Curtin University

Making your Materials Work:

A Quick Guide to Developing Culturally Appropriate and Effective HIV Resource Content

COLLABORATION FOR EVIDENCE, RESEARCH AND IMPACT IN PUBLIC HEALTH

SIREN
WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network

CoPAHM
Community of Practice for Action on HIV & Mobility

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Curtin would like to pay respect to the Aboriginal and Torres Strait Islander members of our community by acknowledging the traditional owners of the land on which the Perth campus is located, the Whadjuk people of the Nyungar Nation.

Contents

Abbreviations

AFAO	*Australian Federation of AIDS Organisations*
AIDS	*Acquired Immunodeficiency Syndrome*
BBV	*Blood-borne virus*
CaLD	*Culturally and linguistically diverse*
CERIPH	*Collaboration for Evidence, Research and Impact in Public Health*
CoPAHM	*Community of Practice for Action on HIV and Mobility*
HIV	*Human Immunodeficiency Virus*
IEC	*Information, education and communication*
NAPWHA	*National Association of People with HIV Australia*
PEP	*Post-Exposure Prophylaxis*
PrEP	*Pre-Exposure Prophylaxis*
SiREN	*Western Australia Sexual Health and Blood-borne Virus Applied Research and Evaluation Network*
STI	*Sexually transmitted infection*

About This Guide

Making your Materials Work: A Quick Guide to Developing Culturally Appropriate and Effective HIV Resource Content (the Guide) is for those working with migrants and people from culturally and linguistically diverse (CaLD) backgrounds in Australia to prevent and manage human immunodeficiency virus (HIV).

People from migrant and CaLD backgrounds

Terminology regarding ethnicity, culture, religion, language and other factors relating to migration is diverse. This Guide uses the terms 'migrant' and 'culturally and linguistically diverse', commonly used by the Australian government and non-government sector. CaLD is a term used to describe people of a non-Anglo-Celtic origin, while migrant refers to an individual born overseas, regardless of their visa status. Together the terms are used to reflect people from diverse backgrounds. It is important to note that people from CaLD or migrant backgrounds may not use these terms to describe themselves. The Federation of Ethnic Communities' Councils of Australia (FECCA) uses the term 'cultural, ethnic and linguistic diversity' to capture consideration of race/ethnicity (FECCA, 2020). There is currently no singular term that captures communities' diverse experiences and backgrounds.

The Guide contains information, practical tools and quick links to assist practitioners in planning, implementing and evaluating culturally and literacy-appropriate HIV information, education and communication (IEC) resources. Information was compiled through a literature review and the results of a health literacy INDEX evaluation of available HIV resources in Australia (Gray et al., 2021).

The Guide was developed in response to a priority action found in the *HIV and Mobility in Australia: Road Map for Action* and the Community of Practice for Action on HIV and Mobility (CoPAHM) Priority Actions to increase health literacy and awareness of available HIV prevention strategies (CoPAHM, 2018). This recommendation is consistent with national and jurisdictional strategies for HIV.

CoPAHM and the Priority Actions

Established in 2015, CoPAHM aims to keep HIV and mobility issues on the national agenda, ensuring migrant and mobile populations are included in the ongoing HIV prevention, treatment and support dialogue. Working with members, CoPAHM released a document outlining six priority actions to address gaps in Australia's current response to HIV and mobility:

- **Local solutions**: Plan and implement jurisdiction-specific responses to HIV in migrant and mobile populations.
- **Health literacy**: Increase health literacy and knowledge of available prevention strategies.
- **Test**: Understand and reduce barriers to HIV testing and make new testing technologies widely available.
- **Treatment and prevention medication**: Advocate for the inception of a policy mechanism to provide access to HIV treatment and PrEP (Pre-Exposure Prophylaxis) for temporary visa holders who are ineligible for Medicare.
- **Inform**: Harmonise surveillance data reporting for migrant and mobile populations, including sexual behaviour, testing rates, notifications, treatment initiation and PrEP.
- **Evaluate**: Develop core indicators to assess the effectiveness of HIV programs for mobile and migrant populations.

For more information about CoPAHM and the Priority Actions, visit: https://www.odysseyresearch.org/priority-actions

Setting The Scene

Internationally, Australia's response to HIV is acknowledged as a global success, with the number of new HIV transmissions continuing to decline. However, not all communities have shared in this success, For example, in 2019, 47 per cent of all HIV diagnoses were in people born outside Australia (The Kirby Institute, 2022). Such figures suggest that suggesting that HIV prevention strategies, including resources, are not meeting the needs or demands of some groups.

Population mobility is a driver of the HIV epidemic in Australia (Deane et al., 2010). Migrants may experience various conditions before, during or after migration, which may influence physical health. These include the acquisition of sexually transmitted infections (STIs) and blood-borne viruses (BBVs) (Abubakar et al., 2018). In addition, health-seeking practices, experiences of stigma, cultural and gender differences and norms, control over decision-making, navigating the health system, and English language ability may exacerbate risks for STI and BBV transmission (Crawford et al., 2016; Guy et al., 2007; Rade et al., 2018; Rademakers et al., 2005). Risk may also be influenced by levels of control over travel, traumatic experiences, transnational health practices, levels of social support and migration and health policies (Wickramage et al., 2018).

Research suggests that migrants and people from CaLD backgrounds experience knowledge gaps regarding the prevention, transmission, testing and treatment of HIV (Gray et al., 2018). *The Migrant Blood-Borne Virus and Sexual Health Survey* identified incomplete knowledge of prevention, testing and treatment concerning STIs and BBVs more broadly (Vujcich et al., 2021). Knowledge gaps were influenced by experiences in the country of origin, low visibility of HIV in Australia, perceptions of 'safety' in Australia and perceived low levels of individual risk (Gray et al., 2019). Western Australian (WA) research supports these findings, highlighting the need for targeted health education resources that extend beyond language translation. Resources need to reflect culture, sexuality, resettlement process, understanding of preventative health and gender norms in sexual health help-seeking (Rade et al., 2018). Other WA research suggests that people from CaLD backgrounds believe that health education resources generally target Caucasian Australians, and they are poorly reflected in resource imagery (Agu et al., 2016).

In brief—HIV and Mobility in Australia: Road Map for Action

The *HIV and Mobility in Australia: Road Map for Action report* highlighted a demand for strategies that specifically address the needs of people from CaLD backgrounds who are from high HIV prevalence countries, as well as people and their partners who travel to high HIV prevalence countries (Crawford et al., 2014). Suggested actions included the development of health promotion interventions for migrants and people from CaLD backgrounds that focus on educating and supporting individuals and communities through better awareness of transmission risks, safer sex practices, reducing HIV-related stigma, accessing healthcare services and earlier testing (Crawford et al., 2016).

The Road Map suggested 10 principles to guide the HIV response in migrant and mobile populations (Crawford et al., 2014). For example, one principle is committing more resources to improve migrant health. A priority for action addresses the reality that important HIV-related messages about PEP (Post-Exposure Prophylaxis) and PrEP are not well utilised or understood by migrant and mobile populations (CoPAHM, 2018). Targeted health literacy is required to improve message comprehension.
Access the Road Map here: https://siren.org.au/hiv-mobility/

Want to know more?

Barriers to accessing HIV and sexual health care for people from a CaLD background: https://www.afao.org.au/wp-content/uploads/2022/06/afao-cald-barriers-discussion-paper.pdf

MiBSS publications. https://www.mibss.org/publications

Getting Started With Information, Education And Communication Resources

Despite significant advances in behavioural and biomedical HIV prevention, key populations are still left behind in Australia (Australian Federation of AIDS Organisations, 2022). Achieving an end to HIV transmission requires appropriate responses for migrants and people from CaLD backgrounds.

Working in public health often requires practitioners to develop resources to increase awareness, knowledge and behavioural intention within particular groups (World Health Organization [WHO], 2014). Examples of different types of resources include:

- pamphlets
- posters
- flyers
- brochures
- emails
- messages for health education sessions
- educational videos
- online factsheets
- newspapers
- podcasts
- radio or TV advertisements.

These initiatives are often called IEC activities. IEC campaigns are a commonly used, cost-effective behavioural intervention strategy (Drysdale, 2004) and are still a crucial tool in HIV prevention—when done right! For example, findings from previous research indicate the usefulness of IEC messages and materials in reducing stigma and discriminatory attitudes towards people living with HIV (Mahapatra, 2014).

While resources may address knowledge gaps and support testing, groups such as the National Association of People with HIV Australia (NAPWHA) have raised concerns that such materials do not reach or resonate with particular groups, including people from CaLD backgrounds (Woods, 2019).

Research also suggests that:

- HIV information resources in Australia are often insufficiently comprehensive or inadequately designed for target groups (Gray et al., 2021).
- Few resources are effectively tailored to address cultural and literacy needs (Bandyopadhyay et al., 2022).
- Few resources are sufficiently tested, appropriately targeted, theory-based or evaluated (Gray et al., 2021).
- IEC materials may be too lengthy, repetitive, generic, outdated or, in some cases, inaccurate (Woods, 2019).
- Translation of English-language health resources is often the first and only step (Michael et al., 2013).
- Translation alone fails to account for contextual factors and the nuance needed to make such resources appropriate (Andrulis & Brach, 2007; Michael et al., 2013).

So, effectively designed health education resources are essential, but there are barriers to their design and use. The effectiveness of an IEC resource will depend on several factors that can enhance or reduce impact.

Considerations include:

- relevance
- appeal
- uniformity
- simplicity of content and language
- accuracy
- length of material
- cultural appropriateness
- availability
- modes of dissemination.

Resources need to:

- be easily understood
- encourage improved health outcomes
- provide the correct information in an appropriate format
- build health literacy.

The WHO (2014) suggests that IEC activities should:

- have a clear **objective**
- target a specific **audience**
- address a **specific problem** rather than deal with several problems at once
- set a **timeframe** for the results to occur
- clearly define the '**problem'** the IEC activity aims to address.

Want to know more?

Integrating culturally, ethnically and linguistically diverse communities in rapid responses to public health crises: https://migrationcouncil.org.au/wp-content/uploads/2022/02/Communication-Guide-CALD-communities-in-public-health-crises.pdf

Health Literacy

‘Health literacy is about people’s ability to obtain, understand, communicate about, and act upon information in health-related settings and situations’ (Centers for Medicare & Medicaid Services, 2012).

Health literacy is a social determinant of health, critical to enabling individuals to take control of their health (Kickbusch et al., 2013). Improving health literacy can increase access to health services and the adoption of preventative behaviours (e.g., increased condom use) (Berkman et al., 2011). This reduces health disparities and associated individual and societal costs (Hill & Sofra, 2018). Providing health information is one strategy to increase health literacy (Fernandez-Gutierrez et al., 2018).

We can conceptualise health literacy into three common categories: functional, interactive and critical health literacy (Nutbeam, 2000). Functional health literacy refers to an individual’s literacy, knowledge and skills. Interactive health literacy describes the skills needed to act on information, enabling individuals to interact better with different health information. Finally, critical health literacy is the stage where an individual can critically analyse health information, supporting greater control over health decisions.

It is important to note that health information resources are likely only to improve individual functional health literacy (Nutbeam, 2000)

Migrants and people from CaLD backgrounds in Australia may have insufficient health literacy skills (Australian Bureau of Statistics, 2006, 2019), associated with lower participation in public health activities, including a willingness to participate in STI and BBV testing. Sharing important health information through effectively developed resources may address lower levels of health literacy. A critical recommendation to improve health literacy ensures that resource developers write comprehensible materials that are understandable by most of the public (Hill & Sofra, 2018). In Australia, this level of comprehension is equivalent to a Grade Eight reading level.

Assessing the health literacy of HIV resources in Australia

Improving information resources is a critical component of building comprehensive health literacy. Different levels of health literacy are associated with HIV knowledge and behaviour, including willingness to test for HIV. Gray and colleagues (2021) assessed the health literacy demands of Australia’s HIV prevention resources available online using the Health Literacy INDEX (the INDEX). Most resources scored below 50 per cent on the index. Resources required a reading level above Grade Eight, and few resources considered audience appropriateness. The review found missed opportunities to encourage HIV prevention or testing. For example, some resources used incorrect language to refer to people living with HIV, and transmission and prevention messages were often inconsistent. The authors suggest that consistent guidelines to develop HIV prevention resources are warranted to improve health literacy, accessibility and appropriateness of resources and ensure consistent messages and framing of HIV risk. INDEX indicators may guide material development and selection in practice (Kaphingst et al., 2012).

The National Association of People with HIV Australia (NAPWHA) developed the *HIV Health Literacy Framework: Literature Review*. The review was completed partly responding to concerns that campaigns may have struggled to resonate with diverse communities (Woods, 2019). In the context of HIV transmission, low health literacy can result in difficulty avoiding HIV infection, inadequate knowledge of HIV and treatments and not continuing with precautionary treatments. The availability of non-print materials or materials that use simple language with more graphics might help raise HIV awareness for communities with low literacy levels.

Want to know more?

HIV Health Literacy Framework: Literature Review: https://napwha.org.au/wp-content/uploads/2019/07/NAPWHA-HIVHealthLiteracyFramework-LiteratureReview_v2.pdf

The solid facts: Health literacy: https://apps.who.int/iris/bitstream/handle/10665/128703/e96854.pdf

What is health literacy?: https://www.ceh.org.au/resource-hub/what-is-health-literacy/

Get To Know Your Audience

Getting to know your audience is essential. When developing resources for migrants and people from CaLD backgrounds, consider common health beliefs, attitudes or practices and tailor your resource accordingly. You may also draw upon certain words or phrases that are well-known in the community to help make your message clear.

The WHO (2014) suggests that effective IEC resources will demonstrate a thorough understanding of people's behaviour and factors that may support or prevent them from following desired practices. You might also consider the educational formats your community is familiar with—for example, using narratives or stories to share information. Additionally, you could consider using a mixture of resources with consistent messaging to increase your resource's reach.

There are some key questions that you can ask to help you refine your resources so that they are specific and relevant to those who will use them. Consider the following behaviour change communication advice (Portsmouth, 2022):

- Who is your audience? What do you want them to do? Why? Do they agree?
- What does your audience know & feel about the health issue? The behaviour?
- What social, environmental and cultural factors need to be considered?
- How can you find audience members to communicate with you and contribute to developing, using and evaluating your materials?
- What are your audience preferred communication channels?
- What does your audience think the materials should look like/say/show?

A resource is likely to be more effective when it:

- has been designed with community input
- identifies the community (e.g., gender, age and culture)
- considers the community's health literacy requirements
- uses appropriate language and images
- reflects cultural values, concepts and understandings
- considers social determinants of health
- is part of a comprehensive health promotion program.

Applying and intercultural lens

When you are working with different communities, it is important to be aware of intercultural communication. When people communicate, they bring with them their own experiences and cultural health understandings.

Intercultural communication is the 'interactions that occur between people whose cultures are so different that the communication between them is altered ... communicating with people whose beliefs, values & attitudes are culturally different ... which can lead to misunderstandings' (Verderber et al., 2010, pp. 151–152).

Want to know more?

Community of Practice for Action on HIV and Mobility: https://www.odysseyresearch.org/copahm

Intercultural Communication: https://www.idrinstitute.org/resources/intercultural-communication/

Australian Multicultural Health Collaborative: https://fecca.org.au/collaborative/

Determining The Resource Purpose

Every health education resource needs a clear purpose. Practitioners typically expect resources to address risk and behavioural factors associated with HIV prevention. Designing and developing culturally appropriate IEC materials to meet the needs of specific groups is also essential to changing community attitudes. The more specific we can be about the nature of HIV, the beneficiaries of intervention and the needs of beneficiaries concerning HIV, the more likely we will develop effective information resources.

Ensure that your program aligns with jurisdictional or national HIV strategies. For example, the Eighth National HIV Strategy 2018–2022 (the Strategy) (Department of Health, 2018) guides the development of HIV prevention, testing and treatment programs.

Two priority areas for action in the Strategy are:

- education and prevention
- addressing stigma and creating an enabling environment.

These priorities highlight key information that should be included in HIV IEC resources. The Strategy suggests the need for messages that counteract stigma and inform means of prevention (e.g., PrEP, condoms and sterile injecting equipment). HIV-specific information materials should also emphasise the availability of testing, treatment and support and how to access them. Similarly, it is also crucial to provide information on how to support individuals who need testing, treatment and support. When determining the purpose of your resource, you should consider the needs and context of your community. For example, suppose your resource aims to encourage a community to test for HIV. In that case, you may need to consider their testing experiences in their country of origin and how that may be different to Australia. You will also need to consider the implications of testing positive for HIV on visas, access to treatment, support and care, and experience of stigma and discrimination.

Support for program planning

Want further information about planning your health program? SiREN offers a range of toolkits that can assist you!

To discover more, visit: https://siren.org.au/program-planning/

Want to know more?

Developing a health communication campaign: https://siren.org.au/resources/tools/developing-a-health-communication-campaign/

Toolkit for the use of social media in the WA sexual health and blood-borne viruses sector: https://siren.org.au/wp-content/uploads/2021/02/SHBBV-Social-Media-Toolkit-FINAL.pdf

Eighth National HIV Strategy: https://www.health.gov.au/sites/default/files/documents/2022/06/eighth-national-hiv-strategy-2018-2022.pdf

Taking A Comprehensive Approach

In some cases, IEC activities may be one activity within a comprehensive strategy, while in many other instances, their use may be isolated (WHO, 2014). While resources aim to affect individual behavioural change, they are only one part of prevention strategies. Resources will be more effective when supported by comprehensive intervention. Implementing a combination of strategies is instrumental to the effectiveness of health promotion practice. For example, your intervention might combine strategies aimed at the individual (i.e., preventative health checks and advice), group (i.e., peer-based education) and/or population (i.e., changes to health services) level.

When designing your intervention, start with your community needs. You may like to use a tool such as PABCAR (a public health decision-making tool) or the PRECEDE-PROCEED model (a comprehensive structure for assessing health needs for designing, implementing and evaluating programs to meet those needs) to help you understand the issue, the causes of the issue and how it might be amenable to change. For example, encouraging HIV testing in your community may be inappropriate if there is a lack of culturally appropriate services for them to access. Comprehensive health promotion programs will consider all segments of the population and plan programs accordingly to maximise everyone's health. Effective health promotion requires a comprehensive strategy that includes a behavioural change approach and a strong policy framework that creates a supportive environment. Additionally, an effective strategy will empower people to gain more control over decisions that affect their health and wellbeing.

Further information on program planning tools

SiREN has developed a toolkit for designing sexual health programs. In it, you can find further details about the PABCAR and PRECEDE-PROCEED models and how to apply them to sexual health program planning.

For details, visit: https://siren.org.au/wp-content/uploads/2022/01/HS-SIREN-Toolkit.pdf

To access templates of the models, visit: https://siren.org.au/program-planning-tools-and-templates/

Want to know more?

Health Promotion Emblem: https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference/emblem

Health Promotion: https://www.vichealth.vic.gov.au/about/health-promotion

Meaningful Community Involvement

Meaningful community engagement is vital to evidence-informed design and evaluation of effective health education resources (Woods, 2019). Meaningful involvement ensures that resources are necessary, consider community needs, values and attitudes, and are designed and disseminated appropriately.

Insights into working with people from CaLD backgrounds from the perspective of stakeholders

The following is a summary of reflections from key stakeholders on working with CaLD communities, compiled by AFAO (2022):

- building partnerships and trust with communities
- adopting a strengths-based approach by supporting communities
- supporting diversity, representation and input from people from a CaLD background
- adaptable, flexible and sustainable programs and services
- providing health information in plain English and community languages.

Read more here: https://www.afao.org.au/wp-content/uploads/2022/06/6.-Insights-into-working-with-CALD-communities.pdf

Meaningful participation also requires understanding HOW and WHEN to involve people with lived experience in developing resources. When involving people in designing resources, you may like to think about levels of participation and what is feasible for your organisation. More involvement will likely develop a more effective result, but this is not always possible or appropriate. Levels of participation may be conceptualised across a continuum incorporating the following domains:

- Inform: Provision of information (i.e., an educational workshop).
- Consult: Obtaining community feedback (i.e., focus groups).
- Involve: Consultation that achieves complete understanding (i.e., a co-design workshop).
- Collaborate: Partnering with the community to plan, implement and evaluate (i.e., a project steering group).
- Empower: Decision-making is in the hands of the community (i.e., the community determines the need for a resource and what should be in it).

Depending on your resources, timeline and requirements, it may not always be feasible or desirable for your project to work at the highest participation level of the continuum; however, it may be an aspirational goal.

Meaningful involvement of people living with HIV

The idea that lived experience shapes the HIV response was voiced by people living with HIV early in the epidemic. In 1994, the GIPA (Greater Involvement of People Living with HIV) Principle was formalised when countries agreed to '*support a greater involvement of people living with HIV at all…levels…and to…stimulate the creation of supportive political, legal and social environments'*.

The principles have evolved to MIPA—Meaningful Involvement of People Living with HIV. It is a principle that aims to realise the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives.

At its core, it means two important things:

- To recognise the important contribution people living with HIV can make to the response.
- To create space within society for involvement and active participation in all aspects of that response.

Read more about MIPA here: https://vpwas.com/gipa-mipa-and-the-denver-principles/

When involving the community, consider how you can support their participation. Effective involvement may require considering your community representatives' language and cultural needs. You may need to include a variety of strategies for involvement (i.e., focus groups, community workshops, interviews), considering WHO is representing the community. For example, you may like to consider representation in terms of gender, age, sexuality, religion, visa status or literacy level while being mindful of people's different experiences and how these factors may intersect. It is also essential to consider how you can further support and acknowledge community members' time (i.e., an appropriate honorarium). We suggest getting advice or partnering with a CaLD service provider if you are unsure how to work with a community effectively. Consider using partnership tools to understand better your relationships with the community and the levels of trust and power that may influence effective ways of working together.

Want to know more?

Consumer Participation and Culturally and Linguistically Diverse Communities: https://www.ceh.org.au/resource-hub/consumer-participation-and-culturally-and-linguistically-diverse-communities/

Health Consumers' Council: https://www.hconc.org.au/cald-community-workshops-and-events-2/

Partnership Analysis Tool: https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool

Partnership Self-Assessment Tool: https://atrium.lib.uoguelph.ca/xmlui/bitstream/handle/10214/3129/Partnership_Self-Assessment_Tool-Questionnaire_complete.pdf

Using Theory

Understanding the process of behavioural change and the context in which it operates is critical. Behavioural change theories can improve our understanding of such complexities by explaining behaviours and suggesting ways to create or enhance change (Nutbeam et al., 2010). Practitioners can use theories to develop and evaluate health interventions based on understanding the dynamics of health behaviour and external and environmental factors that influence them (Glanz, 1997). However, there are few examples of applying theory to the design of IEC resources in the Australian context.

Using theory can be beneficial to resource design. For example, theories related to identified problems help describe why they exist (i.e., the health belief model). A theory might also help to explain or predict how to change health behaviour once you describe the needs and motivations of your target group (i.e., the transtheoretical model). Some theories guide an intervention's development and help to ensure that you base your program on evidence across the planning, strategy selection and evaluation stages (i.e., PRECEDE-PROCEED). In other words, theory can help us understand the WHO, WHY and HOW of health promotion programs and interventions.

So, theories or their components can be helpful to guide the search for WHY people engage in potentially health-harming activities, do not follow public health advice, or do not undertake healthy-enhancing practices. Theory might also assist you in understanding WHO might be more likely to participate in particular practices or hold particular knowledge or attitudes. They can also help you identify WHAT you need to know before developing an intervention. Theory can help you identify HOW program strategies can be shaped to reach your target groups and can assist you in determining the things that program evaluation should measure.

SiREN Short Courses

SiREN offers a range of free online training modules to build the capacity of the sexual health sector in health promotion planning and evaluation.

Find out more at: https://training.siren.org.au/

Want to know more?

Health Promotion and Disease Prevention Theories and Models: https://www.ruralhealthinfo.org/toolkits/health-promotion/2/theories-and-models

Theory at a Glance: A Guide for Health Promotion Practice: https://cancercontrol.cancer.gov/sites/default/files/2020-06/theory.pdf

Framing Messages

Research suggests that communities need to see themselves represented in responses to STIs and BBVs in a manner that does not further reify differences or inadvertently 'blame' specific groups (Woods, 2019). Information about a health behaviour can emphasise the benefits of acting (i.e., a gain-framed appeal) or the costs of failing to act (i.e., a loss-framed appeal). Because prevention behaviours typically afford people the opportunity to maintain their health and minimise the risk of illness, gain-framed messages are predicted to elicit greater interest in and use of prevention behaviours (Rothman & Salovey, 1997; Wansink & Pope, 2015).

Gain frame
There are many benefits or good things you may experience if you get tested for HIV. If you decide to get tested, you may feel the peace of mind that comes with knowing about your health.
There are many problems or bad things you may not experience if you get tested for HIV. If you decide to get tested, you may feel less anxious because you would not wonder if you are ill.
Loss frame
There are many benefits or good things you may not experience if you do not get tested for HIV. If you decide not to get HIV tested, you will not feel the peace of mind that comes with knowing about your health.
There are many problems or bad things you may experience if you do not get tested for HIV. If you decide not to get HIV tested, you may feel more anxious because you may wonder if you are ill.

(Apanovitch et al., 2003)

HIV is still here.

Be in control.

Know your status.

is a resource that uses gain-framed messages to promote HIV testing developed by the Ethnic Communities Council of Queensland (ECCQ).

Available at: https://eccq.com.au/wp-content/uploads/2021/06/ECCQ.A5.FINAL_.HIV-flyer_06_2021.pdf

Health promotion campaigns are often designed to elicit fear, yet fear is often ineffective in achieving the desired behavioural change. Campaigns that use fear as part of a punishment procedure are unlikely to succeed (Kok et al., 2014; Soames Job, 1988). An example of a theoretical model that uses fear as an approach is the Health Belief Model (Carey & Sarma, 2016), which proposes that if individuals perceive risk or feel threatened by a particular health issue, they will change their behaviour (Laranjo, 2016). In the context of HIV prevention, such an approach may be less likely to achieve the desired outcome (Garcia-Retamero & Cokely, 2011).

Current evidence shows that information about the severity of possible negative consequences from risky behaviour may prompt defensive responses, which can impede behavioural change (Ruiter et al., 2014). Therefore, information about self-efficacy and promoting protective action is more likely to be effective in prevention-based messages (Ruiter et al., 2014). However, it is important to note that the effectiveness of either gain-framed or loss-framed messaging depends on the type of behaviour change intended, the individual's receptiveness to framing and cultural relevance (Wansink & Pope, 2015).

Want to know more?

Framing of health information messages: https://www.latrobe.edu.au/__data/assets/pdf_file/0009/566289/framing-health-info-messages2014.pdf

Readability

Because individuals have different skills in reading, listening, calculating and understanding messages, taking a reader-centred approach is crucial. To ensure the intended population can comprehend the communicated messages, consider their culture, language, circumstances and health issues. However, it may not always be appropriate or feasible to tailor your resource for just one specific group. In this case, plain language is a way of communicating so an audience can easily find and understand information.

Plain language uses simple communication to minimise misinterpretation and improve understanding. It has the added benefit of working for any literacy level regardless of cultural or linguistic background (Brega et al., 2015). Plain language does not use 'dumbed-down' or casual language.

Developing materials using a readability formula reaches readers with basic health literacy rates and is considered the gold standard for its broader audience inclusivity (Centers for Medicare & Medicaid Services, 2012). The Fry formula (or Fry readability graph), SMOG (a simple measure of gobbledygook) and Flesch tests (Flesch-Kincaid and Flesch reading ease) are some of the formulas usually employed in measuring readability. The SMOG is a popular method to use for developing health literacy materials.

When considering the readability of your materials, consider what terms or words may be unfamiliar to your intended audience. This is particularly important when considering health information, which may include uncommon words. The Plain Language Dictionary is one resource that can help you determine unfamiliar words and provides some suggested words to use instead.

SMOG Positive

An example of a material with a Grade Eight or less SMOG reading level is a resource from Family Planning NSW: Your Best Defence: Keeping an Eye on STIs'.

Available at: https://www.fpnsw.org.au/sites/default/files/assets/yourbestdefence.pdf

The table below presents examples of words that may need replacement or explanation in the context of HIV:

Word	*Suggested words*
antibody	*your body's way to fight off infections, infection-fighting cells, cells that fight infection*
antiretroviral	*a drug that fights viruses*
communicable	*can be spread, can be passed to other* *people, can make other people sick*
immune system	*the body's ability to keep from getting a disease,* *protection from disease, ability to fight off an illness*

Want to know more?

Plain language thesaurus: https://www.orau.gov/hsc/HealthCommWorks/MessageMappingGuide/resources/CDC%20Plain%20Language%20Thesaurus%20for%20Health%20Communication.pdf

Simple definitions for keywords about BBV and sexual health: https://www.ceh.org.au/resource-hub/bbv-sti-glossary-simple-definitions-for-keywords-blood-borne-viruses-and-sexual-health/

HIV glossary: https://www.mhahs.org.au/index.php/en/hiv/glossary

SMOG online calculator: https://charactercalculator.com/smog-readability/

Toolkit for making written material clear and effective: https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/

When developing your resources, consider whether it is appropriate to translate your materials. Using translation may depend on your project budget and your community's preferences. One option is to have a bilingual resource with information in English and another language—this lets your readers choose the most appropriate language.

Translating resources is complicated, often requiring rewriting information and can be costly and time intensive. Several resources exist in various languages, so consider whether you need to reproduce content again. You may like to read further about translating—several guides are included in the table below.

A Resource In Different Languages

Did you know that the Multicultural HIV and Hepatitis Service provides information about HIV and Hepatitis in 18 languages?

To find out more, visit: https://www.mhahs.org.au/index.php/en/

Want to know more?

Health translations: https://www.healthtranslations.vic.gov.au/

Translation: An introduction: https://www.ceh.org.au/resource-hub/translation-an-introduction/

CaLD assist: https://www.mhcs.health.nsw.gov.au/about-us/campaigns-and-projects/current-campaigns/cald-assist/cald-assist

Health Literacy INDEX

The INDEX is a tool designed to evaluate the health literacy demands of health information (Kaphingst et al., 2012). The INDEX was developed through a review of literature, expert feedback and validity and reliability testing. The INDEX can be used as a guide to assess your resource.

Accessing the INDEX

You can access the complete INDEX, including further detail on each indicator, here: https://www.tandfonline.com/doi/full/10.1080/10810730.2012.712612

The Health Literacy INDEX presents 10 criteria with 63 indicators to assess health literacy, described below:

Criteria	*Indicator*	*Assessment*
1	*Plain language*	*active voice used* *second person used* *jargon is limited and defined when used* *most sentences have 15 words or less* *reading grade level is Grade Eight or lower (refer to SMOG analysis)* *numbers used in key points* *data can be understood without maths* *data phrasing is easy to understand.*
2	*Clear purpose*	*section topics introduced at the beginning of the material* *section topics are reviewed at the end of the material* *sections have five or fewer key points* *purpose can be identified immediately* *purpose can be identified after use* *apparent purpose and stated purpose match* *visual elements communicate purpose* *attention is drawn to key elements.*
3	*Supporting graphics*	*graphics illustrate content* *graphics demonstrate behaviour or record an event* *data in graphics are related to content* *graphics help readers understand abstract concepts* *most visual displays have explanatory labels* *design of visual displays is simple.*
4	*User involvement*	*use advice column format* *use frequently asked questions format* *use quiz or game format* *use story or narrative format* *use teasers (i.e., introduce the topic in the form of a question or interesting statement)* *ask the audience to do something* *provide a place for audience response.*
5	*Skill-based learning*	*addresses health behaviour explicitly* *provides specific action steps* *illustrates action steps or behaviours with examples.*

Criteria	Indicator	Assessment
6	Audience appropriateness	states the audience explicitly in the title states the audience explicitly in the text uses elements or visual cues related to the audience uses data showing how the audience is affected by the topic uses culturally appropriate language for the target audience mentions values, beliefs and experiences shared by the audience.
7	User Instructions	technical instructions provided technical instructions easy to find technical instructions comprehensive user instructions provided user instructions easy to find user instructions comprehensive.
8	Development details	date for development or most recent review provided date of review or development within the last two years contact information provided.
9	Evaluation methods	formative evaluation conducted process evaluation conducted outcome evaluation conducted formative evaluation collected background data formative evaluation included comparable participants process evaluation monitored frequency of use process evaluation monitored reach process evaluation monitored reactions process evaluation monitored implementation outcome evaluation assessed whether objectives met outcome evaluation used pre and post-test outcome evaluation had a comparison group outcome evaluation used random assignment.
10	Strength of Evidence	material reflects formative evaluation findings implementation reflects process evaluation outcome evaluation found significant effect of material several health information materials to which criterion applied.

Evaluation

Evaluation is crucial to determine program strategies and outcomes and identify opportunities for future improvement. Therefore, IEC materials need regular monitoring and evaluation to incorporate necessary changes evidenced by ongoing research over time. A plan should be made for the different types of evaluation when you are planning your resource development.

Types of evaluation include formative, process and impact evaluation (Centers for Disease Control, 2014). Below is a description of each type of evaluation and the data you could collect according to the INDEX (Kaphingst et al., 2012).

Formative evaluation collects background data on the resource's intended issue. It compares participants to the intended target audience and will inform the development or revision of the resource. Formative evaluation is designed to understand the intended audience better and learn the most appropriate and effective approaches to influence audience awareness, knowledge, attitudes and behaviours. You can conduct formative evaluations on a small-scale during resource development before full implementation. Formative evaluations help to answer questions such as:

- What are the gaps/remaining questions?
- What do the users/readers/viewers prefer?
- What type of process would work well here?
- Who is the intended audience?

Types of formative evaluations include needs assessments, pilot or pre-testing and readability assessments.

Pre-testing resources

- Find different members of the target group to work with you. It is best if they do not know the people who helped develop the draft materials.
- Test the draft with open questions (e.g., What do you think about ...?):
- Understandable? Strengths? Weaknesses?
- Relevant? Confusing? Sensitive? Controversial?
- Attractive? Understandable? Acceptable?
- Persuasive? Connect personally/emotionally?
- Who is it 'speaking' to? Is it 'for them'? Why?
- What does it mean to them? Why?
- What do they think it is asking them to do? Why?
- What do the words/ideas/sounds/images make them think/feel?
- Probe for unintended effects.

Process evaluation monitors the frequency of resource use, whether the resource reached the intended target audience, the users' reactions and whether the resource was implemented the way it was designed. A process evaluation is designed to assess effective resource implementation. You can use a process evaluation to determine what services were delivered, to whom, and with what level of effort/resources. Process evaluations answer questions such as:

- To what extent is the resource meeting its intended objectives?
- What are the barriers to implementation?
- Who is using it?
- How are users exposed?
- How is it used?

Types of process evaluations include feedback cards, meetings with developers and partners to review progress, and monitoring public requests for information.

- **Impact evaluation** measures the extent that the resource achieved its stated objectives and the overall performance of the resource. It measures the effectiveness of an intervention on your target audience. You must identify what change you are hoping to achieve before developing and distributing your resource. Outcome evaluation will help answer questions such as:
- Has the overall program goal been achieved?
- What, if any, factors outside the program have contributed to or hindered the desired change?
- What, if any, unintended change has occurred because of the program?

Types of impact evaluations include qualitative methods such as in-depth interviews, focus groups or observational studies, and quantitative methods such as pre-post or cross-sectional self-administered surveys.

Want to know more?
Evaluation and research: https://siren.org.au/resources/tools/

Resource Checklist

Before you launch your resource, you can work your way through this checklist to evaluate the readiness of the resource for use (Centers for Medicare & Medicaid Services, 2012):

- ☐ ***The content was chosen based on the knowledge of the intended readers.***
  Focus on what matters most to the intended readers. Address their issues and concerns, as well as areas of possible misunderstanding.

- ☐ ***The writing is simple and considers the reading skills of my intended audience (use SMOG).***
  Whatever your audience, as a general goal, write as simply as possible without sacrificing content or distorting the meaning.

- ☐ ***The content focuses on the main messages.***
  Use the title and other upfront text to clarify the material, who it is for and how to use it. Remember that readers skim content and make quick judgments about what is worth reading.

- ☐ ***The content anticipates and answers questions the reader may have.***
  Make it easy for people to follow up on what they have just read by telling them what additional information or assistance is available and where they can get it.

- ☐ ***The text is clear and simple, addresses the reader directly and has a friendly and supportive tone.***
  Too much text can be overwhelming, especially to less-skilled readers. If the material is too long, consider other ways to package it. If you condense it, do not oversimplify, or drop the examples and explanations readers need.

- ☐ ***Devices are used that are helpful to readers, such as bulleted points and step-by-step explanations.***
  To make the material easy to skim and show how it is organised, create a clear hierarchy of prominent headings and subheadings.

- ☐ ***Images help to break up the text and add visual interest.***
  Images have a great impact, so select them carefully and use them to highlight key points. Instead of using images to decorate the pages, choose images that reflect the subject matter of your materials. Try to show only the behaviours you want to encourage. Avoid using images that are too abstract or hard for readers to understand, such as parts of the body shown in isolation, cross-sections, and highly magnified images.

- ☐ ***The choice of images is sensitive to issues of cultural appropriateness.***
  Choose culturally appropriate content for the intended readers, reflecting and responding to differences in their experiences and situations.

- ☐ ***Identifying information has been included regarding the organisation that produced the material, publication date and contact information***.
  Including contact information makes it easy for readers to follow up with questions or ask permission to reprint the material. Including the date will help remind you when it is time to update the information.

Further Resources

The following links and documents may provide useful information on developing your resource:

- Australian Commission on Safety and Quality in Health Care. (2017). *Writing health information for consumers*. https://www.safetyandquality.gov.au/sites/default/files/2019-05/health-literacy-fact-sheet-4-writing-health-information-for-consumers.pdf
- CDC's guide to writing for social media. https://www.cdc.gov/socialmedia/tools/guidelines/
- CEH online health literacy course. https://www.ceh.org.au/ceh-online-health-literacy-course/
- McGee, J. (2010). *Toolkit for making written material clear and effective*. https://www.cms.gov/outreach-and-education/outreach/writtenmaterialstoolkit
- Migration Council Australia. (2022). *Integrating culturally, ethnically and linguistically diverse communities in rapid responses to public health crises*. https://migrationcouncil.org.au/wp-content/uploads/2022/02/Communication-Guide-CALD-communities-in-public-health-crises.pdf
- Multicultural Health Communication Services. (2019). *Guidelines for the production of multilingual resources*. https://www.mhcs.health.nsw.gov.au/about-us/services/translation/pdf/guidelines.pdf
- National Cancer Institute. (2002). Making health communication programs work. https://www.cancer.gov/publications/health-communication/pink-book.pdf
- Ministry of Health. (2012). *Rauemi Atawhai: A guide to developing health education resources in New Zealand*. https://www.health.govt.nz/publication/rauemi-atawhai-guide-developing-health-education-resources-new-zealand

References

Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., Dhavan, P., Fouad, F. M., Groce, N., Guo, Y., Hargreaves, S., Knipper, M., Miranda, J. J., Madise, N., Kumar, B., Mosca, D., McGovern, T., Rubenstein, L., Sammonds, P., Sawyer, S. M., Sheikh, K., Tollman, S., Spiegel, P. & Zimmerman, C. (2018). The UCL–Lancet Commission on Migration and Health: The health of a world on the move. *The Lancet, 392*(10164), 2606–2654. https://doi.org/10.1016/s0140-6736(18)32114-7

Agu, J., Lobo, R., Crawford, G. & Chigwada, B. (2016). Migrant sexual health help-seeking and experiences of stigmatization and discrimination in Perth, Western Australia: Exploring barriers and enablers. *International Journal of Environmental Research and Public Health, 13*(5), 485. https://doi.org/10.3390/ijerph13050485

Andrulis, D. P. & Brach, C. (2007). Integrating literacy, culture, and language to improve health care quality for diverse populations. *American Journal of Health Behavior, 31*(1), S122–S133. https://doi.org/10.5555/ajhb.2007.31.supp.S122

Apanovitch, A., McCarthy, D. & Salovey, P. (2003). Using message framing to motivate HIV testing among low-income, ethnic minority women. *Health Psychology, 22*(1), 60–67. https://doi.org/10.1037/0278-6133.22.1.60

Australian Bureau of Statistics. (2006). *Health literacy, Australia, 2006* (Cat. no. 4233.0). https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4233.0Main+Features12006?OpenDocument

Australian Bureau of Statistics. (2019). *National health survey: Health literacy, 2018* (Cat. no. 4364.0.55.014). https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4364.0.55.014Main%20Features702018

Australian Federation of AIDS Organisations. (2022). *Barriers to accessing HIV and sexual health care for people from a CaLD background*. https://www.afao.org.au/wp-content/uploads/2022/06/afao-cald-barriers-discussion-paper.pdf

Bandyopadhyay, M., Stanzel, K., Hammarberg, K., Hickey, M. & Fisher, J. (2022). Accessibility of web-based health information for women in midlife from culturally and linguistically diverse backgrounds or with low health literacy. *Australian and New Zealand Journal of Public Health, 46*(3), 269–274. https://doi.org/10.1111/1753-6405.13192

Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J. & Crotty, K. (2011). Low health literacy and health outcomes: An updated systematic review. *Annals of Internal Medicine, 155*(2), 97–107. https://doi.org/10.7326/0003-4819-155-2-201107190-00005

Brega, A., Barnard, J., Mabachi, N., Weiss, B., DeWalt, D., Brach, C., Cifuentes, M., Albright, K. & West, D. (2015). *AHRQ health literacy universal precautions toolkit*. Agency for Healthcare Research and Quality. https://www.ahrq.gov/sites/default/files/publications/files/healthlittoolkit2_3.pdf

Carey, R. N. & Sarma, K. M. (2016). Threat appeals in health communication: Messages that elicit fear and enhance perceived efficacy positively impact on young male drivers. *BMC Public Health, 16*, 645–645. https://doi.org/10.1186/s12889-016-3227-2

Centers for Disease Control. (2014). *Types of evaluation*. https://www.cdc.gov/std/Program/pupestd/Types%20of%20Evaluation.pdf

Centers for Medicare & Medicaid Services, C. (2012). *Toolkit for making written material clear and effective. 2011*. https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/ToolkitTableOfContents.html

Community of Practice for Action on HIV and Mobility. (2018). *HIV and mobility: Priority actions*. Sexual Health and Blood-Borne Virus Applied Research and Evaluation Network, Curtin University.

Crawford, G., Lobo, R., Brown, G. & Maycock, B. (2016). The influence of population mobility on changing patterns of HIV acquisition: Lessons for and from Australia. *Health Promotion Journal of Australia, 27*(2), 153–154. https://doi.org/10.1071/HE15042

Crawford, G., Roanna Lobo, Brown, G. & Langdon, P. (2014). *HIV and mobility in Australia: Road map for action*. Western Australian Centre for Health Promotion Research and Australian Research Centre in Sex, Health and Society.

Deane, K. D., Parkhurst, J. O. & Johnston, D. (2010). Linking migration, mobility and HIV. *Tropical Medicine & International Health, 15*(12), 1458–1463. https://doi.org/10.1111/j.1365-3156.2010.02647.x

Department of Health and Aged Care. (2018). *Eighth national HIV strategy 2018–2022*. Australian Government. https://www.health.gov.au/resources/publications/eighth-national-hiv-strategy-2018-2022

Drysdale, R. (2004). *Behaviour change communication training needs assessment report*. Franco-Australian Pacific regional HIV/AIDS and STI initiative. https://www.hivpolicy.org/Library/HPP000772.pdf

FECCA. (2020*). If we don't count it … it doesn't count! Towards consistent national data collection and reporting on cultural, ethnic and linguistic diversity*. https://fecca.org.au/wp-content/uploads/2020/10/CALD-DATA-ISSUES-PAPER-FINAL2.pdf

Fernandez-Gutierrez, M., Bas-Sarmiento, P., Albar-Marin, M. J., Paloma-Castro, O. & Romero-Sanchez, J. M. (2018). Health literacy interventions for immigrant populations: A systematic review. *International Nursing Review, 65*(1), 54–64. https://doi.org/10.1111/inr.12373

Garcia-Retamero, R. & Cokely, E. T. (2011). Effective communication of risks to young adults: Using message framing and visual aids to increase condom use and STD screening. *Journal of Experimental Psychology: Applied, 17*(3), 270–287. https://doi.org/10.1037/a0023677

Glanz, K. (1997). *Theory at a glance: A guide for health promotion practice*. US Department of Health and Human Services.

Gray, C., Crawford, G., Lobo, R. & Maycock, B. (2021). Getting the right message: A content analysis and application of the health literacy INDEX tool to online HIV resources in Australia. *Health Education Research, 36*(1), 61–74. https://doi.org/10.1093/her/cyaa042

Gray, C., Crawford, G., Reid, A. & Lobo, R. (2018). HIV knowledge and use of health services among people from South‐East Asia and sub‐Saharan Africa living in Western Australia. *Health Promotion Journal of Australia, 29*(3), 274–281. https://doi.org/10.1002/hpja.168

Gray, C., Lobo, R., Narciso, L., Oudih, E., Gunaratnam, P., Thorpe, R. & Crawford, G. (2019). Why I can't, won't or don't test for HIV: Insights from Australian migrants born in sub-Saharan Africa, Southeast Asia and Northeast Asia. *International Journal of Environmental Research and Public Health, 16*(6), 1034. https://doi.org/10.3390/ijerph16061034

Guy, R. J., McDonald, A. M., Bartlett, M. J., Murray, J. C., Giele, C. M., Davey, T. M., Appuhamy, R. D., Knibbs, P., Coleman, D., Hellard, M. E., Grulich, A. E. & Kaldor, J. M. (2007). HIV diagnoses in Australia: Diverging epidemics within a low‐prevalence country. *Medical Journal of Australia, 187*(8), 437–440. https://doi.org/10.5694/j.1326-5377.2007.tb01353.x

Hill, S. J. & Sofra, T. A. (2018). How could health information be improved? Recommended actions from the Victorian consultation on health literacy. *Australian Health Review, 42*(2), 134–139. https://doi.org/10.1071/AH16106

Kaphingst, K. A., Kreuter, M. W., Casey, C., Leme, L., Thompson, T., Cheng, M. R., Jacobsen, H., Sterling, R., Oguntimein, J., Filler, C., Culbert, A., Rooney, M. & Lapka, C. (2012). Health literacy INDEX: Development, reliability, and validity of a new tool for evaluating the health literacy demands of health information materials. *Journal of Health Communication, 17*(Suppl. 3), 203–221. https://doi.org/10.1080/10810730.2012.712612

Kickbusch, I., Pelikan, J., Tsouros, A. & Tsouros, A. (2013). *Health literacy: The solid facts*. World Health Organization. https://apps.who.int/iris/handle/10665/326432

Kok, G., Bartholomew, L. K., Parcel, G. S., Gottlieb, N. H. & Fernández, M. E. (2014). Finding theory- and evidence-based alternatives to fear appeals: Intervention mapping. *International Journal of Psychology, 49(*2), 98–107. https://doi.org/10.1002/ijop.12001

Laranjo, L. (2016). Social media and health behavior change. In S. Syed-Abdul, E. Gabarron & A. Y. S. Lau (Eds.), *Participatory health through social media* (pp. 83–111). Academic Press.

Mahapatra, T. (2014). Role of information, education and communication materials in HIV control: A perspective. *Annals of Tropical Medicine and Public Health, 7*(1), 3–4. http://dx.doi.org/10.4103/1755-6783.144996

Michael, J., Aylen, T. & Ogrin, R. (2013). Development of a translation standard to support the improvement of health literacy and provide consistent high-quality information. *Australian Health Review, 37*, 547–551. https://doi.org/10.1071/AH13082

Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International, 15*(3), 259–267. https://doi.org/10.1093/heapro/15.3.259

Nutbeam, D., Harris, E. & Wise, M. (2010). *Theory in a nutshell: A practical guide to health promotion strategies*. McGraw-Hill Education (Australia).

Rade, D., Crawford, G., Lobo, R., Gray, C. & Brown, G. (2018). Sexual health help-seeking behavior among migrants from sub-Saharan Africa and South East Asia living in high income countries: A systematic review. *International Journal of Environmental Research and Public Health, 15*(7), 1311. https://doi.org/10.3390/ijerph15071311

Rademakers, J., Mouthaan, I. & De Neef, M. (2005). Diversity in sexual health: Problems and dilemmas. *The European Journal of Contraception & Reproductive Health Care, 10*(4), 207–211. https://doi.org/10.1080/13625180500279847

Rothman, A. J. & Salovey, P. (1997). Shaping perceptions to motivate healthy behavior: The role of message framing. *Psychological Bulletin, 121*(1), 3. https://doi.org.10.1037/0033-2909.121.1.3

Ruiter, R. A. C., Kessels, L. T. E., Peters, G.-J. Y. & Kok, G. (2014). Sixty years of fear appeal research: Current state of the evidence. *International Journal of Psychology, 49*(2), 63–70. https://doi.org/10.1002/ijop.12042

Soames Job, R. F. (1988). Effective and ineffective use of fear in health promotion campaigns. *American Journal of Public Health, 78*(2), 163–167. https://doi.org/10.2105/ajph.78.2.163

The Kirby Institute. (2022). *National HIV quarterly notifications data*. https://data.kirby.unsw.edu.au/national-hiv-quarterly-report

Vujcich, D., Reid, A., Hosny, A., Pillay, V., Mao, L., Guy, R., Brown, G., Hartley, L., Roberts, M., Wilshin, C. & Lobo, R. (2021). *Migrant blood-borne virus and sexual health survey 2020–2021: Western Australian results*. Curtin University. https://566a06e5-b5f7-4968-842a-8779947f9151.filesusr.com/ugd/ed7226_54aed8bf190648009b906b57e1f2cf88.pdf

Wansink, B. & Pope, L. (2015). When do gain-framed health messages work better than fear appeals? *Nutrition Reviews, 73*(1), 4–11. https://doi.org/10.1093/nutrit/nuu010

Wickramage, K., Vearey, J., Zwi, A. B., Robinson, C. & Knipper, M. (2018). Migration and health: A global public health research priority. *BMC Public Health, 18*(1), 987. https://doi.org/10.1186/s12889-018-5932-5

Woods, R. (2019). *HIV health literacy framework: Evaluation framework*. National Association of People With HIV Australia [NAPWHA]. https://napwha.org.au/wp-content/uploads/2019/07/NAPWHA-HIVHealthLiteracyFramework-EvaluationFramework-v3.pdf

World Health Organization [WHO]. (2014). *Information, education and communication*. http://www.emro.who.int/child-health/community-information/information/All-Pages.html


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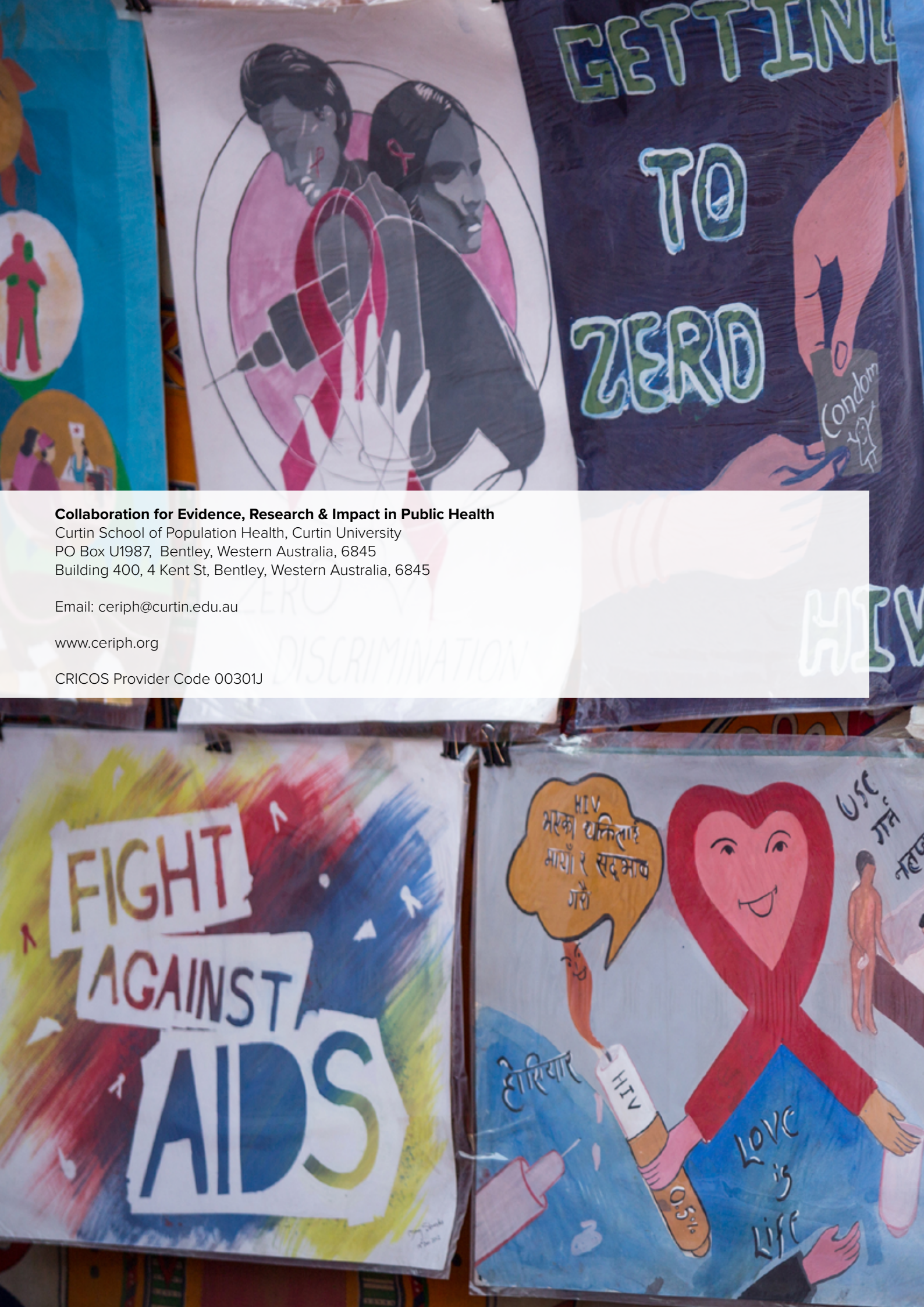

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