-emphasising the statement).
3. If all the group go through the exercise without following your initial instruction of "read all instructions first" ask them why they think this is. How do they feel?
4. If a winner is declared quickly because they had read all the instructions first, ask the others where they were on the Instruction Sheet. How do they feel?
5. When they have fed back close the exercise.

Instruction sheet

1. Write all of your team's initials at the top right-hand corner of this sheet.
2. Write your first name on your sheet of paper.
3. Write the total of 3 + 16 + 32 + 64 here:
4. Underline Instruction 1 above.
5. Check the time by your watch with that of one of your neighbour's.
6. Write down the difference in time between the 2 watches at the foot of this page.
7. Draw 3 circles in the left-hand margin.
8. Put a tick in each of the circles mentioned in Instruction 7.
9. Sign your signature at the foot of the page.
10. On the back of the page, divide 50 by 12.5.
11. When you get to this point in the test, stand up, then sit down and continue with the next instruction.
12. If you have carefully followed all these instructions, call out 'I have'.
13. On the reverse of this page, quickly draw what you think an upright bicycle looks like from overhead.
14. Check your answer to Instruction 10, multiply it by 5 and write the result in the left-hand margin opposite this item.
15. Write the 5th, 10th, 9th and 20th letters of the alphabet here:
16. Punch 3 holes with your pen here : o o o
17. If you think you are the first person to get this far, call out 'I'm in the lead'.
18. Underline all the even digits on the left-hand side of the page.
19. Draw triangles round the holes you punched in Instruction 15.
20. Now you've finished reading all the instructions, obey only 1, 2, 20 & 21.
21. Stand up and say, "We're the greatest team in the World!"

Participants Worksheet: Communication and Interpersonal Skills

Follow All Instructions – sheet

1. Write all of your team's initials at the top right-hand corner of this sheet.
2. Write your first name on your sheet of paper.
3. Write the total of 3 + 16 + 32 + 64 here:
4. Underline Instruction 1 above.
5. Check the time by your watch with that of one of your neighbour's.
6. Write down the difference in time between the 2 watches at the foot of this page.
7. Draw 3 circles in the left-hand margin.
8. Put a tick in each of the circles mentioned in Instruction 7.
9. Sign your signature at the foot of the page.
10. On the back of the page, divide 50 by 12.5.
11. When you get to this point in the test, stand up, then sit down and continue with the next instruction.
12. If you have carefully followed all these instructions, call out 'I have'.
13. On the reverse of this page, quickly draw what you think an upright bicycle looks like from overhead.
14. Check your answer to Item 10, multiply it by 5 and write the result in the left-hand margin opposite this instruction.
15. Write the 5th, 10th, 9th and 20th letters of the alphabet here:
16. Punch 3 holes with your pen here: O O O
17. If you think you are the first person to get this far, call out 'I'm in the lead'.
18. Underline all the even digits on the left-hand side of the page.
19. Draw triangles round the holes you punched in Instruction 15.
20. Now you've finished reading all the instructions, obey only 1, 2, 20 & 21.
21. Stand up and say, "We're the greatest team in the World!"

Informal Exercise Title:
Going to a Party

Study Area/Group:
Communication and Interpersonal Skills

Exercise Aim and/or Purpose:
To help participants build their ability to engage with people, understanding how to extend conversations by using 'open' rather than 'closed' questions.

Expected exercise outcome:
Participants will have experienced the difference between a difficult and easy conversation and learnt how to use open questions to gather information to use in conversation.

Materials Required:
- None

Facilitator Preparation:
- Read through the exercise to understand how it works.

Helpful hints for facilitators:
- Understand how 'open' questions, or questions that allow information rather than a short 'closed' answer to be given help build conversations. In English such questions begin with the words How…, When…, Why…, What… and Who…. The structure of the language you are using on the training may have an effect on how emphasis or words are placed in the sentence used.
- You will need space in your training room to hold this 'party'.

Method:

Explain to the group that we are going to play a game where they are at a party. During their conversations they have to find out 1 thing they didn't know about each person and do this with 3 people. So 3 new personal facts in total. Tell them the information has to come out of the conversations naturally – they cannot just ask someone just to tell them 1 thing they didn't know.

1. Tell them they have 15 mins for this.
2. When this time has elapsed call the group back and ask how difficult or easy this was. Take their feedback and then introduce the concept of 'open questions' – who, how, what, where, when types of questions that give more information to build conversations from.
3. The group then goes back to party scenario and now has to find out 2 things from 3 people that they didn't know before. So 6 things in total.
4. Tell the group they have 15 mins for this again.
5. Make sure that you keep strictly to the time, as the group generally finds this second practice much easier and doesn't believe they were given the same amount of time.

Facilitated Feedback:

1. Ask the groups what (if any) differences they noticed?
2. Was it easier the second time? What made it easier?
3. When the feedback is over or the time has ended close the exercise.

Informal Exercise Title:
Listen Without Speaking

Study Area/Group:
Communication and Interpersonal Skills

Exercise Aim and/or Purpose:
This exercise allows participants to experience being listened to and listening to someone without interruption to learn better active listening skills.

Expected exercise outcome:
Participants will have experienced both being truly listened to and what happens when you don't interrupt someone; and will have built their skills around 'active listening'.

Materials Required:
- None

Facilitator Preparation:
- This exercise is useful to run to help with any Face-to-Face work with gay and other MSM such as Counselling or Motivational Interviewing, and it's generally helpful for peoples communication and interpersonal skills.
- Read through the exercise at least once to understand how to help the pairs as they work – if they need help.

Helpful hints for facilitators:
- If you have space in the room allow participants to have a lot of space between each other. If not, encourage them to place themselves in the room so they don't have eye contact with anyone else but their partner.
- Make sure you keep the pairs updated to the time they have taken so that each person gets 10 mins to talk.

Method: (25 mins)

This is an activity that encourages participants to communicate how they feel about a subject. People get into pairs and one member talks about their opinions. The partner listens without speaking, and then identifies all the times they would have interrupted the person speaking if they had been able to.

1. Ask the group to sit down in pairs. Each one of the pair is to identify a subject that they are passionate about and can speak around for about 10 minutes. It's probably best if it's not too 'controversial' as such subjects sometimes prevent learning.
2. As one of the pairs (the speaker) talks, the other person (the listener) cannot speak. Their task is to listen and identify all the times they would have interrupted if they had been able to.
3. After around 8–10 mins, stop the pairs and ask the listener to recap on when they would have interrupted when their partner was speaking. They have about a minute for this. Next, the roles switch, and the process is repeated.

Facilitated Feedback: (10 mins)

When both partners in the pair have spoken and listened ask them:

1. How did each speaker feel about their partner's ability to listen with an open mind? Did their partner's body language communicate how they felt about what was being said?
2. How did listeners feel about not being able to speak about their own views on the topic? How well were they able to keep an open mind? What did they learn by not interrupting?
3. How can they use the lessons from this exercise at work?
4. When they have fed back or the time has ended close the exercise.

Informal Exercise Title:
Samaritans

Study Area/Group:
Communication and Interpersonal Skills

Exercise Aim and/or Purpose:
This exercise allows participants to explore and learn about communication, empathy and boundaries when involved in working with gay or other MSM.

Expected exercise outcome:
Participants will have experienced building empathy with another person to help with a problem/issue without that person becoming dependant on them.

Materials Required:
- Paper and pens for participants.
- Suitable chairs for the exercise i.e. chairs that can be placed back to back and have a solid arm or leg that makes a noise when tapped.

Facilitator Preparation:
- Read through the exercise to understand how to prepare for it, and work with the participants if needed.

Helpful hints for facilitators:
- This exercise is particularly useful for online or telephone work but can be used to generally help build interpersonal and questioning skills. Helpful with Counselling and Motivational Interviewing.
- You will need some space for the chairs to be moved around and placed back to back.

Method:

Explain to the group that:

- Telephone counselling services often receive silent calls. Sometimes before someone is willing to speak they go through a stage where they will only tap the phone. The 'game' you are about to play recreates this situation.
- You will each have a turn pretending to be the caller who will remain silent (and a turn pretending to be the counsellor). The answers to questions are given by tapping on the back of your partners chair: 1 tap for 'yes', 2 taps for 'no'.
- The questioner/counsellor will need to be quite skilled to discover the problem. It can be easier if you set out to establish the gender, age and broad type of problem of the tapper/caller and then work towards the details of the issue. You will need to word your questions so that they can be answered 'yes' and 'no'.
- At the end of 5 mins I will stop you and ask the tapper/caller to show the questioner/counsellor the problem they have written down. You will then swap roles.

1. Divide the group into pairs. Ask them to sit on chairs with their backs to one another. They should be sitting close enough to be able to communicate by tapping on the back of the chair.
2. Ask the pair to each think of a problem someone might phone the Samaritans about. Your partner has to guess the problem, so please don't make it too complex. When you have a problem, write it on your piece of paper, but do not show it to your partner or allow them to see it.
3. You will take turns pretending to be a person with the problem you've identified. You can change your age, sex and nationality if you want to and you think it helps make the situation more realistic. The problems might be personal, family, financial or legal. The answers to questions are given by tapping on the back of your partners chair: 1 tap for 'yes', 2 taps for 'no'.
4. Start the pairs off working, making sure you give them the 5 mins they are allowed before stopping them and asking them to share the problem/issue. Then ask them to swap so that the 'caller' becomes the 'counsellor' and the 'counsellor' the 'caller'.

Variation: The discussion can continue by looking at the types of problem offered by the tappers/callers. This would be particularly appropriate if the game is part of a sequence looking at helping skills, prejudice or stigma.

Facilitated Feedback:

At the end of the game ask:

1. How difficult was it to discover the problem?
2. As the questioner/counsellor, how did you feel about being able to ask only questions which could receive one-word answers?
3. Was there anything the tapper/caller really wanted to say but could not? If so, what?

At the end of the feedback close the exercise.

Informal Exercise Title:
Situational Awareness

Study Area/Group:
Communication and Interpersonal Skills

Exercise Aim and/or Purpose:
This exercise allows participants to build skills around cognition, awareness, communication and listening, and helps participants build awareness of the situations they are working in, at the settings they work at.

Expected exercise outcome:
Participants will build their skills in and awareness of what is happening in the settings they work in and with the gay and other MSM they work with.

Materials Required:
- None

Facilitator Preparation:
- Read the exercise to understand how it works in practice.

Helpful hints for facilitators:
- This is a useful exercise to run for people involved in Outreach work as well as telephone and Motivational Interviewing work.
- Ensure you have enough space for people to move their chairs to work in pairs.

Method: (10–15 mins)

Listening with 'situational awareness' is critical in many fields, in which workers must 'actively listen' to their 'client' as well as 'scan' the area so as to remain aware. This is an extremely difficult field and the number of people who can both actively listen and still maintain a situation awareness is very small.

This is a useful situational awareness listening technique.

1. Ask the group members to pair up and then think of a topic they would like to discuss for 2 mins. It can be fun or serious.
2. Ask the pairs to start discussing their topic between themselves for 2 mins.
3. When the 2 mins are up ask them what each of their neighbours were talking about – NOT what they discussed. Most of the time they can't give any information at all.
4. Then tell the group you are going to repeat the exercise.
5. Ask the pairs to swap partners so they are working with someone else, chose another topic and repeat the exercise for another 2 minutes.
6. When this 2 minutes is up again ask the pairs to report back on what their neighbours were talking about. This time they are more able to give feedback on what the pairs around them were discussing.

This has been valuable for teaching participants to listen not only to what is being said to the individual but also what is being said 'around' a situation.

Facilitated Feedback: (10 mins)

1. Ask the group to say what they differences were.
2. "How did they remain aware of their own conversation as well as those around them?"

When the feedback has finished or the time is ended close the exercise.

2.5 Icebreakers and Energisers

- Balloon Tower
- Camping Trip
- Cross The Line
- Dragons Tail
- Dreams
- Fruit Salad
- Ha Ha!
- How Much Do You Use?
- Human Bingo and participant worksheet
- Impossible Connections
- Let's Talk About Sex and participant worksheet
- Line Up
- Sentence Starters
- Sharks and Penguins
- Superlatives
- Two Truths And A Lie
- Yes, I Have Done That

Informal Exercise Title:
Balloon Tower

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Energiser-Icebreaker hybrid: To build participants' knowledge of each other as well as raise the energy of the participants.

Expected exercise outcome:
By the end of this exercise the energy of the participants will have been raised by getting them active as well as helping them find out things about each other and build trust in the group.

Materials Required:
- Several large packets of balloons.
- A small roll of clear adhesive tape for each participant.
- Tape measure to measure the 'towers'.

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.
- Buy/obtain all the materials.

Helpful hints for facilitators:
- This is an exercise that helps build teams and works out who thinks logically and who uses chaos theory in their approach to problem solving. It is rare that the 'towers' are taller than 5 layers of balloons, usually reaching to the shoulders of the people making them.

Method: (20 mins)

1. Ask the participants to get into smaller groups of 3 or 4 people.
2. Tell them that you would like them, in their groups, to build the highest freestanding tower that they can, only using the balloons and the adhesive tape that they have been given.
3. The group that will be judged to have 'won' will have built the highest tower that stands on it's own, without support from chairs, tables etc. or by being linked by tape to the floors, ceiling or walls.
4. Reiterate that they can only use the balloons and tape and the tower must be freestanding.
5. Tell the groups they have 10 minutes to build their tower. Tell them they can start.
6. After 10 minutes, you can give them 5 minutes of extra time at your discretion (usually if they are nowhere near building a tower).
7. When all the time is up, compare and measure the towers and declare a winner.

Facilitated Feedback: (10 mins)

1. Review the activity with the groups by asking the following questions:
   - What was your strategy?
   - What challenges were there and how did you overcome them?
   - Did the pressure of time affect the outcome?
   - What approach did you take and why?
   - What would you do differently if they did the activity again?
2. Groups normally take one of 2 approaches – either completely chaotic or very ordered. Each approach can win the game – it's a 50/50 split on how it works out, so ask the groups why they think that could be?
3. When the groups have finished feeding back or the time has ended close the exercise.

Extra Information:

There are variations you can add, if participants have played the game before:

- You could give additional points for the most visually appealing tower.
- You could give additional points for the highest tower using the least amount of resources.
- You could ask participants to build an arch rather than a tower.
- Once each team has built their tower, you could ask them to then work as one large group to combine their towers into one super tower.
- You could ramp up the pressure by giving less time and doing countdowns.
- You could make the activity more about communication by allowing them 5 mins to plan and then not allowing them to talk while they build the tower.

Informal Exercise Title:
Camping Trip

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Energiser/Icebreaker hybrid: To help participants build their thinking, energy and listening skills, and to break down any inhibitions by playing a game.

Expected exercise outcome:
Participant will build their thinking, energy and shared information between themselves.

Materials Required:
- None

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.
- Choose which 'pattern' you are going to use for the word game in the exercise.
- Some suggested patterns are:
  - Things that start with a certain letter of the alphabet such as the letter D (diamond, dog, drink, etc.)
  - Things that end with a certain letter of the alphabet
  - Words with 2 vowels or consonants together (wheel, pizza, book, etc.)
  - Words with a certain letter or sound at the end of the word such as the letter K (rake, book, coke, etc.)
  - Items consisting of 2 words (hot dogs, baking dish, waffle iron etc.)
  - Items of the same colour
  - Items with the same number of letters
  - Items that begin with the last letter of the last item mentioned.

Helpful hints for facilitators:
- Camping Trip takes concentration and a good memory so don't be too judgemental as to who is good or bad at the game.
- It would be useful to have at least 2 word pattern ideas to use as it may take a while for everyone to work out the game.
- Make your pattern choice appropriate to the age and composition of the group. Some are more complicated than others.

Method: (15 mins)

1. Have your group form a circle. Be clear which pattern you are using first.
2. As the facilitator you start the game. You will say, "I'm going on a camping trip and I'm going to bring _____."
3. You are to pick anything that you would like to bring on the trip that follows the chosen pattern. For example, if the pattern is 'things which begin with the letter C,' you might say 'cookies.'
4. You will need a pattern for the players to follow, but only you know the pattern when the game starts. This will make it harder for participants to suggest items to bring on the camping trip.
5. Let us assume that the pattern is 'things that begin with the letter C', so you will say 'cookies'.
6. Players who have figured out the pattern will say things that begin with 'C.'
7. At the beginning of the game only you know the pattern. If a participant correctly follows the pattern, you will say, 'Okay, you can bring that on the camping trip'. As participants get to know the pattern they can join in with you.
8. However, a player who does not get the pattern might say, 'apples.'
9. At that point, you and the players who know the pattern say, "No, you can't bring apples."
10. Play continues around the circle until players have figured out the pattern. If a player thinks they know they pattern, they can begin their turn by whispering to the leader (who is you, the facilitator) what they think the pattern is. You will say yes or no. Sometimes players think they know the pattern, but they simply guess something that happens to fit.
11. Play until your time is up or you have completed 2 rounds of the game. Close the exercise.

Informal Exercise Title:
Cross the Line

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Icebreaker: This exercise allows participants to use and/or build their influencing, negotiating or persuasion skills.

Expected exercise outcome:
Participants will have built skills in influencing, persuading or negotiating with people.

Materials Required:
- Masking Tape / string / chalk to mark lines on the floor (whichever is the most appropriate for training space you are using).

Facilitator Preparation:
- ✓ Read the exercise to understand how to facilitate it effectively.
- ✓ Buy/obtain the materials required.

Helpful hints for facilitators:
- You'll need a clear space in the room you are using to run this exercise.
- A useful exercise to build influencing skills. Linked to Face-to-Face and Motivational Interviewing interventions.
- This could be a good exercise to run before Partnership Working with and between LGBTQI+/MSM Organisations and Other Services as it ends with the idea of a win-win approach.

Method: (5–10 mins)

1. Tell the participants that you are now going to do an activity that uses influencing, negotiating and persuasion skills.
2. Set up the activity by marking a line or series of lines on the training room floor.
3. Organise participants into pairs (if you are working with odd numbers of participants a co-facilitator can step in to 'play') and arrange the pairs facing each other on opposite sides of the line/s. They should be no more than an arm's length apart.
4. Tell the group that when you say 'Go' they have 30 seconds to persuade their partner to cross to their side of the line. They cannot use physical force to get their partner to cross the line.
5. At 30 seconds, call a halt to what's happening (30 seconds is ample time) and ask to participants to look around and see how many of them have been persuaded to 'cross the line'.
6. Ask the group:
   - What strategies did you use to persuade your partner to cross?
   - Why do they think these strategies were effective or ineffective?
7. Make the point that most effective strategies are when both parties win – for example, saying: "Let's both cross the line, that way we'll both achieve the objective"
8. This activity works well as part of a programme involving influencing, persuading and/or negotiating skills. When the activity is over close the exercise.

Informal Exercise Title:
Dragons Tail

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Energiser: To build energy in the group after a long 'sit down' or discussion session, or after lunch.

Expected exercise outcome:
That participants will have rebuilt their energy.

Materials Required:
- Two brightly coloured cloths/handkerchiefs.

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.
- Be aware if any participants have mobility issues.

Helpful hints for facilitators:
- Make sure that people feel comfortable being in the front or back of the 'dragons'.
- Make sure the 'tails' are easily seen and grabbed.

Method: (5 mins)

1. Split the group into 2 and ask them to form up into 2 'dragons', by either holding onto each other's waists (belts or waistbands of trousers/skirts) or their shoulders to form a line or 'dragon'.
2. The last person in this dragon formation has a brightly coloured handkerchief tucked into a back pocket, their waistband or belt – this is the 'dragons tail'.
3. The object is for one of the 'dragons' to catch the tail of the other 'dragon' without losing their own tail in the process.
4. Play at least 2 rounds of the chase and catch, but don't exceed 5 minutes playing time. When you have finished playing close the exercise.

Informal Exercise Title:
Dreams

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Icebreaker: To get participants to share information and learn more about each other.

Expected exercise outcome:
That participants will have learnt more about each other and built trust for group working.

Materials Required:
- Flipchart easel, pad and pens.
- Paper and pens for the participants.

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.

Helpful hints for facilitators:
- Encourage the participants to think about their dreams not connected to the work they are doing at the moment – what are their other dreams?
- Think about your own 'dreams' before running the exercise to use as a prompt if a participant has difficulty identifying anything.

Method: (5 mins)

1. Tell the group that they are to imagine a situation where there is nothing stopping them or restricting them, no financial restrictions etc. etc. Ask them:
   - What would you really like to do or to be?
   - What is your secret dream? You can keep this dream secret, although I want you to think about it.
2. Tell the group they have 2 or 3 minutes to think about this and to write down brief notes on what their dream is.
3. When everyone in the group has finished this, ask them to write down 5 reasons why they would like to be or to do what they said their dream was – they have 5 minutes to do this.
4. When this 5 minutes is up, ask the group to share 3 of their **REASONS** (not dreams) from their list. As they do this, capture them on the flipchart without commenting on them.

Facilitated Feedback:

1. When everyone has shared their 3 reasons, open up the group for discussion.
2. What have they noticed about the reasons? Are there some similarities or are they all very different? How many of them are related to what we assume about each other?
3. Other points that can be made:
   - A person without needs is dead.
   - Needs give us the drive to do things.
   - Satisfaction of needs doesn't just happen – we have to do something.
   - The things we aim for to get satisfaction can be called goals. The dream you identified in the exercise is a goal.
4. Identifying the reasons for the dream can help achieve some of the dream, for example:

   Dream: To be a top football player/tennis player etc.
   Reason: Physical exercise
   Enjoy appearing in public
   Thing I know most about me
   Make people respect me

Though it may not be possible to achieve this dream, couldn't many of the reasons be satisfied by being a referee or an umpire? This could become a realistic goal if the dream is not possible for any reason.

5. When people have shared and talked about their reasons, or 30 minutes has ended, close the exercise.

Informal Exercise Title:
Fruit Salad or Unmusical Chairs

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Energiser: To raise the energy of the participants after a long session or break from the training such as lunch.

Expected exercise outcome:
Participants will have built their energy levels.

Materials Required:
- Appropriate chairs i.e. single chairs that can be moved easily but that don't have wheels.

Facilitator Preparation:
- Read the exercise to understand how to facilitate it effectively.
- Decide if you are playing Fruit Salad or Unmusical Chairs (see Extra Information).
- Be aware of any mobility issues of the participants – there are better Icebreaker and Energiser exercises to use with people who are wheelchair users or have other mobility issues.

Helpful hints for facilitators:
- You will need to be able to have a space large enough for a circle of chairs that all the participants can move around.

Method: (5-10 mins)

1. Ask the participants to form a circle with their chairs (facing into the circle). Ensure there are only as many chairs as there are people, then take 2 chairs away, but make sure the circle isn't too small or constricts movement too much.
2. Ask those 2 people without chairs to stand in the middle of the circle (ensure that you are on the outside of the circle).
3. Go around the circle and name each person in turn as a lemon, orange or apple (so 'lemon, orange, apple, lemon, orange, apple…' and so on) until everyone has been assigned as a fruit. Do NOT forget to name the 2 people standing in the centre of the circle.
   - Tell the group: "I will shout out a name of a fruit, either lemon, orange or apple. If you hear your fruit called out you must leave your own seat and find another.
   - You can't just get up and sit down in the same seat, it must be a different seat to the one you were sitting in. If you are in the middle of the circle and your fruit is called you must find a seat to sit in, but you can only move and find a seat when your fruit is called.
   - If I call out 'Fruit Salad' then everyone must leave their seat and find another. Remember, only move when your fruit name or Fruit Salad is called out – and there will always be 2 of you left without seats who stand in the middle of the circle."
4. Ensure that everyone understands these 'rules' and then start the Energiser.
5. Call out different fruits in a random mix/sequence, remembering to occasionally add in 'Fruit Salad'.
6. Continue the process until you feel that energy levels have increased. Close the exercise.

Extra Information:

This Energiser is also known as Unmusical Chairs. In this version, only 1 chair is taken out of the circle, with 1 person left in the middle. The nominated person in the middle picks a card held by the facilitator that has an activity written on it. This can be a sexual activity if appropriate for the training).

They are then say 'I like' or 'I dislike' as appropriate for the way they feel about the activity and name the activity. For example, the activity on the card is 'swimming', so they could say 'I like swimming'.

Everyone who agrees with their statement gets up and has to find a different chair to the one they were sitting in, and the person in the middle has to find themselves a chair.

The person who can't find a chair and is left standing becomes the person in the middle who takes the next card and carries on the process. If only 1 person gets up in response to a statement, they are to take the standing position in the middle of the group and next choose a card.

It plays like Fruit Salad from there as outlined above.

Informal Exercise Title:
Ha Ha!

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Energiser: This exercise raises the energy of the participants by getting them active as well as helping them build trust in the group.

Expected exercise outcome:
Participants will have built their energy levels.

Materials Required:
- None

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.

Helpful hints for facilitators:
- This is a fun game but be aware it can become chaotic.
- Make sure that you keep aware of who plays the game without laughing so a 'winner' can be found.

Method: (5 – 10 mins)

1. Tell the group you are now going to play a game called 'Ha Ha'.
2. Have the group sit in a circle, so that everyone can see each other.
3. Tell them that they have to remain as solemn and serious as they can throughout the game.
4. Pick one player to start the game – they are to start the game by saying 'Ha' once.
5. The player on their right then says the word 'Ha' twice.
6. Following this pattern, the third player (to the right of the second player) says 'Ha' 3 times.
7. The game continues with the numbers of 'Ha's' increasing relative to how many went just before (4, 5, 6, 7 and so on).
8. As the game progresses eliminate any players who laugh or make noise when it is not their turn.
9. The player who avoids laughing throughout the game wins. When you have declared a 'winner' close the exercise.

Informal Exercise Title:
How Much Do You Use?

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Icebreaker: To build participants' knowledge of, and trust in each other. This exercise allows participants to get to know more information about each other in a way that is controlled by the individual.

Expected exercise outcome:
Participants will have shared information about themselves and heard lots of information about their fellow participants, thereby building links and trust in the group.

Materials Required:
- A number of toilet rolls (1 to start with.)

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.

Helpful hints for facilitators:
- Some people may take large numbers of 'squares' so keep an eye on the time and consider the number of participants. You may have to limit the number of things they share. Try and keep to the time given, moving participants along if they have many 'squares' of paper, or specify "tell us 7 things…"

Method: (10 mins)

1. Ask the participants to sit in a circle.
2. Tell them that you are going to pass around a roll of toilet paper, and that they are to take as many 'squares' of the paper as they normally use; "take as much as you normally need to get the job done"
3. When everyone has taken their amount of toilet paper, tell the group that for every 'square' of toilet paper they have taken, they must tell the group 1 thing about themselves.
4. Everyone in the group goes through the process, including the facilitators.
5. When everyone has shared, close the exercise.

Informal Exercise Title:
Human Bingo

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Icebreaker-Energiser hybrid: To build participants' knowledge of each other as well as raise the energy of the participants after a long session or break from the training such as lunch by getting them active, as well as building trust within the group.

Expected exercise outcome:
Participants will have built their energy levels and learnt more about each other.

Materials Required:
- The Bingo Cards you have chosen to use – one for each participant.
- Pens.

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.
- Decide which of the Bingo Cards you will use, based on how many participants are expected. The 9 question card has sexually explicit questions.

Helpful hints for facilitators:
- Dependent on which Bingo Card is used, this exercise can break barriers and taboos around the use of sexualised language and activities, allowing people to be more comfortable using such language during the training. Useful if running a session around sexual health, language or sexual activities.
- This exercise is also known as People Bingo and Treasure Hunt.

Method: (10 mins)

1. Inform the participants that you are now going to play Human Bingo which is a variation on Bingo, but instead of sitting waiting to hear the right thing, participants must walk around talking to each other to find answers to complete their card and then shout 'Bingo!'.
2. Give each participant a Bingo Card and a pen. The bingo cards can have 3 x 3, 4 x 4 or 5 x 5 squares, therefore 9, 16 or 25 questions for the participants to find answers for.
3. Tell the group that you want them to complete their Bingo Card by finding someone and asking them a question on their card. If they say yes (or agree) then that square is completed and they should write that person's name in that square.
4. They can only ask a person 1 question, which is where the choice of which card and how many questions on it is key.
5. If you are asked a question it is bad manners to ask a question straight back to the person who has just asked you. You have to initiate the questioning; you CAN ask people who have asked you questions, just not at the same time.
6. The first person to get all their squares filled out shouts 'Bingo!' The facilitator checks all the squares have been filled out and verifies it is the 'winning card'. When a 'winner' has been declared, close the exercise.

Human Bingo – Question Card – Sexually Explicit (9 questions)

Having an audience when having sex	**Having sex while wearing high heels**	**Having sex in the shower or bath**
Watching porn while having sex	**Having sex outdoors**	**Fucking in the morning**
My tits being played with	**Exploring my arse with my fingers**	**Using sex toys when masturbating**

Human Bingo – Question Card – Generic (9 questions)

Has lived abroad	**Has a pet**	**Loves summer**
Likes 'Star Wars'	**Eats chocolate**	**Posted a 'selfie' in the past 24 hours**
Likes tomato ketchup	**Has attended an opera in the past 12 months**	**Likes to cook/bake**

Human Bingo Card – Question Card - Generic (16 questions)

Has visited 5 or more countries	**Has been to a professional sports event**	**Can play a musical instrument**	**Doesn't like/drink coffee**
Likes the colour pink	**Who can whistle**	**Has had their name misspelt or mispronounced**	**Has a grandparent from a different country**
Likes to draw/paint	**Has cried during a movie**	**Has spoken with a famous person/ celebrity**	**Prefers salty over sweet snacks**
Wears contact lenses	**Has an allergy**	**Speaks 2 or more languages**	**Is younger than you**

Human Bingo Card – Question Card – Generic (25 questions)

Plays 2 or more sports	**Has a phobia**	**Has the same first letter of their first name as you**	**Is an only child**	**Doesn't like/ eat chocolate**
Has 3 or more siblings	**Has an 'S' in their name**	**Can play piano**	**Can roller-skate**	**Likes playing/ building with Lego**
Has read 3 or more books in the last 3 month	**Is vegan or vegetarian**	**Has been in a play or musical**	**Owns more than 5 pairs of shoes**	**Has spent 3 or more hours playing video games last weekend**
Knows where their grandparents were born	**Has a celebrity autograph**	**Has never been on a plane/ helicopter**	**Likes singing karaoke**	**Has a tattoo or piercing that's not easily visible**
Has been to a Disney theme park	**Prefers cold weather**	**Cuts their own hair**	**Has never played Monopoly or Twister**	**Was not born in the country where they now live**

Participants Worksheet: Communication and Interpersonal Skills

Human Bingo – Question Card

Having an audience when having sex	**Having sex while wearing high heels**	**Having sex in the shower or bath**
Watching porn while having sex	**Having sex outdoors**	**Fucking in the morning**
My tits being played with	**Exploring my arse with my fingers**	**Using sex toys when masturbating**

Human Bingo – Question Card

Has lived abroad	**Has a pet**	**Loves summer**
Likes 'Star Wars'	**Eats chocolate**	**Posted a 'selfie' in the past 24 hours**
Likes tomato ketchup	**Has attended an opera in the past 12 months**	**Likes to cook/bake**

Human Bingo Card – Question Card

Has visited 5 or more countries	**Has been to a professional sports event**	**Can play a musical instrument**	**Doesn't like/drink coffee**
Likes the colour pink	**Who can whistle**	**Has had their name misspelt or mispronounced**	**Has a grandparent from a different country**
Likes to draw/paint	**Has cried during a movie**	**Has spoken with a famous person/ celebrity**	**Prefers salty over sweet snacks**
Wears contact lenses	**Has an allergy**	**Speaks 2 or more languages**	**Is younger than you**

Human Bingo Card – Question Card

Plays 2 or more sports	**Has a phobia**	**Has the same first letter of their first name as you**	**Is an only child**	**Doesn't like/eat chocolate**
Has 3 or more siblings	**Has an 'S' in their name**	**Can play piano**	**Can roller-skate**	**Likes playing/ building with Lego**
Has read 3 or more books in the last 3 month	**Is vegan or vegetarian**	**Has been in a play or musical**	**Owns more than 5 pairs of shoes**	**Has spent 3 or more hours playing video games last weekend**
Knows where their grandparents were born	**Has a celebrity autograph**	**Has never been on a plane/helicopter**	**Likes singing karaoke**	**Has a tattoo or piercing that's not easily visible**
Has been to a Disney theme park	**Prefers cold weather**	**Cuts their own hair**	**Has never played Monopoly or Twister**	**Was not born in the country where they now live**

Informal Exercise Title:
Impossible Connections

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Energiser: To raise the energy of the participants after a long session or break from the training such as lunch by getting them active.

Expected exercise outcome:
Participants will have built their energy levels

Materials Required:
- None.

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.

Helpful hints for facilitators:
- Be aware if any participants have mobility issues, so as to understand which Impossible Connections can be made.

Method: (5–10 mins)

1. Make sure that all the participants feel OK with a physical exercise (they are asked to move around the room – it doesn't have to be at speed necessarily)
2. Ask the participants to start moving around the room and tell them that when you call out an instruction, they are to get into that Impossible Connection. For example, if you call out '3 left elbows' then as quick as they are able, participants should gather in groups of 3 with their left elbows touching.
3. Get the group moving and then call out an instruction like '4 hips'.
4. You can follow this with any combination like '2 right feet', '6 knees', '2 shoulders', '7 left-hands' etc.
5. Do no more than 6 combinations. When you have finished close the exercise.

Informal Exercise Title:
Let's Talk About Sex

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Icebreaker: To build participants' knowledge of, and trust in each other. This exercise allows participants to get to know more information about each other in a way that is controlled by the individual. It also helps to break down barriers associated with talking about sexual activity.

Expected exercise outcome:
Participants will have shared information about themselves and heard lots of information about their fellow participants, thereby building links and trust and breaking down any taboos about sex and sexual activity and talking about it within the group.

Materials Required:
- Let's Talk About Sex cards

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.

Helpful hints for facilitators:
- A useful Icebreaker to use when dealing with sexual health issues or activities for gay and other MSM.

Method: (5–10 mins)

1. Ask the participants to sit in a circle and tell the group they are now going to undertake an exercise called Let's Talk About Sex.
2. Tell the group that you are going to place some cards face down in the middle of the floor/room and explain the exercise:
   - One participant at a time is to pick up and look at a card, and then say what their initial reaction is to the card's content. They are then to answer 2 of the questions you have written on the flip chart.
3. Tell the group that everyone will take at least one turn doing this, and it's more fun if they 'go with the flow' rather than resist.
4. Now place the cards face down on the floor in the middle of the circle, while a co-facilitator writes up the following 4 questions onto the flip chart.
   - "Have you tried this? If you haven't, would you like to?"
   - "What about this activity turns you on (or off)?"
   - "Have you ever seen it or done it yourself?"
   - "Do you have an experience of the activity that you would like to briefly share?"

5. When ready to proceed, ask the participants for a volunteer to go first. If you feel the group to be particularly shy or resistant, then one of the facilitators can start the exercise. This is also useful to do if you wish to set the tone and parameters for the exercise.
6. You can encourage discussions, responses, questions (within boundaries) and repetition of the exercise, depending on the time available. One of the facilitators needs to take responsibility for keeping to time on the exercise.
7. Ensure that everyone has had a chance to participate, and stop when you run out of time or cards.
8. Paraphrase the learning from this exercise as follows:

   "Thanks for taking part. We do this to get us onto topic and over any early nervous responses we can often experience when called upon to talk about sex and sexual activities, especially within a group. It's also an exercise that highlights the range of sexual activities that gay and other MSM enjoy with each other, so it helps remind us of that."

Extra Information:

These are the subject discussion cards:

fuck buddies
glory holes
shaved balls
doggy style
cock rings
69
food sex
frottage
cum
poppers
fetish gear
sucking cock
backroom sex
treasure trail
spanking
baby oil
condoms

boyfriend
electroplay
dildos
Gaydar / Hornet / Scruff
fisting
massage
wanking
active
passive
licking
piercings
size queen
rimming
douching
butt plugs
fucking
anal
cottaging
saunas
sounding
scat
cuddling
hairy
vibrator
nipples

topping
bottoming
bondage
threesomes
group sex
sling
body hair
CBT
kissing
tit torture
bareback
master / slave
watersports
making love

Participants Worksheet: Icebreakers and Energisers

Lets Talk About Sex – subject discussion cards

fuck buddies
glory holes
shaved balls
doggy style
cock rings
69
food sex
frottage
cum
poppers
fetish gear
sucking cock
backroom sex
treasure trail
spanking
baby oil
condoms
boyfriend
electroplay
dildos
Gaydar / Hornet / Scruff
fisting
massage
wanking
active
passive
licking

piercings
size queen
rimming
douching
butt plugs
fucking
anal
cottaging
saunas
sounding
scat
cuddling
hairy
vibrator
nipples
topping
bottoming
bondage
threesomes
group sex
sling
body hair
CBT
kissing
tit torture
bareback
master / slave
watersports
making love

Informal Exercise Title:
Line Up or From Top to Bottom

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Icebreaker-Energiser hybrid: To raise the energy of the participants after a long session or break from the training such as lunch by getting them active. Depending on the 'criteria options' used, participants also find out things about each other. This is a useful activity for groups of 16 or more.

Expected exercise outcome:
Participants will have built their energy levels and they will also have found out things about each other dependent on the criteria options used.

Materials Required:
- None.

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.

Helpful hints for facilitators:
- Be aware if participants have mobility issues.
- This exercise is quite similar to 'Superlatives'.
- Alternatively use Line Up criteria that are relevant to the topic/workshop.
- Use this activity periodically during longer sessions as a quick Energiser.

Method: (5–10 mins)

1. For large groups, organise participants into smaller groups of 8–20 people.
2. Explain to the participants that when they are asked to line up in a particular way, they need to get into the lines as quickly as possible. When any one group finishes a Line Up, the group's members should clap to indicate they have finished.
3. Line up criteria options include:
   - Age
   - Shoe size
   - Length of arms reach
   - Height (shortest to tallest)
   - Alphabetically (first names)
   - Date of Birth (January to December)
   - The number of siblings you have
   - Length of time in current job
   - Number of pets/animals you have.
4. When you have completed as many Line Ups as you feel necessary to raise the energy of the participants close the exercise.

Extra Information:

Ask the groups to come up with their own ways of letting you know they have finished (e.g. hum a song, yell, put up their hands etc.) This can add a lot of fun to the exercise, and can differentiate it from any other times you've run it on the same workshop.

Informal Exercise Title:
Sentence Starters

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Icebreaker: To encourage participants to get to know and trust each other.

Expected exercise outcome:
That participants will have shared information about themselves and learnt about each other.

Materials Required:
- Sentence Starters – at least 2 per participant.

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.
- Decide which Sentence Starters you want to use and add your own. If you know the participants you can make sure the 'starters' relate to the group members.
- Before the course, write the 'starters' you want to use on slips of paper.

Helpful hints for facilitators:
- Don't overfill your bowl with 'starters' – 2 are recommended for each participant (so if you have 10 participants you have 20 'starters')
- This exercise could be used alongside Awareness About the Use of TasP (U=U), PrEP, PEP and Self-testing or Self-sampling for MSM, by using some related Sentence Starters. See Extra Information for some examples, build more from your knowledge and experience in your region/country.

Method: (10–15 mins)

1. Have each person pull a slip from a bowl and say their name, read the sentence starter, and then complete it.
2. They could also provide several additional sentences of information that goes with their sentence starter.
3. Make sure that everyone reads out and completes at least one 'starter'
4. When you have heard enough 'starters' or you have reached 15 minutes close the exercise.

Extra Information:

The following is a sample list of Sentence Starters:

- Although most people don't find…
- I am…
- I have never…
- I love it when…
- I love to…
- I think I have the best…
- I would never…
- My idea of beauty is…
- The best thing I've done for my child was…
- The best way for me to relax is…
- The best way to save…
- The biggest and best…
- The funniest thing that ever happened to me was…
- The greatest thing my child ever did was…
- The lowest…
- The most important decision I ever made in my life was…
- The most unbelievable thing…
- The thing that makes me laugh is…
- There is nothing I enjoy more than…
- When I think of prunes…
- In my country, I can get a self-test for…
- In my service PrEP is…
- In my country use of PEP is…

Variation:
Have the participants sit in a circle and pull one slip at a time from a bag, basket, or box. Read the sentence starter and have each person take turns completing them.

Informal Exercise Title:
Sharks and Penguins

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Energiser: To raise the energy of the participants after a long session or break from the training such as lunch by getting them active.

Expected exercise outcome:
Participants will have built their energy levels.

Materials Required:
- Two sheets of A4 paper.

Facilitator Preparation:
- Read the exercise to understand how to facilitate it effectively.
- Be aware of any participants with mobility issues.

Helpful hints for facilitators:
- You will need a quite large clear space in the room to play this game.

Method: (5–10 mins)

1. Inform the participants that you are now going to play Sharks and Penguins which is a very active game. You need to be aware if any of the participants has a mobility issue (is a wheelchair user or uses crutches) although this does not stop them being involved with the activity. In fact it can add to the fun if the shark is in a wheelchair (and better still if they hum the 'Jaws' theme…). Tell the group that the point of the game is to remain a penguin while all the penguins around you get turned into 'sharks'.
2. Depending on the size of the group (i.e. if over 8 people) put the 2 sheets of A4 paper on either end of the floor of the cleared space you are working in (you will need a large-ish space for the activity). The sheets represent 'icebergs', which are the only 'safety zones' for the penguins.
3. Ask one person to volunteer to be the shark; as the shark it is their job to 'catch' the penguins by touching them lightly (no grabbing) and turn them into sharks.
4. The rest of the group become the penguins, who move around the room. Penguins cannot hover near the icebergs waiting; any penguin who does this automatically becomes a shark.
5. Tell the group you will start them off by calling out "Free Swimming Time" and sometime during this you will call out "Shark Attack". When they hear this, the penguins have to try and get part of their foot/hand/wheel/crutch onto one of the 'icebergs', which are their safety zone. The 'shark' attacks by lightly touching penguins, who freeze in place. "Shark Attack" lasts until all penguins have a part of their foot/wheel/hand on the 'iceberg' or are frozen in place by a shark. These frozen penguins then become additional sharks, who now hunt penguins alongside the original shark.
6. Check that the participants understand the rules of the activity, and if they do, start the activity by calling out "Free Swimming Time".
7. Choose a time to call out "Shark Attack" Check that the shark and penguins abide by the rules; that penguins who are caught freeze in place, and the shark doesn't attack penguins in the iceberg safety zone. Remind penguins who were caught that they are now sharks and are to hunt penguins alongside the original shark.
8. Call out "Free Swimming Time" so that the penguins can swim free of the icebergs. Before you shout "Shark Attack" again, rip each of the pieces of A4 paper (the icebergs) in half, putting only half of the paper back on the floor again (so 2 pieces of half-sized A4 paper). The penguins now have a smaller 'safety zone'.
9. The game continues with the facilitator shouting "Shark Attack", new sharks being made, and the paper icebergs being torn in half after every Shark Attack. The winner is the last penguin standing. When you have a winner close the exercise.

Informal Exercise Title:
Superlatives

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Energiser-Icebreaker hybrid: To build participants' knowledge of each other as well as raise the energy of the participants by getting them active as well as helping them build trust in the group.

Expected exercise outcome:
By the end of the exercise participants will have built their energy levels and learnt things about each other.

Materials Required:
- None.

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.
- Choose the categories you want to use for the exercise.

Helpful hints for facilitators:
- Be aware that people in the group may have mobility issues i.e. may be a wheelchair user, so choose categories accordingly and avoid things that may offend.

Method: (5–10 mins)

1. Tell the group you are now going to play a game called Superlatives.
2. Divide the group into teams of 5–10 people (dependent on numbers) and have them choose a 'leader'.
3. Tell them that the goal for this game is for them to re-order themselves as quickly as they can according to the category.
4. Use your own categories or one of the following:
   - From shortest to longest – how many letters are in your first name
   - From furthest away to closest to this venue – your birthplace
   - From least to most – how many brothers and sisters you have
   - Shortest to tallest – height
   - Beginning to end of year – birth dates.
5. Once a team has arranged itself, the 'leader' of the group makes sure they have done so.
6. The first group to do so, once checked by the facilitator, wins the game. You can play 'best of 3' if the groups are quick at solving their puzzles.

Informal Exercise Title:
Two Truths and a Lie

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Icebreaker: To build participants' knowledge of, and trust in each other. This exercise allows participants to get to know more information about each other in a way that is controlled by the individual.

Expected exercise outcome:
Participants will have shared information about themselves and heard lots of information about their fellow participants, thereby building links and trust in the group.

Materials Required:
- None.

Facilitator Preparation:
- Read through the exercise to understand how to facilitate it effectively.

Helpful hints for facilitators:
- Give people a couple of minutes to think about the truths and lie they share.

Method: (5–10 mins)

1. Ask the participants to sit in a circle.
2. Tell the group that each person will introduce themselves by stating 2 truths about themselves and 1 lie. The rest of the group will try and identify which statement is the lie.
3. Example: "Hi, I'm Mary. My hair was almost to my waist in high school, I talked to Cher in an airport coffee lounge and I speak 4 languages."
4. Everyone in the group goes through the process, including the facilitators. When everyone has spoken, close the exercise.

Informal Exercise Title:
Yes, I Have Done That

Study Area/Group:
Icebreakers and Energisers

Exercise Aim and/or Purpose:
Energiser and Icebreaker hybrid: To raise the energy of the participants after a long session or break from the training such as lunch. This exercise allows participants to get to know more information about each other and build their energy again.

Expected exercise outcome:
Participants will have built their energy and also shared information about themselves and heard lots of information about their fellow participants, thereby building links and trust in the group.

Materials Required:
- The Yes, I Have Done That question and signature sheet – 1 for each participant.

Facilitator Preparation:
- Read the exercise to understand how to facilitate it effectively.

Helpful hints for facilitators:
- This is a useful Energiser to use when training around Communication, Motivational Interviewing and Counselling skills.

Method: (10 mins)

1. Tell the participants that you are now going to play a game where they will be asking each other some questions, and trying to be the first to complete their sheet.
2. Pass out the question sheet. Tell the participants: 'Your objective is to find people in the group who can answer questions on the sheet with 'Yes, I have done that…'. When someone can answer, ask them to sign their name next to that question. The winner is first person who gets an answer to every question.'
3. If there are more questions than participants, they can get double signatures but they have to get a 'yes' and a signature from all the participants before they start getting double signatures. In other words, they can't ask the same person multiple questions at the same conversation/meeting.
4. It could be that people cannot find a 'new' someone to answer yes to a particular statement. In that case, they must backtrack and remove the name of someone's yes to one statement to allow them to answer yes to another statement.
5. The first person to complete their list wins.
6. The questions on the list are:
   - Have you ever been to Australia?
   - Have you ever ridden a motorbike?
   - Have you ever lived in another country?
   - Have you ever met a celebrity?
   - Have you ever been to a Disney theme park?
   - Have you ever planted a vegetable garden?
   - Have you ever worked in a shop?
   - Have you ever planned a wedding?
   - Have you ever ridden in a limousine?
   - Have you ever driven a ride on lawnmower?
   - Have you ever participated in a marathon?
   - Have you ever been mountain climbing?
   - Have you ever been to an acupuncturist?
   - Have you ever been to a dog show?
   - Have you ever been somewhere while an earthquake occurred?
   - Have you ever been somewhere when a tornado happened?
7. When someone wins, close the exercise.

‘Yes, I’ve done that...’

Question and Signature Sheet

Been to Australia...	**Ridden a motorbike...**	**Lived in another country...**	**Met a celebrity...**
Been to a Disney park...	**Planted a veg garden...**	**Worked in a shop...**	**Planned a wedding...**
Ridden in a limo...	**Driven a ‘ride on’ mower...**	**Run a marathon...**	**Been mountain climbing...**
Been to an acupuncturist...	**Been to a dog show...**	**Been in an earthquake...**	**Been in a tornado...**

3. Annex

3.1 Participants worksheets

Worksheets are already provided as part of the training material and therefore will not be replicated here.

3.2 Evaluation Tools

Measuring the impact of the training.

Introduction:

We want to be able to measure the effectiveness of the training that you will be undertaking to ensure that you are getting what you need from the training.
To do this please fill in this pre-course assessment form. When you have completed the course you will be asked to fill out a post-course assessment form so that we can measure the changes.

Pre-course assessment:

Please indicate your level of confidence with each of the following:

Prevention	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Prevention and transmission of HIV				
Prevention and transmission of HIV				
Symptoms and treatments of HIV				
Prevention and transmission of STIs				
Symptoms and treatments for STIs				
Prevention and transmission of Viral Hepatitis				
Symptoms and treatments for Viral Hepatitis				
The epidemiology of HIV (across Europe and in your local region)				
The epidemiology of STIs (across Europe and in your local region)				
The epidemiology of Viral Hepatitis (across Europe and in your local region)				
HIV 90-90-90c The Continuum of Care				
The use of Motivational Interviewing techniques in my work				
The use of Treatment as Prevention (U = U)				
The use of post-exposure prophylaxis (PEP)				

The use of pre-exposure prophylaxis (PrEP)				
The use of Self Testing kits				
The use of Self Sampling kits				
Current safer sex practices for Gay and other MSM				
The use of recreational drugs during sexual encounters (ChemSex)				
Health Promotion Models (HPMs) used in work for Gay and other MSM				
The use of Face-to-Face (F2F) and group information and advice				
The use of Face-to-Face (F2F) and group based work				

Provision of screening, testing and counselling services	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
The screening and/or testing for HIV				
The screening and/or testing for Viral Hepatitis (B and/or C)				
The screening and/or testing for other STIs (gonorrhoea, syphilis etc.)				
Pre- and/or post-test counselling at these services				

Delivery points for prevention and screening and testing activities...	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Working in a gay/gay-friendly entertainment venue (café, bar, club, sauna etc.)				
Working in a Community setting (drop in, community centre, social club, Pride events)				
Working at an outdoor setting (bus/van, cruising ground, streets/public space etc.)				
Working at a State/public sector setting (education, prison, state social services etc.)				
Working at a private setting (private home/dwelling, hotel, care home etc.)				
Working Online or via mail (website/online chat, mobile phone apps, social media)				

Knowing the community you are working with (Cultural Competence)	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
How our attitudes affect my work				
Working with the MSM community to improve access and linkage to care				
How aspects of MSM identity affect sexual health				

Challenging Stigma and Discrimination	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Identifying and working with vulnerable groups of Gay and other MSM				
Engaging and Involving service users in your services				
Creating a non-judgemental service for Gay and other MSM				
How social, economic and environmental influences impact on health				
How issues Gay and other MSM face can be linked to their health				
Stigma around: MSM sexual practices				
Stigma around: Sexual Orientation				
Stigma around: Gender Identity				
Stigma around: HIV/STIs/Viral Hepatitis (A, B and C)				
Challenging Discrimination: Sexual Orientation				
Challenging Discrimination: living with HIV				
Challenging Discrimination: HIV Prevention: the choices MSM make				
Challenging Discrimination: Gender and Gender Identity				
Challenging Discrimination: Provision of Prevention and Treatment tools				

Working in Partnerships	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Building partnerships with and between Community and Statutory Health Services				
Building partnerships with and between MSM/LGBTQI+ organisations				

Skills building	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Building my ability to communicate effectively with people				
Building my skills to engage effectively with people				
Using Social Media (Facebook/Twitter/YouTube/Hornet etc) to engage with Gay and other MSM				
Building and providing training for other specialist services (e.g. Prisons)				

Thank you for completing the pre-course evaluation.

Post-course evaluation:

Now that you have completed your training session, it would be very helpful if you could indicate how you feel about your understanding and confidence about the following:

Prevention	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Prevention and transmission of HIV				
Prevention and transmission of HIV				
Symptoms and treatments of HIV				
Prevention and transmission of STIs				
Symptoms and treatments for STIs				
Prevention and transmission of Viral Hepatitis				
Symptoms and treatments for Viral Hepatitis				
The epidemiology of HIV (across Europe and in your local region)				
The epidemiology of STIs (across Europe and in your local region)				
The epidemiology of Viral Hepatitis (across Europe and in your local region)				
HIV 90-90-90 The Continuum of Care				

The use of Motivational Interviewing techniques in my work				
The use of Treatment as Prevention (U = U)				
The use of post-exposure prophylaxis (PEP)				
The use of pre-exposure prophylaxis (PrEP)				
The use of Self Testing kits				
The use of Self Sampling kits				
Current safer sex practices for Gay and other MSM				
The use of recreational drugs during sexual encounters (ChemSex)				
Health Promotion Models (HPMs) used in work for Gay and other MSM				
The use of Face-to-Face (F2F) and group information and advice				
The use of Face-to-Face (F2F) and group based work				

Provision of screening, testing and counselling services	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
The screening and/or testing for HIV				
The screening and/or testing for Viral Hepatitis (B and/or C)				
The screening and/or testing for other STIs (gonorrhoea, syphilis etc.)				
Pre- and/or post-test counselling at these services				

Delivery points for prevention and screening and testing activities...	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Working in a gay/gay-friendly entertainment venue (café, bar, club, sauna etc.)				
Working in a Community setting (drop in, community centre, social club, Pride events)				
Working at an outdoor setting (bus/van, cruising ground, streets/public space etc.)				
Working at a State/public sector setting (education, prison, state social services etc.)				
Working at a private setting (private home/dwelling, hotel, care home etc.)				
Working Online or via mail (website/online chat, mobile phone apps, social media)				

Knowing the community you are working with (Cultural Competence)	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
How our attitudes affect my work				
Working with the MSM community to improve access and linkage to care				
How aspects of MSM identity affect sexual health				

Challenging Stigma and Discrimination	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Identifying and working with vulnerable groups of Gay and other MSM				
Engaging and Involving service users in your services				
Creating a non-judgemental service for Gay and other MSM				
How social, economic and environmental influences impact on health				
How issues Gay and other MSM face can be linked to their health				
Stigma around: MSM sexual practices				
Stigma around: Sexual Orientation				
Stigma around: Gender Identity				
Stigma around: HIV/STIs/Viral Hepatitis (A, B and C)				
Challenging Discrimination: Sexual Orientation				
Challenging Discrimination: living with HIV				
Challenging Discrimination: HIV Prevention: the choices MSM make				
Challenging Discrimination: Gender and Gender Identity				
Challenging Discrimination: Provision of Prevention and Treatment tools				

Working in Partnerships	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Building partnerships with and between Community and Statutory Health Services				
Building partnerships with and between MSM/LGBTQI+ organisations				

Skills building	Very Confident	Confident	Some Confidence	Not Confident
I am confident I have a good knowledge and understanding of:	**4**	**3**	**2**	**1**
Building my ability to communicate effectively with people				
Building my skills to engage effectively with people				
Using Social Media (Facebook/Twitter/YouTube/Hornet etc) to engage with Gay and other MSM				
Building and providing training for other specialist services (e.g. Prisons)				

Thank you for completing the post-course evaluation.

3.3 Needs assessment

Introduction:

We are asking you to fill out this Needs Assessment to understand more about your practice, what you do, and how and where you do it. We are asking you to think honestly about the knowledge, skills and comfort levels you have around a range of subjects. This is to enable us to target the training appropriately to your needs.

To be very clear, your answers will only be used to help identify the possible training modules to be used to help increase your confidence, knowledge, skills and competencies across this range of issues. For this purpose, you are strongly advised to answer the questions as honestly as possible.

The assessment asks you to consider your confidence level around three things in relation to the subjects;

- your knowledge levels (how much you feel you know about the issue)
- your skill levels (how much experience and skills you have built around an issue), and
- comfort levels (how comfortable you personally feel dealing with the issue)

from a range of Very Confident (4) to Not Confident (1) for each of them.

These three areas have been chosen for assessment because the training modules have been written to affect them. To give some examples to help clarify;

- people may have knowledge of something and few skills in that subject, or
- may have skills with an issue and are uncomfortable dealing with it.

There is also another column Not Involved with this (0) to tick if you are not involved in the work being asked about.

The final section asks you to consider a range of statements and how much you agree or disagree with them.

The assessment will take around 10–15 mins to complete so please make sure that you have enough time to finish the form before starting it.

Thank you for your co-operation. It will help us design training that fits your needs.

Prevention		Very Confident	Confident	Some Confidence	Not Confident	Not involved with this
	Item	**4**	**3**	**2**	**1**	**0**
Prevention and transmission of HIV	Knowledge of					
	Skills in					
	Comfort with					
Symptoms and treatments of HIV	Knowledge of					
	Skills in					
	Comfort with					
Prevention and transmission of STIs	Knowledge of					
	Skills in					
	Comfort with					
Symptoms and treatments for STIs	Knowledge of					
	Skills in					
	Comfort with					
Prevention and transmission of Viral Hepatitis	Knowledge of					
	Skills in					
	Comfort with					

Symptoms and treatments for Viral Hepatitis	Knowledge of					
	Skills in					
	Comfort with					
The epidemiology of HIV (across Europe and in your local region)	Knowledge of					
	Skills in					
	Comfort with					
The epidemiology of STIs (across Europe and in your local region)	Knowledge of					
	Skills in					
	Comfort with					
The epidemiology of Viral Hepatitis (across Europe and in your local region)	Knowledge of					
	Skills in					
	Comfort with					
HIV 90-90-90 The Continuum of Care	Knowledge of					
	Skills in					
	Comfort with					
Using Motivational Interviewing techniques in my work	Knowledge of					
	Skills in					
	Comfort with					
Understanding and use of Treatment as Prevention (U = U)	Knowledge of					
	Skills in					
	Comfort with					
Understanding and use of post-exposure prophylaxis (PEP)	Knowledge of					
	Skills in					
	Comfort with					

Understanding and use of pre-exposure prophylaxis (PrEP)	Knowledge of					
	Skills in					
	Comfort with					
Understanding and use of self-testing kits	Knowledge of					
	Skills in					
	Comfort with					
Understanding and use of self-sampling kits	Knowledge of					
	Skills in					
	Comfort with					
Current safer sex practices for Gay and other MSM	Knowledge of					
	Skills in					
	Comfort with					
The use of recreational drugs during sexual encounters (ChemSex)	Knowledge of					
	Skills in					
	Comfort with					
Health Promotion Models used in work for Gay and other MSM	Knowledge of					
	Skills in					
	Comfort with					
The use of Face-to-Face (F2F) and group information and advice	Knowledge of					
	Skills in					
	Comfort with					
The use of Face-to-Face (F2F) and group-based work	Knowledge of					
	Skills in					
	Comfort with					

Provision of screening, testing and counselling services		Very Confident	Confident	Some Confidence	Not Confident	Not involved with this
	Item	**4**	**3**	**2**	**1**	**0**
The screening and/or testing for HIV	Knowledge of					
	Skills in					
	Comfort with					
The screening and/or testing for Viral Hepatitis (A, B and/or C)	Knowledge of					
	Skills in					
	Comfort with					
The screening and/or testing for other STIs (gonorrhoea, syphilis etc.)	Knowledge of					
	Skills in					
	Comfort with					
Pre and/or post-test counselling at these services	Knowledge of					
	Skills in					
	Comfort with					

Delivery points for prevention and screening and testing activities...		Very Confident	Confident	Some Confidence	Not Confident	Not involved with this
	Item	**4**	**3**	**2**	**1**	**0**
Working in a gay/gay-friendly entertainment venue (café, bar, club, sauna etc.)	Knowledge of					
	Skills in					
	Comfort with					
Working in a Community setting (drop in, community centre, social club, Pride events)	Knowledge of					
	Skills in					
	Comfort with					
Working at an outdoor setting (bus/van, cruising ground, streets/public space etc.)	Knowledge of					
	Skills in					
	Comfort with					
Working at a State/public sector setting (education, prison, state social services etc.)	Knowledge of					
	Skills in					
	Comfort with					
Working at a private setting (private home/dwelling, hotel, care home etc.)	Knowledge of					
	Skills in					
	Comfort with					
Working Online or via mail (website/online chat, mobile phone apps, social media)	Knowledge of					
	Skills in					
	Comfort with					

Challenging Stigma and Discrimination		Very Confident	Confident	Some Confidence	Not Confident	Not involved with this
	Item	**4**	**3**	**2**	**1**	**0**
Identifying and working with vulnerable groups of Gay and other MSM	Knowledge of					
	Skills in					
	Comfort with					
Engaging and Involving service users in your services	Knowledge of					
	Skills in					
	Comfort with					
Creating a non-judgemental service for Gay and other MSM	Knowledge of					
	Skills in					
	Comfort with					
Understanding social, economic and environmental influences on health	Knowledge of					
	Skills in					
	Comfort with					
Understanding how issues Gay and other MSM face can be linked to their health	Knowledge of					
	Skills in					
	Comfort with					
Understanding Stigma: MSM sexual practices	Knowledge of					
	Skills in					
	Comfort with					

Understanding Stigma: Sexual Orientation	Knowledge of					
	Skills in					
	Comfort with					
Understanding Stigma: Gender Identity	Knowledge of					
	Skills in					
	Comfort with					
Understanding Stigma: HIV/STIs/Viral Hepatitis (A, B and C)	Knowledge of					
	Skills in					
	Comfort with					
Challenging Discrimination: Sexual Orientation	Knowledge of					
	Skills in					
	Comfort with					
Challenging Discrimination: Living with HIV	Knowledge of					
	Skills in					
	Comfort with					
Challenging Discrimination: HIV Prevention – the choices MSM make	Knowledge of					
	Skills in					
	Comfort with					
Challenging Discrimination: Gender and Gender Identity	Knowledge of					
	Skills in					
	Comfort with					
Challenging Discrimination: Provision of Prevention and Treatment tools	Knowledge of					
	Skills in					
	Comfort with					

Working in Partnerships		Very Confident	Confident	Some Confidence	Not Confident	Not involved with this
	Item	**4**	**3**	**2**	**1**	**0**
Building partnerships with and between Community and Statutory Health Services	Knowledge of					
	Skills in					
	Comfort with					
Building partnerships with and between MSM/LGBTQI+ organisations	Knowledge of					
	Skills in					
	Comfort with					

Skills Building		Very Confident	Confident	Some Confidence	Not Confident	Not involved with this
	Item	**4**	**3**	**2**	**1**	**0**
Building my ability to communicate effectively with people	Knowledge of					
	Skills in					
	Comfort with					
Building my skills to engage effectively with people	Knowledge of					
	Skills in					
	Comfort with					
Using social media (Facebook/Twitter/YouTube/Hornet etc) to engage with Gay and other MSM	Knowledge of					
	Skills in					
	Comfort with					
Building and providing training for other specialist services (e.g. prisons)	Knowledge of					
	Skills in					
	Comfort with					

Now we would like you to indicate how you feel about a number of statements. Again, please be as honest as you can with your answers.

	Very Confident	Confident	Some Confidence	Not Confident	Disagree Strongly
	4	**3**	**2**	**1**	**0**
It is easy for me to speak with MSM about HIV/AIDS.					
I feel ashamed if a MSM talks to me about his sexual practices and his last sexual encounter.					
I don't like that gay men are so often effeminate.					
If a guy tells me he doesn't use condoms, I tell him how important it is to use them and that he should work on this.					
Sometimes I think that gay men who sleep with lots of partners deserve the STIs they get.					
I think that MSM who aren't open about their sexuality are living a lie.					
The biggest problem for gay men is the amount of sex they have.					
I believe that condoms are better than PrEP at protecting people against HIV.					
I'm concerned that new initiatives like PrEP will stop men using condoms and let them behave how they want with no consequences.					
I don't need to know about MSM and their lives to be able to work with them effectively.					
My family know that my work involves HIV and AIDS.					
I am able to build trusting relationships with a wide variety of MSM.					
I worry that too much emphasis is put on homophobia and stigma instead of HIV.					
I feel comfortable using words like 'fuck', 'wank' and 'fisting' when discussing someone's sex life with them.					

	Very Confident	Confident	Some Confidence	Not Confident	Disagree Strongly
	4	**3**	**2**	**1**	**0**
I don't believe that homophobia has impacted upon me and my ability to work with MSM.					
As our service deals with everyone, I don't see why we have to make a special effort to attract MSM.					
I wouldn't feel comfortable talking about PrEP when the guy can use condoms easily enough.					
I am able to have a fulfilling and happy life, including sex life, outside of my work.					
MSM with female partners should stop lying to everyone and admit they are gay.					
I don't like talking with MSM about sexual practices I find distasteful.					
I'm able to relax and enjoy conversations with MSM about their lives.					
I'm able to engage and assist a wide range of MSM with a number of issues they identify.					
I feel comfortable talking with MSM about their sex lives.					
I feel comfortable with seeing/meeting ex partners/sexual partners when I'm out working.					
I'm able to engage with men who are ashamed of being MSM.					
I often feel ashamed of being LGBTQI+ myself.					

Finally – one last question... 'The three things I hope this training covers are…'

1.
2.
3.

Resilience

Resilience is defined as positive adaptation to the experience of stigma and discrimination.

- Men who have sex with men experience high rates of psychosocial health problems such as depression, substance use, and victimisation that may be in part the result of adverse life experiences related to cultural marginalisation and homophobia.
- MSM show great resilience to both the effects of adversity and of syndemics. Using these natural strengths and resiliencies may enhance HIV prevention.
- MSM are involved in: challenging social and societal norms & stigmatising and discriminatory behaviour; activism around issues such as HIV/AIDS, civil rights and equal marriage; care of others they personally know as well as care of community and Community Involvement.

Knowing the Community – Cultural Competency

Deutsche Aidshilfe

Terrence Higgins Trust

How to improve access, services and retention in care

Cultural competence has four main components: Awareness, Attitude, Knowledge and Skills.

Awareness:

It is important to examine our own values and beliefs in order to recognise any deep seated prejudices and stereotypes that can create barriers for our learning, personal development and work we are involved in. Many of us have blind spots when it comes to our beliefs and values; diversity training/education can be useful for uncovering them.

Attitude:

Values and beliefs impact effectiveness across cultural issues because they show the extent to which we are open to differing views and opinions. The stronger we feel our beliefs and values, the more likely we will react emotionally when they collide with cultural differences.

Knowledge:

The more knowledge we have about people from different cultures and backgrounds, the more likely we are able to avoid making mistakes. Knowing how culture impacts problem solving, managing people, asking for help etc. can help us remain aware when we are in cross cultural interactions.

Skills:

One can have the 'right' attitude, considerable self awareness and a lot of knowledge about cultural differences, yet still lack the ability to effectively manage differences. If we have not learnt skills or have had little opportunity to practice, our knowledge and awareness are insufficient to avoid and manage cross cultural land mines.

Working across MSM Communities or populations

Cultural competence has four main components: Awareness, Attitude, Knowledge and Skills.

Awareness:

It is important to examine our own values and beliefs in order to recognise any deep seated prejudices and stereotypes that can create barriers for our learning, personal development and work we are involved in. Many of us have blind spots when it comes to our beliefs and values; diversity training/education can be useful for uncovering them.

Attitude:

Values and beliefs impact effectiveness across cultural issues because they show the extent to which we are open to differing views and opinions. The stronger we feel our beliefs and values, the more likely we will react emotionally when they collide with cultural differences.

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One can have the 'right' attitude, considerable self awareness and a lot of knowledge about cultural differences, yet still lack the ability to effectively manage differences. If we have not learnt skills or have had little opportunity to practice, our knowledge and awareness are insufficient to avoid and manage cross cultural land mines.

Vulnerable MSM Groups

An ASTOR is a simple and useful project building tool that helps identify some of the key elements you need for an intervention. It breaks down as:

AIM: What are you trying to do?

SETTING: Where are you doing what you are trying to do?

TARGET: Who is the intervention for?

OBJECTIVES: What are the steps needed to reach the AIM?

RESOURCES: What do you need to make the intervention happen?
For example: money, staff time, office space, any other resources?

Challenging Stigma and Discrimination

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Non Judgemental Services

Defining Stigma

UNAIDS defines stigma and discrimination as:

"…a 'process of devaluation' of people living with or associated with HIV and AIDS…Discrimination follows stigma and is the unfair or unjust treatment of an individual based on…perceived HIV status."

Challenging Stigma and Discrimination

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Non Judgemental Services

Reducing stigma in health facilities

- Increase awareness of what stigma is and the benefits of reducing it
- Fears and misconceptions around HIV transmission must be addressed
- Understand and confront the association of HIV and AIDS with assumed 'immoral' or 'improper' behaviours
- Develop and routinely monitor clear guidance or specific policies to challenge discriminatory behaviour

Non Judgemental Services

Cultural competence' has four main components: Awareness, Attitude, Knowledge and Skills.

Awareness:

It is important to examine our own values and beliefs in order to recognise any deep seated prejudices and stereotypes that can create barriers for our learning, personal development and work we are involved in. Many of us have blind spots when it comes to our beliefs and values; diversity training/education can be useful for uncovering them.

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Engaging and Involving Users of Service

The Five Steps of 'Patient' or 'Service User' Engagement

- Inform Me: Attracting new 'service users' with (online) information services
- Engage Me: Attracting those 'users' to engage with you
- Empower me : Retaining those 'users' and partnering with them
- Partner With Me: Creating interactions and collaborations between you
- Support my (e)communication: The 'user' defines their own (e)community

Challenging Stigma and Discrimination

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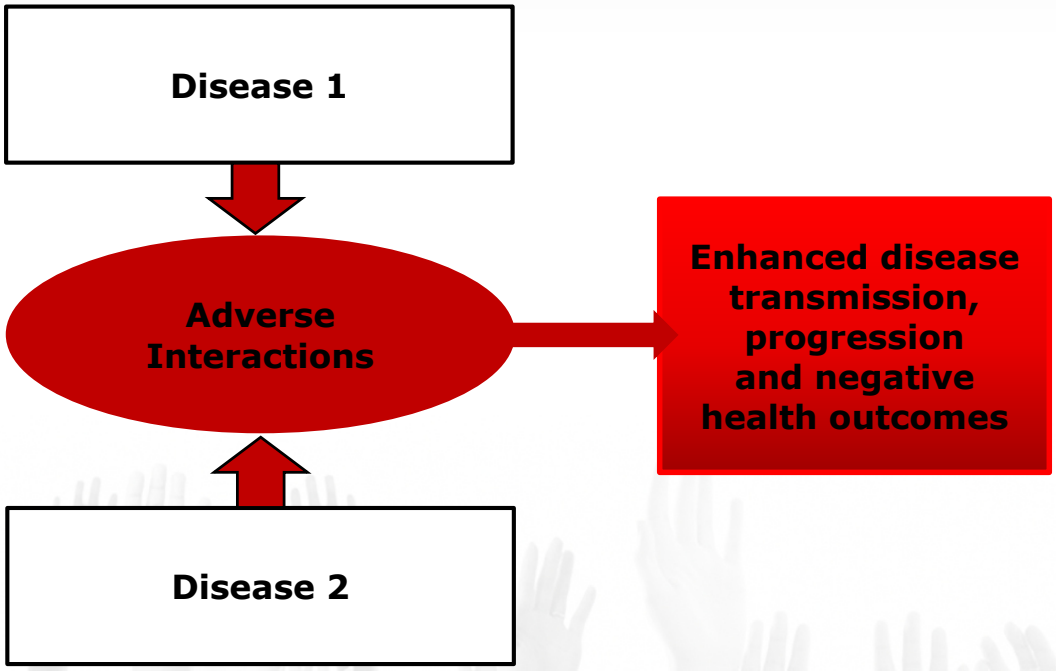
Understanding Syndemic Production Models

A syndemic is the presence of two or more disease states or issues that negatively interact with each other, affecting the course of each issue or disease, enhancing vulnerability to the disease, and which are worsened by any inequalities faced.

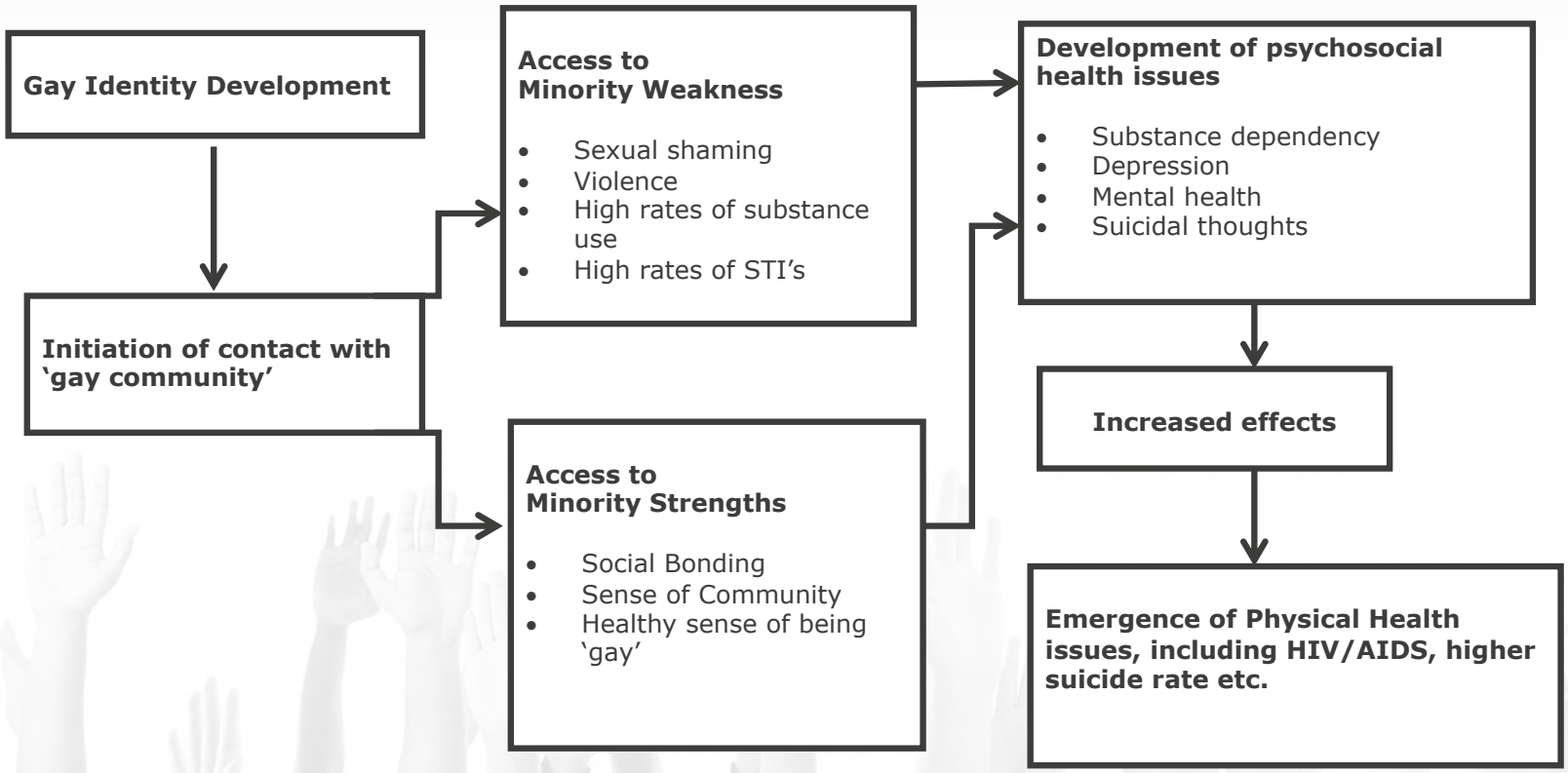
Identified in the 1990s, the notion of a syndemic was used to describe the interactions among **S**ubstance **A**buse, **V**iolence and **A**IDS (SAVA) that had become a full blown crisis in Hartford, USA.

In the years since SAVA was identified, there have been other syndemics described that include HIV/AIDS and sexual health as components.

Understanding Syndemic Production Models



Understanding Syndemic Production Models



Recognising Complex Health Systems

Definition of Whole Systems Approaches

Whole systems approaches involve identifying the various components of a system and assessing the nature of the links and relationships between each of them.

Challenging Stigma and Discrimination

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Recognising Complex Health Systems

Silo Thinking

Diseases and health conditions are usually studied in separate silos.

This means they are thought about singularly and in a linear way rather than acknowledging possible overlaps that could affect change.

Health is not a stand-alone phenomenon with clear boundaries, it has individual, social, economic and environmental factors that influence it.

Recognising Complex Health Systems

Disease Silos

Diseases and health conditions have multiple causes, including social, economic and environmental. They are interrelated with what you may be genetically predisposed to as well as the ability to look after your health, and both evolve over time.

Health systems defy simple representation. A holistic framework is needed to capture multiple diseases and health conditions and the way they interact into a unified approach. It is important not to concentrate on only one 'silo' i.e. behaviours.

Recognising Complex Health Systems

EMIS 2010: Components of a 'Best Sex Life' (for MSM)

- Relationship Formation
- Emotional/Sexual connection with sexual partner
- Volume and Variety (of sexual contact)
- Sexual Action / Behaviour (specific sexual acts)
- Free from physical harm
- Idealised physical attributes (of partner/s)
- Overcoming psychological and social barriers (To be confident and/or assertive; To enjoy sex without stress)
- Settings or physical spaces
- Don't know…

Recognising Complex Health Systems

EMIS 2010

"The content of these answers may also reflect a widespread desire among single MSM for a steady partner, and the social and community needs that fuel this desire."

"Emotionally meaningful relationships are the most commonly valued feature. Therefore, programmes concerned with increasing the quality of MSM's sex lives should focus on emotional & interpersonal aspects and capacities alongside the more commonly addressed topics of safety and technique."

EMIS shows a country level average of 47% of MSM being unhappy with their sex lives.

The benefits:

- Reducing sexual unhappiness is itself a worthwhile goal.
- HIV prevention is strengthened if not in direct competition with what MSM seek from their sex life.
- A 'good' sex life is positively associated with effective treatment of HIV

Statutory and Community Heath Partnerships

Elements of Effective Partnerships

- *Leadership and vision* – the management and development of a shared, realistic vision for the partnership's work through the creation of common goals.
- *Organisation and involvement* – the participation of all key local players and, particularly the involvement of communities as equal partners.
- *Strategy development and co-ordination* – the development of a clear, community focussed strategy covering the full range of issues supported by relevant policies, plans, objectives, targets, delivery mechanisms and processes. Development of local priorities for action will rely on the assessment of local needs, sharing of data, and a continuing dialogue between partners.

Statutory and Community Heath Partnerships

Elements of Effective Partnerships

- *Learning and development* – effective partnerships will not only invest in shared objectives and joint outcomes, but will also add value through secondments. Willingness to listen and learn from each other builds trust.

- *Resources* – the contribution and shared utilisation of information, financial, human and technical resources.

- *Evaluation and review* – assessing the quality of the partnership process and measuring progress towards meeting objectives.

Partnerships with LGBT/MSM Organisations

Elements of Effective Partnerships

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Partnerships with LGBT/MSM Organisations

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- *Evaluation and review* – assessing the quality of the partnership process and measuring progress towards meeting objectives.

Motivational Interviewing

Is a guided and client based communication strategy

Helps clients explore and resolve feelings in order to amend or change problem behaviours

Offers specific, re-enforcing steps to help the client

Prevention

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Motivational Interviewing

Motivational Interviewing Tools - OARS

OPEN (rather than closed) questions

- "How do you feel about that?" (open) versus "Did that make you angry?" (closed)

AFFIRMATIONS (for positive re-enforcement)

- "Congratulations on taking you medications regularly, that can be difficult for many people."

REFLECTIONS (repeat, rephrase, paraphrase)

- "Are you are saying you find it difficult to ask your partners to use condoms?"

SUMMARY (2 or 3 key points raised by the person)

- "So the main things you want to do today are see your test results and find out about the support group?"

Motivational Interviewing

Motivational Interviewing Tools – LURE

LISTEN to the person

- MI involves as much listening as informing, and you can only understand someone's motivation by listening.

UNDERSTAND their motivations

- Their reasons for change, rather than yours, are more likely to help behaviour change.

RESIST the urge to 'correct' the person you are talking with.

- It's their conversation, not yours.

EMPOWER the person you are talking with

- Health outcomes are better when someone takes an interest in and plays an active role in their own care.

New Technologies

Treatment as Prevention (TasP) or U=U Undetectable = Untransmittable

- When people with HIV are on effective treatment and have an undetectable viral load, they cannot pass HIV onto someone else during sex. We do not have enough data yet to be sure that this is also the case for injecting drug users who may share equipment/needles.
- HIV treatment stops the virus from reproducing and reduces the amount of HIV in the blood. The amount of HIV is measured by a blood test called a viral load test.
- When someone has an undetectable viral load this means that there is hardly any HIV in their bodily fluids.
- When there is hardly any HIV in semen HIV cannot be passed on during sex – even if condoms aren't used.
- Not everyone taking treatment has an undetectable viral load, particularly if they have started treatment within the last six months or if they often take their treatment late or miss doses.

New Technologies

PrEP - or pre-exposure prophylaxis

- PrEP is a pill taken to protect the person from HIV. It is extremely effective when taken properly. PrEP only protects you against HIV.
- One of the main drugs approved for use as PrEP is the branded drug Truvada. PrEP is also available in generic, sometimes unbranded form which contain the same ingredients as Truvada and work in the same way, both contain 2 active drugs: Tenofovir & Emtricitabine
- On Demand dosing (or Event Based Dosing) and 4 pills per week are methods suitable only for anal sex.
- Daily PrEP and Holiday PrEP are the only methods of taking PrEP that are suitable for both anal and vaginal or frontal sex and is the recommended method for both trans people or people with chronic Hepatitis B.

New Technologies

PEP

- A month long course of HIV treatment taken within 72 hours maximum of supposed infection risk.
- Recommended that PEP be started as soon as possible after supposed exposure to risk, ideally within 24 hours.
- Mainly used for occupational needle stick injuries, and when a condom breaks or is not used with a sexual partner of unknown or different HIV status.

New Technologies

Self Testing & Self Sampling

- HIV self-sampling: a kit that allows a user to take a blood spot or saliva sample, post it to a testing lab and receive the results by phone, text or email.
- HIV self-testing: a kit to obtain a blood or saliva sample, test this sample themselves using the test and then gain the result.
- Many countries have approved the use of self sampling and self testing kits.
- Self Testing or Self Sampling kits for certain STI's are also available in some countries.

The 7 A's of Accessibility

1. Awareness: of the 'product', and any associated issues; and of the agencies and services involved in the provision of both information about the product and the product itself.
2. Accessibility: to the 'product'; and also to the associated agencies, services and advocates involved.
3. Affordability: of the product; both to the supplier and to the user; and of any associated services.
4. Appropriateness: of a product in the situation for the client, based on discussion with clients on whether their needs would be or are being met.
5. Adequacy: are the clients needs being met?
6. Acceptability: is the product acceptable to the client based on their physical, emotional, psychological and cultural needs?
7. Availability: is the product available to the supplier/client? Are there financial or legal barriers?

Frontline Interventions

1to1 or Group – Information and/or Advice

To give information or advice to a person or a group of people on a range of social or personal issues.

Online Outreach: To perform this task in an online forum via a website or online app.

They are usually a one off intervention.

Prevention

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Frontline Interventions

Motivational Interviewing (MI)

- Motivational Interviewing is a brief treatment model designed to help clients low in motivation to change and realise the need for change with self identified risk behaviours.

- 1to1 Therapeutic work (Counselling)

Assisting and guiding clients/people, especially by a trained person on a professional basis, to resolve personal, social or psychological issues, problems or difficulties. Usually a multiple session intervention, although single sessions of counselling usually given alongside HIV testing.

- Group Therapeutic work (Groupwork)

Groupwork describes a variety of interventions, delivered to a collection of people with a common interest and can have a number of functions including the imparting of information, building of skills, social capacity and knowledge and the resolution of psychosocial conflicts.

Frontline Interventions

Community Testing: HIV & STI's

- Usually carried out within 'Checkpoints' or other community settings (CBVCT), MSM can be checked for both HIV and a range of STI's using rapid and lab sample tests (blood, saliva and urine)

- Community Testing can be seen to have an advantage over clinical based testing because of it's link to the community it serves. Issues of identification, homophobia and being 'outed' are lessened within community contexts.

- Information and a toolkit around checkpoints has been developed by Euro HIV EDAT https://eurohivedat.eu/ or www.msm-checkpoints.eu

- Information and tools to challenge barriers to testing and linkage to care have been developed by OptTest www.opttest.eu

STI's – symptoms and treatments

STI Treatment Options – a simple approach

Parasitical

- Parasitic skin infections can be relieved and treated with creams and lotions which can be purchased over the counter at the chemist. For parasitic gut infections, a doctor can prescribe specific antibiotic medications that can help.

Fungal

- Fungal infections can be relieved and treated with creams and lotions which can be purchased over the counter.

STIs that present symptoms within three days are normally bacterial infections. Viral infections have longer incubation periods. Sometimes they only manifest when the immune system is impaired or run down.

STI's – symptoms and treatments

There are 4 groups of infections which can be transmitted sexually:

Bacterial, Viral, Parasitic & Fungal.

Viruses are capsules of genetic material (DNA or RNA) surrounded by a protective coat of protein. They can't multiply on their own, so they have to invade a 'host' cell and take over its machinery in order to be able to make more virus particles. The cells of the mucous membranes, such as those in your arse, throat and urethra (piss tube) are particularly open to attacks because they are not covered by protective skin.

Bacteria are organisms made up of just one cell. They are capable of multiplying by themselves, as they have the ability to divide. Bacteria exist everywhere, inside and outside of our bodies. Most bacteria are completely harmless, some of them are useful and some cause diseases. Some bacteria cause disease because they end up in the wrong part of the body or because they are evolved to invade us.

Parasites are minute creatures that live on or inside another creature (the host) and takes its nourishment from the host. A parasite cannot live independently though they can survive for a while without the host.

Fungus/Fungi are plant-like organisms that lack chlorophyll. Since fungi do not have chlorophyll, they must absorb food from other organisms. Fungi like warm, dark and damp places to live.

STI's – symptoms and treatments

Bacteria	Virus	Parasitic	Fungal
Gonorrhoea NSU Chlamydia Syphilis Gut Infections	Hep A Hep B Hep C Herpes Warts HIV	Crabs Scabies	Thrush

STI's – symptoms and treatments

STI Treatment Options – a simple approach

Bacterial

- Bacterial infections can be quickly treated with antibiotics.

Viral

- Generally, there are no treatments for viruses; they generally have to run their own course. However, there are treatments to keep the virus suppressed. There are vaccines for Hepatitis A and B, individually or together. However there is currently no vaccine for Hepatitis C although drug treatment is available and known as direct acting antivirals (DAAs).
- There is no vaccine for HIV yet there are treatments that can suppress the virus.

STI's – symptoms and treatments

STI Treatment Options – a simple approach

Parasitical

- Parasitic skin infections can be relieved and treated with creams and lotions which can be purchased over the counter at the chemist. For parasitic gut infections, a doctor can prescribe specific antibiotic medications that can help.

Fungal

- Fungal infections can be relieved and treated with creams and lotions which can be purchased over the counter.

STIs that present symptoms within three days are normally bacterial infections. Viral infections have longer incubation periods. Sometimes they only manifest when the immune system is impaired or run down.

ChemSex: Main drugs used: GHB/GBL

- Also known as G or Gina
- Depressant drugs or 'downers'
- Have a sedative and euphoric effect similar to being drunk
- Overdoses can be common as its hard to know what is a 'safe dose'
- Is used as 'knock out drops' in peoples drinks at bars and parties

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

ChemSex: Main drugs used: Methamphetamine

- Also known as Crystal Meth, T or Tina
- Super strength stimulant drug
- Releases 'stress' hormone Norpinephrine and 'feel good' hormones Dopamine and Serotonin into the blood stream.
- Increases body temperature, heart beat and blood pressure so increases risk of heart attack, stroke or comas.

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

ChemSex: Main drugs used: Mephedrone

- Also known as Meow Meow
- Stimulant drug similar to amphetamines
- Induces euphoria, alertness, confidence, feelings of empathy to people around you as well as making you feel horny and talkative.
- Powerful comedown, with tiredness, depression and no ability to concentrate for a few days after taking it. Mixing it with alcohol causes problems.

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

ChemSex: Main drugs used: Ketamine

- Also known as K or Special K
- An anaesthetic drug, also known as a horse tranquiliser.
- Users feel 'high', numb, have 'out of body' experiences (known as k-holes)
- K-Holes can lead to swallowing and breathing difficulties and sexual and physical assaults can happen while under the affects of K.

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

ChemSex: How the drugs are used: Injection

- Also known as 'Slamming'
- Carries risk of HIV and Hep C transmission if needles, spoons, filters or water are shared
- Use own syringe and utensils – a new syringe for every shot.

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

ChemSex: How the drugs are used: Snorting

- Cocaine, Crystal Meth, Mephedrone, Speed and Heroin are all snorted
- Carries risk of HIV and Hep C transmission if tubes shared
- Use own tube – never use banknotes.

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

ChemSex: How the drugs are used: Smoking

- Cocaine, Crystal Meth and Heroin are all smoked
- Carries risk of Hep C transmission if pipes shared because of high temperatures causing mouth blisters
- Use own pipe – never share with anyone else.

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

ChemSex: How the drugs are used: Swallowing and anal ingestion

- Pill and liquid forms of many drugs are swallowed.
- Anal use (booty bumping) can irritate the anal lining, cause bleeds and increase risk of HIV and Hep C transmission.
- Less control over amounts taken and their effects, but less damage caused to the body i.e. nose, lungs and veins. Measure out amounts taken carefully and remember how much taken to avoid overdosing.

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

EMIS 2017 data on chemsex in Europe

{Data to be included after it's publication}

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

ChemSex: How to help

- Refer to appropriate local services
- Read the E-Learning module to find out more about the drugs used and their safer use
- David Stuarts ChemSex Care Plan – www.davidstuart.org/care-plan
- David Stuarts ChemSex First Aid – www.davidstuart.org/chemsex-first-aid
- 56 Dean Street ChemSex pages – www.dean.st/chemsex-support
- THT fridaymonday – www.fridaymonday.org.uk

Prevention

Deutsche Aidshilfe

Terrence Higgins Trust

3.5 Draft exercise 'HIV 90-90-90' – what are the targets

Note: This module was developed as part of the training programme. It was decided not to include it in the final training material. The treatment cascade 90-90-90 remains relevant for policy and the planning of health interventions, but it is of less practical use for Community Health Workers. Therefore, the module has not been finalised. However, it can be adapted, updated, and used as needed.

E-Learning: Prevention

HIV 90-90-90: What are the targets?

THE TREATMENT TARGET

- 90% diagnosed
- 90% on treatment
- 90% virally suppressed (= 73% of all PLHIV will have a durable viral suppression)

Diagnosis is dependant on testing technologies, now improving with rapid tests, and self-sampling and self-testing kits.

Treatment is dependent on economics and access to treatments – costs of effective first-line treatments; use of effective generics; and ability to access treatment regimes.

Viral suppression is dependent on: effective treatment; treatment adherence and support for it; and access to viral load testing.

When this three-part target is achieved, at least 73% of all people living with HIV worldwide will be virally suppressed – a two- to three-fold increase over current rough estimates of viral suppression. Modelling suggests that achieving these targets by 2020 will enable the world to end the AIDS epidemic by 2030, which in turn will generate profound health and economic benefits.

HIV treatment is a critical tool towards ending the AIDS epidemic, but it is not the only one.

While taking action to maximize the prevention effects of HIV treatment, urgent efforts are similarly needed to scale-up other core prevention strategies, including elimination of mother-to-child transmission, condom programming, pre-exposure antiretroviral prophylaxis, voluntary medical male circumcision in priority countries, harm reduction services for people who inject drugs, and focused prevention programming for other key populations. To put in place a comprehensive response to end the epidemic, concerted efforts will be needed to eliminate stigma, discrimination and social exclusion.

HIV treatment prevents HIV-related illness

In 2013, in recommending an increase in the CD4 count threshold for initiation of HIV treatment from 350 to 500 cells/mm3, WHO cited growing evidence of the clinical benefits of earlier treatment initiation. Since the launch of the guidelines, additional analysis of the HPTN 052 results found that study participants randomised to the early treatment arm (CD4 count 250-500) had higher median CD4 counts during two years of follow-up, were 27% less likely to experience a primary clinical event, 36% less likely to experience an AIDS-defining clinical event and 51% less likely to be diagnosed with tuberculosis.

HIV treatment averts AIDS-related deaths

Whereas someone who acquired HIV in the pre-treatment era could expect to live only 12.5 years, a young person in an industrialized country who becomes infected today can expect to live a near normal lifespan (or an additional five decades) with the use of lifelong, uninterrupted HIV treatment. A rapidly expanding body of evidence indicates that comparable results are achievable in resource-limited settings.

HIV treatment prevents new HIV infections

Among prevention interventions evaluated to date in randomised, controlled trials, HIV treatment has demonstrated by far the most substantial effect on HIV incidence.

Interim findings from the PARTNER study indicate that among 767 serodiscordant couples, no case of HIV transmission occurred when the person living with HIV had suppressed virus – after an estimated 40 000 instances of sexual intercourse. As a prevention tool, HIV treatment should be seen as a critical component of a combination of evidence based approaches (known as 'combination prevention').

HIV treatment saves money

Early initiation of treatment enhances both health and economic gains. According to another modelling exercise, investments in HIV treatment scale-up generate returns more than two-fold greater when averted medical costs, averted orphan care and labour productivity gains are taken into account. Nor will it be necessary to wait decades to see the economic benefits of early investments in rapid treatment scale-up. In some countries, savings from investments in HIV treatment scale-up would be immediately felt. Actual costs savings would emerge somewhat later in countries with high HIV prevalence.

Region or sub-region	Status	2020 target	2018 result	Global Target met?
European and Central Asian Region	Diagnosed (n=40)	90%	80%	Not met
	On ART (n=41)	90%	64%	Not met
	Virally suppressed (n=35)	90%	86%	Within 10 of target
	Viral suppression of all PLHIV (n=34)	73%	43%	Not met
West sub-region	Diagnosed (n=19)	90%	87%	Within 10 of target
	On ART (n=19)	90%	91%	Met or exceeded
	Virally suppressed (n=16)	90%	93%	Met or exceeded
	Viral suppression of all PLHIV (n=16)	73%	74%	Met or exceeded
Centre sub-region	Diagnosed (n=10)	90%	83%	Within 10 of target
	On ART (n=10)	90%	73%	Not met
	Virally suppressed (n=8)	90%	75%	Not met
	Viral suppression of all PLHIV (n=8)	73%	46%	Not met
East sub-region	Diagnosed (n=11)	90%	76%	Not met
	On ART (n=12)	90%	46%	Not met
	Virally suppressed (n=11)	90%	78%	Not met
	Viral suppression of all PLHIV (n=10)	73%	26%	Not met

West, 24 countries:

Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Liechtenstein, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, the United Kingdom.

Centre, 16 countries:

Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Hungary, Kosovo, the former Yugoslav Republic of Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, Turkey.

East, 15 countries:

Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

Link to 2018 ECDC Continuum of HIV care Special Report, including European Figures:

https://ecdc.europa.eu/sites/portal/files/documents/HIV-continuum-of-care-monitoring-dublin-declaration-progress-report-2018.pdf

Health Promotion Model: Nutbeams Model

Information sourced from Understanding Public Health: Health Promotion Theory

Ed: Davies, M & McDowell, W. Open University Press.

If you are interested in Health Promotion models and how they can work there is a larger table in the Annex that helps to understand how all of the models are used and the development of the interventions from those models fits together into the larger developmental and implementation programme/s that a health promotion service may be providing.

It can seem quite complex, and is only of real use when programme planning and understanding how a range of models and interventions can push different 'buttons' for the target audiences, as not everyone will respond to the same model in the same way. It's called Nutbeams 'Planning model for Health Promotion' and more information about it can be found online. The text following the illustration of the model helps understand the basics of how it fits together. Looking through the top headings of the model to help explain how the framework fits together you can see that:

A planning model for Health Promotion (Planning and Implementing Prevention Programmes) source: Nutbeam (2001)

Problem Definition	Solution Generation	Capacity Building		Health Promotion Actions		Health Promotion Outcomes	Intermediate Health Outcomes	Health and Social Outcomes
Epidemiological & demographic information	Theory and Interventions Models	Mobilising Resources (people, money, materials)	Development and pre-testing methods and materials	**Education** Examples include: patient education, school education, broadcast media and print media, communication.	Monitoring and recording of programme implementation and quality control.	Health Literacy Measures include: Health related knowledge, attitudes, motivation, behavioural intentions, personal skills, self efficacy.	Healthy Lifestyles Measures include: Tobacco use, food choices, physical activity, alcohol and illicit drug use.	Social Outcomes Measures include: Quality of life, functional independence, equity.
Behavioural & social research on the determinants of health	Evidence from past programmes	Building Capacity (training and Infrastructure development)		Social Mobilisation Examples include: community development, group facilitation, targeted mass communication		Social Action & Influence Measures include: Community participation, community empowerment, social norms, public opinion	Social action & influence Measures include: Provision of preventative services, access to and appropriateness of health services.	Health Outcomes Measures include: Reduced morbidity, disability, avoidable mortality.
Community needs and perceived priorities	Experiences from practitioners	Raising Public and Political Awareness		Advocacy Examples include: lobbying, political organisation and activism, overcoming bureaucratic inertia.		Health Public Policy and Organisational Practice Measures include: Policy statements, legislation, regulation, resource allocation, organisational practices.	Healthy Environments Measures include: Safe physical environment, supportive economic and social conditions, restricted access to tobacco & alcohol.	

Problem definition

"Identification of the parameters of the health problem to be addressed may involve drawing on a wide range of epidemiological and demographic information, as well as information from the behavioural and social sciences and knowledge of community needs and priorities. Here, different theories can help you identify what should be the focus for an intervention. Specifically, theory can inform your choice for the focus for the intervention. This might be individual characteristics, beliefs and values that are associated with different health behaviours and that may be amenable to change. Alternatively, the focus might be organizational characteristics that may need to be changed."

Solution generation

"The second step involves the analysis of potential solutions, leading to the development of a programme plan which specifies the objectives and strategies to be employed, as well as the sequence of activity. Theory is at its most useful here in providing guidance on how and when change might be achieved in the target population, organization or policy. It may also generate ideas which might not otherwise have occurred to you.

Different theories can help you understand the methods you could use as the focus of your interventions; specifically by improving understanding of the processes by which changes occur in the target variables (i.e. people, organizations and policies), and by clarifying the means of achieving change in these target variables. For example, theory may help explain the influence of different external environments and their impact on individual behaviour. These insights will help in the design of a programme, for example by indicating how changes to the environment can have an impact on health behaviour.

Thus, those theories that explain and predict individual and group health behaviour and organizational practice, as well as those that identify methods for changing these determinants of health behaviour and organizational practice, are worthy of close consideration in this phase of planning. Some theories also inform decisions on the timing and sequencing of your interventions in order to achieve maximum effects."

Capacity building

"Once a programme plan has been developed, the first phase in implementation is usually directed towards generating public and political interest in the programme, mobilizing resources for programme implementation, and building capacity in organizations through which the programme may operate (e.g. schools, worksites, local government). Models theories which indicate how to influence organizational policy and procedures are particularly useful here, as too is theory which guides the development of media activities."

Health promotion actions

"The implementation of a programme may involve multiple strategies, such as education and advocacy. Here, the key elements of theory can provide a benchmark against which actual selection of methods and sequencing of an intervention can be considered in relation to the theoretically ideal implementation of programmes. In this way, the use of theory helps you to understand success or failure in different programmes, particularly by highlighting the possible impact of differences between what was planned and what actually happened in the implementation of the programme. It can also assist in identifying the key elements of a programme that can form the basis for disseminating successful programmes."

Outcomes

"Health promotion interventions can be expected to have an impact initially on processes or activities such as participation and organizational practices. Theory can provide guidance on the appropriate measures that can be used to assess such activities. For example, where theory suggests that the target of interventions is to achieve change in knowledge or changes in social norms measurement of these changes becomes the first point of evaluation. Such impact measures are often referred to as health promotion outcomes (note, not outcomes in the sense of improvements in health – see below).

Intermediate outcome assessment is the next level of evaluation. Theory can also be used to predict the intermediate health outcomes that are sought from an intervention. Usually these are modifications of people's behaviour or changes in social, economic and environmental conditions that determine health or influence behaviour. Theories can predict that health promotion outcomes will lead to such intermediate health outcomes.

Health and social outcomes refer to the final outcomes of an intervention in terms of changes in physical or mental health status, in quality of life, or in improved equity in health within populations. Definition of final outcomes will be based on theoretically predicted relationships between changes in intermediate health outcomes and final health outcomes."

4. Glossary and List of Abbreviations

AAE: AIDS ACTION EUROPE is a regional network of a diverse group of more than 420 NGOs, national networks and community-based groups, most of which are AIDS service organisations, in 47 countries spanning the WHO European Region (www.aidsactioneurope.org).

AIDS: Without effective treatment, HIV damages the body's own defences, which are also called the immune system. Without treatment, the body can no longer fight invading pathogens such as bacteria, fungi or viruses. In the worst case, certain life-threatening illnesses occur, for example severe pneumonia. Then one speaks of AIDS. AIDS stands for Acquired Immune Deficiency Syndrome. HIV drugs suppress the virus in the body and thus prevent the outbreak of AIDS. People with HIV who are on effective treatment can live well and as long as people without HIV.

ART: Anti Retroviral Treatment is the combination of various medications for the treatment of an HIV infection.

ASTOR: An ASTOR is a simple and useful project-building tool that helps identify some of the key elements you need for an intervention. It breaks down as Aim, Setting, Target, Objectives, Resources.

CBVCT: Community-based voluntary counselling and testing. Services that offer voluntary, free and anonymous HBV, HCV, STI and/or HIV testing outside formal health facilities designed to target specific communities like Gay and other MSM. The CBVCT services for MSM are also often called Checkpoints.

CDC (Centers for Disease Control and Prevention): The National Health Protection Agency of the United States of America.

CD4 (Cluster of differentiation 4): A glycoprotein found on the surface of immune cells such as T-helper cells and others. They are white blood cells and important for the immune system. They are often called T-helper cells or CD4 cells. When they become depleted, for example in a non-treated HIV infection, the body is left vulnerable against a wide range of infections that normally would be fought.

ChemSex: Sex, mainly between Gay and other MSM, under the influence of drugs that enhance the sexual experience. The main ChemSex substances are GHB, Crystal Meth (Methamphetamine), Ketamine and Mephedrone.

CHAFEA: Consumers, Health, Agriculture and Food Executive Agency.

CHW: The term Community Health Worker (CHW) is common in America or Africa and new to the European context in the work with Gay and other MSM. Based on the results of the ECHOES survey among European CHWs, the definition of CHW in this context actually is: 'Community Health Workers (CHWs) are people who provide sexual health and other health-related support (whether being paid or unpaid) to gay, bisexual and other MSM. A CHW may deliver health promotion and/or public health activities outside of formal health settings. They may be members of, or connected to, the communities they serve (peers).' (ECHOES survey report).

COBATEST: The COBATEST Network links organisations across Europe who offer community-based voluntary counselling and STI/HIV testing (CBVCT) services and promotes testing, early diagnosis and linkage to care in at-risk populations (www.cobatest.org).

Community and population: The term 'community' in this context describes a group sharing or having certain attitudes and interests in common. To define a community might help targeting services to the needs of the users. The term is not very specific and has limitations. Therefore, we also use the term 'population' to describe a certain group (e.g. MSM) that can be addressed as group, but where common attitudes or interests may not be described.

Cultural Competence: A defined set of ethics and principles, demonstrated behaviours, attitudes, policies and structures that enables work to happen effectively across cultures.

DAA (Direct Acting Antivirals): A relatively new class of medications that act to target specific steps in the HCV viral life cycle. Hepatitis C can be cured in nearly all cases in a short timeframe of 8–12 weeks with the DAAs available.

DAH: Deutsche Aidshilfe, Berlin, Germany, www.aidshilfe.de

DG Sante: Directorat-General for Health and Food Safety of the European Commission.

EATG: European AIDS Treatment Group.

EC: European Commission.

ECDC (European Centre for Disease Control and Prevention): ECDC is an EU agency aimed at strengthening Europe's defences against infectious diseases.

ECHOES (European Community Health Worker OnlinE Survey): An online survey about knowledge, attitudes, practices, and training needs of CHW who provide counselling, testing, and psychosocial care and support services for MSM in the EU and neighbouring countries (www.esticom.eu).

ECOM: Eurasian Coalition on Male Health.

EL: E-Learning Training Material.

EMCDDA: European Monitoring Centre for Drugs and Drug Addiction.

EMIS (European Men who have Sex with Men Internet survey): The world's biggest internet survey addressing Gay and other MSM. The overall aim of EMIS is to generate data useful for the planning of HIV and STI prevention and care programmes and the monitoring of national progress in this area (www.esticom.eu).

ESTICOM (European Surveys and Training to Support MSM Community Health): A European-wide project consisting of the EMIS and ECHOES surveys and the ESTICOM Training Programme (www.esticom.eu).

EU/EEA: European Union/European Economic Area (EU countries plus Norway, Iceland, Lichtenstein).

Euro HIV EDAT: European project on 'Operational knowledge to improve HIV early diagnosis and treatment among vulnerable groups in Europe' (www.eurohivedat.eu; www.msm-checkpoints.eu).

EuroTEST: European initiative, originally named HIV in Europe, began in 2007 as way to bring attention to the importance of earlier diagnosis and to care for people living with HIV, STIs and TB.

F2F: Face-to-Face training material.

GAT (Grupo de Ativistas em Tratamentos): Portuguese NGO working with different groups most affected by HIV and run the Checkpoint in Lisbon.

Gender: Gender can have different meanings, as a biological term or social determined construct or a combination of both. It describes the range of diverse characteristics between 'masculinity' and 'femininity'. In this context we use it as: the person's gender identity as a social category (e.g. in terms of self-awareness, self-esteem or role behaviour).

GP: General Practitioner.

HEP/Hepatitis/Viral Hepatitis: Hepatitis means liver inflammation. Liver inflammation can have many causes, including viruses and bacteria, as well as alcohol and other drugs. For CHWs working with Gay and other MSM, liver inflammations caused by viruses are the most relevant. There are several types of hepatitis viruses, the main ones are known as HAV, HBV and HCV (Hepatitis A, B, C virus). The consequences of the infections are very different. There is a vaccine against Hepatitis A and B and it is recommended for Gay and other MSM to get vaccinated against both Hepatitis'. There is no vaccination for Hepatitis C but it is curable.

HIV: HIV is an abbreviation and means 'human immunodeficiency virus'. HIV damages the body's own defences, which are also called the immune system. Without treatment, the body can no longer fight invading pathogens such as bacteria, fungi or viruses. In the worst case, certain life-threatening illnesses occur, for example severe pneumonia. This is AIDS which stands for Acquired Immune Deficiency Syndrome. HIV drugs suppress the virus in the body and thus prevent the outbreak of AIDS. People with HIV who are on effective treatment can live well and as long as people without HIV.

Homo-Transphobia: Range of negative attitudes and feelings towards homosexuality or people who are identified or perceived as being lesbian, gay, bisexual, transgender, queer or intersexual (LGBTQI+). It often builds on contempt, prejudice, aversion, hatred or antipathy and is often based on irrational fear and/or cultural norms.

HTS: HIV Testing Services.

IDU: Injecting Drug Use.

Incidence: Indicates the frequency of a new infection or illness in a particular group or area, over a defined period of time. Example: in 2017 around 2.700 people were newly infected with HIV in Germany.

INTEGRATE: Joint Action on Integrating Prevention, Testing and Linkage to Care Strategies Across HIV, Viral Hepatitis, TB and STIs in Europe (www.integrateja.eu).

Kahoot!: A game-based learning platform. You can design your own learning game or trivia quiz and use it as an amusing and interactive tool to introduce a topic. Participants can answer your questions on their own mobile devices. More on www.kahoot.com.

LGBTQI+*: Lesbian, Gay, Bisexual, Transgender (*= and everything in between), Queer, Intersexual + all other minority sexual and gender identities is one of many possible and different variations to address these communities. The main aim is to help ensure that services and organisations are inclusive and respectful to all different forms of gender identity.

LURE: Motivational Interviewing techniques working with four steps: Listen, Understand, Resist, Empower.

MI: Motivational Interviewing.

Mins.: Minutes.

MSM (Men who have Sex with Men): The training package uses a mix of 'MSM' (or men who have sex with men) or 'Gay and other MSM' to describe the people CHWs are generally working with. The issue is that MSM is not usually a term understood or used by the target audience (the MSM themselves) and many of the issues faced are faced by all men who are sexually attracted to and engaged with other men, however they may describe themselves. The issue is the stigma and discrimination that is experienced, not what the target audience of our work is identified as.

N/A: Not Available.

NPT: National Pilot Training.

OARS: Motivational Interviewing techniques working with: Open questions, Affirmations, Reflections and Summary.

NAM aidsmap: Internet information platform (www.aidsmap.com).

NGO: Non-Governmental Organisation.

NSU: Non-specific urethritis, non-gonococcal urethritis.

OptTEST: EU-project on 'Optimising Testing and Linkage to Care for HIV Across Europe' (www.opttest.eu).

Outreach: Type of health service that mobilises health workers to provide services to a population away from location where providers usually work, e.g. in a club, sauna, bar, but also online outreach on internet platforms.

Patient/User/Client: The persons CHWs are working with (Gay and other MSM) will be generally referred to as 'service users' or just 'users' in the document as generally CHWs do not see the men they work with as 'patients' or 'clients'. Facilitators have the option of asking the group of participants they are working with how they refer to the men they work with and use their definition if they feel comfortable with that.

PEP (Post-exposure prophylaxis): Use of antiretroviral therapy following exposure to HIV infection to try to prevent establishment of infection.

PLHIV: People living with HIV and AIDS

PPT: PowerPoint.

PrEP (Pre-exposure prophylaxis): In this prevention method, HIV-negative people take HIV medication either daily or before and after sexual intercourse to protect themselves from HIV infection. PrEP protects as well as condoms and TasP (protection from effective HIV treatment) when used properly.

Prevalence: Number of patients or frequency of a feature (e.g. a disease or new infection); often given as prevalence rate = number of infected or ill persons in relation to the number of persons examined. Example: in Western Europe less than 1% of the general population is infected by HIV.

QA: Quality Assurance, also Quality Action (www.qualityaction.eu).

Resilience: An individual's ability to adapt in the face of adverse conditions, like stigma, discrimination or a crisis.

RKI: Robert Koch Institut, Berlin, Germany.

SDG: Sustainable Development Goals.

Self-sampling: User collects a blood or saliva sample. These can often be ordered (regularly) by post. The user sends the tests to a laboratory and gets feedback on the results mainly by internet or phone.

Self-testing: User collects blood or saliva sample, then uses rapid diagnostic kit to process sample, obtain results and interpret them by themselves according to instructions provided with testing kit.

STI (Sexually Transmitted Infections): Most people will have to deal with sexually transmitted infections sooner or later. For example, chlamydia, herpes, fungal diseases and genital warts are widespread. But, especially for MSM, gonorrhoea and syphilis are also common. Most STIs can be cured easily. It is important to test regularly if sexually active, as STIs can also be asymptomatic.

Stigma/Discrimination: Social stigma is the disapproval of, or discrimination against, a person based on perceivable social characteristics that serve to distinguish them from other members of a group/society. Discrimination is normally realised by consideration/treatment of or making a distinction towards a person based on the group, class, or category to which the person is perceived to belong. Social stigmas are commonly related to culture, gender, race, intelligence and health.

Syndemics/SPM (Syndemic Production Model): A syndemic is the presence of two or more disease states or issues that negatively interact with each other, affecting the course of each issue or disease, enhancing vulnerability to the disease, and which are worsened by any inequalities faced.

TasP: Treatment as Prevention (see also U=U).

THT: Terrence Higgins Trust, London, England, (www.tht.org.uk).

ToT: Training of Trainers workshop.

UNAIDS: The Joint United Nations Programme on HIV/AIDS.

U=U: Undetectable = Untransmittable means that people on effective HIV treatment can't pass HIV to someone else sexually.

Whole Systems Approach: Whole systems approaches involve identifying the various components of a system and assessing the nature of the links and relationships between each of them.

WP: Work Package.

5 C's: Five core principles for all HIV testing services according to WHO guidelines: Consent, Confidentiality, Counselling, Correct results and Connection (linkage to care).

7 A's of Accessibility: Seven basic principles to secure low-threshold accessibility to services: Awareness, Accessibility, Affordability, Appropriateness, Adequacy, Acceptability, Availability.

90-90-90: Also called the 'treatment cascade', 90-90-90 is a goal expressed by UNAIDS in 2014 with the aim of ending the AIDS crisis worldwide. The goal is that by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, 90% of all people receiving antiretroviral therapy will have viral suppression. Actually UNAIDS increased the goals to 95-95-95 by 2030. HIV organisations and organisations often complement the goals to 0-90-90-90, as without reducing HIV stigma to zero, the 90-90-90 targets will not be met. In many countries these targets are amended with regional extras, like a fourth 90 goal etc.

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