

HEALTHY RELATIONSHIPS

A small group-level intervention with
people living with HIV

Implementation Manual

Revised 2015

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Important Information for Users

This HIV/STD risk-reduction intervention is intended for use with persons who are at high risk for acquiring or transmitting HIV/STD and who are voluntarily participating in the intervention. The materials in this intervention package are not intended for general audiences.

The intervention package includes implementation manuals, training and technical assistance materials, and other items used in intervention delivery. Also included in the packages are: 1) the Centers for Disease Control and Prevention (CDC) fact sheet on male latex condoms, 2) the CDC Statement on Study Results of Products Containing Nonoxynol-9, 3) the Morbidity and Mortality Weekly Report (MMRW) article "Nonoxynol-9, Spermicide Contraception Use—United States, 1999," and 4) the CDC guidelines on the content of HIV educational materials prepared or purchased by CDC grantees (Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in CDC Assistance Programs).

Before conducting this intervention in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved, the intervention package materials are to be used by trained facilitators when implementing the intervention.

Acknowledgments

We acknowledge the support provided by the Centers for Disease Control and Prevention (CDC) through cooperative agreement #U61/CCU622170 for the development of this product and by Dr. Seth Kalichman for the research on which this product is based. Healthy Relationships is one in a series of products sponsored by CDC's Prevention Research Branch-*Replicating Effective Programs (REP)*.

Other CDC-funded REP products can be found at http://www.cdc.gov/hiv/topics/prev_prog/rep/.

The original implementation research was done by the Southeast HIV/AIDS Research and Evaluation (SHARE) research group of the University of Connecticut and AIDS Survival Project (Atlanta, GA) and was supported by the National Institute of Mental Health Grant MH57624. The research outcomes are published in: Kalichman S.C., Rompa D., Cage M., DiFonzo K., Simpson D., Austin J., Luke W., Buckles J., Kyomugrsha F., Benotsch E., Pinkerton S., and Graham. J. (2001). Effectiveness of an Intervention to Reduce HIV Transmission Risks in HIV Positive Persons. *American Journal of Preventive Medicine* 21 (2): 84-92. A second article based on additional study of the research data was published in: Kalichman S.C. (2005). The Other Side of the Healthy Relationships Intervention: Mental Health Outcomes and Correlates of Sexual Risk Behavior Change. *AIDS Education and Prevention* 17 (A): 66-75.

Special thanks to these agencies for the testing the Healthy Relationships intervention package:

Arkansas AIDS Foundation (Little Rock, AR)
BEAT AIDS (San Antonio, TX)
Community Counseling of Bristol County (Taunton, MA)
Jefferson Comprehensive Care System (Little Rock, AR)
Montrose Clinic (Houston, TX)
North Jersey Community Research Initiative (Newark, NJ)
PROCEED Inc. (Elizabeth, NJ)
Roxbury Comprehensive Community Health Care (Roxbury, MA)

We appreciate the support given to these case study sites by:

Arkansas Department of Health
New Jersey Department of Health
Massachusetts Department of Health

Special thanks to the efforts and feedback from J. Gabriel Rendón, Dr. Dean Blevins, Maria Carmela Keys, and Dr. Charles Collins for the 2015 revision.

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Advancing HIV Prevention

Healthy Relationships supports the initiative of the Centers for Disease Control and Prevention to reduce HIV transmission through one of the four priority strategies. Since the intervention is specifically designed to be conducted with persons living with HIV/AIDS and directly addresses prevention of transmission to others, it supports Strategy 3: Prevent new infections by working with persons diagnosed with HIV.

Explanation of Implementation Manual

This manual is divided into the following sections: Getting Started, Pre-Implementation, Implementation, Maintenance, and Appendices. The following is a brief overview of each section of the manual.

Getting Started

The getting started section addresses the primary concerns your agency has when becoming familiar with a new intervention. In the getting started section of the manual you will find: an overview of the intervention, benefits of prevention with positives, the social and behavioral science used in **Healthy Relationships**, a review and explanation of the Core Elements and Key Characteristics of **Healthy Relationships**, and three *getting started* activities (assessing fit, addressing agency capacity issues, and developing a budget). This section also contains various checklists and tools your agency can use when getting started.

Pre-Implementation

The pre-implementation section addresses staffing requirements, evaluations, and the issues that arise when preparing for implementation. This section also contains various tools, checklists, and helpful reminders your agency can use during the pre-implementation phase.

Implementation

The implementation section addresses the issues that your agency will focus on while implementing **Healthy Relationships**. The implementation section contains the **Facilitator's Handbook** which is necessary in order to facilitate **Healthy Relationships'** five sessions. This section also has ideas on recruitment and a list and explanation of the forms used in **Healthy Relationships**.

Maintenance

The maintenance section contains ideas that will help your agency integrate **Healthy Relationships** into the regular prevention services your agency offers. Refer to Appendix VIII for evaluation tools your agency may want to use to evaluate the effectiveness of **Healthy Relationships** and ideas about how to improve your next delivery of the sessions.

Appendices

There are nine appendices. Appendix I contains samples of the cards for the Risk Continuum Banner activities, information on how to create your own cards, and the key for the third Risk Continuum Banner activity on the risks of various sexual behaviors. Appendix II has samples of the Easel Chart Guides used in each session. Appendix III has forms that can be used with the session participants, including samples of the Initial Assessment Survey (IAS) and Personal Feedback Report (PFR) forms. Appendix IV contains forms for use in evaluating sessions and the facilitators; it also contains a section on group facilitation skills and tips. Appendix V lists helpful resources for agencies implementing this intervention. Appendix VI contains information on the clips used in the original research and suggestions for creating a tape appropriate for your target population. Appendix VII is a copy of the original research article. Appendix VIII contains sample evaluation forms. Appendix IX contains several CDC documents, including information on male latex condoms and sexually transmitted diseases (STDs); statements on nonoxynol-9 spermicide; and Program Review Panel Guidelines for Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs.

Getting Started

What is Healthy Relationships?

Healthy Relationships is a five-session, small group intervention with men and women living with HIV/AIDS. It is based on the Social Cognitive Theory and focuses on the development of coping skills needed to make decisions regarding whether, when, and how to:

- Disclose to family and friends,
- Disclose to sexual partners, and
- Build healthier/safer sexual relationships

The intervention was tested with men who have sex with men, heterosexual men, and women and was effective with all three.

Although disclosure is addressed, this is not a disclosure intervention; the skills that are developed are decision-making and problem-solving skills that enable the participants to make informed and safe decisions about disclosure and behaviors. **Healthy Relationships** addresses participants' HIV status, disclosure skills, and safer sex negotiation skills. Sessions involve both the practice of coping skills and motivational feedback. Participants see behaviors modeled for them, practice those skills, receive feedback, and reevaluate their behaviors. **Healthy Relationships** uses Personal Feedback Report (PFR) forms to help participants identify behaviors they want to change. In each of the three life areas, a series of activities is repeated to create and develop the decision-making and problem-solving skills. The primary activity is using a prepared introduction to set up a scene for a short clip from a popular movie or other source with high production values ("movie-quality"), viewing the clip, discussing the skills used in the scene, and role-playing to practice the skills.

The intervention can be easily adapted, based on the choice of movie clips, and is intended to create a positive, engaging, and creative atmosphere. There are a variety of types of "clips" shown in the five sessions of **Healthy Relationships**: personal statements, HIV/AIDS information, condom demonstration, and, most importantly, segments from popular movies. The term "clip" is used whether the clip is short or long or even an entire video; the term "video" is used to refer to source material, such as documentaries and movies. Facilitators use brief descriptions or "scenarios" to introduce clips while tying them to the objectives of that session.

Healthy Relationships' intervention study was conducted at the AIDS Survival Project in Atlanta, Georgia in 1997-98. Results from this randomized, controlled study showed many positive effects on the behaviors of intervention group participants.¹ Immediately after finishing the five sessions, persons who received **Healthy Relationships** reported greater self-efficacy for suggesting condom use with new sexual partners and being able to satisfy sexual partners and themselves by practicing safer sex. Participants also reported intentions to consider the pros and cons of HIV status disclosure to partners and to engage in safer sex

¹ Kalichman, Seth et al. "Effectiveness of an Intervention to Reduce HIV Transmission Risks in HIV-Positive People". *American Journal of Preventive Medicine* 21 (2): 84-92, 2001.

with partners who did not know their HIV status. When participants were contacted three months after the sessions ended, significant numbers had considered the pros and cons of HIV status disclosure to sexual partners. Significant numbers also had engaged in less sex overall and less unprotected sex with partners who are not infected with HIV. Six months after the program, significantly more intervention group participants reported having refused to engage in unsafe sex, compared to control group participants. Significant numbers of participants also reported less unprotected intercourse, more protected intercourse, and fewer sexual contacts overall. They also continued to have less sexual intercourse and less unprotected intercourse with partners who were not infected with HIV. Estimates of HIV transmission risk showed that the intervention resulted in lower male-to-male and male-to-female transmission. Further analysis indicates that the intervention had similar effects across a variety of groups, including those with different sexual orientations, incarceration history, psychiatric history, or current or past drug use. These results demonstrate that **Healthy Relationships** is broadly applicable across subpopulations. They also show that the effects are long-term (at least up to six months) and affect both reported behaviors and perceived self-efficacy. **For readers who want more details on the intervention study, a copy of the article can be found in Appendix VII.**

Healthy Relationships sessions are not classes, lectures, or forums. They are interactive sessions that have both an educational and an entertaining aspect. They create a context through which people can:

- Examine their risks
- Develop skills to reduce their risks
- Receive feedback from others

Groups consist of five to twelve people of common backgrounds. These small groups are closed to new members and are similar in style to support groups. Participants sit in a circle and share common experiences. The group meets for a minimum of five 120-minute sessions. Two facilitators, one of whom may be a peer who is living with HIV/AIDS, use Easel Chart Guides and clips to lead participants through the **Healthy Relationships** content.

Benefits of prevention with people living with HIV/AIDS

Prevention with people who are living with HIV/AIDS is necessary to reduce the transmission of HIV. Working with people living with HIV/AIDS will help stop the transmission of HIV by teaching the negotiation and practice of safer sex skills. In addition, prevention with people living with HIV/AIDS will enhance their quality of life by providing them with the skills to prevent re-infection and to be pro-active about their health maintenance. This type of prevention can help persons living with HIV/AIDS adhere to medical care, including drug regimens and doctor visits. Prevention with people living with HIV/AIDS can provide a link to prevention, social, and support services (such as support groups) that are important for their survival. Finally, conducting prevention with people living with HIV/AIDS may increase access to others living with the virus. Utilizing peers who are living with HIV/AIDS provides an opportunity for their unique perspective to be incorporated into prevention efforts. Furthermore, this peer-focused approach creates social

networks that current prevention efforts could tap to strengthen the quality of prevention services.

As a prevention intervention with people living with HIV/AIDS, **Healthy Relationships** provides persons with the skills necessary to make effective disclosure decisions and negotiate safer sex. **Healthy Relationships** works on the premise that the decision about whether or not to disclose one's HIV status is an important factor in reducing the risk of transmitting HIV. **Healthy Relationships** utilizes the concept of peers reaching peers through encouraging the use of a person living with HIV/AIDS as a possible peer facilitator. Finally, **Healthy Relationships** seeks to increase participants' self-efficacy through the modeling of safer behaviors and through the identification of behaviors that put them at risk. Prevention with people living with HIV/AIDS will enhance the quality of prevention services your agency offers, and **Healthy Relationships** can be a great tool in the fight to reduce the transmission of HIV.

Social and behavioral science used in Healthy Relationships

The **Healthy Relationships** intervention is based on Social Cognitive Theory,² which states that persons learn by observing other people successfully practice a new behavior. Of course, behavior change is not simple, and many factors affect a person's ability to change. Social Cognitive Theory considers that behaviors, environment, attitudes, and beliefs influence and depend on each other.³ Therefore, behavior change is influenced by:

- Information—Awareness of risk and knowledge of techniques for coping with the environment
- Self-efficacy—Belief in one's ability to control one's own motivations, thoughts, emotions, and specific behaviors
- Outcome expectations—Belief that good things will happen as a result of the new behavior
- Outcome expectancies—Belief that the results of the new behavior are valuable and important
- Social skills within interpersonal relationships—The ability to communicate effectively, to negotiate, and to resist pressures from others
- Self-regulating skills—The ability to motivate, guide, and encourage oneself and to problem-solve
- Reinforcement value—"Rewards" produced by attempts at a new behavior, as opposed to "costs"

According to Social Cognitive Theory, successful behavior change can be achieved by:

- Observing other people's behaviors and experiences
- Learning information from other people
- Discussing strategies with other people

² Albert Bandura. Social cognitive theory and exercise of control over HIV infection. *Preventing AIDS: Theories and Methods of Behavioral Interventions*, edited by Ralph J. DiClemente and John L. Peterson. New York: Plenum Press, 1994, pp. 25-59.

³ Seth C. Kalichman. *Preventing AIDS: A Sourcebook for Behavioral Interventions*. Mahwah, NJ: Lawrence Erlbaum Associates, 1998.

- Hearing the positive outcomes of other people's new behaviors
- Observing new behaviors being modeled
- Having guided practice or rehearsal of new behaviors and skills
- Receiving corrective feedback on one's performance of the new behaviors or skills
- Acquiring personal experience with new behaviors and skills
- Receiving social support for the new behavior

Healthy Relationships also uses strategies from Motivational Enhancement.⁴ These strategies encourage favorable group processes by actively involving participants in the behavior change process and in developing risk reduction strategies that are suited to their own circumstances. Examples of Motivational Enhancement strategies include:

- Fostering a collaborative atmosphere
- Affirming strengths and self-efficacy
- Providing feedback based on the results of a baseline assessment, which helps the participant identify reasons for change and self-motivating statements

The goal of the **Healthy Relationships** intervention is to reduce sexual risk behavior among women and men living with HIV infection. Social Cognitive Theory predicts that enhancing self-efficacy for managing life stress, including risk-producing situations, leads to effective coping responses. Coping with risky situations involves using behavioral skills and practicing risk-reduction behaviors. Coping responses that are effective in reducing stress also can be used to cope with risky sexual situations and with other interpersonal situations.

⁴ WR Miller, A Zweben, C. DiClemente, R Rychtarik. *Motivational Enhancement Therapy Manual*. Washington, DC: US Government Printing Office, 1992.

Core Elements and Key Characteristics

Evidence-based interventions, such as **Healthy Relationships**, have components that must be maintained without alteration to ensure the programs' effectiveness. These components are called Core Elements. Core Elements are the components that are central features of an intervention's intent and design and that are thought to be responsible for its effectiveness. The Core Elements are derived from components of behavioral theories and/or the experience of implementing the intervention. **Healthy Relationships'** five Core Elements are as follows:

1. Defining stress and reinforcing coping skills with people living with HIV/AIDS across three life areas:
 - a. disclosing to family and friends,
 - b. disclosing to sexual partners, and
 - c. building healthier and safer relationships.
2. Using modeling, role-play, and feedback to teach and practice skills related to coping with stress.
3. Teaching decision-making skills about disclosure of HIV status.
4. Providing participants with Personal Feedback Reports, based on the Initial Assessment Survey, to motivate change of risky behaviors and continuance of protective behaviors.
5. Using movie-quality clips to set up scenarios about disclosure and risk reduction to stimulate discussions and role-plays.

These five Core Elements must be maintained without alteration to ensure *fidelity* to the intervention and its effectiveness. *Fidelity* is conducting and continuing an intervention by following the Core Elements, protocols, procedures, and content set by the research study that determined its effectiveness. While the Core Elements cannot be altered, implementing agencies can adapt Key Characteristics. Key Characteristics are activities and delivery methods for conducting an intervention that, while considered of great value to the intervention, can be altered without changing the outcome of the intervention. These activities and delivery methods can be adapted for different agencies and at-risk populations. *Adaptation* describes the process of customizing delivery of interventions to agency circumstances and ensuring that messages are appropriate for target populations without altering, deleting, or adding to the intervention's Core Elements.

Remember, Key Characteristics are important aspects of an intervention that can be adapted to be more appropriate for your community. Some Key Characteristics identified from the original research for **Healthy Relationships** are:

- **Participants meet in small groups, similar in style to support groups. The groups are “closed,” which means that new members cannot join once the series of sessions has begun.**
- **Groups meet for at least five 120-minute sessions.**
- **Participants sit in circle, face-to-face.**
- **Groups are divided by gender and sexual orientation of the members.**
- **At least one group facilitator is an experienced and skilled counselor and, preferably, is a mental health professional. This facilitator may or may not be living with HIV/AIDS.**
- **One facilitator is a peer counselor who is living with HIV/AIDS.***
- **One facilitator is male and the other female.***
- **At least one facilitator matches the ethnicity of the majority of group members.***
- **Both facilitators have the personal characteristics and group skills of effective facilitators.**

*These Key Characteristics bring immediate credibility and access to groups.

Organizational Assessment Activities

Addressing agency capacity issues and developing the budget are two central getting started activities. It is important to note that these activities do not happen strictly in the order they appear in this manual; they may happen simultaneously. These activities appear in this order in the manual because they build on one another: capacity issues lead to discussions around budget development.

Getting Started: Agency Capacity Issues

The first getting started activity is addressing the capacity issues. Capacity issues are focused on securing the “buy-in” of stakeholders in the agency.

Securing “buy-in” is crucial because it assures the support of agency administration and allows for agency resources to be utilized for intervention implementation. Obtaining “buy-in” is most effectively accomplished with an intervention *champion*, but the *champion* could be an individual or a group of people. Regardless of the number of *champions*, the central issue is convincing the agency that implementing **Healthy Relationships** would enhance the quality of its prevention services and that the agency is capable of implementing **Healthy Relationships**. A *champion* is someone within the agency generally who is a mid-to-upper level administrator who serves as a link between administration and staff. The *champion* needs to be adept at answering questions and mediating any changes in organizational structure; they can serve as a negotiator of any necessary trade-offs or compromises. The *champion* becomes the intervention’s spokesperson, anticipating the reservations of staff and answering questions about the intervention needs and resources. The *champion* must have an excellent knowledge of the intervention including its costs, Core Elements, and Key Characteristics. In addition, the *champion* can use the marketing video available in the intervention package to garner support for the intervention. The *champion* can use the information presented in this manual and the rest of the package to further field any questions or concerns about **Healthy Relationships**.

Your agency’s intervention *champion* can use the following stakeholder’s checklist to obtain support for implementing **Healthy Relationships**. The stakeholders are those persons (e.g., Board of Directors/Executive Board, community members, agency partners, staff, funders) who have a stake in the successful implementation of an intervention. The stakeholder’s checklist contains those items the *champion* can use to convince the stakeholders that **Healthy Relationships** is an intervention that your agency can and should implement because it meets the needs of the community your agency serves.

Stakeholder's Checklist

1. Assess the community to determine whether they will support the Core Elements of **Healthy Relationships**
2. Identify your stakeholders
 - a. Your agency's Board of Directors/Executive Board
 - b. Staff members from your agency who will have a role in the operation of the intervention
 - i. Administrators who will obtain support
 - ii. Supervisors who will monitor the intervention
 - iii. Staff who will interact with participants at any level
 - c. Local agencies from which you could recruit participants, facilitators, or both
 - i. Agencies offering support groups for people living with HIV/AIDS
 - ii. Health care providers and mental health professionals serving people living with HIV/AIDS
 - iii. Social service agencies reaching people living with HIV/AIDS
 - iv. Organizations of people living with HIV/AIDS and organizations which may have members who are living with HIV/AIDS
 - d. Organizations that could provide assistance or other resources
 - i. Merchants for incentives, loan of videos, refreshments
 - ii. Video production groups, such as college video production classes, community cable organizations, corporate video production departments, videographers, for help with clip assembly
 - iii. Agencies, merchants, printers, publishers, broadcasters, and others that can advertise the intervention
 - iv. Agencies that can provide a venue for the intervention
 - v. Agencies that can provide child care
 - vi. Agencies that can provide transportation
 - vii. Advisory board to help adapt intervention (e.g., selecting culturally appropriate clips)
 - viii. Other collaborating agencies to provide information for Resource Packets
 - e. Agencies with which your agency needs to maintain good community or professional relations
 - i. Local health department
 - ii. Local medical and mental health associations
 - iii. Your funding source(s)
 - iv. Others

3. Getting stakeholders informed, supportive, and involved
 - a. Getting them informed about the intervention
 - i. Decide in advance what specific roles you want each stakeholder to play. Who will you ask to:
 - (a) provide financial support
 - (b) refer people living with HIV/AIDS to the intervention
 - (c) serve as an intervention facilitator
 - (d) be a resource to which you can refer participants
 - (e) join your community advisory board
 - (f) help adapt the intervention for your target population
 - (g) help identify appropriate clips
 - (h) lend videos for duplication
 - (i) provide equipment access and/or skills to assemble DVD of all clips
 - (j) assist in advertising the intervention
 - (k) provide a room in which the sessions can be held
 - (l) supply refreshments for participants
 - (m) donate small incentives or prizes for participants
 - (n) speak supportively about **Healthy Relationships** in conversations with their associates
 - ii. Send letters that tell stakeholders about **Healthy Relationships**, its importance, that your agency is/will be making the intervention available, what specific role(s) you think that they might play in the success of the intervention, and opportunities for them to learn more.
 - iii. Call in two weeks, and assess their interest. If they are interested, schedule a time to meet (e.g., one-on-one, lunch-and-learn at your agency with a group of other stakeholders, presentation at their agency for several of their staff or association members).
 - iv. Hold the meeting, show **Healthy Relationships** marketing video if the setting and time allow, and answer questions.
 - b. Getting them supportive
 - i. Describe several specific roles they could play.
 - ii. Emphasize the benefits of their involvement to themselves, their agency, the community, and persons living with HIV/AIDS and answer questions.
 - iii. Invite them to commit to supporting **Healthy Relationships** by taking on one or more roles. Keep track of commitments.

- c. Getting them involved
 - i. Soon after meeting, send a thank you letter that specifies the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later.
 - ii. For persons who committed to a role that is important to pre-implementation, put them to work as soon as possible.
 - iii. For persons who committed to involvement later in the process, send them brief progress updates and an idea of when you will be calling on their support.
 - iv. Hold periodic celebratory meetings for supporters to acknowledge your appreciation for and the value of their contributions, update them on the intervention's progress, and keep them engaged.

Getting Started: Budget

The final getting started activity is developing the budget.

This budget is meant as an example of possible costs associated with implementing **Healthy Relationships**. Depending on the number of times you implement or your specific agency needs, these figures will vary from organization to organization. This is meant only as a guide.

Besides the trained facilitators, the time needed to train in the intervention, and the time for assembling the clips (which can be compiled at very low cost), the costs of this intervention are minimal. The Personal Feedback Report (PFR) forms can be simplified and incentives reduced, if necessary. To conduct **Healthy Relationships**, an agency will need a 100 percent Full Time Equivalent (FTE) paid, experienced counselor or mental health professional (MHP), one 25 percent FTE peer facilitator (volunteer or paid) for each population of people living with HIV/AIDS for whom you will be offering **Healthy Relationships** sessions (women, heterosexual men, MSM), and one 25 percent FTE program manager for evaluation and quality assurance. We estimate that each counselor and peer facilitator will need to attend 30 hours of training in **Healthy Relationships**. An agency will need from 40 to 60 hours to find and assemble 13 clips to use during the sessions. (Three clips are provided in the intervention package.) The actual number of hours and costs for assembling the clips depends on: 1) staff knowledge of movies and appropriate clips, 2) equipment access and staff skill to assemble clips on a DVD or contract for these services, and 3) the number of populations of persons living with HIV/AIDS who will be receiving the intervention, since most of the selections are population-specific. The original intervention study provided participants with a \$10 incentive per session. However, if **Healthy Relationships** is used in ongoing support groups, incentives for the intervention would not be necessary. An agency will need to acquire, if they do not already own, a TV and a DVD player with remote control. The intervention also involves the use of an easel, easel paper, markers, and one small prize to be given away through random drawing at the end of each session. **Healthy Relationships** is not a high maintenance intervention and can be made feasible for almost all agencies.

Cost Sheet

As mentioned before, to conduct **Healthy Relationships**, an agency will need a 100 percent FTE paid, experienced counselor to serve as a facilitator and one 25 percent FTE peer to serve as a co-facilitator (volunteer or paid) for each population of persons living with HIV/AIDS for whom **Healthy Relationships** sessions will be offered. An agency will need from 40 to 60 hours to find and assemble 13 clips to use during the sessions. The actual number of hours and costs for assembling the clips depends on: 1) staff knowledge of movies and appropriate clips, 2) equipment access and staff skill to assemble clips on a DVD disk or contract for these services, and 3) the number of populations who will be receiving the intervention, since most of the selections are population-specific. The cost sheet assumes that the agency will be finding and assembling the clips they will use. If this is not the case with your agency, you will need to add contractual costs for these services. The cost sheet also assumes that your agency already has access to intervention participants. If this is not the case, you will need to add recruitment costs. In using this cost sheet to create a budget, pretend that there will be no donations, volunteers, or in-kind contributions and include costs/values as if everything needed to be paid for.

Your agency may have questions about using clips from movies and television shows that are copyrighted. The Fair Use Doctrine found in Sections 107-118 of the copyright act, (title 17, U.S. Code) addresses this issue. If you have any questions, refer to the webpage of the U.S. Copyright Office or consult an attorney. All of the videos that are included in the package were either produced by Dr. Seth Kalichman (the researcher who developed the intervention), are in the public domain, or permission was received to include them in the intervention package.

Categories for Provider Costs to Implement the Healthy Relationships Intervention

Categories	Pre-Implementation (start-up)		Implementation ¹ (intervention delivery)	
Personnel	# staff	% time or # hrs/wk (% FTE time spent on intervention)	# staff	% time or # hrs/wk (% FTE time spent on intervention)
Salaried:				
Program Mgr.	1	50%	1	25%
Admin. Asst.	1	20%	1	10%
Facilitator, MHP ²	1	100%	1	25%
Hourly:				
Facilitator, peer ^{2,3}	1	10 hrs/wk	1	10 hrs/wk
Fringe benefits		25%		25%
Facility(ies)		(% time used for intervention)		(% time used for intervention)
Rent: Office	\$	x	\$	x
Small group meeting space	0	%	\$	x
Utilities	\$	x	\$	x
Telephone/fax	\$	x	\$	x
Maintenance	\$	x	\$	x
Insurance	\$	x	\$	x
Equipment		(% time used for intervention)		(% time used for intervention)
Television	\$	x	\$	x
DVD Player with remote ⁴	\$	x	\$	x
Computer	\$	x	\$	x
Copier	\$	x	\$	x
Easel	\$	x	\$	x
Equipment maintenance	\$	x	\$	x
Internet service provider	\$	x	\$	x
Supplies				
Videos (other than in pkg./kit and by target population) ^{4,5}	10 x # target pops. x	\$ /each =	0	
Postage & mailing	\$		\$	
Copying & printing	\$		\$	
Office supplies:				
Paper (white)	1 ream x	\$ /ream =	5 reams x	\$ /ream =
Paper (colored)	0		3 reams x	\$ /ream =
Certificate paper	0		1 pkg. x	\$ /pkg. =

Categories	Pre-Implementation	Implementation ¹
Pens	1 dozen x \$ /doz. =	3 dozen x \$ /doz. =
Name badges	0	100 x \$ /each =
Easel paper	0	2 pads x \$ /pad =
Markers	0	1 pkg. x \$ /pkg. =
Push pins	0	1 box x \$ /box =
Masking tape	0	1 roll x \$ /roll =
Pocket folders	0	10 x \$ /each =
Blank DVDs (by target population) ⁴	2 x # target pops. x \$ /each =	0
Condoms:		
Male	0	2 dozen x \$ /doz. =
Female ⁶	0	2 dozen x \$ /doz. =
Lubricant	0	
Anatomical models:		
Male	10 x \$ /each =	0
Female ⁶	10 x \$ /each =	0
Printed materials: ¹		
IAS	0	10 x \$ /each =
Easel Chart	36 x # target	
Guides (by target population)	pops. x \$ /each =	0
PFR forms	0	30 x \$ /each =
Information Sheets/flyers	5 gross x \$ /grs. =	
Other materials: ¹		
Prizes	0	8 x \$ /each =
Catering/refreshments		80 x \$ /pers. =
Recruitment (of staff/volunteers)		
Advertising	10 column inches x \$ /inch =	10 column inches x \$ /inch =
Travel		
Miles to/from intervention location (if other than regular work place)	# miles x ¢/mile =	# miles x ¢/mile =

¹ Intervention delivery costs are based on an average of 10 participants times eight sessions (80). The eight sessions are figured as follows: one introductory meeting, the five **Healthy Relationships** sessions, one extra meeting time in case a session could not be finished in two hours, and one reunion meeting. Numbers of printed and other materials are calculated as follows: for the complete intervention you will need one Initial Assessment Survey (IAS) and three Personal Feedback Report (PFR) forms for each participant. For each session you also will need one name badge and one “refreshments” per participant. One prize is awarded at each session.

² Both facilitators, Mental Health Professional (MHP)/skilled counselor and peer, will need to be compensated for their time spent recruiting, interviewing participants, training (four days), and practicing during pre-implementation. Intervention delivery time includes review before each session, travel to the sessions, session time, and debriefing time and assumes weekly sessions for eight weeks, plus a week for preparation and wrap-up.

³ Figures are based on one implementation of the complete intervention to one target population. Additional peer facilitators will be needed for each implementation delivered to a different target population. Peer facilitator compensation may need to take into account whether or not the individual is receiving disability payments.

⁴ This budget lists a DVD player and DVDs. If a different media is used, substitute appropriate text for DVD player and DVDs in the cost sheet.

⁵ Additional, substitute videos may be needed over time to keep the intervention up to date.

⁶ Female anatomical models do not have to be used with groups of men who have sex with men.

⁷ As staff turns over, additional money must be allocated for training new staff.

Pre-Implementation

What is Pre-Implementation?

Pre-Implementation prepares the implementing agency to perform the intervention. It is during this period your agency can make any necessary organizational changes, assess resource needs, and develop marketing and evaluation plans. Pre-Implementation is also the time to explore the needs for adapting **Healthy Relationships**. For **Healthy Relationships** pre-implementation activities are focused on the following:

- Staffing requirements
- Recruiting, selecting, and managing the advisory board
- Securing the intervention resources
- Adapting the intervention
- Developing an evaluation plan
- Planning for any legal and ethical issues
- Marketing **Healthy Relationships** and recruiting participants

Staffing Requirements

In order for **Healthy Relationships** to run smoothly you will need a program manager; at least one trained counselor, preferably a mental health professional; and at least one peer facilitator for each population you plan to serve.

Program Manager

The list of items below contains some of the program manager's primary responsibilities. However, they are not the only tasks that the program manager will do in the course of the intervention.

The program manager is primarily responsible for the following tasks:

- | | |
|---|---|
| ➤ Preparing the agency for the intervention | ➤ Establishing and overseeing the evaluation plan |
| ➤ Determining the necessity of collaboration with other organizations | ➤ Overseeing the intervention and intervention team |
| ➤ Securing the intervention resources and materials | ➤ Conducting debriefing sessions |
| ➤ Hiring and managing the intervention team | ➤ Managing the budget |
| ➤ Setting up training and technical assistance | ➤ Ensuring quality assurance |
| | ➤ Monitoring fidelity |

The program manager will assist with the following tasks:

- Recruiting and selecting of the advisory board
- Managing the advisory board
- Adapting the intervention materials
- Preparing the intervention materials
- Collaborating with other agencies
- Recruiting participants

Facilitators

As mentioned before, **Healthy Relationships** requires two facilitators. At least one facilitator should match the ethnicity of the majority of the participants. Also, at least one of the two should be an experienced and skilled counselor, preferably a mental health professional (MHP). The other should be a peer from the community (one of the Key Characteristics suggests that the peer facilitator be living with HIV/AIDS). It is important to remember that the facilitators for **Healthy Relationships** will not operate in the role of counselors. The trained facilitators need to be clear that **Healthy Relationships** is a behavioral intervention; the sessions are not counseling sessions.

One facilitator should be a male and the other female. Experiences in delivering the intervention have found that women feel more comfortable and safe discussing issues of sex and sexuality with women facilitators. If any of the women have been victims of domestic violence or any crimes against women, the presence of a female facilitator will help to create a safe and supportive environment. Delivery experiences also found that men were more likely to limit inappropriate sexual talk and “acting out” with a female facilitator present.

Where to Find Effective Facilitators

This section contains some suggestions on how to find effective facilitators. You can use the characteristics and skills of effective facilitators on page 17 of this Pre-Implementation section to help you choose the right facilitators. Once you identify potential facilitators, provide them with basic information about **Healthy Relationships** and their expected roles and responsibilities. Examples of these roles and responsibilities are listed on pages 19-20 of this Pre-Implementation section. Both facilitators will be required to attend training on the intervention. You can use the information on the above pages to help facilitator candidates understand what the intervention is, what their job will involve, and what skills and experience you are looking for in the facilitators.

Where Can You Find Effective Facilitators?

Peer

- Ask your advisory board to make recommendations
- Local AIDS service organization
- Attend support meetings for people living with HIV/AIDS

MHP

- Social work programs at local colleges and universities
- Network within your own organization or other similar organizations for recommendations
- Observe support groups and other group leaders in action

Characteristics and Skills

Healthy Relationships is not a class or a public health forum. The facilitators will direct the intervention sessions, guiding the participants through the content of **Healthy Relationships**. The intervention depends on the rapport facilitators are able to build with and among participants. The following are lists of the skills and characteristics to look for and the characteristics to avoid when selecting facilitators for **Healthy Relationships**. Many would also be applicable when choosing any group facilitator.

Look for the Following Characteristics and Skills:

- Trustworthy
- Flexible
- Active listener
- Follows up on identified needs
- Good knowledge of group process
- Ability to promote communication
- Maintains eye contact
- Understanding of group dynamics
- Ability to adapt to changing dynamics in the group
- Understanding and non-judgmental
- Not chemically dependent (sober or in recovery)
- Ability to manage and control problems
- Dynamic and friendly
- Respect for confidentiality
- Patient
- Knowledge of HIV/AIDS
- Culturally competent
- Good observer
- Authentic
- Empathetic and supportive
- Uses humor effectively and appropriately
- Ability to make appropriate referrals to services
- Interested in working with groups
- Creates warm and welcoming environment
- Respectful of others and their opinions
- Ability to build rapport
- Willingness to learn from the group
- Ability to adjust agenda times to meet needs of the group
- Focuses on group needs instead of own personal agenda
- Aware of own comfort level, skills and limits
- Ability to work with people where they are/client centered
- Shares and discloses personal information appropriately

Avoid the Following Characteristics:

- Anxious in group settings
- Acts superior to the participants
- Dominates discussion
- Withdraws physically or emotionally from the group
- Lacks sensitivity to the needs of others
- Needs to be the center of attention
- Inflexible and non-adaptive
- Places their own personal needs before the needs of the group
- Oriented more towards individuals than the group as whole
- Pushes personal agenda
- Has a bias favoring disclosure of HIV status

Skilled Counselor/Mental Health Professional

The selection of a skilled counselor or mental health professional (MHP) is an important part of **Healthy Relationships**. The MHP for **Healthy Relationships** could be someone with a bachelor's level training in counseling/mental health work, a psychologist, a social worker, a Licensed Practicing Counselor or a Licensed Chemical Dependency Counselor. Hiring someone with an advanced degree is not necessary for **Healthy Relationships**. Hopefully, the wide range of credentials will make finding a MHP easy and not create implementation barriers.

In addition to the general facilitator characteristics just listed, the MHP should have experience working with groups of people living with HIV/AIDS. Participants in **Healthy Relationships** may have issues that require special attention. The MHP could have to deal with participants who are having suicidal or homicidal thoughts or just needing to talk after sessions if something is bothering them. It is necessary for the successful facilitation of the group to allow time for participants to discuss how they are feeling after the showing of the clips and after some other activities. The intervention (at any point or all the way through) could be emotionally moving or life changing for some participants. Both facilitators need to be aware and sensitive at all times.

The **Healthy Relationships** intervention includes discussions about personal behaviors such as sexual practices, major life events, and personal experiences of disclosing HIV serostatus. Topics of discrimination, violence, and sexual coercion may arise as well. It is not unusual for some participants to feel uncomfortable talking about these topics. It is important for facilitators to be able to distinguish between normal discomfort and an adverse event. These events must be taken seriously and handled in a consistent manner based on agency written protocol. If an adverse event occurs, the group facilitators should follow the agency's protocol. The agencies implementing **Healthy Relationships** should develop a plan for addressing participants who may experience suicidal or homicidal ideation, violent outbursts, or other adverse events. This plan will assist the facilitators in knowing where and how to refer participants for either additional assessment or treatment services.

The roles and responsibilities of the Skilled Counselor/MHP
as a facilitator of **Healthy Relationships** are:

- Prepare for sessions
 - Assist with adaptation
 - Balance the needs of the participants and the structure of the sessions
 - Facilitate discussion while following the session's curriculum
 - Practice and review materials
 - Build group cohesion
 - Inform group participants of the duty to warn, confidentiality and other relevant laws
 - Guide the group process
 - Handle emotional issues
 - Create balance between content and mechanism of delivery
- Along with peer facilitator:
- Create safe, welcoming and non-judgmental environment for participants
 - Affirm participants' past experiences while communicating an expectation for better future experiences
 - Create Resource Packets that provide information about other services offered to people living with HIV/AIDS in their area
 - Probe for clarity
 - Deal with inappropriate behavior problems
 - Keep the momentum of the conversation going
 - Along with peer facilitator and group participants: set the group rules and enforce them
 - Along with peer facilitator and the program manager: create a plan to deal with attendance issues and other logistical issues

Peer Facilitators

The selection of peer facilitators is also an important process. Like the MHP, the peer facilitators should have experience working with people who are living with HIV/AIDS and with diverse populations. They should also be aware of and sensitive to the emotional state of the participants. Remember, one of the Key Characteristics suggests the peer facilitator be living with HIV/AIDS. Your agency may want to consider selecting and training several peer facilitators if you are working with more than one population, to allow an appropriate cultural and gender mix of facilitators.

The roles and responsibilities of the peer facilitator of **Healthy Relationships** are:

- Prepare for sessions
- Assist with adaptation
- Promote communication
- Facilitate discussion while following the session's curriculum
- Practice and review materials
- Build group cohesion
- Do the things listed as mutual responsibilities with the Skilled Counselor/MHP

When working with immune-compromised individuals there are several issues that need to be considered. During the course of **Healthy Relationships** participants may be absent as a result of health events such as doctor's visits, HIV/AIDS related illness, or any other issue related to their disease. The **Healthy Relationships** intervention team should be aware of the side effects caused by HIV/AIDS medicines. These side effects can impact the physical, emotional, and mental well-being of group participants. Your agency should establish attendance policies to deal with the absences or the cancellation of group sessions. Because one of the Key Characteristics suggests that the peer facilitator be a peer from the community who is living with HIV/AIDS, your agency should be aware that the peer facilitator may also experience a health crisis, which may lead to an absence. Also, immune-compromised individuals are more susceptible to communicable diseases, so your agency staff and the **Healthy Relationships** intervention team should plan accordingly.

Facilitation Coordination and Practice

The facilitation coordination and practice is a specially scheduled time when the two facilitators hold simulated **Healthy Relationships** sessions. Participants for these sessions can be recruited from the staff or agency volunteers; however, if volunteers participate, it is important to make sure they understand their role and the goals of the practice sessions. One of the goals of the coordination and practice is to give the facilitators an opportunity to spend time learning the Facilitator's Handbook, the Easel Chart Guides, and the intervention forms before the intervention begins. Before the sessions begin, the facilitators should decide who will lead which parts of the sessions, though these roles may be adjusted between practices. Facilitators may also want to practice introducing the clips, segues between the clips, discussions, and the role-plays. In addition, the coordination and practice will give the facilitators a feel for the basic logistics of **Healthy Relationships**.

During facilitation coordination and practice, facilitators practice being aware of participants' emotional state and establish signals to each other. These signals can help one facilitator tell the other that an activity's time is up, the discussion has run its course, one participant is dominating the conversation, or it is time to take a temperature check, for example. The actual signals can be a phrase, a posture, or a motion agreed upon in advance. The practice sessions will increase facilitators' comfort-level with the group process and promote flexibility in adjusting the agenda to the needs of the participants. In addition, facilitation coordination and practice will help facilitators assess their facilitation skills. Program managers and relevant staff members may want to observe the practice sessions and provide facilitators with feedback. Facilitators and program managers should consider questions, such as:

- How did the session facilitation go?
- What went well? Why did it go well?
- What did not go well? Why did it not go well?
- How was the pace of the session?

Program managers should assess and provide feedback on the facilitators' knowledge of the intervention content. This could be done by observing the practice sessions and debriefing afterwards. Program manager could follow along in the Facilitator's Handbook or use the session outlines found in Appendix IV. Program managers could also evaluate facilitators' understanding of the intervention by asking them to describe specific activities and using questions, such as:

- What are the objectives of this session?
- What is the purpose of (*insert name of specific activity*)?
- What will the participants learn by the end of this session?

The end result of facilitation coordination and practice is that the facilitators will learn and develop strategies for improving their facilitation skills and the quality of session delivery.

Advisory Board

The advisory board serves as a community advisory panel. The advisory board is not necessary in order to successfully implement **Healthy Relationships**. However, because of the members' unique insight into the target population your agency is working with, the advisory board can be helpful in adapting **Healthy Relationships**. Assembling an advisory board is not a long or extensive process, and the size of the board is not important. The advisory board is composed of people in the community who understand the various needs of the community and know the best way to effectively communicate with the target population. Your agency can use the advisory board to select appropriate and culturally relevant clips. The advisory board can also help your agency customize the Easel Chart Guides, by helping make the language culturally appropriate. In addition, your agency can pilot the intervention sessions with the board, and the members' feedback can help your agency improve the quality of delivery. Some other ways that the advisory board can assist your agency are by providing marketing, recruiting, and retention ideas. The advisory board is a valuable resource in making **Healthy Relationships** a culturally appropriate intervention for your community.

Resources Needed

Supplies

In order to implement **Healthy Relationships**, your agency will need to ensure it has the following supplies:

- Blank DVD disks
- Colored paper for Personal Feedback Reports and other handouts (we suggest using colors that correspond to the divider colors from the implementation manual: Session One-gold, Session Two-green, Session Three-blue, Session Four-orange, Session Five-purple)
- Name badges (we suggest first names/nicknames only)
- Food/snacks
- Male and female anatomical models for condom demonstration
- Condoms (male and female)
- Lubricant (Lube)
- Push pins
- Poster putty and/or masking tape
- Easel Chart Guides enlarged to poster size and with set-the-scenes for selected clips included
- Resource Packets (see Implementation, pages 36-37)

Location, Room Logistics and Time

Healthy Relationships is designed to take place in a private and secure location. The following are some suggestions for location selection and room logistics:

- Central location
 - Along major transit routes so participants without transportation can easily and readily access the location
- Depending on your population's concerns about stigma, you might want to avoid venues that advertise services provided to people living with HIV/AIDS. Possible alternative locations include:
 - Non-descript locations with a private entrance
 - Local religious and community centers
- Handicapped accessible
- Flexible seating arrangements
 - Room needs to be big enough to seat 14 comfortably in a circle
- Tables for food
- Allow for audio/visual equipment and easel charts (which need to be set-up near the facilitators)
- Open at flexible times to make the intervention more accessible

Several factors should be considered when choosing the days and times for your sessions. If you do a community assessment, you can ask about the most appropriate times for holding these kinds of group sessions. Otherwise, your staff may be aware of some of the factors, such as the meeting time for HIV/AIDS support groups, that will affect the decision. The availability of the facilitators and the room also needs to be considered.

Intervention Video(s)

Selecting the clips for your target population is central to the implementation of **Healthy Relationships**. Selected clips can be put together into a customized intervention video to simplify clip usage in the sessions. A customized intervention video is a collection of culturally appropriate or relevant clips for your target population; if you are implementing **Healthy Relationships** with more than one target population, you may need more than one intervention video. DVDs which are cued up to the appropriate counter time can also be used.

In the package are educational clips and a Clip Essence Table (Appendix VI). These tools are provided to guide your agency in the compilation of the intervention video. The Clip Essence Table explains in detail the elements and purposes of each clip. This table is designed to assist your agency in selecting effective clips to use for your target population. The table contains helpful notes about the selection of culturally appropriate clips and how the clips are used in the intervention. Choosing clips can be a difficult task, but the Clip Essence Table should make that task easier for the **Healthy Relationships** intervention team. **Healthy Relationships** makes use of clips from popular movies. Such movies can be rented from local or online video rental stores, or agencies may want to purchase the videos or borrow them from employees or board members.

If agencies do not want to choose clips more specific to their target population, they can use the clips that were used in the original research. The Clip Essence Table also contains information on the clips that were used in the original research. These are available on DVD and with closed captioning. The DVD can be ordered on the **Healthy Relationships** page under “More Information” at www.effectiveinterventions.org (the DEBI website).

Incentives

In the original research, incentives were given to encourage intervention participants to arrive on time. Another use of incentives is to keep participants engaged during sessions; food is a great way to hold participants’ attention. Incentives are not a Core Element or Key Characteristic of **Healthy Relationships**, so your agency is not required to provide incentives. We encourage your agency to consider using incentives for the same reasons they were used in the original research. Suggestions are fast food coupons, discount store gift cards, and movie rental cards. We also encourage your agency to be creative with using and delivering the incentives. If your agency doesn’t have the financial capabilities to purchase gift cards and gift certificates, it may be possible to solicit donations from the community and offer those donations as incentives. The incentives can be raffled off at the end of each session, with only the participants who arrived on time for the session eligible to participate in the raffle. One of the facilitators could draw the winner’s name out of a hat at the end of the session.

Other Intervention Materials

Other resources needed for the intervention are in the **Healthy Relationships** intervention package. The electronic kit includes the CD/DVD-ROM of all materials (including the educational clips and the marketing video), and the agency staff who attend a **Healthy Relationships** training also receive a hard copy of the Implementation Manual and a Risk Continuum Banner in a poster tube.

The materials found either on the CD/DVD-ROM or in the training materials are:

- Implementation Manual
 - Facilitator's Handbook
 - Initial Assessment Survey
 - Personal Feedback Report Forms
 - Evaluation Materials
 - Clip Essence Table
 - Sample Easel Chart Guides
 - Risk Continuum Banner and Cards
 - Marketing Information Sheet Template
- Electronic version of forms and handouts (Word XP)
- Marketing Video
- Educational Clips:
 - *HIV/AIDS Infecting and Affecting Our Community*
 - *When Men Talk About AIDS*
 - *Safe in the City*

The following items are not included in the package. An agency will need to acquire them before implementing **Healthy Relationships**, along with the supplies listed in the budget.

- TV and DVD player with remote control
- Computer with printer (optional, for ease of adapting intervention materials)
- Intervention video (or individual copies of clips)
- Either video equipment to copy selected clips onto an intervention video or funds for a video contractor to create the intervention video for you (optional)

Adapting the Intervention

Adapting **Healthy Relationships** involves customizing delivery of the intervention and ensuring that messages are appropriate for target populations without altering, deleting or adding to the intervention's Core Elements. In addition, it refers to making decisions about the target population to serve and the location for the intervention. In other words, adaptation refers to the "who," "what," "when," "where," and "how" of the intervention.

An example of adaptation is making the clips culturally appropriate or relevant for intended participants. Agencies should work closely with their advisory board to adapt the clips for specific populations. The board can suggest popular movies and specific scenes that may work with specific populations. Remember to use the Clip Essence Table when compiling the clips; it can guide your agency on how to choose appropriate clips.

Another example of adaptation is deciding on the frequency of the intervention sessions. The Dallas implementation met once a week for seven weeks (which included the five regular sessions and an introduction and reunion session). In the original research group, the group met twice a week for two and one-half weeks, instead of once a week. Attempting to do the entire intervention in one 10-12 hour day is not recommended. Participants need time to internalize and deal with the information shared in each session; doing the intervention in one marathon session does not provide the participants with that time.

The facilitators for the Dallas implementation of **Healthy Relationships** decided to start building group cohesion by having an introduction session in addition to the regular five sessions. This session was held before the first session and lasted about 30-45 minutes. During this session, introductions and a "getting to know you" activity were done. The facilitators also explained the intervention in greater detail, answered questions about the intervention, and provided snacks. This introduction session began at the same time and on the same day of the week as the sessions would occur. This was done deliberately, allowing participants to become accustomed to meeting on that day and time.

When adapting this intervention, it is important to think of the impact of the adaptation on the participants. Adaptation does not and should not affect the Core Elements, intent, or internal logic of the intervention. Adaptation should:

- Enhance the delivery of the intervention
- Make the information more accessible for the participants
- Give your agency a chance to be creative with the intervention

Adaptation could involve collaborating with another agency in your area. For example, one agency could host intervention sessions, and the other agency could recruit participants and provide the personnel and volunteers necessary to implement the intervention. There are many ways to adapt **Healthy Relationships**; be creative and have fun!

Adaptation needs to take into consideration the needs of the population, agency resources and capacity, and the Core Elements, internal logic, and intent of the intervention. Training on how to adapt effective behavioral interventions, such as **Healthy Relationships**, is available through CDC-funded capacity building assistance providers and training centers.

Program Review Board

If CDC will be funding all or part of your agency's implementation of **Healthy Relationships**, your agency must follow the "Requirements for Contents of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs" and submit the intervention's sessions, content, information collection forms, participant handouts, and clips you plan to use for approval by a local Program Review Board (PRB). The PRB's assessment will be guided by the CDC Basic Principles found in 57 Federal Register 26742. If all of your funding for **Healthy Relationships** is coming from another source, check with that source for their policy on PRB approvals.

We recommend that you first find out what the local PRB's procedures are and work within them. Since **Healthy Relationships** contains a lot of material, the PRB may not want to review every page. Your PRB may want an abstract or Executive Summary of the intervention sessions to accompany submission of all or part of the materials. If so, copy the section "What is **Healthy Relationships**?" from the Implementation Manual. Attaching this text to a copy of the research article (found in Appendix VII of the Implementation Manual) may be useful for PRB members who are interested in the scientific evidence supporting the intervention.

We recommend that you provide the PRB with a list of materials in the order in which they should be reviewed--starting with the marketing video--so that the members of the PRB understand what **Healthy Relationships** is about and have a context for the other materials. Phased submission may be desirable, if allowed by your local PRB. Phased submission means requesting approval of the intervention concept and session content first and later requesting approval of the specific clips you plan to use. Do not use a phased approach if different PRB members may be reviewing the separate submissions.

When you are requesting approval for the clips you plan to use, do not submit the entire videos from which the clips were taken. Submit a DVD that contains only those clips that you plan to use. Label the DVD "The **Healthy Relationships** intervention was designed for HIV-infected heterosexual men, women, and men who have sex with men and uses clips from popular movies to illustrate different situations where communication may be difficult and to build skills in coping with similar situations. This video is to be used only when conducting **Healthy Relationships** sessions for [*list intended population*]. This video contains language, images, and/or situations that some persons may find offensive." Attach a signed list of persons, with their affiliations, who helped your agency select the clips. This list will establish that community and target population input was involved in the selection.

Indicate which activities that are Core Elements of the intervention, and emphasize that these elements are required in order to obtain results similar to those of the original research. Be prepared to answer questions, provide clarification, or refer PRB members to sections of the package materials for information.

Developing an Evaluation Plan

An implementing agency can conduct the following types of evaluation: formative, process monitoring, process evaluation, and outcome monitoring. There are two key reasons to evaluate a program or intervention: accountability and program improvement.

Accountability could be to the community, staff, clients, or funding source. Implementing agencies must consider their accountability to properly implement any program or intervention. For **Healthy Relationships**, an agency could look at whether the funds designated for this intervention were spent on its needs, such as: facilitator and program manager salaries, benefits and training; video equipment and clips; condoms; marketing materials; and meeting space. Evaluation can help improve the quality of the content and delivery of the program by looking at what worked and what did not work. The evaluation plan created by the agency should identify specific goals of the implementation, such as: number of sessions to be held, length of sessions, number of participants to be recruited, and number of participants to attend all sessions. The information gathered can then be used to help agencies fine-tune their programs by addressing the areas where the agency plan encounters problems.

Formative Evaluation

Formative evaluation is the first type of evaluation that agencies will need to conduct. Formative evaluation is defined as the process of collecting data that describes the needs of the population and the factors that put them at risk.

The **Healthy Relationships** Initial Assessment Survey (IAS) provides baseline information that can be utilized as a pre-test to gather these data, as well as for the creation of the Personal Feedback Reports (PFRs). (See Appendix III)

Process Monitoring

Process monitoring is the next type of evaluation that agencies can conduct. Process monitoring can be defined as the process of collecting data that describes the characteristics of the population served, the services provided, and the resources used to deliver those services.

Process monitoring answers such questions as:

- How many sessions did we conduct?
- How many people living with HIV/AIDS attended the sessions?
- What resources have we used to deliver the intervention?

Process Evaluation

Process evaluation is the third type of evaluation that agencies can conduct. Process evaluation can be defined as the process of collecting more detailed data about how the intervention was delivered, differences between the intended population and the population served, and access to the intervention.

Process evaluation looks at whether the agency maintained fidelity to the intervention's Core Elements and what Key Characteristics the agency adapted. Process evaluation is a quality assurance piece that ensures agencies are delivering **Healthy Relationships** and not some unproven variation of the intervention. Some sample questions include:

- Was each Core Element presented as outlined in the manual?
- Was the intended target population enrolled?
- Were the chosen clips appropriate for the target population?

Adherence to the Core Elements of **Healthy Relationships** might be evaluated by asking such specific questions as:

- Were the Personal Feedback Report (PFR) forms for family members and friends passed out in Session One? If not, why not?
- Were all Five Coping Skills taught in Session Two? If not, list the skill(s) not taught and explain why.
- Were Clips #3-1 to #3-3 used in Session Three to reinforce and practice the Five Coping Skills? If not, list the clip(s) not used and explain why it was not used.

Outcome Monitoring

The last type of evaluation agencies can conduct is called outcome monitoring. Outcome monitoring is defined as the process of collecting data about client outcomes (e.g., knowledge, attitudes, skills, or behaviors) before and after the intervention.

Outcome monitoring cannot be done until agencies have done formative evaluation, process monitoring, and process evaluation, and the intervention is being delivered as planned. Outcome monitoring looks at an outcome or change in behavior, such as increased condom use, and answers the question "did the expected outcome occur?" It involves comparing individual responses on the Initial Assessment Survey to those on the Post Assessment Survey and measuring the differences. Agencies may have an evaluation expert on their staff or may have consultants to perform this analysis.

Planning for Evaluation

Before an agency begins to implement **Healthy Relationships**, the staff members need to review the sample evaluation forms in Appendix VIII and adapt the forms to fit the planned implementation. The following questions need to be answered to plan the evaluation:

Process Monitoring

- What process data are required by the funding agency and in what format?
- What other process data could be helpful to know and in what format will it be available?
- What type of data collection form will be used?
- How will the data be collected?
- How will the data be compiled (a computerized data system, a single computer spreadsheet, or a written spreadsheet)?
- Who is responsible for each step?
- How will quality assurance over the evaluation occur?

Process Evaluation

- All of the same questions as process monitoring
- How will the comparison between the activities and progress be made and by whom?
- What actions will occur if discrepancies are found?
- How will the results be used to improve the program?

Outcome Monitoring

- What are the expected outcomes from **Healthy Relationships**?
- What outcome data can be collected and in what format?
- What type of data collection form will be used?
- How will the data be collected?
- How will the data be compiled (a computerized data system, a single computer spreadsheet, or a written spreadsheet)?
- Who is responsible for each step?
- How will the analysis be conducted and by whom?
- How will the results be reported and to whom?
- How will the results be used to improve the program?

Planning for Legal and Ethical Issues

One crucial step in preparing for the intervention is setting up the proper policies and procedures that will protect the agency, the **Healthy Relationships** intervention team, and the participants. It is important to keep in mind that **Healthy Relationships** is an intervention that deals with disclosure of HIV status. **Healthy Relationships** also includes discussion of many relationship issues. Each state has their own set of laws and statutes regarding requirements to disclose to sexual partners, and experienced counselors are often subject to various reporting requirements as licensed mental health professionals. With that in mind, agencies and staff must know their state laws and licensing requirements regarding disclosure of HIV status to sexual partners and the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse. Agencies and staff are obligated to inform participants of any limits to confidentiality required by law or licensure. Agencies need to have a consent form which explains carefully and clearly, in accessible language, the agency's responsibilities and the participants' rights.

Marketing and Participant Recruitment

The final step in preparing for implementation is planning for marketing **Healthy Relationships** to your community. Included in the package are some generic marketing tools that agencies can use to advertise **Healthy Relationships**. The advisory board is another useful marketing tool because the members can advise your agency where to place the marketing brochure and identify other ways to engage the community. Agencies want to concentrate their recruitment efforts where there are substantial numbers of people living with HIV/AIDS. Advertising attempts need not be limited to traditional venues such as AIDS service organizations and support groups, but agencies can send fliers, press releases, and public service announcements to local religious organizations and radio and TV stations, or take out advertisements in local newspapers. They can also post information on the Internet.

Agencies should have a process for interviewing potential participants before assigning them to a **Healthy Relationships** group. Not all potential participants are a good fit for this type of intervention, and agencies will need to redirect those people to other services. Even ideal participants need to be assigned to a group appropriate for them; agencies may have to postpone these participants' enrollment until a suitable group is available. Appendix III has a pre-assessment interview form on page 2 that can be used as a starting point for questions to ask, but each agency should adapt the questions to be most appropriate for their implementation. This interview form was not used in the original research study because the study accepted anyone who was living with HIV/AIDS and willing to participate in the intervention.

For more information on pre-assessment interviews, see Implementation, page 32.

Implementation

Implementation is defined as the actual delivery of the intervention.

Recruitment of Participants

As previously mentioned, your agency should have a recruitment plan in place that details how participants will be recruited, recruitment venues and locations, recruitment/marketing tools, and number to be recruited. The advisory board can provide your agency with the answers to some recruitment questions, such as:

- Where is the best place to recruit?
- What are the best recruitment strategies for your populations?
- What might motivate members of the target population(s) to attend **Healthy Relationships**?

In the package there is a generic marketing information sheet template that can be adapted, with the assistance of the advisory board, and used to recruit potential participants.

Participant Retention

Keeping clients engaged in the process can be a difficult task. The facilitators have much of the responsibility for making sure that all participants:

- Have a chance to contribute to discussions
- Have a chance to participate in activities
- Have a chance to have their thoughts heard
- Feel welcomed, safe, and supported

Facilitators also should work hard to make the content exciting and their presentation of the content innovative. To aid this process we suggest having popcorn and other snacks available during the sessions. Incentives also will keep participants involved in the sessions.

Part of retention is more administrative. Sending out reminders about the next session can help participants to remember to attend. Selecting a meeting facility where participants feel comfortable can make them more likely to return.

Attendance Policy

Implementing agencies should have an attendance policy in place. The policy should clearly explain the agency's expectation that participants attend every session and that the sessions are closed to new members. The attendance policy should also address tardiness and the notification process for absences. Each session builds on the previous session, so missing sessions undermines the ability of participants to fully participate in the intervention. If a participant misses Session Two, they should be rescheduled for another group since Session Two introduces the skills that are practiced throughout the other sessions. If a participant misses two sessions, they also can be asked to join a future group. Participants who miss a session can come early the next time to allow facilitators to "bring them up to speed."

Pre-Assessment Interviews

Pre-assessment interviews are an opportunity for your agency to interview potential **Healthy Relationships** participants and assess their readiness to participate in the intervention. The interviews can be conducted by the facilitators in a private room where the potential participant can freely answer the questions in a welcoming and supportive environment. During the interviews, the facilitators ask the potential participants about their previous group experience and their ability to handle conflict. The pre-assessment interviews provide facilitators with an opportunity to assemble a group of participants whose personalities work well together. Additionally, during the pre-assessment interviews, participants can complete the Initial Assessment Survey (IAS) and have their questions about **Healthy Relationships** answered. Some sample questions are:

- What has been your experience with support groups or discussion groups?
- What do you like most/least about groups?
- How do you handle tension or conflict within a group of people?

A sample pre-assessment interview questionnaire is in Appendix III, page 2. This tool can be adapted to fit your population.

Forms

The following section is an explanation of the forms in the package, their location, and how they are used in implementing **Healthy Relationships**.

Initial Assessment Survey

The Initial Assessment Survey (IAS) is completed by the participants before the first session. This can be done as part of the pre-assessment interview, or another time can be scheduled, as long as the IAS is completed in time to transfer the relevant information to the first Personal Feedback Report (PFR). This survey can be adapted for specific populations. See Appendix III, beginning on page 3, for a sample version.

The survey has five sections. The first section asks participants to assess stressors in their daily life. The second section gauges the participant's ability to disclose their HIV status to family and friends. The third section asks participants to assess their ability to disclose their HIV status to sexual partners and inquires about participants' ability to practice safer sex. The fourth section asks about history of sexually transmitted diseases (STD). The final section is about needle-sharing and drug-using behavior. The facilitators may want to review each participant's assessment so they can gauge each participant's development as the intervention progresses.

We suggest encoding the IAS to ensure the privacy of the participants. The participant ID code can be created from any information you get from the participant, such as birth month plus the first three letters of their first name, from a list of random numbers/letters, or in any other manner an agency prefers. Make sure participants know their ID code, so it can be used to identify their Personal Feedback Report forms.

For more information on the IAS, see Implementation, page 44.

Personal Feedback Report Forms

Personal Feedback Report (PFR) forms are created based on each participant's answers on their Initial Assessment Survey (IAS). The participant's answers are transferred, sometimes combining answers, to the appropriate PFR. Anyone on the intervention team can prepare the PFR forms. See Appendix III, pages 10-15, for copies of the three forms (PFR-A, PFR-B, PFR-C) and keys that show which questions on the IAS are used to create each of the forms. These forms need to be filled out before the beginning of the session in which they are to be used; it may be helpful to do all of the forms before the intervention cycle begins to avoid last-minute problems. PFR forms can be coded with the participants' ID codes and folded to help protect the participants' privacy.

The individual PFR forms are handed back to participants in Sessions One, Three, and Four. The PFR forms will be color coordinated according to session: PFR-A for Session One is gold, PFR-B for Session Three is blue, and PFR-C for Session Four is orange. The forms are used in several ways. First, they remind participants how they responded to questions on the IAS. Second, the forms can be used to help motivate participants to change their

behaviors. The forms can motivate in two ways. The PFR forms can help participants identify what they do as compared to what they want to do. The PFR forms can also reinforce existing safer behaviors participants want to maintain.

During the first, third, and fourth sessions, facilitators should display a poster-sized PFR, found in the Easel Chart Guides (1-e, 3-a, and 4-e). These are identical to the ones handed back to the participants, except that no answers are recorded on them and the “blanks” include a definition of what goes there. For example, if the answer that goes in the “blank” is a number, the guide will show “_(#)_,” if the answer is based on a scale, the guide will show the scale options (e.g., “very sure” to “not sure at all”). These enlarged PFR forms are used to review the questions and frame that session’s discussion topics. The guides should be large enough that participants can read them from their seats in the circle, so the size you make them may vary.

For more information on PFR forms, see Implementation, page 44.

Facilitator Forms

In Appendix IV there are three types of forms: session evaluations, session outline forms, and facilitator evaluations. The session evaluation form should be filled out by the facilitators at the end of each **Healthy Relationships** session. These session evaluations can be used to help with the debriefing sessions, especially if they are delayed for any reason, and process evaluation. The session outline forms provide a checklist of tasks for before, during, and after each session. The next two forms look at personal characteristics and group process skills of the facilitators. These forms are designed for use when selecting new facilitators or re-evaluating current ones.

For more information on facilitator forms, see Implementation, page 44 and Appendix IV.

Other Session Materials

Risk Continuum Banner and Cards

In the sessions where the PFR forms are distributed, **Healthy Relationships** has related Risk Continuum Banner activities. These activities involve a long banner, which is used for all three activities, and three sets of cards, one for each session. In Session One, the activity deals with disclosure to family and friends, so the cards used in that session are labeled with various types of family members and friends. The activity in Session Three deals with disclosure to sexual partners; these cards are labeled with different type of sexual partners. In Session Four, the activity is about the level of risk of various sexual behaviors, and the cards are labeled with different types of sexual activities. It is important to note that these activities focus on risk because all of the situations addressed, whether involving disclosure or risk reduction, are potentially risky to the participants.

Participants attach the cards to various points along the Risk Continuum Banner based on their personal evaluation of the risk involved. For the first two activities, facilitators need to make the connection between how risky someone feels it is to disclose to a particular type of person and the related amount of stress the participant might feel. For these two activities, facilitators should also emphasize that there are no right and wrong answers; the purpose is for participants to identify their personal continuum of risk related to disclosing their HIV status. The third activity covers HIV transmission risks and is the only one with correct answers; the facilitators must make this point clear to the participants. A key to the correct answers is in Appendix I on page 25; agencies may need to revise this key in the future based on new discoveries about the way HIV is transmitted.

Samples of the Risk Continuum Cards are in Appendix I. The risk continuum is printed on a banner that is rolled up in a poster tube and provided to those attending **Healthy Relationships** training classes. This long banner has a double-ended arrow labeled from high to low (see Figure 1 below). A “no risk” area can be added if agencies want. In the intervention study, the line of the arrow was covered with Velcro®, and the cards had corresponding pieces of Velcro® on the back to allow them to be attached and detached easily from the banner. The banner you will be given at the **Healthy Relationships** training does not have Velcro®; this allows for more flexibility in where the cards are attached to the banner. For example, the third activity is designed so that most of the cards are placed at the low end of the Risk Continuum Banner; with the Velcro® the cards could only be attached on the line of the arrow. Participants exhibited frustration or confusion when they could not attach their cards where they felt they belonged. If tape, poster putty, or similar temporary adhesives are used, the cards could be grouped all around the desired area.

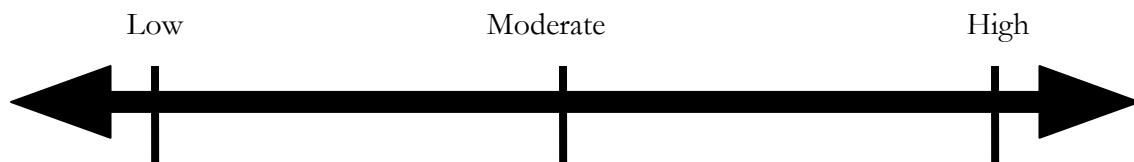


Figure 1: Risk Continuum Banner

For more information on Risk Continuum Cards, see Implementation, page 43 and Appendix I.

Easel Chart Guides

The guides were developed so the facilitators won't have to read from the Facilitator's Handbook during the sessions. The Easel Chart Guides are provided to give visual reinforcement to the participants of the subjects under discussion and questions to consider. The guides can serve to remind the facilitators of all of the most important points in a session.

Copies of the guides are included in Appendix II. Many of the guides can be copied as is, but always consider their appropriateness for the participants and adapt them as needed. The Easel Chart Guides about clips will need to be adapted based on the clips selected for the group and the "set-the-scenes" created for the clips.

The guides need to be large enough for participants to be able to read them. The original study enlarged and laminated each page; the guides were then comb-bound at the top to allow them to be turned easily. However, creating Easel Chart Guides this way costs a lot, and lamination does not allow for changes to be made easily.

For more information on Easel Chart Guides, see Implementation, page 43 and Appendix II.

Resource Packets

Participants in **Healthy Relationships** may have questions and needs that cannot be addressed during the actual sessions. Because of this, each participant should receive a Resource Packet during the first session. The facilitators should encourage participants to make use of these resources and remind them of the packet at the end of each session.

The Resource Packet should be compiled and copies made before the first session, following the suggestions below. Agencies need to create a packet to fit the services and other resources available to people in their community. The packet should include the following information:

- An introduction to the **Healthy Relationships** intervention,
- A statement about confidentiality limits and relevant notification laws,
- The basics about the sponsoring organization, including why they are implementing **Healthy Relationships**,
- A variety of resource information sheets specific to the community (e.g., information about where in the immediate area to find HIV/AIDS services and support groups; assistance with housing, food, medical treatments, prescriptions, domestic or other violence; etc.),
- Up-to-date information on HIV/AIDS transmission, drugs, and therapy/treatment, and
- A list of the "key contacts" for people living with HIV/AIDS.

Here is a list of some additional types of materials that might be included.

- Business card or other contact information for the facilitator(s) and the sponsoring agency.
- Printouts from websites of interest to your participants.
- List of contributors for any donated gift certificates or coupons.
- Any other materials you believe might serve as a resource to your participants.

Pre-Delivery Checklist

The pre-delivery checklist is a quick reference of items that should be in place before **Healthy Relationships** is delivered.

- Participants recruited
- Participants assigned to groups
- Location selected and room set-up
 - Table for food/snacks (prepared)
 - Functioning TV/DVD player with remote control
- Sessions scheduled
- Pre-assessment interviews completed
- Initial Assessment Surveys (IAS) completed
- Personal Feedback Report (PFR) forms completed
- Facilitation coordination and practice sessions held and completed
- Resource Packets compiled and copied
- Supplies acquired
- Customized intervention video completed or individual DVDs cued up
- Condoms, condom models, and lubricant (lube) acquired
- Incentives obtained
- Other intervention material on-hand, prepared, copied, enlarged
- Easel Chart Guides (including changing set-the-scenes for any new clips)
- Risk Continuum Banner
- Risk Continuum Cards (cut, laminated [optional], with tape, poster putty, Velcro®, or other adhesive on the back to allow them to be attached and detached easily from the banner)

Debriefing

Healthy Relationships deals with issues that may cause varied emotional responses for both the participants and the facilitators. Debriefing allows the facilitators a time to release those emotions in a supportive space. Your agency may have some specific methods for debriefing; the following is designed to add to your agency's existing procedures.

The program manager may want to lead the debriefing sessions for the facilitators. Debriefing is the outlet for the facilitators to express their feelings about the sessions through journaling or talking through any issues that arose during the sessions. The debriefing session also can be for discussing what is and is not engaging participants and what alterations in delivery need to be made. Facilitators can seek advice or brainstorm solutions to issues or questions that came up during the session. They can make plans on how to deal with situations that are likely to be repeated, such as a participant who does not let others talk.

Here are some specific questions that might be asked in debriefing:

- **Participants:**
 - Who needs to be coaxed to participate?
 - Who needs to be kept from dominating the group?
 - Who might need referrals?
 - Who needs referral appointments made for them?
 - Who needs help with transportation? Child-care?

- **General session notes:**
 - What went well?
 - What did not go well?
 - How could delivery of the next session be improved?
 - What concepts did participants have trouble grasping?
 - What concepts need to be reinforced next time?

- **Environment:**
 - Was the room too hot/cold?
 - Were there enough chairs?
 - Could the participants be overheard?
 - Were there enough snacks?

How to Conduct Debriefing Sessions

The program manager or other person conducting the debriefing session acts as a “guide,” not a counselor, for the debriefing. On the other hand, since many emotions may be expressed, it can be helpful for the guide to have a working knowledge of mental health issues, such as the five stages of grief (denial, anger, bargaining, depression, and acceptance).

The guide should create an environment where the **Healthy Relationships** facilitators can relax and voice their opinion without fear of scrutiny, allowing each facilitator between five and seven minutes to convey both negative and positive feelings about the session. This time is used to allow time for each facilitator to let go of the emotions they felt during the session.

Guilt is an example of an emotion that may be expressed by the facilitators. The facilitators who are not living with HIV may experience guilt while listening to the group testimonials. The feeling of guilt could be a result of recognizing similar behavior patterns or risky behaviors in themselves and not understanding why or how they have not acquired HIV.

Questionnaires can be used to help elicit feelings, opinions, and behaviors, so that the facilitators can express their emotions, thoughts, and actions. The guide may prefer to ask the questions themselves or allow facilitators to complete a written form. Sample questions include:

- How did you identify with the group members today?
- What made you uncomfortable during the session?
- What was the highlight of today’s session?
- What was the low point of today’s session?
- What would you like to see different about group activities?
- What behavior do you feel indicated how uncomfortable you were with the group topic or an individual’s statement?

Journaling may be suggested to allow for the expression of personal issues and thoughts. Journaling can also be used to brainstorm ideas and to describe issues about the group sessions. The program manager can review the journals and schedule a meeting as needed to address anything that may be hindering the group’s progress.

Most of the debriefing topics should be work-related, focus on the **Healthy Relationships** sessions, and not veer into personal issues (if possible). If personal issues are a problem and impede the group debriefing, it might be suggested that the facilitators work with a personal counselor to address such issues. Staff could utilize their Employee Assistance Program, if available.

If the program manager has observed a session, they could provide feedback to the facilitators during the debriefing session. The Facilitators’ Session Outlines (Appendix IV) are one tool for collecting notes during observations; the forms are particularly helpful for providing feedback on the facilitators’ understanding of the **Healthy Relationships** content. Appendix IV also contains Facilitator Evaluations that can be used to assess personal characteristics and group process skills.

Another way to help focus the debriefing on the **Healthy Relationships** groups is to use questions like those on page 38 about the participants, general session delivery, and the environment. If facilitators complete the session evaluations from Appendix IV after each session, these forms can help reinforce the facilitators' memories during debriefing. These forms also can help the guide cover many important details of session delivery and logistics, such as:

- Session objectives: If specific session objectives were not met, discuss how that can be addressed in the next series of **Healthy Relationships** groups.
- Participant engagement: If participants are anything but “very engaged,” spend time developing ideas for increasing engagement.
- Attitude and behavior change: Signs of either type of change are very positive results and can be used to help facilitators focus on what they are accomplishing.
- Referrals: If referrals are requested, this allows the guide to make sure that facilitators are following through on this.
- Problems with room, supplies, and equipment: As with referrals, this ensures that such situations are dealt with before the next session.
- Additional comments: This refers the guide to other issues that facilitators may want to discuss.

End each debriefing session with a recap of the topics discussed, any action items, and positive reinforcement for the facilitators.

HEALTHY RELATIONSHIPS

A small group-level intervention with people living with HIV/AIDS

Facilitator's Handbook

Delivering the Sessions

How To Use The Session Guidance

Guidance for conducting the five sessions and related materials follow. Each of the five sessions has its own section, which begins with a listing of the goals, an agenda, and the materials needed. The text relates back to the agenda and includes all the basic subject matter for that meeting.

Core Elements



An apple symbol appears at the top of the first page of every activity that is directly related to a Core Element. These are the activities that must be included in order to have the same outcomes as the original research.

Actions



The symbol indicates the **points where the facilitator needs to take action** other than showing clips. Actions include passing out the Resource Packets, Personal Feedback Report (PFR) forms, Risk Continuum Cards, worksheets, and so forth. The symbol also indicates when breaks are taken and the lottery drawing is held.

Activities

All activities have **step-by-step instructions (procedures)**. The facilitator will find much of the same information on the Easel Chart Guide related to that portion of the session. The procedures are more detailed and directed at the facilitator; they are not instructions to be given to the participants.

Agendas

Agendas are given for each session with suggested lengths of time for each activity. Facilitators need to be flexible about the schedule to some extent. If participants are seriously discussing a topic of importance to them, they should be allowed to continue somewhat past the normal time limit for that segment. It is the responsibility of the facilitators to make adjustments to the agenda in each session as needed. Facilitators should not leave out any component of the intervention and should not keep the participants longer than the announced session length.

Five minute breaks are built into each agenda, since the sessions last two hours. This allows participants to go to the restroom, stretch, and relax briefly, without interrupting the flow of the intervention too much. If snacks are provided, this is an appropriate time for having them brought in.

Appendices

In the Appendices, there are various materials relevant to the intervention sessions, some of which may need to be adapted to fit the lives and cultures of the group's participants. These materials include samples of the cards needed for the risk continuum activities, Easel Chart Guides, facilitator evaluation forms, feedback reports, and resources and information on selecting clips. The sample materials can be photocopied and enlarged as necessary, attached to cards if appropriate or, in the case of the guides, produced into an easel chart. They also may be handwritten, if preferred, on the appropriate media.

The materials in the Appendices can be adapted in any way appropriate to the group's participants. For example, if the persons in the group do not use the words "mate" or "husband" to refer to partners, more appropriate language should be substituted. Terms may be added as needed. If participants respond well to pictures, these may be combined with the text provided or used in place of some or all of the text.

Risk Continuum Cards (Appendix I)

The risk continuum activities use the banner and cards described on pages 35-36 of this Implementation section. These activities focus on each of the life areas mentioned in the first Core Element:

- **Activity 1: the risk/stress of disclosure to family and friends**
- **Activity 2: the risk/stress of disclosure to sexual partners**
- **Activity 3: the risk of various sexual behaviors**

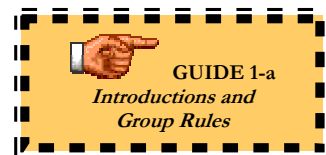


Each time the Risk Continuum Cards are to be used, a symbol like the one to the left is displayed. This is a sign to look in Appendix I for a sample of cards to be created. Remember that, while cards and a banner are included in the intervention package, the words on the cards can be changed to reflect the terms used by the participants. The Risk Continuum Banner can be left up throughout the sessions, but any attached cards should be taken down at the end of each session.

Easel Chart Guides (Appendix II)

Facilitators should not read from this handbook during the sessions. The Easel Chart Guides are provided to visually reinforce the subjects under discussion and present questions for the participants to consider. The Easel Chart Guides can serve to remind the facilitators of all the most important points in a session.

Each time an Easel Chart Guide is to be used, a symbol like the one to the right is displayed. The background of each is tied to the color designated for that session, and the text that matches it is underlined. As with the Risk Continuum Cards, a sample of the corresponding Easel Chart Guide is found in the Appendices. Many of the guides can be copied as is, but always consider their appropriateness for the participants and adapt them as needed. The Easel Chart Guides about clips will need to be adapted based on the clips



you select for your group and the “set-the-scenes” you create for those clips. The guides in Appendix II include separate pages for each of the original clips.

See Appendix VI on Video and Movie Clips for more information on creating new guides.



Participant Forms (Appendix III)

There are three forms in Appendix III: participant interview questions, the Initial Assessment Survey (IAS), and three Personal Feedback Report (PFR) forms. The PFR forms are created based on each participant’s answers on his/her IAS. This questionnaire needs to be filled out before the date of the first session to allow for transferring the responses onto the individual PFR forms used in Sessions One, Three, and Four. Keys for tying each of the PFR forms to the IAS are also included.

Make copies of the PFR forms as needed, circling and filling in the answers from each participant’s IAS. These PFR forms can be color-coded to avoid confusion; the handbook codes PFR-A gold, PFR-B blue, and PFR-C orange. As with all materials, these PFR forms and the corresponding IAS can be adapted to fit the participants’ lives and cultures.

The PFR forms can reinforce participants’ motivation to change. Some ways that the PFR forms may accomplish this are by helping participants to identify:

- What they do
- What they want to do
- Existing safer behaviors they can maintain

Each of the blank PFR forms is available on Easel Chart Guides 1-e, 3-a, and 4-e. The guides are used in Sessions One, Three, and Four to explain the PFR for that session. For more information, see Implementation, page 34.

The appendix also includes a worksheet that can be used when teaching about “I” messages.

Facilitator Materials (Appendix IV)

Appendix IV includes post-session evaluations, facilitators’ session outlines, and facilitator evaluations. These three forms are designed for use by the facilitators and/or program managers. At the end of this appendix is a section on group facilitation skills and tips. This is intended as an introduction to good group facilitation. It should not be considered a substitute for facilitation training, practice, and experience.

Resources (Appendix V)

Appendix V includes websites that could help in finding information about HIV/AIDS and in locating clips for creating your customized intervention video.



Video and Movie Clips (Appendix VI)

As mentioned elsewhere, there are a variety of types of video and movie “clips” shown in the five sessions of **Healthy Relationships**: personal statements, HIV/AIDS information, condom demonstration, and, most importantly, segments from popular movies. Remember that the term “clip” is used, regardless of whether the clip is short or long or even an entire video. Appendix VI gives information about both the original clips used during the research and how to choose new clips, if desired or appropriate. All clips should be “movie-quality” (that is, with high production values) and chosen based on the composition of the groups.

Brief descriptions or “set-the-scenes” of all clips selected for use during the interventions need to be created in advance. Facilitators use these descriptions to introduce clips, while tying them to the objectives of that session. Correctly setting up the scenes facilitates both role-playing and discussion. These “set-the-scene” descriptions are also used on many of the Easel Chart Guides. “Set-the-scenes” for the original clips appear on the guides in Appendix II and are also found in the Clip Essence Tables of Appendix VI.



The symbol to the left will be used in the handbook to indicate points where clips are shown. Clips are numbered in order by session, with the first number referring to the session during which they are viewed. For example, the second clip shown in the first session is called Clip #1-2.

Discussion follows all clips, except the ones at the end of Session One. It is important that these clips (Clips #1-2 and #1-3) are entertaining, since they are used to help ensure participants return for the next session. Movie clips (Clips #2-1, #2-2, #3-1, #3-2, #3-3, #5-2, #5-3, #5-4, and #5-5) are used to help participants practice the coping skills and model behaviors.

For the movie clips, there are specific procedures listed in the handbook that show facilitators how to set up a context for the clips, show the clips, and guide discussion at selected points. Facilitators use guided discussion with these clips to have participants practice awareness in the situation shown in the clip; create a list of identified triggers and barriers to disclosure (Sessions Two and Three) or negotiating safer sex (Session Five); brainstorm options to problem-solve one of the identified triggers or barriers, and complete a Decision-making Grid of the costs and benefits of disclosing (Sessions Two and Three) or practicing safer sex (Session Five). The practice of the first four skills leads to participants role-playing the action they would take if they were in a similar situation.

Article on Original Research (Appendix VII)

The results of the original research of the **Healthy Relationships** intervention are reported in the article included in Appendix VII. This article was printed in the *American Journal of Preventive Medicine* 2001;(21):84-92.

Evaluation Forms (Appendix VIII)

Each agency's funding source will have different requirements for process monitoring, process evaluation, and outcome monitoring. Appendix VIII includes forms that are supplied as suggestions. Each can be modified to fit your agency's requirements, target population, resources, and needs. Included are a Process Monitoring Form, Process Evaluation Form, Participant Feedback Form, and Post Assessment Survey.

CDC Materials (Appendix IX)

Appendix IX contains information from the Centers for Disease Control and Prevention on male latex condoms, on nonoxynol-9, and on content of AIDS-related materials and educational sessions.

Notes to the facilitator



The handbook is primarily written as instructions for the facilitators. Certain statements are particularly helpful in terms of understanding the purposes of the intervention. These have the “don't forget” symbol above.

Temperature taking



To make groups successful, it is necessary for facilitators to allow time for participants to discuss how they are feeling at certain points in the **Healthy Relationships** sessions. Suggested moments for this are marked with this symbol.

Session One

Session Objectives:

- Introduce the goals and expectations of the program.
- Establish group cohesiveness and trust.
- Introduce connection between stress and HIV/AIDS.
- Introduce disclosure to family and friends as a potential stressor.
- Identify personal disclosure to family and friends risk continuum.

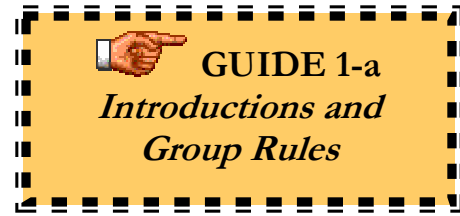
Agenda for Session One




•	Introductions	10 minutes
•	Group Rules	5 minutes
•	Getting to Know You: Interview Pairs	25 minutes
•	Dealing with Stress Factors	10 minutes
•	Communicating Effectively	5 minutes
•	Break	5 minutes
•	Personal Feedback Report/PFR-A: Stress and Disclosure to Family and Friends	10 minutes
•	Stress and Disclosure: Discussion of Clip #1-1	15 minutes
•	Risk Continuum Banner: Disclosing to Family and Friends	25 minutes
•	Summary and Close Clips #1-2 and #1-3	10 minutes
		<hr/>
		2 hours
•	Post-session: Debriefing	20 minutes

Preparation and materials needed for Session One:


- Prepared Easel Chart Guides
- Easel, blank easel pad, and markers
- Masking tape or push pins
- Resource Packets
- DVD of Clips #1-1 to #1-3
- TV, DVD player, and remote control
- Completed Personal Feedback Report (PFR-A) forms (gold)
- Risk Continuum Banner and Family/Friends Cards
- Popcorn and other snacks
- Prize(s) and lottery tickets
- Evaluation forms for facilitators

Introductions



	Purpose:	Participants will learn about Healthy Relationships.
	Time:	10 minutes
	Materials:	Guide 1-a Lottery tickets




Procedure:

1.  Give a “lottery ticket” to participants who arrive early or on time, explaining that you will hold a drawing for a prize at the end of each session.
2. Group co-facilitators should introduce themselves.
3. Thank participants for coming. Acknowledge that it is difficult for people to deal with issues of living with HIV/AIDS, and affirm participants’ willingness to come to the group sessions.
4. Tell participants about:
 - The reasons for the sessions:
 - To share information
 - To help participants improve the quality of their relationships
 - To help participants stay healthy by reducing their stress and sexual risk behaviors
 - What the intervention will do:
 - Give them an opportunity in a fun way to explore the stress related to disclosure and relationships
 - What everyone can hope to learn:
 - New and more effective ways to deal with challenges

5. Cover housekeeping tasks:

- Location of the restrooms
- How long the sessions/break will last
- Bad weather policy
- Being on time/attendance policy
- Transportation issues
- Child care availability
- Health issues
- Anything specific to the time or location

Group Rules

	Purpose:	Participants will establish an agreed-upon, appropriate code of behavior for the group.
	Time:	5 minutes
	Materials:	Easel Blank easel pad and markers

Procedure:

1. Explain the value that groups bring and reasons we meet in groups, including:
 - To share ideas
 - To learn from each other's experience
 - To benefit mutually from collective energy
2. Explain that the group is closed to additional members and that the same facilitators and participants will meet each time.
3. Explain that, because the group will discuss sensitive issues, participants should agree upon group rules. The purpose of the group rules is to help participants feel comfortable and be able to discuss issues.
4. Ask participants to generate group rules, making sure that the following elements are included:
 - Confidentiality
 - Openness/honesty
 - Respect
 - No putdowns or judgments
 - Everyone has a chance to talk
 - No cell phones/pagers
 - Freedom to ask questions
 - Right to pass/not participate in specific activities
 - No inappropriate touching
 - No dating other participants during series of sessions
5. Get agreement to the group rules. Write these rules on a sheet of easel paper so that they can be posted for reference at each session.

6. Emphasize that the main goal of the group is to learn something new and have fun while learning.

Additional Notes for Facilitators:



The elements of the group rules listed in #4 above may also be addressed as part of recruitment interviews.






Use whatever term you and your participants feel most comfortable using for “Group Rules,” such as “Group Agreements,” “The Code,” or other variations.



Remind participants at the beginning of each of the remaining sessions that they can add to the group rules at any time during the sessions.

Getting to Know You: Interview Pairs



	Purpose:	Participants will build group cohesion by getting to know each other.
	Time:	25 minutes
	Materials:	Guide 1-b

Procedure:

1. Tell participants that we are going to begin with an activity called "Interview Pairs" that will aid in the process of bonding and group cohesion.
2. Point out to participants that the activity relates to disclosure. Everyone will "disclose" something about themselves in this activity.
3. Ask participants to think about the different types of stress that people mention and the ways they deal with it.
4. Have everyone pair off with someone they don't know and interview their partner for five minutes using the following questions (also found on Guide 1-b). Point out that the questions are on the easel chart.

Questions for the pairs:

- Who are you?
 - What is one thing you find stressful, and how do you cope (or deal) with it?
 - If this was your day and you could do anything you wanted, what would it be?
5. Ask participants to use only first names.
 6. After both partners have completed their interviews, reconvene the whole group.
 7. Let partners introduce each other and share the answers to the questions.
 8. Guide discussion by focusing on similarities and differences.



Dealing with Stress Factors



GUIDE 1-c
Dealing with Stress
Factors



Purpose: Participants will understand what is meant by stress and learn some skills to cope with stress.
(Core Element 1)




Time: 10 minutes



Materials: Guide 1-c
Resource Packet

Procedure:

1. State that we all have things that create stress in everyday life.
2. Discuss some stress factors in life. Use some of the following statements to help facilitate discussion:
 - Some stressors are minor and easy to deal with, while other stressors are significant (major) and can be overwhelming.
 - HIV/AIDS can be a long-term stressor that is difficult to deal with.
 - For some people, HIV/AIDS can be at the top of the list as a stressor; for others, HIV/AIDS may not be the number one stressor in their life.
 - In either case, HIV/AIDS can present added problems and stress that can affect health.
 - The things we will discuss in these sessions, what you learn from each other, and the activities you participate in will help you cope better with these stressful aspects of living with HIV/AIDS. We hope it will also make you healthier.
3. Reinforce that these sessions address some of the stressful aspects of living with HIV/AIDS, specifically:
 - Disclosing to family and friends
 - Disclosing to sex partners
 - Building healthier and safer relationships

4.  Provide each participant with a Resource Packet that includes information about the **Healthy Relationships** intervention, a statement about confidentiality limits, information on the sponsoring organization, a variety of resource information sheets, and a list of the “key contacts” for people living with HIV/AIDS. This packet should be made in advance (suggestions for making Resource Packets are in the Implementation section, pages 36-37).
5. Identify supportive resources available to the group, as the sessions will not address every stressor that is important to participants.
6. Instruct participants to use these resources for questions and assistance outside the scope of this five session intervention.

Additional Notes for Facilitators:



For those stressors not covered in the five **Healthy Relationships** sessions, information about resources outside the group will be helpful.



Refer participants back to the materials in their Resource Packet throughout the sessions.



Communicating Effectively



GUIDE 1-d *Communicating* *Effectively*



Purpose: Participants will learn communication skills to cope with stress.
(Core Element 1)




Time: 5 minutes



Materials: Guide 1-d
Resource Packet
Popcorn and/or other snacks

Procedure:

1. State that using effective communication skills is another way to reduce stress in certain situations.
2. Introduce the idea of using “I” statements as a possible way of communicating in the group by tying them to the group rules about “respect” and “no putdowns or judgments.” Use the following concepts:
 - Assertive messages, such as “I” messages, are signs of self-confidence and respect for one’s self and others.
 - “I” statements help you to express yourself clearly in a non-judgmental way and are most appropriate when you feel strongly about a subject.
3. Tell participants that there are different ways to do “I” statements but that for these sessions we will use the following “fill in the blank” formula: “I feel... (*emotion*) ... when you... (*recent specific act by listener*)... because ... (*reason*). This is followed by: “I want/need (*future specific act by the listener*) because... (*reason*).”
4. Give examples of “I” statements, one good and one not, such as:
 - “I feel frustrated when you interrupt me while I’m talking, because I am trying to let you know what’s going on in my life. I need you to let me finish what I’m trying to say, because I value your opinion.” (*GOOD*)
 - “I feel like crying when you act like that. I want you to just stop it.” (*NOT GOOD*)
5. Guide the participants quickly through discussion that compares the last statement with the example of a good “I” statement. Have participants discuss how to improve the statement and why it is not a good statement.

- Make sure the participants take each of the underlined phrases and compare it to the descriptions in parentheses in the general formula for “I” statements. “Act like that” is not a specific recent act, “like crying” is not an emotion, the “it” in “you would stop doing it” is not specific enough, and the reasons (“because”) are missing.
6. Ask the participants to discuss very briefly the difference between these two examples of “I” statements. Tell participants that they can use “I” statements with themselves to recognize their feelings and what causes them, which helps to control emotions. “I” statements also can be used to communicate their needs to others.
 7. Ask participants if they would like to add something about using “I” statements to the group rules.
 8. Introduce the skill of active listening by listing the following elements:
 - Listen to what people are saying.
 - Listen to how they are saying it.
 - Work to find any hidden meanings. Watch people’s body language for clues to their attitudes or state of mind. Realize your body language may tell others about your attitudes or state of mind.
 - Restate what you hear to make sure you understand.
 - Ask open-ended questions to obtain more information, if you don’t understand some part of what the person says. Open-ended questions are ones that require more than a one or two word answer. For example:
 - Close-ended question: “How many children do you have?”
 - Open-ended question: “What can you tell me about your family?”
 8. If time allows, suggest one situation or “set-the-scene” that involves listening, and let someone demonstrate stating what they need. For example:
 - You are at dinner with a friend and want to tell them you are living with HIV/AIDS. The restaurant is very crowded, and the tables are close together. You don’t feel comfortable in this setting, so you want to go somewhere more private. How would you tell your friend that you want to do this?
 - You are visiting your mother at her home and want to tell her that you are living with HIV/AIDS. She is talking about her problems at work and interrupts you every time you try to tell her. What would you say or do to make her listen to you?
 - Your sister comes over with her young children, and you want to tell her you are living with HIV/AIDS. The kids are running in and out of the room every few minutes and making lots of noise in the background. How would you tell her that you need some private time with her?
 9. Tell participants that there will be a very short break before the next activity. After five minutes, you will begin again promptly.
 10.  **Break for five minutes, and have snacks.**



Personal Feedback Report/PFR-A: Stress and Disclosure to Family and Friends



GUIDE 1-e
Personal Feedback
Report/PFR-A



Purpose: Participants will reflect on their experiences in hopes of motivating change of risky behaviors and continuance of protective behaviors around disclosure to family and friends.
(Core Element 4)



Time: 10 minutes



Materials: Guide 1-e
Completed PFR-A forms (gold)

Notes for Facilitators:



This activity is designed to build motivation for change by having participants reflect on their experiences and behaviors. It is a starting point for thinking and generalized discussion. Participants will have the opportunity to consider how stressful (how personally risky) disclosure to family and friends is for them.



When the first Personal Feedback Report (PFR-A) about disclosure to family and friends is distributed, a common question is about disclosure to sexual partners. Facilitators should reassure participants that the topic will be discussed at length in a later session, but for now the discussion needs to stay around disclosure to family and friends.




It is important to deliver the PFR information in a non-judgmental manner.



PFR forms are created based on each participant's answers on their Initial Assessment Survey (IAS). The participant's answers should be transferred, sometimes combining answers, to the appropriate PFR; this can be done by anyone on the intervention team and must be done before the session.

Procedure:

1. Tell the participants that this is the first of three Personal Feedback Report (PFR) forms that they will receive throughout the five sessions.
2. Explain to participants that the information on their forms was taken from the health survey and interview they did when they enrolled in **Healthy Relationships**. The information is based on their responses to questions about stress from disclosure to family member and friends.
3. Assure participants that their PFR forms and the information on the forms do not have to be shared with the group.
4.  Distribute Personal Feedback Report (PFR-A) forms (gold) to participants.
5. Review each item with the group by using the blank PFR-A on Guide 1-e.
6. Ask participants to think about the information on their form as you review each item starting with the stress inventory.
7. Help participants with the concept of the Personal Feedback Report (PFR) forms being different for each person. For example, you could point out that while one person might find sexual dysfunction and telling a family member most stressful, another person might find losing their job and loneliness the most stressful. Ask the participants to discuss why that might be.

Additional Notes for Facilitators:



If participants ask whether it matters that their answers are different now than when they took the survey, tell them that it's great that they're thinking about the topic. The important thing is that they know what their stressors are.



Stress and Disclosure: Discussion of Clip #1-1



GUIDE 1-f
Stress and Disclosure



Purpose: Participants will watch clip and discuss the connection between stress and HIV/AIDS. (Core Elements 1 & 5)



Time: 15 minutes




Materials: Guide 1-f
Clip #1-1
TV, DVD player, and remote control

Procedure:

1. Introduce the concept of using video and movie clips as a springboard for discussion around various topics throughout the sessions. Say something like:

“We’re now going to watch a video clip. We will be watching many clips during our sessions. They may be scenes from a movie or TV program that you recognize. Instead of thinking about the show that the clip comes from, we want you to focus on the scene we’re showing. We will set up a disclosure or relationship context for the scene and show the clip all the way through. Watch what the characters go through. With some clips, we will just show them once and then talk about them. With other clips, we’ll ask you to think about places during the clip where we can stop and discuss the characters’ thoughts, feelings, and actions. We will play those clips a second time and stop at the places you’ve chosen. We also will ask for volunteers to act out those scenes, adding their own words to change the ending of the scenes. Are there questions about the ways we will use the clips?”

“This first clip is used as a springboard for discussion around the connection between stress and disclosing one’s HIV status. We won’t be replaying this clip with pauses. This isn’t one that we will role-play afterwards.”

2. Introduce the clip using the prepared “set-the-scene” description from Guide 1-f.
3.  Show Clip #1-1.

4. Following Guide 1-f, initiate a discussion about disclosure experiences of the participants. Ask participants some questions to stimulate discussion, such as:

(if the character in the scene has disclosed)

- What do you think was the most stressful thing about disclosing for *(insert character's name)*?
- What were the most stressful things for you when you first disclosed to a member of your family?
- What feelings was *(insert character's name)* dealing with when s/he was getting ready to disclose?
- What were your feelings when you were deciding to disclose?
- What kind of reaction did *(insert character's name)* expect when s/he disclosed?
- What kind of reaction did you get when you disclosed? Was it what you expected?

(if the character in the scene has not disclosed)

- What do you think was keeping *(insert character's name)* from disclosing?
- What things have stopped you from disclosing to a family member or friend?
- What feelings was *(insert character's name)* dealing with since s/he was not ready to disclose?
- What were your feelings when you were deciding about disclosing to a family member or friend?
- What kind of reaction do you think *(insert character's name)* expected if s/he did disclose?
- What kind of reaction did you expect you would get if you disclosed? If you have disclosed to a family member or friend, did you get the reaction that you expected?

Additional Notes for Facilitators:



Participants may share some personal disclosure stories making it clear that sometimes disclosure is very stressful and other times it works out all right. You can use those comments as a lead-in to the next section.



Risk Continuum Banner: Disclosing to Family and Friends



GUIDE 1-g
*Risk Continuum Banner:
Disclosing to
Family and Friends*



Purpose: With the first Risk Continuum Banner activity, participants will continue the process of identifying how risky/stressful disclosure to family and friends can be.
(Core Element 1)



Time: 25 minutes



Materials: Guide 1-g
Risk Continuum Cards (family and friends) and Banner

Notes for Facilitators:



With the Risk Continuum Banner activity, it is time to make a transition from talking about stress to talking about risk. This is important in order to keep consistency between the three life areas.



You can distribute the Risk Continuum Cards by holding them face down and having each participant select at least one card, dealing the cards out, or using any other method you choose. The important thing is that the same method be used each time the Risk Continuum Banner activity is done.




Depending on the size and shape of your meeting space and your preference, you can have the participants put their cards up as a group or one at a time; the individual method generally takes more time.



Validate differences of opinion by reminding participants that the risk of disclosure is a very individual matter and will differ from person to person.



Procedure:

1. Introduce the Risk Continuum Banner activity as a means for establishing a personal continuum of the risks and stress related to disclosure. Emphasize that the risk of disclosure is a very individual matter and differs from person to person.
2. Ask participants to think of the various people to whom they might disclose their HIV status. With which person would they feel the least risk (or stress)? With which person would they feel the most risk/stress? Tell participants that this can help them plan ahead and reduce their stress.
3.  Distribute the **Risk Continuum Cards** all at once.
4. Instruct the group to think about each type of person listed on their card(s) and the kind of relationship involved.
5. Ask participants, if they have already disclosed to the person on their card, to think back to how risky they felt the disclosure would be before they did it.
6. Let participants know they can trade cards with other participants if they want or if one of their cards is not relevant to them.
7. Ask participants to think about the following questions:
 - How risky do you think it is for you to disclose to the person(s) on your card(s)?
 - Which person would be “very risky” to disclose HIV status to?
 - Who might be a “low risk” person to disclose to?
8. Have each participant place their card(s) on the Risk Continuum Banner.
9. After all the cards are up, go through each card, and ask various participants why they placed their cards where they did. Ask if other participants might have placed the same card in a different place. Discuss.
10. Guide a group discussion of how both disclosing and not disclosing to family members and friends can be risky and stressful. Elicit comments from the group about their personal experiences.
11. Ask participants how they have handled their most risky disclosure experiences.
12. Ask how their experience with disclosure has changed since they first tested HIV-positive.

13. Take the group's emotional "temperature." Ask:



"Does anyone want to talk about his/her feelings around what we just did?"



Summary and Close: Clips #1-2 and #1-3



Purpose: Participants will summarize what they have learned about stress related to disclosure to family and friends. (Core Element 1)



Time: 10 minutes



Materials: Clips #1-2 and #1-3
TV, DVD player, and remote control
Prize for lottery winner

Notes for Facilitators:





The group should enjoy the comical nature of the two clips, and no discussion is necessary after the tapes are viewed.



These clips do not relate to one of the Easel Chart Guides.

Procedure:

1. Briefly review the concepts from this session, especially some of the stressful aspects of living with HIV/AIDS, including:
 - Disclosing to family and friends
 - Disclosing to sex partners
 - Safer sex/risk reduction
2. Recap the Risk Continuum Banner activity by pointing out that everyone has different comfort levels with disclosure to different people in their lives.
3. Introduce Clips #1-2 and #1-3, using a prepared “set-the-scene” that emphasizes their comedic nature. These two clips are shown together and need only one introduction.
4. Tell participants that these clips will only be shown once and that there will not be discussion or role-playing afterwards.
5.  Show Clips #1-2 and #1-3 through in their entirety without pauses.

6. After viewing the clips, thank the participants for attending the session and for doing a good job.
7. Remind participants about the Resource Packet they received.
8. Remind them of the date, time, and location of the next group meeting.
9.  Conduct the giveaway drawing for participants who arrived on time.

Post-session: Debriefing



Purpose: Facilitators will share with their colleagues how the group went.
Facilitators will release emotions from the session and gain support from their colleagues.
Staff will plan for the next session.



Time: 20 minutes



Materials: Evaluation forms for facilitator

Notes for Facilitators:



See Implementation, pages 38-40, for more information about conducting debriefing sessions.

Procedure:

1. Facilitators should fill out an evaluation form.
2. All evaluation forms should be placed in an envelope marked “Session One” and returned to the appropriate agency staff.
3. The facilitators should meet to debrief as soon after each session as possible and definitely before the next meeting time. At least some of these debriefings should also include the program manager and, possibly, other staff who work on the project.
4. The debriefing is a time to share impressions from the session, release emotions generated by the session, and plan for the next session. Below are some specific questions that might be asked in the debriefing session.

Participants:

- Who needs to be coaxed to participate?
- Who needs to be kept from dominating the group?
- Who might need referrals?
- Who needs referral appointments made for them?
- Who needs help with transportation? Child-care?

General session notes:

- What went well?
- What did not go well?
- How could delivery of the next session be improved?
- What concepts did participants have trouble grasping?
- What concepts need to be reinforced next time?

Environment:

- Was the room too hot/cold?
- Were there enough chairs?
- Could the participants be overheard?
- Were there enough snacks?

Session Two

Session Objectives:

- Explore the elements of disclosure to family and friends.
- Introduce and practice awareness skills.
- Introduce and practice identification of triggers and barriers.
- Introduce and practice problem-solving.
- Introduce and practice decision-making and how it leads to action.




Agenda for Session Two

- | | |
|---|----------------|
| • Welcome Back and Check-in | 5 minutes |
| • Overview of Awareness Skills | 10 minutes |
| • Listening for Meaning:
Speakers-Listeners-Observers Activity | 15 minutes |
| • Overview of Trigger and Barrier Identification | 15 minutes |
| • Overview of Problem-solving | 20 minutes |
| • Break | 5 minutes |
| • Overview of Effective Decision-making and Action | 20 minutes |
| • Dealing with Disclosure to Family and Friends:
Role-play and Discussion: Clip #2-1 | 15 minutes |
| • Dealing with Disclosure to Family and Friends:
Role-play and Discussion: Clip #2-2 | 10 minutes |
| • Summary and Close | 5 minutes |
| | <hr/> |
| | 2 hours |
| • Post-session: Debriefing | 20 minutes |


Preparation and materials needed for Session Two:

- Prepared Easel Chart Guides
- Easel, blank easel pad, and markers
- Masking tape or push pins
- Group rules
- DVD of Clips #2-1 to #2-2
- TV, DVD player, and remote control
- Prepared sheets of easel paper with blank copies of Decision-making Grid
- Popcorn and/or other snacks
- Prize(s) and lottery tickets
- Evaluation forms for facilitators

Welcome Back and Check-in

	Purpose:	Participants will be welcomed back and reminded of group rules.
	Time:	5 minutes
	Materials	Lottery tickets

Procedure:

-  1. Give a “lottery ticket” to participants who arrive early or on time, reminding them that you will hold a drawing for a prize at the end of each session.
2. Thank participants for attending, and note which members are missing.
3. Remind participants about the posted group rules, and add any new items they feel are needed.
4. Mention to participants that they will learn and practice five skills for coping with stress in this session: awareness, trigger and barrier identification, problem-solving, decision-making, and action. In this session, the skills are learned and practiced in terms of disclosure to family and friends. All the skills learned in this session will be practiced in the remaining sessions as they relate to either disclosure to sex partners or building healthier and safer relationships.

Additional Notes for Facilitators:



If participants know that others may be late or absent, facilitators should encourage supportive sharing of this information.



Overview of Awareness Skills



GUIDE 2-a
Awareness Skills



Purpose: Participants will learn about awareness skills around the issue of disclosure.
(Core Element 3)



Time: 10 minutes



Materials: Guide 2-a

Notes for Facilitators:



Do this section quickly. Focus on broad concept of awareness skills, including active listening and using assertive messages. Do not focus on “communication.” Communication is harder to tie to the triggers and barriers that come later.

Procedure:

1. Introduce the value of being aware using some of the following ideas:
 - The first step in deciding about disclosure is awareness.
 - Listening to others can give you information about whether or not the time is right to disclose.
 - Make sure you understand each other.
 - Being aware can help you make better decisions about disclosure and reduce your stress regarding disclosure.
2. Define awareness – the ability to read and understand your surroundings and yourself.
3. Explain that you read and understand your surroundings and yourself by noticing what is going on:
 - Outside of yourself – what you can see, hear and sense. Listening to what people are saying, how they are saying it and any hidden meanings.
 - Inside of yourself – what you are feeling (e.g., stressed, relaxed) and thinking, and knowing how you usually react.
 - In short – Check around you. Check your heart. Check your stomach.

Additional Notes for Facilitators:



Throughout the skills covered in this session, we will include notes that use driving in traffic as an example of each skill. The example shows how the Five Coping Skills can be applied in other stressful situations.

SKILL: Awareness

Pretend you have an important all-day meeting for which you have been preparing for two weeks. You are in your car driving to work in morning rush hour, you are running late, and traffic starts slowing down. You are considering whether or not to let your boss know that you may be late.

You read your surroundings by...

Noticing (Outside): Check around you.

You see what the cars around you are doing.

You see traffic signs and road conditions.

You hear a siren in the distance or noises your car is making.

You hear drivers shouting and car horns blaring.

You remember leaving your cell phone at home.

Noticing (Inside): Check your heart. Check your stomach.

You feel upset.

You think, "I'm late for work, and today's meeting is really important."

You know that you usually drive faster when you're running late.

You are concerned that you will lose your job if you're late for the meeting.

4. Remind the participants about the skills learned in Session One. Use the following concepts:
 - Assertive messages, such as "I" statements, are signs of self-confidence and respect for one's self and others.
 - Using "I" statements with yourself helps you notice what is going on inside of you and understand why.
 - "I" statements help you to express yourself clearly in a non-judgmental way and are most appropriate when you feel strongly about a subject.
 - Active listening helps you understand what people are saying. Watch body language and use restating to make sure you understand. Be aware of what your body language is saying. Use open-ended questions to obtain more information.



Listening for Meaning: Speakers-Listeners- Observers Activity



Purpose: Participants will explore and practice the basic skills of good listening around the issue of disclosure. (Core Element 2)



Time: 15 minutes



Materials: Guide 2-b

Procedure:

1. Tell the participants that it is time to explore and practice the basic skills of good listening.
2. Begin by telling them the topic for the round: **share an experience, one that you feel comfortable talking about, in which you disclosed your HIV status to a friend or family member and had a good response.** If someone does not have an experience that had a good response or they feel uncomfortable talking about it, they can just play the listener and observer roles, or they can sit out the activity.
3. Divide participants into groups of three with each member playing one of three roles: speaker, listener, or observer.
4. Define the roles.
 - **Speaker:** Share your experience.
 - **Listener:** Listen to the Speaker's story. Demonstrate that you understand what is being said by *restating* the speaker's feelings and content of their statement. Use *open-ended questions*.
 - **Observer:** Watch the listener. At the end of the round, give feedback on their *restating*, *open-ended questions*, and *body language*.
5. Explain the seating arrangements, which have the listener and speaker facing one another with the observer sitting behind the speaker facing the listener.
6. Mention that the facilitators will be the timekeepers and each round will last for three minutes.

7. After three minutes, ask them to talk about the experience very briefly in their small groups using the following questions in this order:
 - **Speaker:** Did you feel heard and understood? Why or why not?
 - **Observer:** What did the listener do well? Something to improve?
 - **Listener:** What seemed hard or easy?
8. Following each round (including the small group discussion), have the participants switch to one of the roles they haven't played. Then have them begin again. Do this until everyone (who is willing) has played all three roles once.
9. Debrief the whole group by asking for comments about the experience from the viewpoint of each of the different roles, following the same speakers-observers-listeners order.
10. Do a quick recap of all comments at the end.
11. Relate the activity experience to the cues (words and body language) that indicate a person's attitudes or state of mind.
12. Take the group's emotional "temperature." Ask:



"Does anyone want to talk about his/her feelings around what we just did?"

Additional Notes for Facilitators:



The previous section on awareness creates a context for triggers and barriers. Being aware of yourself, the environment, people's feelings and what people are saying allows you to identify the triggers and barriers in a situation.



Overview of Trigger and Barrier Identification



GUIDE 2-c

Triggers and Barriers



Purpose: Participants will learn to identify triggers and barriers around the issue of disclosure.
(Core Element 3)



Time: 15 minutes



Materials: Guide 2-c

Notes for Facilitators:



Trigger and barrier identification is used to help participants develop a “stop and think” mentality.

Procedure:

1. Mention the Session One discussion about stress and how awareness can be the first step in managing some stressful situations, like disclosing HIV status to certain people.
2. Point out that a key factor to dealing with stressful situations is recognizing when a situation may be stressful and understanding the barriers to dealing with the situation.
3. Define trigger and barrier identification – the ability to recognize events or situations inside and outside of you that can encourage or discourage you from doing something.

4. Give disclosure examples of “triggers” and “barriers.”

- Triggers can encourage you to disclose.
 - A trigger could encourage thoughtful disclosure: A friend who doesn't know that you're living with HIV/AIDS says s/he thinks it's awful when people reject folks living with HIV/AIDS.

Or

 - A trigger could encourage unplanned disclosure or disclosure that is not well thought out: You have too much to drink and start talking about living with HIV/AIDS to whoever will listen.

- Barriers are things that discourage you from engaging in disclosure. A barrier could be something like:
 - Your uncle, who doesn't know about you're living with HIV/AIDS, says he thinks that people with HIV/AIDS should be in jail.

Or

 - The last time you tried to talk seriously to your sister about HIV/AIDS she accused you of being immoral.

- Sometimes aspects of a situation can be both a trigger and a barrier. For example, you might experience both when you visit a friend who is in the hospital and does not know you're living with HIV/AIDS.
 - *Trigger:* You remember that the last time you visited the hospital was to get your test results, and that makes you think of disclosing your status.

Also...

 - *Barrier:* There are people coming in and out of your friend's room, and you don't think there is enough privacy for you to feel comfortable disclosing.

5. Introduce the following four types of triggers and barriers: people, places, feelings, and substances.
 - **People** who influence our behavior can be triggers and/or barriers. For example, consider these two people who do not know you are living with HIV/AIDS:
 - Trigger: A friend you feel close to
 - Barrier: A parent who doesn't understand you
6. Ask participants to name some potential people who can serve as triggers for when to disclose or who are barriers for disclosing.
 - **Place** triggers and/or barriers involve where you are and what is going on around you. For example, in terms of disclosure:
 - Trigger: visiting a friend's house that is intimate and private.
 - Barrier: talking with a friend at work where others could overhear.
7. Ask participants to name some potential places that can serve as triggers for or barriers against disclosing.
 - **Thoughts and Feelings** can also be triggers and/or barriers for disclosure. For example:
 - Thought trigger: believing that a minister is a liberal person
 - Thought barrier: believing that a minister is a conservative person
 - Feeling trigger: loneliness
 - Feeling barrier: depression
8. Ask participants to name some potential thoughts or feelings that can serve as triggers for or barriers against disclosing.
 - **Substances** can also be triggers to disclosure and can create barriers to disclosure. Substances include drugs and alcohol, as well as material things, such as money, music, or cars. Drugs and alcohol are examples of substances that can be either triggers or barriers, because they can:
 - Trigger: lower inhibitions
 - Barrier: affect ability to make decisions
9. Ask participants to name some potential substances that can serve as triggers for or barriers against disclosing.
10. Sum up the activity by stating that, "now we can identify triggers and barriers, in the next activity we will focus on how to deal with triggers and barriers through problem-solving."

Additional Notes for Facilitators:



Throughout the skills covered in this session, we will include notes that use driving in traffic as an example of each skill.

SKILL: Trigger and barrier identification

Triggers and barriers can help you to do something or hold you back from doing something. Take a traffic light for example:

Barrier: The red light represents barriers – it holds you back from driving.

Trigger: The green light is for triggers – it encourages you to keep driving, or it tells you it is OK to start driving.

After you notice the traffic light, it is up to you to decide what to do. Acting immediately on a trigger may or may not be the right decision. It depends on what else is going on around you.

If someone is running the red light in front of you or the traffic is backed up on the other side of the intersection, going ahead might be the wrong decision. A green light also might encourage you to drive too fast.

Remember our example:

Pretend you have an important all-day meeting for which you have been preparing for two weeks. You are in your car driving to your office in morning rush hour, you are running late, and traffic starts slowing down. You are considering whether or not to let your boss know that you may be late.

See list below of a few possible triggers and barriers to contacting your boss.

Triggers	Barriers
Anxious about being late Worried about losing job Boss stressed importance of meeting	Left cell phone at home Worried about getting lost (no phone/no GPS) People may not let you over



Overview of Problem-solving



Purpose: Participants will learn problem-solving skills to deal with triggers and barriers around the issue of disclosure.
(Core Element 2)



Time: 20 minutes



Materials: Guide 2-d
Popcorn and/or other snacks

Procedure:

1. Reinforce the importance of awareness, and introduce the relationship between awareness, triggers and barriers, and problem-solving by sharing the following ideas with the participants:
 - Being aware of each situation allows you to look for triggers and barriers.
 - Both triggers and barriers can add to your stress, if they encourage you to do something you don't want to do or discourage you from doing something you do want to do.
 - Learning how to think and act differently to overcome the negative effects of triggers and barriers can help you feel less stress and make healthier decisions.
 - Problem-solving skills will help you achieve the results you want, while dealing with triggers and barriers.
2. Define problem-solving – ability to think of possible plans to achieve the long-term and short-term results you want, including overcoming any problems (triggers or barriers).
3. Explain **Healthy Relationships'** approach to problem-solving:

- **Identify a problem (trigger or barrier).**
- **Brainstorm possible options to deal with the problem.**
- **Identify the results you want - both short-term and long-term.**

Additional Notes for Facilitators:



Throughout the skills covered in this session, we will include notes that use driving in traffic as an example of each skill.

Remember our example and the list of triggers and barriers:

Pretend you have an important all-day meeting for which you have been preparing for two weeks. You are in your car driving to your office in morning rush hour, you are running late, and traffic starts slowing down. You are considering whether or not to let your boss know that you may be late. Triggers: Anxious about being late, Worried about losing job, Boss stressed importance of meeting. Barriers: Left cell phone at home, Worried about getting lost (no phone/no GPS), People may not let you over.

SKILL: Problem-solving

Identify a problem:

Left cell phone at home

Brainstorm possible options:

Get over at first opportunity and find somewhere you can make a call.

Explain when you get to office.

If traffic stops completely, ask driver in next car to make call for you.

Identify short-term and long-term results you want:

I want my boss not to be angry that I'm late (short-term) and to keep my job (long-term).

4. Tell participants that they will now get a chance to practice using the first three coping skills.
5. Assign a situation: "being at the house of someone you recently met who does not know you are living with HIV/AIDS, and feeling lonely."
6. Ask participants what they might be aware of in such a situation. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to disclosure.
7. On a blank sheet of easel paper make two columns: one headed "Triggers" and the other "Barriers." As participants identify possible triggers and barriers, put the identified items in the columns indicated by the participants.
8. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to disclosure that they see as a problem (trigger to disclosure that they don't want/aren't ready for OR barrier to disclosure that they do want/are ready for).

9. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem.”
10. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.

Additional Notes for Facilitators:




The activity should last about 10 minutes, but some extra time could be taken from the discussion/role-play of Clip #2-1 or Clip #2-2 to make sure that the group understands these concepts.



If participants have difficulty with the activity, use the “possible answers” suggestions in the box below to stimulate discussion. Be sure to encourage participants to think about whether or not this might be the right time/situation to disclose to the friend.

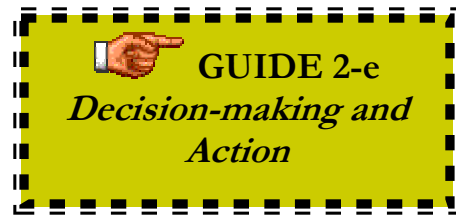
POSSIBLE ANSWERS

- **Triggers:** Tired of keeping status secret, Want to feel closer to friend, Need support, Beers make you talkative
- **Barriers:** Don’t know what friend thinks about HIV, Want to just “hang out,” Worried friend will tell others
- **Identify a problem:** Worried friend will tell others
- **Brainstorm possible options:** Ask the friend if you can talk about something important, Ask the friend not to repeat what you say, Think of what you need and want from the friend before you go to his/her house, etc.
- **Identify the short-term and long-term results you want:** Lower your anxiety, Get support from friends, Ease your loneliness, etc.

11. Encourage discussion but do not problem-solve for participants. If it appears the participants do not understand one or more of the steps or the idea of triggers and barriers, review the basic concept and/or ask participants who do understand to explain it for the group.
12. Do a quick recap of all steps at the end.
13. Tell the group that there will be a very short break before the next activity. After five minutes you will begin again promptly.
14.  **Break for five minutes, and have snacks.**



Overview of Effective Decision-Making and Action



Purpose: Participants will learn more thoughtful decision-making skills around the issue of disclosure.
(Core Element 3)



Time: 20 minutes



Materials: Guide 2-e

Notes for Facilitators:



After dealing with triggers and barriers, deciding to disclose or not to disclose is a balancing act.

Procedure:

1. Define decision-making – ability to weigh the pros and cons of two options and to choose an option, such as to disclose or not to disclose, whichever will work best for you.
2. Define pros and cons:
 - Pros are possible positive results from an option.
 - Cons are possible negative results from an option.
3. Explain that the Decision-making Grid is a visual image to allow participants to weigh out decisions for themselves, based on what they see to be the pros and the cons of two options. This is how they choose the option that is most appropriate for the situation and them personally.
4. Define a healthy decision as one that:
 - Is realistic,
 - Is fair and balanced,
 - Meets the needs of all the participants, and
 - Considers the future.

5. Explain that, once they make a decision, they can take action.
6. Define action – ability to act on the option you chose and to communicate your decision to others.

Additional Notes for Facilitators:



Throughout the skills covered in this session, we will include notes that use driving in traffic as an example of each skill.

SKILL: Decision-making

Remember our example, list of triggers and barriers, and problem identified:

Pretend you have an important all-day meeting for which you have been preparing for two weeks. You are in your car driving to your office in morning rush hour, you are running late, and traffic starts slowing down. You are considering whether or not to let your boss know that you may be late. Triggers: Anxious about being late, Worried about losing job, Boss stressed importance of meeting. Barriers: Left cell phone at home, Worried about getting lost trying to find pay phone (no phone/no GPS), People may not let you over. Problem identified: Left cell phone at home. Possible options: Get over at first opportunity and find somewhere you can make a call; Explain when you get to office; If traffic stops completely, ask driver in next car to make call for you. Results you want: I want my boss not to be angry that I'm late (short-term) and to keep my job (long-term).

If I know a traffic jam may cause me to be late and have no phone with me, what action should I take?

- Call boss?
- Don't call boss?

Use grid below to evaluate each plan and choose the most appropriate action. Consider the four parts of a healthy decision.

You decide to call your boss.

	Pros	Cons
To Call	Boss knows why I'm late	Makes me even later
Not to Call	Don't get lost	Get in trouble with boss

7. Once the participants understand the grid concept, return to the previous potential disclosure situation (“being at the house of someone you recently met who does not know you are living with HIV/AIDS, and feeling lonely.”). Ask participants to weigh the pros and cons of telling a particular person that they are living with HIV/AIDS.
8. Tell participants to think of pros as positive results and cons as negative results from an option. To tell would be making a change and not to tell would be not changing. Both telling and not telling are considered choices, options, and actions.
9. Ask participants to help you fill in a blank version of the grid with what they see as pros and cons to telling or not telling from the example in the disclosure problem-solving activity. These skills will be used again in the clips that follow.

Additional Notes for Facilitators:



Participants’ perceptions of triggers and barriers influence their identification of pros and cons.



Sometimes there are participants who are unfamiliar with tables and grids. Such participants may have difficulty grasping the decision-making process because of the grid format. Thoughtful decision-making is a more important skill than is using a grid. If participants are struggling, try a list like that below:

To Call:

Pros: Boss knows why I’m late.

Cons: Makes me even later.

Not to Call:

Pros: Don’t get lost.

Cons: Get in trouble with boss.

You could also make the list just like the grid but without the lines. You can then draw in the lines after the list is created, if you want. You may also want to use “shorthand” to list comments, as shown below.

	<u>Pros</u>	<u>Cons</u>
To Call:	Boss knows	Even later
Not to Call:	Not lost	Trouble with boss

	Pros	Cons
To Tell (Do)		
Not to Tell (Don't)		

10. Explain to participants that sometimes the pros for telling and the cons for not telling (and vice versa) can be the same, but often they are different. Tell participants that the grid can help them consider all sides of a possible decision before taking action.
11. Ask participants to choose an option, either telling or not telling, and to describe how they would put that decision into action.

Additional Notes for Facilitators:



Throughout the skills covered in this session, we will include notes that use driving in traffic as an example of each skill.

SKILL: Action

Remember our example, triggers and barriers, problem identified, and decision made using the grid:
You choose to stop and find a place to call your boss. You think this is the more responsible action. You feel confidence in your plan and your ability to act on it.

Communicate your decision to other drivers. Signal your turn. Wave to a driver who pauses so you can change lanes into the space ahead of him. Stop at a convenience store with a pay phone. Call your boss, and explain your situation.

You feel relieved to have communicated with your boss.

Even without knowing the final result of your decision, choosing either plan is okay as long as it is based on careful thought.

12. Sum up the activity by stating that “we will use the Five Coping Skills learned so far in this session in the next activity in which we will practice deciding about disclosing to family and friends.”



**Dealing with Disclosure
to Family and Friends:
Role-play and Discussion:
Clip #2-1**



Purpose: Participants will discuss and practice disclosing to family and friends.
(Core Elements 1, 2, & 5)



Time: 15 minutes



Materials Guide 2-f, page 1
Blank easel pad and markers
Clip #2-1
TV, DVD player, and remote control

Notes for Facilitators:



These clips are used as a springboard for discussion and role-playing around the concepts covered in the session: awareness, triggers and barriers, problem-solving, decision-making, and taking action. Make sure the “set-the-scene” description reinforces the concepts covered in the session and prepares the participants for the role-plays.



Remember, the first time the scene is played is for familiarity.



Don't allow too much discussion between showings of scenes.






Try to be consistent in the way you facilitate the role-plays. This session sets up the way role-plays should be handled with all clips. “Prompting” participants to watch the actor's skills is particularly important at first and is less necessary in the later sessions.



The following steps allow you to guide discussion around awareness, triggers and barriers, problem-solving, decision-making, and taking action as related to disclosure to family and friends.

Procedure:

1. Tell participants that you will be showing scenes from popular movies (or other movie-quality source) that they may have seen before, but the idea is to think of each scene as the facilitator describes it, not as it appeared in the movie.
2. Tell participants that you will be playing this clip once straight-through and repeating it with pauses.
3. Tell participants to think about the skills that have been covered so far in this session (awareness, trigger and barrier identification, problem-solving, decision-making, and taking action).
4. Tell participants that they will be practicing these skills through discussion and role-playing based on the clip.
5. Prompt the participants to watch the awareness, including listening, and problem-solving skills of the character designated as living with HIV. Ask them to think about how that affects his/her decision-making. Ask them also to think about how they would have reacted in a similar situation.
6. Introduce Clip #2-1 using the “set-the-scene” from Guide 2-f, page 1.
7.  Play Clip #2-1 through in its entirety.
8. Ask participants some questions to stimulate discussion around awareness, such as:
 - Do you think the time or situation was right for (*insert character's name*) to disclose? How could you tell?
 - What do you think (*insert character's name*) was really aware of (or not) in this situation?
9. Ask participants what else they were aware of in the scene. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to disclosure.
10. On a blank sheet of easel paper make two columns: one headed “Triggers” and the other “Barriers.” As participants identify triggers and barriers, put the identified items in the columns indicated by the participants.
11. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to disclosure that they see as a problem (trigger to disclosure that they don't want/aren't ready for OR barrier to disclosure that they do want/are ready for).

12. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem” and brainstorm options.
13. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.
14. Tell participants that they’ll now get to see the clip one more time.
15. Give the remote control to one of the participants, and tell them you want them to pause the scene where they think things could be done or said differently.
16.  Play Clip #2-1 again, allowing that participant to decide where to pause the clip.
17. During the pause, ask the participant why they stopped the clip where they did. How would they have handled the situation? What might they have said?
18. If the participant who is selecting the “pause point” does so early in the scene and time permits, allow a second participant to take the remote control and pause it a second time. Repeat Procedure 17.
19. Tell participants that you will now re-show the remainder of the clip.
20. Again, prompt the participants to watch the character’s awareness and problem-solving skills and how the character’s skill level affects his/her decision-making. Ask them to think about what they might have done differently if they were in that situation.
21.  Continue Clip #2-1 to the end.
22. Create a copy of the Decision-making Grid on a blank sheet of easel paper, and use it to record participants’ responses to questions about the pros and cons of disclosing and not disclosing. Sample questions are listed below. The questions do not have to be asked in any particular order.
 - If you were in this situation and decided to disclose, what do you think some of the pros would be? What’s something good that might result from disclosure?
 - What would be some of the cons or negative results from disclosing?
 - If you were in this situation and decided not to disclose, what do you think some of the pros of that would be? What positive results might there be from not disclosing?
 - What would be some of the cons of not disclosing?

23. Ask participants to volunteer to act out a role-play based on the scene demonstrating the action skill, how they might handle the situation, and what they would do or say differently.
24. Remind participants that healthy decisions are realistic, fair and balanced, meet the needs of all the participants, and consider the future.
25. Tell participants they may use their own ideas and words, as well as suggestions from the group, to reenact the scene. Remind participants that “I” statements can provide a way to deliver effective messages.
26. Work through one or two role-plays, and be sure to give a round of applause after each performance.
27. If participants have difficulty generating a role-play, you can prompt them. For example:
 - “James, you indicated you wouldn't have said the things (*insert character's name*) did. Why don't you come and play that part? Louis, will you play the other person in the scene?”
28. Take the group's emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Dealing with Disclosure to Family and Friends: Role-play and Discussion: Clip #2-2



GUIDE 2-f
The Discussions



Purpose: Participants will discuss and practice disclosing to family and friends.
(Core Elements 1, 2, & 5)



Time: 10 minutes



Materials Guide 2-f, page 2
Blank easel pad and markers
Clip #2-2
TV, DVD player, and remote control

Notes for Facilitators:



This clip is used as a springboard for discussion and role-playing around the concepts covered in the session: awareness, triggers and barriers, problem-solving, decision-making, and taking action. Make sure the “set-the-scene” description reinforces the concepts covered in the session and prepares the participants for the role-plays.



Remember, the first time the scene is played is for familiarity.



Don't allow too much discussion between showings of scenes.






Try to be consistent in the way you facilitate the role-plays. This activity should be conducted in a similar fashion to the last activity.



The following steps allow you to guide discussion around awareness, triggers and barriers, problem-solving, decision-making, and taking action as related to disclosure to family and friends.

Procedure:

1. Remind participants that the scene is from a popular movie (or other movie-quality source) that they may have seen before, but the idea is to think of each scene as the facilitator describes it, not as it appeared in the movie.
2. Remind participants that you will be playing this clip once straight-through and repeating it with pauses.
3. Remind participants to think about the five coping skills: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
4. Remind participants that they will be practicing these skills through discussion and role-playing based on the clip.
5. Prompt the participants to watch the awareness, including listening, and problem-solving skills of the character designated as living with HIV. Ask them to think about how that affects his/her decision-making. Ask them also to think about how they would have reacted in a similar situation.
6. Introduce Clip #2-2 using the prepared “set-the-scene” from Guide 2-f/page 2.
7.  Play Clip #2-2 through in its entirety.
8. Ask participants some questions to stimulate discussion around awareness, such as:
 - Do you think the time or situation was right for (*insert character's name*) to disclose? How could you tell?
 - What do you think (*insert character's name*) was really aware of (or not) in this situation?
9. Ask participants what else they were aware of in the scene. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to disclosure.
10. On a blank sheet of easel paper make two columns: one headed “Triggers” and the other “Barriers.” As participants identify triggers and barriers, put the identified items in the columns indicated by the participants.
11. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to disclosure that they see as a problem (trigger to disclosure that they don’t want/aren’t ready for OR barrier to disclosure that they do want/are ready for).

12. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem” and brainstorm options.
13. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.
14. Tell participants that they’ll now get to see the clip one more time.
15. Give the remote control to one of the participants, and tell them you want them to pause the scene where they think things could be done or said differently.
16.  Play Clip #2-2 again, allowing that participant to decide where to pause the clip.
17. During the pause, ask the participant why they stopped the clip where they did. How would they have handled the situation? What might they have said?
18. If the participant who is selecting the “pause point” does so early in the scene and time permits, allow a second participant to take the remote control and pause it a second time. Repeat Procedure 15.
19. Tell participants that you will now re-show the remainder of the clip.
20. Again, prompt the participants to watch the character’s awareness and problem-solving skills and how the character’s skill level affects his/her decision-making. Ask them to think about what they might have done differently if they were in that situation.
21.  Continue Clip #2-2 to the end.
22. Create a copy of the Decision-making Grid on a blank sheet of easel paper, and use it to record participants’ responses to questions about the pros and cons of disclosing and not disclosing. Sample questions are listed below. The questions do not have to be asked in any particular order.
 - If you were in this situation and decide to disclose, what do you think some of the pros would be? What’s something good that might result from disclosure?
 - What would be some of the cons or negative results from disclosing?
 - If you were in this situation and decide not to disclose, what do you think some of the pros of that would be? What positive results might there be from not disclosing?
 - What would be some of the cons of not disclosing?

23. Ask participants to volunteer to act out a role-play based on the scene demonstrating the action skill, how they might handle the situation, and what they would do or say differently.
24. Remind participants that healthy decisions are realistic, fair and balanced, meet the needs of all the participants, and consider the future.
25. Tell participants they may use their own ideas and words, as well as suggestions from the group, to reenact the scene. Remind participants that “I” statements can provide a way to deliver effective messages.
26. Work through one or two role-plays, and be sure to give a round of applause after each performance.
27. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Summary and Close



Purpose: Participants will summarize what they have learned about making decisions around disclosure.
(Core Element 1)




Time: 5 minutes







Materials: Prize for lottery winner

Procedure:

1. Review concepts from the session, including awareness, trigger and barrier identification, problem-solving, decision-making, and action.
2. Thank the participants for attending the session and for doing a good job.
3. Remind participants about the Resource Packet they received.
4. Remind them of the date, time, and location of the next group meeting.
5. Ask the participants, between now and the next session, to think about how disclosure to sex partners is different.
6.  Conduct the giveaway drawing for participants who arrived on time.

Post-session: Debriefing

	Purpose:	<p>Facilitators will share with their colleagues how the group went. Facilitators will release emotions from the session and gain support from their colleagues. Staff will plan for the next session.</p>
	Time:	20 minutes
	Materials:	Evaluation forms for facilitator
Notes for Facilitators:		
		See Implementation, pages 38-40, for more information about conducting debriefing sessions.

Procedure:

1. Facilitators should fill out an evaluation form.
2. All evaluation forms should be placed in an envelope marked “Session Two” and returned to the agency staff.
3. The facilitators should meet to debrief as soon after each session as possible and definitely before the next meeting time. At least some of these debriefings should also include the program manager and, possibly, other staff who work on the project.
4. The debriefing is a time to share impressions from the session, release emotions generated by the session, and plan for the next session. Below are some specific questions that might be asked in the debriefing session.

Participants:

- Who needs to be coaxed to participate?
- Who needs to be kept from dominating the group?
- Who might need referrals?
- Who needs referral appointments made for them?
- Who needs help with transportation? Child-care?

General session notes:

- What went well?
- What did not go well?
- How could delivery of the next session be improved?
- What concepts did participants have trouble grasping?
- What concepts need to be reinforced next time?

Environment:

- Was the room too hot/cold?
- Were there enough chairs?
- Could the participants be overheard?
- Were there enough snacks?

Session Three

Session Objectives:

- Introduce disclosure to sex partners as a potential stressor.
- Identify personal disclosure to sex partners risk continuum.
- Review skills building: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
- Practice skills as related to disclosure to sex partners.

Agenda for Session Three

- | | |
|---|----------------|
| • Welcome Back and Check In | 5 minutes |
| • Personal Feedback Report Form B:
Stress and Disclosure to Sex Partners | 5 minutes |
| • Risk Continuum Banner:
Disclosing to Sex Partners | 20 minutes |
| • Skills Building Review:
Telling Sex Partners | 20 minutes |
| • Break | 5 minutes |
| • Dealing with Disclosure to Sex Partners:
Role-play and Discussion: Clip #3-1 | 20 minutes |
| • Dealing with Disclosure to Sex Partners:
Role-play and Discussion: Clip #3-2 | 20 minutes |
| • Dealing with Disclosure to Sex Partners:
Role-play and Discussion: Clip #3-3 | 15 minutes |
| • Summary and Close | 10 minutes |
| | <hr/> |
| | 2 hours |
| • Post-session: Debriefing | 20 minutes |

Preparation and materials needed for Session Three:

- Prepared Easel Chart Guides
- Easel, blank easel pad, and markers
- Masking tape or push pins
- Prepared sheets of easel paper with blank copies of Decision-making Grid
- Group rules
- DVD of Clips #3-1 to #3-3
- TV, DVD player, and remote control
- Completed Personal Feedback Report (PFR-B) forms (blue)
- Risk Continuum Banner and Sex Partner Cards
- Popcorn and/or other snacks
- Prize(s) and lottery tickets
- Evaluation forms for facilitators

Welcome Back and Check-in



Purpose: Participants will be welcomed back and reminded of group rules.




Time: 5 minutes



Materials: Lottery tickets

Procedure:

1.  Give a “lottery ticket” to participants who arrive early or on time, reminding them that you will hold a drawing for a prize at the end of each session.
2. Thank participants for attending, and note which members are missing.
3. Remind participants about the posted group rules, and add any new items they feel are needed.

Additional Notes for Facilitators:



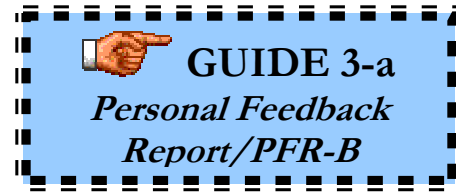
If participants know that others may be late or absent, facilitators should encourage supportive sharing of this information.



Session Three tends to be very emotional for some participants. We recommend that no outside observers be allowed to attend this session.



Personal Feedback Report/PFR-B: Stress and Disclosure to Sex Partners



Purpose: Participants will reflect on their experiences in hopes of motivating change of risky behaviors and continuance of protective behaviors around disclosure to sex partners.
(Core Element 4)



Time: 5 minutes



Materials: Guide 3-a
Completed PFR-B forms (blue)

Notes for Facilitators:




Remember this activity is designed to build motivation for change by having participants reflect on their experiences and behaviors.



It is important to deliver the information here in a non-judgmental manner.

Procedure:

1. Tell the participants that this is the second of the three Personal Feedback Report (PFR) forms that they will receive throughout the five sessions.
2. Remind participants that the information on their forms was taken from the Initial Assessment Survey (IAS) and interview they did when they enrolled for **Healthy Relationships**. The information is based on their responses to questions about stress from disclosure to sex partners.
3. Remind participants that their PFR forms and the information on the forms do not have to be shared with the group.
4. Remind them that, as discussed in the first session, disclosure to family and friends can be stressful.
5. Explain that now it is time to consider the stress of disclosure to sex partners and how that might differ from disclosure to family and friends.

6.  Distribute Personal Feedback Report (PFR-B) forms (blue) to participants.
7. Review each item with the group by using the blank PFR-B on Guide 3-a.
8. Ask participants to think about the information on their form as you review each item.
9. Initiate brief discussion of issues that make disclosure to partners different from disclosure to other people.



Risk Continuum Banner: Disclosing to Sex Partners



GUIDE 3-b *Risk Continuum Banner: Disclosing to Sex Partners*



Purpose: With the second Risk Continuum Banner activity, participants will continue the process of understanding how risky/stressful disclosure to sex partners can be.
(Core Element 1)



Time: 20 minutes



Materials: Guide 3-b
Risk Continuum Cards (sex partners) and Banner

Notes for Facilitators:




Continue to guide discussion around understanding how stressful disclosure to sex partners can be with the second Risk Continuum Banner activity.



Validate differences of opinion by noting that the risk of disclosure is a very individual matter and will differ from person to person.



Procedure:

1. Remind the participants about the Risk Continuum Banner activity being a means for establishing a personal continuum for the risks and stress related to disclosure and that this activity can help them plan ahead and reduce their stress
2. Remind participants that the risk of disclosure is a very individual matter and differs from person to person.
3.  Pass around all the **Risk Continuum Cards** using the same method used in Session One.

4. Instruct the group to think about each type of sex partner listed on their card(s) and the kind of relationship involved. Remind them that they can trade cards.
5. Ask participants, if they have already disclosed to the person on their card, to think back to how risky they felt the disclosure would be before they did it.
6. Let participants know they can trade cards with other participants if they want or if their card is not relevant to them.
7. Ask participants to think about the following questions:
 - Which kind of sex partner would it be “risky” to disclose HIV status to?
 - Who might be a “low risk” sex partner to disclose to?
8. Have each participant place their card(s) on the Risk Continuum Banner.
9. After all the cards are up, go through each card, and ask the group why someone might have placed the card where they did. Ask if other participants might have placed the same card in a different place. Discuss.
10. Remind participants that both disclosing and not disclosing can be risky and stressful
11. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Skills Building Review: Telling Sex Partners



GUIDE 3-c
Telling Sex Partners



Purpose: Participants will continue the process of understanding how risky/stressful disclosure to sex partners can be through discussion.
(Core Elements 1 & 2)




Time: 20 minutes



Materials Guide 3-c
Risk Continuum Cards (sex partners) and Banner
Popcorn and/or other snacks

Procedure:

1. Review the following skills as applied to disclosure to sex partners by using examples from the Risk Continuum Banner activity.
2. Awareness: Ask participants to give examples of how they might use awareness, active listening, and assertive messages in a high-risk disclosure situation with a sex partner.
3. Triggers and Barriers: Have the group identify triggers and barriers for disclosure to sex partners.
4. Problem-solving: Have the group work through the problem-solving approach when disclosing to sex partners.
 - Identify the problem.
 - Brainstorm possible options.
 - Identify short-term and long-term results you want.
5. Decision-making: Create a Decision-making Grid to consider all the factors in determining whether or not to disclose to a sex partner.
6. Action: Remind participants that this skill is about making your decision about disclosure to a specific sex partner, and acting accordingly.
7. Tell the group that there will be a very short break before the next activity. After five minutes you will begin again promptly.
8.  **Break for five minutes, and have snacks.**



Dealing with Disclosure to Sex Partners: Role-play and Discussion: Clip #3-1



GUIDE 3-d
*Dealing with
Disclosure to Sex
Partners*



Purpose: Participants will discuss and practice disclosing to sex partners.
(Core Elements 1, 2, & 5)



Time: 20 minutes



Materials Guide 3-d, page 1
Blank easel pad and markers
Clip #3-1
TV, DVD player, and remote control

Notes for Facilitators:



Make sure the “set-the-scene” reinforces the concepts covered in the session and prepares the participants for the role-plays and discussion. The “set-the-scene” description should include the notion of deciding when, where, and how to disclose to a sex partner.



Facilitate the role-plays the same way you did in Session Two, but be sure the introduction to the clip includes the fact that the sex partner’s HIV-status is either negative or unknown. It is also helpful to include the type/length of relationship.






You may substitute “one-liners” for one of the role-plays. Just go around the group and ask participants to say in one sentence what they would have said differently.



The following steps allow you to guide discussion around awareness, triggers and barriers, problem-solving, decision-making, and taking action as related to disclosure to sex partners.

Procedure:

1. Remind participants that the scene is from a popular movie (or other movie-quality source) that they may have seen before, but the idea is to think of the scene as the facilitator describes it, not as it appeared in the movie.
2. Remind participants that you will be playing this clip once straight-through and repeating it with pauses.
3. Remind participants to think about the five coping skills: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
4. Remind participants that they will be practicing these skills through discussion and role-playing based on the clip.
5. Prompt the participants to watch the awareness, including listening, and problem-solving skills of the character designated as living with HIV. Ask them to think about how that affects his/her decision-making. Ask them also to think about how they would have reacted in a similar situation.
6. Tell participants that the partner of the character living with HIV is presumed to be HIV-negative or status unknown.
7. Introduce Clip #3-1 using the prepared “set-the-scene” from Guide 3-d, page 1.
8.  Play Clip #3-1 through in its entirety.
9. Ask participants some questions to stimulate discussion around awareness, such as:
 - Do you think the time or situation was right for (*insert character's name*) to disclose? How could you tell?
 - What do you think (*insert character's name*) was really aware of (or not) in this situation?
10. Ask participants what else they were aware of in the scene. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to disclosure.
11. On a blank sheet of easel paper make two columns: one headed “Triggers” and the other “Barriers.” As participants identify triggers and barriers, put the identified items in the columns indicated by the participants.
12. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to disclosure that they see as a problem (trigger to disclosure that they don't want/aren't ready for OR barrier to disclosure that they do want/are ready for).

13. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem” and brainstorm options.
14. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.
15. Tell participants that they’ll now get to see the clip one more time.
16. Give the remote control to one of the participants, and tell them you want them to pause the scene where they think things could be done or said differently.
17.  Play Clip #3-1 again, allowing that participant to decide where to pause the clip.
18. During the pause, ask the participant why they stopped the clip where they did. How would they have handled the situation? What might they have said?
19. If the participant who is selecting the “pause point” does so early in the scene and time permits, allow a second participant to take the remote control and pause it a second time. Repeat Procedure 18.
20. Tell participants that you will now re-show the remainder of the clip.
21. Again, prompt the participants to watch the character’s awareness and problem-solving skills and how the character’s skill level affects his/her decision-making. Ask them to think about what they might have done differently if they were in that situation.
22.  Continue Clip #3-1 to the end.
23. Create a copy of the Decision-making Grid on a blank sheet of easel paper and use it to record participants’ responses to questions about the pros and cons of disclosing and not disclosing. Sample questions are listed below. The questions do not have to be asked in any particular order.
 - If you were in this situation and decided to disclose, what do you think some of the pros would be? What’s something good that might result from disclosure?
 - What would be some of the cons or negative results from disclosing?
 - If you were in this situation and decided not to disclose, what do you think some of the pros of that would be? What positive results might there be from not disclosing?
 - What would be some of the cons of not disclosing?

24. Ask participants to volunteer to act out a role-play based on the scene demonstrating the action skill, how they might handle the situation, and what they would do or say differently.
25. Remind participants that healthy decisions are realistic, fair and balanced, meet the needs of all the participants, and consider the future.
26. Tell participants they may use their own ideas and words, as well as suggestions from the group, to reenact the scene. Remind participants that “I” statements can provide a way to deliver effective messages.
27. Work through one or two role-plays, and be sure to give a round of applause after each performance.
28. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Dealing with Disclosure to Sex Partners: Role-play and Discussion: Clip #3-2



GUIDE 3-d
*Dealing with
Disclosure to Sex
Partners*



Purpose: Participants will discuss and practice disclosing to sex partners.
(Core Element 1, 2, & 5)



Time: 20 minutes



Materials Guide 3-d, page 2
Blank easel pad and markers
Clip #3-2
TV, DVD player, and remote control

Notes for Facilitators:



Make sure the “set-the-scene” reinforces the concepts covered in the session and prepares the participants for the role-plays and discussion. The “set-the-scene” description should include the notion of deciding when, where, and how to disclose to a sex partner.



Facilitate the role-plays the same way you did in Session Two, but be sure the introduction to the clip includes the fact that the sex partner’s HIV-status is either negative or unknown. It is also helpful to include the type/length of relationship.






You may substitute “one-liners” for one of the role-plays. Just go around the group and ask participants to say in one sentence what they would have said differently.



The following steps allow you to guide discussion around awareness, triggers and barriers, problem-solving, decision-making, and taking action as related to disclosure to sex partners.

Procedure:

1. Remind participants that the scene is from a popular movie (or other movie-quality source) that they may have seen before, but the idea is for them to think of the scene as the facilitator describes it, not as it appeared in the movie.
2. Remind participants that you will be playing this clip once straight-through and repeating it with pauses.
3. Remind participants to think about the five coping skills: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
4. Remind participants that they will be practicing these skills through discussion and role-playing based on the clip.
5. Prompt the participants to watch the awareness, including listening, and problem-solving skills of the character designated as living with HIV. Ask them to think about how that affects his/her decision-making. Ask them also to think about how they would have reacted in a similar situation.
6. Tell participants that the partner of the character living with HIV is presumed to be HIV-negative or status unknown.
7. Introduce Clip #3-2 using the prepared “set-the-scenes” from Guide 3-d, page 2.
8.  Play Clip #3-2 through in its entirety.
9. Ask participants some questions to stimulate discussion around awareness, such as:
 - Do you think the time or situation was right for (*insert character's name*) to disclose? How could you tell?
 - What do you think (*insert character's name*) was really aware of (or not) in this situation?
10. Ask participants what else they were aware of in the scene. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to disclosure.
11. On a blank sheet of easel paper make two columns: one headed “Triggers” and the other “Barriers.” As participants identify triggers and barriers, put the identified items in the columns indicated by the participants.
12. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to disclosure that they see as a problem (trigger to disclosure that they don't want/aren't ready for OR barrier to disclosure that they do want/are ready for).

13. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem” and brainstorm options.
14. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.
15. Tell participants that they’ll now get to see the clip one more time.
16. Give the remote control to one of the participants, and tell them you want them to pause the scene where they think things could be done or said differently.
17.  Play Clip #3-2 again, allowing that participant to decide where to pause the clip.
18. During the pause, ask the participant why they stopped the clip where they did. How would they have handled the situation? What might they have said?
19. If the participant who is selecting the “pause point” does so early in the scene and time permits, allow a second participant to take the remote control and pause it a second time. Repeat Procedure 18.
20. Tell participants that you will now re-show the remainder of the clip.
21. Again, prompt the participants to watch the character’s awareness and problem-solving skills and how the character’s skill level affects his/her decision-making. Ask them to think about what they might have done differently if they were in that situation.
22.  Continue Clip #3-2 to the end.
23. Create a copy of the Decision-making Grid on a blank sheet of easel paper, and use it to record participants’ responses to questions about the pros and cons of disclosing and not disclosing. Sample questions are listed below. The questions do not have to be asked in any particular order.
 - If you were in this situation and decided to disclose, what do you think some of the pros would be? What’s something good that might result from disclosure?
 - What would be some of the cons or negative results from disclosing?
 - If you were in this situation and decided not to disclose, what do you think some of the pros of that would be? What positive results might there be from not disclosing?
 - What would be some of the cons of not disclosing?

23. Ask participants to volunteer to act out a role-play based on the scene demonstrating the action skill, how they might handle the situation, and what they would do or say differently.
24. Remind participants that healthy decisions are realistic, fair and balanced, meet the needs of all the participants, and consider the future.
25. Tell participants they may use their own ideas and words, as well as suggestions from the group, to reenact the scene. Remind participants that “I” statements can provide a way to deliver effective messages.
26. Work through one or two role-plays, and be sure to give a round of applause after each performance.
27. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Dealing with Disclosure to Sex Partners: Role-play and Discussion: Clip #3-3



GUIDE 3-d
*Dealing with
Disclosure to Sex
Partners*



Purpose: Participants will discuss and practice disclosing to sex partners.
(Core Elements 1, 2, & 5)



Time: 15 minutes



Materials Guide 3-d, page 3
Blank easel pad and markers
Clip #3-3
TV, DVD player, and remote control

Notes for Facilitators:



Make sure the “set-the-scene” reinforces the concepts covered in the session and prepares the participants for the role-plays and discussion. The “set-the-scene” description should include the notion of deciding when, where, and how to disclose to a sex partner.



Facilitate the role-plays the same way you did in Session Two, but be sure the introduction to the clip includes the fact that the sex partner’s HIV-status is either negative or unknown. It is also helpful to include the type/length of relationship.






You may substitute “one-liners” for one of the role-plays. Just go around the group and ask participants to say in one sentence what they would have said differently.



The following steps allow you to guide discussion around awareness, triggers and barriers, problem-solving, decision-making, and taking action as related to disclosure to sex partners.

Procedure:

1. Remind participants that the scene is from a popular movie (or other movie-quality source) that they may have seen before, but the idea is to think of the scene as the facilitator describes it, not as it appeared in the movie.
2. Remind participants that you will be playing this clip once straight-through and repeating it with pauses.
3. Remind participants to think about the five coping skills: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
4. Remind participants that they will be practicing these skills through discussion and role-playing based on the clip.
5. Prompt the participants to watch the awareness, including listening, and problem-solving skills of the character designated as living with HIV. Ask them to think about how that affects his/her decision-making. Ask them also to think about how they would have reacted in a similar situation.
6. Tell participants that the partner of the character living with HIV is presumed to be HIV-negative or status unknown.
7. Introduce Clip #3-3 using the prepared “set-the-scene” from Guide 3-d, page 3.
8.  Play Clip #3-3 through in its entirety.
9. Ask participants some questions to stimulate discussion around awareness, such as:
 - Do you think the time or situation was right for (*insert character's name*) to disclose? How could you tell?
 - What do you think (*insert character's name*) was really aware of (or not) in this situation?
10. Ask participants what else they were aware of in the scene. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to disclosure.
11. On a blank sheet of easel paper make two columns: one headed “Triggers” and the other “Barriers.” As participants identify triggers and barriers, put the identified items in the columns indicated by the participants.
12. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to disclosure that they see as a problem (trigger to disclosure that they don't want/aren't ready for OR barrier to disclosure that they do want/are ready for).

13. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem” and brainstorm options.
14. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.
15. Tell participants that they’ll now get to see the clip one more time.
16. Give the remote control to one of the participants, and tell them you want them to pause the scene where they think things could be done or said differently.
17.  Play Clip #3-3 again, allowing that participant to decide where to pause the clip.
18. During the pause, ask the participant why they stopped the clip where they did. How would they have handled the situation? What might they have said?
19. If the participant who is selecting the “pause point” does so early in the scene and time permits, allow a second participant to take the remote control and pause it a second time. Repeat Procedure 18.
20. Tell participants that you will now re-show the remainder of the clip.
21. Again, prompt the participants to watch the character’s listening and problem-solving skills and how the character’s skill level affects his/her decision-making. Ask them to think about what they might have done differently if they were in that situation.
22.  Continue Clip #3-3 to the end.
23. Create a copy of the Decision-making Grid on a blank sheet of easel paper and use it to record participants’ responses to questions about the pros and cons of disclosing and not disclosing. Sample questions are listed below. The questions do not have to be asked in any particular order.
 - If you were in this situation and decided to disclose, what do you think some of the pros would be? What’s something good that might result from disclosure?
 - What would be some of the cons or negative results?
 - If you were in this situation and decided not to disclose, what do you think some of the pros of that would be? What positive results might there be from not disclosing?
 - What would be some of the cons of not disclosing?

23. Ask participants to volunteer to act out a role-play based on the scene demonstrating the action skill, how they might handle the situation, and what they would do or say differently.
24. Remind participants that healthy decisions are realistic, fair and balanced, meet the needs of all the participants, and consider the future
25. Tell participants they may use their own ideas and words, as well as suggestions from the group, to reenact the scene. Remind participants that “I” statements can provide a way to deliver effective messages.
26. Work through one or two role-plays, and be sure to give a round of applause after each performance.
27. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Summary and Close



Purpose: Participants will summarize what they have learned about disclosure to sex partners.
(Core Element 1)




Time: 10 minutes







Materials: Prize for lottery winner

Procedure:

1. Review concepts from session including personal disclosure to sex partners risk continuum and skills building review.
2. Thank the participants for attending the session and for doing a good job.
3. Remind participants about the Resource Packet they received.
4. Remind them of the date, time, and location of the next group meeting.
5. Ask the participants, between now and the next session, to think about how disclosure to sex partners who are living with HIV/AIDS is different than disclosure to other sex partners.
6.  Conduct the giveaway drawing for participants who arrived on time.

Post-session: Debriefing

	Purpose:	Facilitators will share with their colleagues how the group went. Facilitators will release emotions from the session and gain support from their colleagues. Staff will plan for the next session.
	Time:	20 minutes
	Materials:	Evaluation forms for facilitator
Notes for Facilitators:		
		See Implementation, pages 38-40, for more information about conducting debriefing sessions.

Procedure:

1. Facilitators should fill out an evaluation form.
2. All evaluation forms should be placed in an envelope marked “Session Three” and returned to the agency staff.
3. The facilitators should meet to debrief as soon after each session as possible and definitely before the next meeting time. At least some of these debriefings should also include the program manager and, possibly, other staff who work on the project.
4. The debriefing is a time to share impressions from the session, release emotions generated by the session, and plan for the next session. Below are some specific questions that might be asked in the debriefing session.

Participants:

- Who needs to be coaxed to participate?
- Who needs to be kept from dominating the group?
- Who might need referrals?
- Who needs referral appointments made for them?
- Who needs help with transportation? Child-care?

General session notes:

- What went well?
- What did not go well?
- How could delivery of the next session be improved?
- What concepts did participants have trouble grasping?
- What concepts need to be reinforced next time?

Environment:

- Was the room too hot/cold?
- Were there enough chairs?
- Could the participants be overheard?
- Were there enough snacks?

Session Four

Session Objectives:

- Explore disclosure to sex partners.
- Explore relationships with positive and negative partners.
- Introduce safer sex/risk reduction.
- Identify personal safer sex/risk reduction risk continuum.
- Review the Five Coping Skills as related to safer sex/risk reduction.

Agenda for Session Four

- | | |
|--|----------------|
| • Welcome Back and Check In | 5 minutes |
| • Deciding About Disclosure to Sex Partners | 15 minutes |
| • Relationships with Positive and Negative Partners, Clip #4-1 | 25 minutes |
| • Break | 5 minutes |
| • Personal Feedback Report Form C: Safer Sex/Risk Reduction | 10 minutes |
| • Risk Continuum Banner: Safer Sex/Risk Reduction | 10 minutes |
| • HIV/AIDS Education: Clip #4-2 | 25 minutes |
| • Skills Building Review and Application: How Can Sex Be Made Safer? | 20 minutes |
| • Summary and Close | 5 minutes |
| | <hr/> |
| | 2 hours |
| • Post-session: Debriefing | 20 minutes |

Preparation and materials needed for Session Four:

- Prepared Easel Chart Guides
- Easel, blank easel pad, and markers
- Masking tape or push pins
- Prepared sheets of easel paper with blank copies of Decision-making Grid
- Group rules
- DVD of Clips #4-1 to #4-2
- TV, DVD player, and remote control
- Completed Personal Feedback Report (PFR-C) forms (orange)
- Risk Continuum Banner and Sexual Behaviors Cards
- Popcorn and/or other snacks
- Prize(s) and lottery tickets
- Evaluation forms for facilitators

Welcome Back and Check-in



Purpose: Participants will be welcomed back and reminded of group rules.




Time: 5 minutes



Materials: Lottery tickets

Procedure:

1.  Give a “lottery ticket” to participants who arrive early or on time, reminding them that you will hold a drawing for a prize at the end of each session.
2. Thank participants for attending, and note which members are missing.
3. Remind participants about the posted group rules, and add any new items they feel are needed.

Additional Notes for Facilitators:



If participants know that others may be late or absent, facilitators should encourage supportive sharing of this information.



Deciding About Disclosure to Sex Partners



GUIDE 4-a
*Deciding About
Disclosure to Sex
Partners*



Purpose: Participants will discuss disclosing to sex partners and review their own personal risks related to disclosing to various types of partners.
(Core Elements 1 & 3)



Time: 15 minutes



Materials: Guide 4-a, 4-b, and 4-c

Notes to Facilitators:



When participants decide to disclose to sex partners, that is often how they find out if they are in a sero-concordant or a sero-discordant relationship.

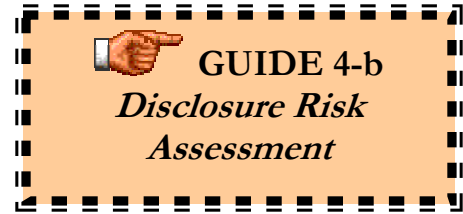


It is essential that all discussions of disclosing HIV status emphasize that disclosure is a personal choice that only the participant can make for a given situation. Choosing not to disclose is an option.

Procedure:

1. Acknowledge that deciding when and if to disclose to a sex partner can be stressful.
2. Remind participants that triggers and barriers, such as people, places, feelings, and substance use, can make disclosure more stressful.
3. Remind them that it is important for each person to understand what they personally consider risks in disclosing and to think about how to reduce stress in situations where they are making a decision about disclosure.
4. Remind participants that you asked them at the end of the last session to think about how disclosing to sex partners who are living with HIV/AIDS is different from disclosure to other sex partners.
5. Lead a large group discussion in which participants will review their own personal risks related to disclosing to various types of partners.

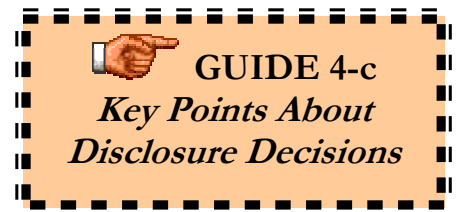
6. After discussing risks for disclosure in the group, introduce participants to the Disclosure Risk Assessment composed of the following steps:



- Identify the potential negative reactions that the person being considered for disclosure may have.
 - Use problem-solving skills to brainstorm options to reduce the stress/risk of each negative reaction.
 - Even if participants do not consider the following outcomes to be likely, have them consider the possibility that a partner may:
 - Abandon them following disclosure
 - React with violence
 - Disclose this information to others
7. Ask participants to generate potential “set-the-scenes” in which each of these reactions may occur and discuss how one could:
- Look for warning signs.
 - Avoid the reaction.
 - Deal with the reaction if it cannot be avoided.
 - Develop a plan for managing the negative aftermath.

Key Points About Disclosure Decisions

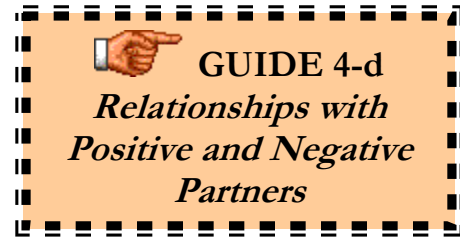
8. Summarize the key points of deciding whether or not to disclose:



- The decision is personal and very individual.
- Anticipate reactions, and problem-solve possible negative reactions.
- Set personal priorities for disclosure.
- Choosing not to disclose to someone is an option.



Relationships with Positive and Negative Partners: Discussion of Clip #4-1



Purpose: Participants will discuss relationships with positive and negative partners.
(Core Elements 1 & 5)



Time: 25 minutes



Materials: Guide 4-d
Clip #4-1
TV, DVD player, and remote control
Popcorn and/or other snacks

Notes to Facilitators:




This clip is used as a springboard for discussion around the issue of disclosure to sex partners, especially in sero-discordant relationships.



Make sure the “set-the-scene” description reinforces the concepts covered in the session and prepares the participants for the discussion.

Procedure:

1. Introduce the clip using the prepared “set-the-scene” from Guide 4-d.
2. Tell participants that you will be playing this clip once straight-through. Tell participants they will be discussing, but not role-playing, based on the clip.
3. Ask the participants to think about how they would have reacted in a similar situation.
4.  Play Clip #4-1 in its entirety.

5. Lead a discussion about the advantages and disadvantages of relationships where both partners are living with HIV/AIDS (sero-concordant) and where only one partner is living with HIV/AIDS (sero-discordant).
6. Acknowledge that both types of relationships may create stress for a person living with HIV/AIDS.
7. Facilitate sharing of experiences and issues that others may have dealt with related to these types of relationships.
8. Identify the issues for a person living with HIV/AIDS who is with someone who is also living with HIV/AIDS.
9. Identify the issues for a person living with HIV/AIDS who is with someone who is not living with HIV/AIDS.
10. Discuss the differences in the development of relationship roles with the progression of HIV/AIDS.
11. Ask participants for their opinion on the following question:
 - If choosing not to disclose is an option, what do you think about safer sex with a partner to whom you haven't disclosed?
12. Elicit comments from the group about various issues of disclosing to sex partners, such as:
 - Disclosing to new versus old partners
 - Disclosing to casual versus steady sex partners
 - Ways people try to figure out if someone is living with HIV/AIDS or to reveal they are living with HIV/AIDS without actually asking or telling (and how reliable/unreliable these ways are)
13. Take the group's emotional "temperature." Ask:



"Does anyone want to talk about his/her feelings around what we just did?"

11. Tell the group that there will be a very short break before the next activity. After five minutes you will begin again promptly.



12. **Break for five minutes, and have snacks.**



Personal Feedback Report/PFR-C: Safer Sex/Risk Reduction



GUIDE 4-e
*Personal Feedback
Report/PFR-C*



Purpose: Participants will reflect on their experiences in hopes of motivating change of risky sexual behaviors and continuance of protective sexual behaviors.
(Core Element 4)



Time: 10 minutes



Materials: Guide 4-e
Completed PFR-C forms (orange)

Notes for Facilitators:




Remember this activity is designed to build motivation for change by having participants reflect on their experiences and behaviors.



Remember that this is the transition point in the sessions for applying skills from disclosure to safer sex. It is important to make sure the participants make the connection. All the same skills that have been taught and practiced in the previous sessions are now applied to risk reduction.

Procedure:

1. Tell participants that this is the last of the three Personal Feedback Report (PFR) forms that they will receive.
2. Remind participants that the information on their forms was taken from the Initial Assessment Survey and interview they did when they enrolled for **Healthy Relationships**. The information is based on how they responded to questions about safer sex.
3. Remind participants that their PFR forms and the information on the forms do not have to be shared with the group.
4. Acknowledge that negotiating safer sex can be stressful.

5. Explain that now it is time to consider the stress of negotiating safer sex.
6.  Distribute Personal Feedback Report (PFR-C) forms (orange) to participants.
7. Review each item with the group by using the blank PFR-C on Guide 4-e.
8. Ask participants to think about the information on their forms as you review each item.



Risk Continuum Banner: Safer Sex/Risk Reduction



GUIDE 4-f
*Risk Continuum
Banner: Safer Sex/Risk
Reduction*



Purpose: With the third Risk Continuum Banner activity, participants will continue the process of understanding levels of risk among sexual behaviors in order to build healthier and safer relationships. (Core Element 1)



Time: 10 minutes



Materials: Guide 4-f
Risk Continuum Cards (sexual behaviors) and Banner

Notes to Facilitators:



This activity is designed to build motivation for change by having participants reflect on their experiences and behaviors.



If you do not customize the names of the sexual behaviors on these cards, you may have to help participants with the definition of “frottage” and possibly other terms.




Unlike the previous Risk Continuum Banner activities, there are “right and wrong” answers for the risk level of various sexual behaviors. See the Answer Key at the end of the activity instructions on the next page or the key in Appendix I with the cards.



Procedure:

1. Remind participants that understanding personal risky situations can help avoid risks, and negotiating with a partner can address interpersonal issues in sexual situations. However, personal choices of what to do and not to do with a partner are important aspects of any given sexual situation.

2. Add that reviewing what creates risks for partners/self and the relative “safety” of various sexual practices is important information to have in the decision-making process.
3. Introduce this activity by stating it is designed to review the relative “safety” of sexual practices in the context of both sero-concordant and sero-discordant relationships.
4. Tell the participants that this time the risk continuum activity is related to sexual behaviors and how risky each one is, so for the first time there are right and wrong answers. As before, this activity can help them plan ahead and reduce their stress about safer sex/risk reduction issues.
5.  Pass around all the **Risk Continuum Cards** using the same method used in Session One.
6. Instruct participants to think about each type of sex listed on their card(s) and the risk of them transmitting HIV to or acquiring a different strain of HIV from a sex partner.
7. Tell participants not to consider the “what if” questions. For example, “What if I have just been to the dentist and have bleeding gums?”
8. Tell participants also not to consider what the sex listed on their card might lead to. For example, “What if fantasizing leads to unprotected sex?”
9. Ask participants these questions (see Answer Key on the next page):
 - Which types of sexual behavior would be “High Risk”?
 - Which types of sexual behavior would be “Moderate Risk”?
 - Which types of sexual behavior would be “Low Risk”?
10. Have each participant place their card(s) on the Risk Continuum Banner.
11. After all the cards are up, review each card and discuss the relative risks of each sex practice.
12. When differences of opinion arise, discuss the risk of various routes of transmission to establish the actual risk of a behavior for the group. If need be, tell participants that they are just about to watch a video about the relative safety of various sexual behaviors.
13. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”

ANSWER KEY: Always adapt this key to the latest available information on what behaviors are most risky. (See Appendix IX for more information.)

High risk behaviors: anal sex without a condom, vaginal sex without a condom.

Moderate risk behaviors: behaviors such as oral sex without a condom or latex dam, where there isn't clear-cut scientific information about risk can be placed anywhere on a sliding scale between high and low, however oral sex without a condom or latex dam should be placed higher than oral sex with a condom or latex dam.

Between moderate and low risk behaviors: all other penetrative sexual behavior with a condom, including anal and vaginal sex with a condom, oral sex with a condom or latex dam, mutual masturbation with shared sex toys, etc.

Low risk behaviors: all non-penetrative sexual behavior and abstinence. Abstinence should be placed the lowest risk of all behaviors.



HIV/AIDS Education: Clip #4-2



GUIDE 4-g
*Where Do People Get
Their HIV Risk
Information?*



Purpose: Participants will reflect on where to get HIV information.
(Core Element 5)



Time: 25 minutes




Materials: Guide 4-g
Clip #4-2
TV, DVD player, and remote control

Notes to Facilitators:



It is important to deliver or discuss any information about HIV risks in a non-judgmental manner.

Procedure:

1. Initiate a discussion of where participants get their safer sex information, making the point that there are still lots of myths and misinformation about HIV/AIDS.
2. Introduce the educational video by reminding participants that the group just talked about some of the myths about HIV and AIDS and that it is important we all have the same factual information about HIV and AIDS.
3.  Play Clip #4-2 through in its entirety.
4. Lead discussion of the risk of various routes of transmission and whether participants may have held any misconceptions before seeing the video.



Skills Building Review and Application: How Can Sex Be Made Safer?



GUIDE 4-h
How Can Sex Be Made Safer?



Purpose: Participants will discuss applying the Five Coping Skills to make sex safer.
(Core Elements 1 & 2)



Time: 20 minutes



Materials: Guide 4-h
Blank easel pad and markers

Procedure:

1. Review the following skills as applied to "how can sex be made safer?" by using safer sex/risk reduction examples from the Risk Continuum Banner activity and the video.
2. Awareness: ask participants to give examples of how they might use awareness, listening, and assertive messages in a high-risk sex situation to negotiate safer sex.
3. Triggers and Barriers: have the group identify triggers and barriers (people, places, things, substances) for negotiating safer sex/risk reduction for sex practices listed on the Risk Continuum Banner. Write responses on a blank sheet of easel paper.
4. Problem-solving: have the group work through the **Healthy Relationships** approach to problem-solving triggers or barriers for negotiating in safer sex/risk reduction.
 - Identify the problem.
 - Brainstorm possible options.
 - Identify short-term and long-term results you want.
5. Decision-making: ask participants to consider all the factors in determining how to ensure safer sex/risk reduction. Create a copy of the Decision-making Grid on a blank sheet of easel paper, and use it to record participants' responses about the pros (possible positive results) and cons (possible negative results) of practicing and not practicing safer sex.
6. Action: remind participants that once a decision is made, action can be taken.



Summary and Close



Purpose: Participants will summarize what they have learned about disclosure to sex partners and safer sex. (Core Element 1)




Time: 5 minutes







Materials: Prize for lottery winner

Procedure:

1. Thank the participants for attending the session and for doing a good job.
2. Remind participants about the Resource Packet they received.
3. Remind them of the date, time, and location of the next group meeting and, if applicable, that it will be the last of these group meetings.
4.  Conduct the giveaway drawing for participants who arrived on time.

Post-session: Debriefing

	Purpose:	Facilitators will share with their colleagues how the group went. Facilitators will release emotions from the session and gain support from their colleagues. Staff will plan for the next session.
	Time:	20 minutes
	Materials:	Evaluation forms for facilitator
Notes for Facilitators:		
		See Implementation, pages 38-40, for more information about conducting debriefing sessions.

Procedure:

1. Facilitators should fill out an evaluation form.
2. All evaluation forms should be placed in an envelope marked “Session Four” and returned to the agency staff.
3. The facilitators should meet to debrief as soon after each session as possible and definitely before the next meeting time. At least some of these debriefings should also include the program manager and, possibly, other staff who work on the project.
4. The debriefing is a time to share impressions from the session, release emotions generated by the session, and plan for the next session. Below are some specific questions that might be asked in the debriefing session.

Participants:

- Who needs to be coaxed to participate?
- Who needs to be kept from dominating the group?
- Who might need referrals?
- Who needs referral appointments made for them?
- Who needs help with transportation? Child-care?

General session notes:

- What went well?
- What did not go well?
- How could delivery of the next session be improved?
- What concepts did participants have trouble grasping?
- What concepts need to be reinforced next time?

Environment:

- Was the room too hot/cold?
- Were there enough chairs?
- Could the participants be overheard?
- Were there enough snacks?

Session Five

Session Objectives:

- Build condom skills and alternatives to unsafe sex.
- Identify the pros and cons of condoms, and problem-solve cons.
- Practice the Five Coping Skills as related to safer sex/risk reduction.

Agenda for Session Five

- | | |
|--|----------------|
| • Welcome Back and Check In | 5 minutes |
| • Review the Five Coping Skills | 5 minutes |
| • Condom Skills and Other Alternatives to Unsafe Sex: Discussion, Viewing of Clip #5-1 and Condom Practice | 30 minutes |
| • Break | 5 minutes |
| • Dealing with Safer Sex/Risk Reduction: Role-play and Discussion of Clip #5-2 | 15 minutes |
| • Dealing with Safer Sex/Risk Reduction: Role-play and Discussion of Clip #5-3 | 15 minutes |
| • Dealing with Safer Sex/Risk Reduction: Role-play and Discussion of Clip #5-4 | 15 minutes |
| • Dealing with Safer Sex/Risk Reduction: Role-play and Discussion of Clip #5-5 | 15 minutes |
| • Summary and Close | 15 minutes |
| | <hr/> |
| | 2 hours |
| • Post-session: Debriefing | 20 minutes |

Preparation and materials needed for Session Five:

- Prepared Easel Chart Guides
- Easel, blank easel pad, and markers
- Masking tape or push pins
- Prepared sheets of easel paper with blank copies of Decision-making Grid
- Group rules
- DVD of Clips #5-1 to #5-5
- TV, DVD player, and remote control
- Male and female condom packets and lubricant
- Male and female anatomical models
- Paper towels
- Popcorn and/or other snacks
- Prize(s) and lottery tickets
- Awards and certificates (acknowledgement of appreciation)
- Evaluation forms for facilitators

Welcome Back and Check-in



Purpose: Participants will be welcomed back and reminded of group rules.




Time: 5 minutes



Materials: Lottery tickets

Procedure:

1.  Give a “lottery ticket” to participants who arrive early or on time, reminding them that you will hold a drawing for a prize at the end of each session
2. Thank participants for attending, and note which members are missing.
3. Remind participants about the posted group rules, and add any new items they feel are needed.

Additional Notes for Facilitators:



If participants know that others may be late or absent, facilitators should encourage supportive sharing of this information.



Review the 5 Skills



Purpose: Participants will review the **Five Coping Skills** learned in previous sessions.
(Core Element 1)



Time: 5 minutes



Materials: Blank easel pad and markers

Procedure:

1. Review the Five Coping Skills by asking participants the questions indicated below. If desired, list their responses on a blank sheet of easel paper.
2. Awareness: ask participants to give examples of awareness, listening, and assertive messages.
3. Triggers and Barriers: ask the participants to give examples of triggers and barriers to disclosure and safer sex (people, places, things, substances).
4. Problem-solving: ask the participants to describe **Healthy Relationships'** problem-solving approach.
 - Identify the problem.
 - Brainstorm possible options.
 - Identify short-term and long-term results you want.
5. Decision-making: ask participants to give examples of how to use the Decision-making Grid.
6. Action: ask participants to give examples of what actions would come from various decisions.



Condom Skills and Other Alternatives to Unsafe Sex: Discussion, Viewing of Clip #5-1 and Condom Practice



Purpose: Participants will discuss and practice using condoms.
(Core Element 2)



Time: 30 minutes



Materials: Guide 5-a, 5-b, 5-c
Clip #5-1
TV, DVD Player, and remote control
Male and female condom packets and lubricant
Male and female anatomical models
Popcorn and/or other snacks

Notes for Facilitators:



As with the Risk Continuum Banner: Safer Sex/Risk Reduction, this portion of the intervention involves some right and wrong answers. Make sure that you, the facilitators, use accurate information.



It is important to make sure all the participants have the opportunity to practice proper condom use.

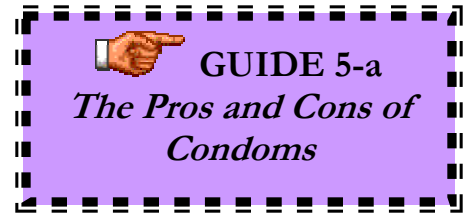


Remember that this activity is not decision-making at this stage but problem-solving.

Procedure:

1. Remind participants that in the last session they discussed safer sex and risk reduction.
2. Ask participants to suggest some ways to be safe.
3. Lead discussion to the idea that using condoms correctly every time you have sex is one way to have safer sex.

The Pros and Cons of Condoms and Condom Practice



4. Discuss the pros and cons of condoms by having participants generate a list of commonly held attitudes toward condoms. Record these on blank easel paper. Divide them into “disadvantages” (cons) and “advantages” (pros).
5. Discuss how the “cons” could be turned or reframed into “pros” through the use of problem-solving.
6. Introduce the condom demonstration video by reminding participants that there is always something new to learn about condoms.



7. Show Clip #5-1: Condom demonstration video
8. Following the video, demonstrate the key points for proper male condom use:



- Checking expiration date
 - Opening packet without damaging the condom
 - Removing air from reservoir tip
 - Rolling condom on all the way down
 - Using a water-based lubricant
 - Using the condom from start to finish
 - Removing the condom while the penis is still erect
 - Disposing of the condom properly afterwards
9. Have the participants break up into two or three groups for condom practice using a model.
 10. Provide each smaller group with at least one penis model and male condoms. Have them practice putting condoms on the model.
 11. Follow the practice with the distribution of packets of male condoms and lubricant.
 12. With women’s and heterosexual men’s groups, demonstrate lubricating and inserting the female condom in the female anatomical model.
 13. If possible, provide each small group with a female anatomical model and female condoms. Have them practice lubricating and putting female condoms in the model. If you do not have enough models for all the groups, have them practice inserting the female condoms into a paper towel or toilet tissue roll.
 14. Follow the practice with the distribution of packets of female condoms and lubricant.


15. Have the group discuss how condom negotiation can be easier if eroticized by being made fun and sexy to use.
16. Elicit examples of ways participants have made or think they can make condom use more erotic with their partners.
17. Point out to participants that sometimes actions speak louder than words. Simply bringing out a condom and putting it on, or handing one to a partner may work just as well as talking about condoms.

Negotiating Safety

18. Lead discussion about negotiating safety and how taking personal control in sexual situations can equal maximum pleasure while staying in a personal, safer sex, comfort zone.



19. Remind participants of the roles of awareness (including listening and assertive messages), identifying triggers and barriers to negotiating safer sex, problem-solving, and decision-making regarding practicing safer sex (taking action).
20. Tell the group that there will be a very short break before the next activity. After five minutes you will begin again promptly.

21.  **Break for five minutes, and have snacks.**

Additional Notes for Facilitators:



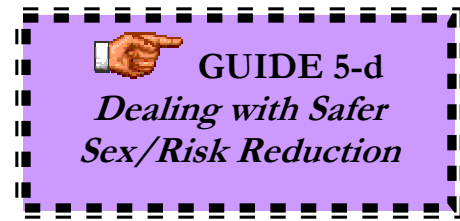
Negative images of condoms can be directly addressed through desensitization techniques incorporated with methods for eroticizing condom use.



Don't get too stuck on the details of condom use such as the air bubble in the tip. Make the practice fun to support the motivational-change component.



Dealing with Safer Sex/Risk Reduction: Role-play and Discussion of Clip #5-2



Purpose: Participants will discuss and practice applying the Five Coping Skills to risk reduction in relationships. (Core Elements 1, 2, & 5)



Time: 15 minutes



Materials: Guide 5-d, page 1
Blank easel pad and markers
Clip #5-2
TV, DVD player, and remote control

Notes for Facilitators:



Make sure the “set-the-scene” reinforces the concepts covered in the session and prepares the participants for the role-plays and discussion. The “set-the-scene” description should include the notion of deciding when, where, and how to negotiate safer sex. Make sure to say that the sexual partner’s HIV-status is either negative or status unknown. It is also helpful to include the type/length of relationship.



You may substitute “one-liners” for one of the role-plays. Just go around the group and ask participants to say in one sentence what they would have said differently.






Make sure the clips are ordered so that the least difficult risk reduction negotiation scene is first and the most difficult last.



The following steps allow you to guide discussion around awareness, triggers and barriers, problem-solving, and decision-making as related to negotiating/practicing safer sex/risk reduction (taking action).

Procedure:

1. Remind participants that the scene is from a popular movie (or other movie-quality source) that they may have seen before, but the idea is to think of each scene as the facilitator describes it, not as it appeared in the movie.
2. Remind participants that you will be playing this clip once straight-through and repeating it with pauses.
3. Remind participants to think about the five coping skills: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
4. Remind participants that they will be practicing these skills through discussion and role-playing based on the clip.
5. Prompt the participants to watch the awareness, including listening, and problem-solving skills of the character designated as living with HIV. Ask them to think about how that affects his/her decision-making. Ask them also to think about how they would have reacted in a similar situation.
6. Tell participants that the partner of the character living with HIV is presumed to be HIV-negative or status unknown.
7. Introduce Clip #5-2 using the prepared “set-the-scene” from Guide 5-d, page 1.
8.  Play Clip #5-2 through in its entirety.
9. Ask participants some questions to stimulate discussion around awareness, such as:
 - Do you think the time or situation was right for (*insert character's name*) to negotiate safer sex? How could you tell?
 - What do you think (*insert character's name*) was really aware of (or not) in this situation?
10. Ask participants what else they were aware of in the scene. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to negotiating safer sex.
11. On a blank sheet of easel paper make two columns: one headed “Triggers” and the other “Barriers.” As participants identify triggers and barriers, put the identified items in the columns indicated by the participants.
12. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to negotiating safer sex that they see as a problem (trigger or barrier to negotiating safer sex that might put them or their partner at risk).

13. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem.”
14. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.
15. Tell participants that they’ll now get to see the clip one more time.
16. Give the remote control to one of the participants, and tell them you want them to pause the scene where they think things could be done or said differently.
17.  Play Clip #5-2 again, allowing that participant to decide where to pause the clip.
18. During the pause, ask the participant why they stopped the clip where they did. How would they have handled the situation? What might they have said?
19. If the participant who is selecting the “pause point” does so early in the scene and time permits, allow a second participant to take the remote control and pause it a second time. Repeat Procedure 18.
20. Tell participants that you will now re-show the remainder of the clip.
21. Again, prompt the participants to watch the character’s awareness and problem-solving skills and how the character’s skill level affects his/her decision-making. Ask them to think about what they might have done differently if they were in that situation to make this a safer sex encounter.
22.  Continue Clip #5-2 to the end.
23. Create a copy of the Decision-making Grid on a blank sheet of easel paper, and use it to record participants’ responses to questions about the pros and cons of practicing and not practicing safer sex. Sample questions are listed below. The questions do not have to be asked in any particular order. The questions also could be asked in terms of using condoms instead of practicing safer sex.
 - If you were in this situation and decided to practice safer sex, what do you think some of the pros would be? What’s something good that might result from practicing safer sex?
 - What would be some of the cons or negative results from practicing safer sex?
 - If you were in this situation and decided not to practice safer sex, what do you think some of the pros of that would be? What positive results might there be from not practicing safer sex?
 - What would be some of the cons of not practicing safer sex?

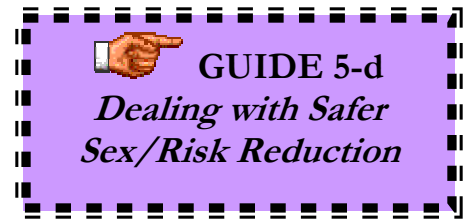
24. Ask participants to volunteer to act out a role-play based on the scene demonstrating the action skill, how they might have handled the situation, and what they would do or say differently. Explain that the volunteers do not have to “act out” the role-plays in this session but can describe what they would do and use words as appropriate.
25. Remind participants that healthy decisions are realistic, fair and balanced, meet the needs of all the participants, and consider the future.
26. Tell participants they may use their own ideas and words, as well as suggestions from the group, to reenact the scene. Remind participants that “I” statements can provide a way to deliver effective messages.
27. Work through one or two role-plays, and be sure to give a round of applause after each performance.
28. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Dealing with Safer Sex/Risk Reduction: Role-play and Discussion of Clip #5-3



Purpose: Participants will discuss and practice applying the Five Coping Skills to risk reduction in relationships. (Core Elements 1, 2, & 5)



Time: 15 minutes



Materials: Guide 5-d, page 2
Blank easel pad and markers
Clip #5-3
TV, DVD player, and remote control

Notes for Facilitators:



Make sure the “set-the-scene” reinforces the concepts covered in the session and prepares the participants for the role-plays and discussion. The “set-the-scene” description should include the notion of deciding when, where, and how to negotiate safer sex. Make sure to say that the sexual partner’s HIV-status is either negative or status unknown. It is also helpful to include the type/length of relationship.



You may substitute “one-liners” for one of the role-plays. Just go around the group and ask participants to say in one sentence what they would have said differently.






Make sure the clips are ordered so that the least difficult risk reduction negotiation scene is first and the most difficult last.



The following steps allow you to guide discussion around awareness, triggers and barriers, problem-solving, and decision-making as related to negotiating/practicing safer sex/risk reduction (taking action).

Procedure:

1. Remind participants that the scene is from a popular movie (or other movie-quality source) that they may have seen before, but the idea is to think of each scene as the facilitator describes it, not as it appeared in the movie.
2. Remind participants that you will be playing this clip once straight-through and repeating it with pauses.
3. Remind participants to think about the five coping skills: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
4. Remind participants that they will be practicing these skills through discussion and role-playing based on the clip.
5. Prompt the participants to watch the awareness, including listening, and problem-solving skills of the character designated as living with HIV. Ask them to think about how that affects his/her decision-making. Ask them also to think about how they would have reacted in a similar situation.
6. Tell participants that the partner of the character living with HIV is presumed to be HIV-negative or status unknown.
7. Introduce Clip #5-3 using the prepared “set-the-scene” from Guide 5-d, page 2.
8.  Play Clip #5-3 through in its entirety.
9. Ask participants some questions to stimulate discussion around awareness, such as:
 - Do you think the time or situation was right for (*insert character's name*) to negotiate safer sex? How could you tell?
 - What do you think (*insert character's name*) was really aware of (or not) in this situation?
10. Ask participants what else they were aware of in the scene. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to negotiating safer sex.
11. On a blank sheet of easel paper make two columns: one headed “Triggers” and the other “Barriers.” As participants identify triggers and barriers, put the identified items in the columns indicated by the participants.
12. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to negotiating safer sex that they see as a problem (trigger or barrier to negotiating safer sex that might put them or their partner at risk).

13. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem.”
14. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.
15. Tell participants that they’ll now get to see the clip one more time.
16. Give the remote control to one of the participants, and tell them you want them to pause the scene where they think things could be done or said differently.
17.  Play Clip #5-3 again, allowing that participant to decide where to pause the clip.
18. During the pause, ask the participant why they stopped the clip where they did. How would they have handled the situation? What might they have said?
19. If the participant who is selecting the “pause point” does so early in the scene and time permits, allow a second participant to take the remote control and pause it a second time. Repeat Procedure 18.
20. Tell participants that you will now re-show the remainder of the clip.
21. Again, prompt the participants to watch the character’s awareness and problem-solving skills and how the character’s skill level affects his/her decision-making. Ask them to think about what they might have done differently if they were in that situation to make this a safer sex encounter.
22.  Continue Clip #5-3 to the end.
23. Create a copy of the Decision-making Grid on a blank sheet of easel paper, and use it to record participants’ responses to questions about the pros and cons of practicing and not practicing safer sex. Sample questions are listed below. The questions do not have to be asked in any particular order. The questions also could be asked in terms of using condoms instead of practicing safer sex.
 - If you were in this situation and decided to practice safer sex, what do you think some of the pros would be? What’s something good that might result from practicing safer sex?
 - What would be some of the cons or negative results from practicing safer sex?
 - If you were in this situation and decided not to practice safer sex, what do you think some of the pros of that would be? What positive results might there be from not practicing safer sex?
 - What would be some of the cons of not practicing safer sex?

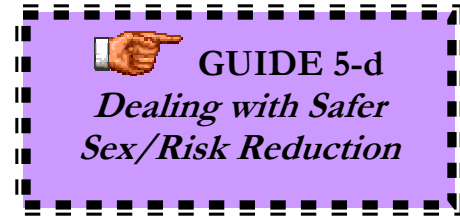
24. Ask participants to volunteer to act out a role-play based on the scene demonstrating the action skill, how they might have handled the situation, and what they would do or say differently. Remind them that the volunteers do not have to “act out” the role-plays in this session but can describe what they would do and use words as appropriate.
25. Remind participants that healthy decisions are realistic, fair and balanced, meet the needs of all the participants, and consider the future.
26. Tell participants they may use their own ideas and words, as well as suggestions from the group, to reenact the scene. Remind participants that “I” statements can provide a way to deliver effective messages.
27. Work through one or two role-plays, and be sure to give a round of applause after each performance.
28. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Dealing with Safer Sex/Risk Reduction: Role-play and Discussion of Clip #5-4



Purpose: Participants will discuss and practice applying the Five Coping Skills to risk reduction in relationships. (Core Elements 1, 2, & 5)



Time: 15 minutes



Materials: Guide 5-d, page 3
Blank easel pad and markers
Clip #5-4
TV, DVD player, and remote control

Notes for Facilitators:



Make sure the “set-the-scene” reinforces the concepts covered in the session and prepares the participants for the role-plays and discussion. The “set-the-scene” description should include the notion of deciding when, where, and how to negotiate safer sex. Make sure to say that the sexual partner’s HIV-status is either negative or status unknown. It is also helpful to include the type/length of relationship.



You may substitute “one-liners” for one of the role-plays. Just go around the group and ask participants to say in one sentence what they would have said differently.






Make sure the clips are ordered so that the least difficult risk reduction negotiation scene is first and the most difficult last.



The following steps allow you to guide discussion around awareness, triggers and barriers, problem-solving, and decision-making as related to negotiating/practicing safer sex/risk reduction (taking action).

Procedure:

1. Remind participants that the scene is from a popular movie (or other movie-quality source) that they may have seen before, but the idea is to think of each scene as the facilitator describes it, not as it appeared in the movie.
2. Remind participants that you will be playing this clip once straight-through and repeating it with pauses.
3. Remind participants to think about the five coping skills: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
4. Remind participants that they will be practicing these skills through discussion and role-playing based on the clip.
5. Prompt the participants to watch the awareness, including listening, and problem-solving skills of the character designated as living with HIV. Ask them to think about how that affects his/her decision-making. Ask them also to think about how they would have reacted in a similar situation.
6. Tell participants that the partner of the character living with HIV is presumed to be HIV-negative or status unknown.
7. Introduce Clip #5-4 using the prepared “set-the-scene” from Guide 5-d, page 3.
8.  Play Clip #5-4 through in its entirety.
9. Ask participants some questions to stimulate discussion around awareness, such as:
 - Do you think the time or situation was right for (*insert character's name*) to negotiate safer sex? How could you tell?
 - What do you think (*insert character's name*) was really aware of (or not) in this situation?
10. Ask participants what else they were aware of in the scene. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to negotiating safer sex.
11. On a blank sheet of easel paper make two columns: one headed “Triggers” and the other “Barriers.” As participants identify triggers and barriers, put the identified items in the columns indicated by the participants.
12. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to negotiating safer sex that they see as a problem (trigger or barrier to negotiating safer sex that might put them or their partner at risk).

13. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem.”
14. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.
15. Tell participants that they’ll now get to see the clip one more time.
16. Give the remote control to one of the participants, and tell them you want them to pause the scene where they think things could be done or said differently.
17.  Play Clip #5-4 again, allowing that participant to decide where to pause the clip.
18. During the pause, ask the participant why they stopped the clip where they did. How would they have handled the situation? What might they have said?
19. If the participant who is selecting the “pause point” does so early in the scene and time permits, allow a second participant to take the remote control and pause it a second time. Repeat Procedure 18.
20. Tell participants that you will now re-show the remainder of the clip.
21. Again, prompt the participants to watch the character’s awareness and problem-solving skills and how the character’s skill level affects his/her decision-making. Ask them to think about what they might have done differently if they were in that situation to make this a safer sex encounter.
22.  Continue Clip #5-4 to the end.
23. Create a copy of the Decision-making Grid on a blank sheet of easel paper, and use it to record participants’ responses to questions about the pros and cons of practicing and not practicing safer sex. Sample questions are listed below. The questions do not have to be asked in any particular order. The questions also could be asked in terms of using condoms instead of practicing safer sex.
 - If you were in this situation and decided to practice safer sex, what do you think some of the pros would be? What’s something good that might result from practicing safer sex?
 - What would be some of the cons or negative results from practicing safer sex?
 - If you were in this situation and decided not to practice safer sex, what do you think some of the pros of that would be? What positive results might there be from not practicing safer sex?
 - What would be some of the cons of not practicing safer sex?

24. Ask participants to volunteer to act out a role-play based on the scene demonstrating the action skill, how they might have handled the situation, and what they would do or say differently. Explain that the volunteers do not have to “act out” the role-plays in this session but can describe what they would do and use words as appropriate.
25. Remind participants that healthy decisions are realistic, fair and balanced, meet the needs of all the participants, and consider the future.
26. Tell participants they may use their own ideas and words, as well as suggestions from the group, to reenact the scene. Remind participants that “I” statements can provide a way to deliver effective messages.
27. Work through one or two role-plays, and be sure to give a round of applause after each performance.
28. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Dealing with Safer Sex/Risk Reduction: Role-play and Discussion of Clip #5-5



GUIDE 5-d
*Dealing with Safer
Sex/Risk Reduction*



Purpose: Participants will discuss and practice applying the Five Coping Skills to risk reduction in relationships. (Core Elements 1, 2, & 5)



Time: 15 minutes



Materials: Guide 5-d, page 4
Blank easel pad and markers
Clip #5-5
TV, DVD player, and remote control

Notes for Facilitators:



Make sure the “set-the-scene” reinforces the concepts covered in the session and prepares the participants for the role-plays and discussion. The “set-the-scene” description should include the notion of deciding when, where, and how to negotiate safer sex. Make sure to say that the sexual partner’s HIV-status is either negative or status unknown. It is also helpful to include the type/length of relationship.



You may substitute “one-liners” for one of the role-plays. Just go around the group and ask participants to say in one sentence what they would have said differently.






Make sure the clips are ordered so that the least difficult risk reduction negotiation scene is first and the most difficult last.



The following steps allow you to guide discussion around awareness, triggers and barriers, problem-solving, and decision-making as related to negotiating/practicing safer sex/risk reduction (taking action).

Procedure:

1. Remind participants that the scene is from a popular movie (or other movie-quality source) that they may have seen before, but the idea is to think of each scene as the facilitator describes it, not as it appeared in the movie.
2. Remind participants that you will be playing this clip once straight-through and repeating it with pauses.
3. Remind participants to think about the five coping skills: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
4. Remind participants that they will be practicing these skills through discussion and role-playing based on the clip.
5. Prompt the participants to watch the awareness, including listening, and problem-solving skills of the character designated as living with HIV. Ask them to think about how that affects his/her decision-making. Ask them also to think about how they would have reacted in a similar situation.
6. Tell participants that the partner of the character living with HIV is presumed to be HIV-negative or status unknown.
7. Introduce Clip #5-5 using the prepared “set-the-scene” from Guide 5-d, page 4.
8.  Play Clip #5-5 through in its entirety.
9. Ask participants some questions to stimulate discussion around awareness, such as:
 - Do you think the time or situation was right for (*insert character's name*) to negotiate safer sex? How could you tell?
 - What do you think (*insert character's name*) was really aware of (or not) in this situation?
10. Ask participants what else they were aware of in the scene. As they make comments that qualify as triggers or barriers, ask if they think that was a trigger or barrier to negotiating safer sex.
11. On a blank sheet of easel paper make two columns: one headed “Triggers” and the other “Barriers.” As participants identify triggers and barriers, put the identified items in the columns indicated by the participants.
12. After the lists are made, review them quickly, asking participants to pick one trigger or barrier to negotiating safer sex that they see as a problem (trigger or barrier to negotiating safer sex that might put them or their partner at risk).

13. Ask participants for options (plans) for dealing with the chosen trigger or barrier. If they cannot come up with any options, tell them that it looks like that trigger/barrier is not problem-solvable, and ask them to pick a different “problem.”
14. Remind participants that the next part of problem-solving is considering the short- and long-term results that they want from a situation. Ask them to consider which of the possible options might fit in with the results they want personally.
15. Tell participants that they’ll now get to see the clip one more time.
16. Give the remote control to one of the participants, and tell them you want them to pause the scene where they think things could be done or said differently.
17.  Play Clip #5-5 again, allowing that participant to decide where to pause the clip.
18. During the pause, ask the participant why they stopped the clip where they did. How would they have handled the situation? What might they have said?
19. If the participant who is selecting the “pause point” does so early in the scene and time permits, allow a second participant to take the remote control and pause it a second time. Repeat Procedure 18.
20. Tell participants that you will now re-show the remainder of the clip.
21. Again, prompt the participants to watch the character’s awareness and problem-solving skills and how the character’s skill level affects his/her decision-making. Ask them to think about what they might have done differently if they were in that situation to make this a safer sex encounter.
22.  Continue Clip #5-5 to the end.
23. Create a copy of the Decision-making Grid on a blank sheet of easel paper, and use it to record participants’ responses to questions about the pros and cons of practicing and not practicing safer sex. Sample questions are listed below. The questions do not have to be asked in any particular order. The questions also could be asked in terms of using condoms instead of practicing safer sex.
 - If you were in this situation and decided to practice safer sex, what do you think some of the pros would be? What’s something good that might result from practicing safer sex?
 - What would be some of the cons or negative results from practicing safer sex?
 - If you were in this situation and decided not to practice safer sex, what do you think some of the pros of that would be? What positive results might there be from not practicing safer sex?
 - What would be some of the cons of not practicing safer sex?

24. Ask participants to volunteer to act out a role-play based on the scene demonstrating the action skill, how they might have handled the situation, and what they would do or say differently. Explain that the volunteers do not have to “act out” the role-plays in this session but can describe what they would do and use words as appropriate.
25. Remind participants that healthy decisions are realistic, fair and balanced, meet the needs of all the participants, and consider the future.
26. Tell participants they may use their own ideas and words, as well as suggestions from the group, to reenact the scene. Remind participants that “I” statements can provide a way to deliver effective messages.
27. Work through one or two role-plays, and be sure to give a round of applause after each performance.
28. Take the group’s emotional “temperature.” Ask:



“Does anyone want to talk about his/her feelings around what we just did?”



Summary and Close



Purpose: Participants will summarize what they have learned from the sessions and how they have changed or plan to change their behavior as a result of their new skills. (Core Element 1)



Time: 15 minutes




Materials: Prize for lottery winner

Notes for Facilitators:







The point of the question, “does everybody have a plan?” is to make sure participants think about moving from decision-making to taking action. Facilitators can encourage participants to create a personalized action plan, either by themselves or with their prevention case manager, if they have one. This plan should be based on the behaviors they now want to maintain or change.

Procedure:

1. Review the main concepts from all the sessions including awareness, triggers and barriers, problem-solving, disclosure and risk-reduction decision-making (including the Decision-making Grid), and taking action.
2. Go around the circle, and have each participant share what was the most important or valuable message they received from the sessions and give examples of how they have changed their behavior as a result.
3. Discuss “does everybody have a plan?”
4. Thank the participants for attending the sessions and for doing a good job.
5. Remind participants about the Resource Packet they received.
6. At the closure activity, present each participant with an award, a certificate, and a final acknowledgement of appreciation for all the hard work the group has done.
7.  Conduct the giveaway drawing for participants who arrived on time.

Post-session: Debriefing

	Purpose:	Facilitators will share with their colleagues how the group went. Facilitators will release emotions from the session and gain support from their colleagues. Staff will plan for the next series of sessions.
	Time:	20 minutes
	Materials:	Evaluation forms for facilitator
Notes for Facilitators:		
		See Implementation, pages 38-40, for more information about conducting debriefing sessions.

Procedure:

1. Facilitators should fill out an evaluation form.
2. All evaluation forms should be placed in an envelope marked “Session Five” and returned to the agency staff.
3. The facilitators should meet to debrief as soon after this final session as possible and definitely before the next series of **Healthy Relationships** sessions are implemented. This debriefing should also include the program manager and, possibly, other staff who work on the project.
4. The debriefing is a time to share impressions from the session, release emotions generated by the session, and plan for the next series of sessions. Below are some specific questions that might be asked in the debriefing session.

Participants:

- Who needs referral appointments made for them?
- Who, if anyone, might be interested in becoming a peer facilitator for future series?
- Who, if anyone, might help with recruitment for future series?

General session notes:

- What went well?
- What did not go well?
- How could delivery of the next series of sessions be improved?
- What concepts did participants have trouble grasping?
- What changes would you like to see in the future series?

Maintenance

The final stage in the technology transfer process is maintenance. This stage addresses the need to continue to work on the adaptation of the intervention and the organization and to evaluate the intervention. Institutionalization, or embedding the intervention into the organization's mission, hierarchy, standard operation, and budget, is a potential goal of this phase. Maintenance begins after the final session of the first series of **Healthy Relationships** has been delivered and continues as long as the agency does the intervention. During this stage process monitoring, process evaluation, and outcome monitoring data are entered into a database and/or submitted to appropriate stakeholders. It is this information, along with quality assurance documentation, that will assist an agency in adapting the intervention to meet the needs of their target populations. Following is a discussion of the process that an agency may follow to incorporate **Healthy Relationships** into on-going prevention efforts for clients who are living with HIV/AIDS.

Institutionalizing Healthy Relationships

It is very important that agencies take ownership of **Healthy Relationships** and incorporate it into their prevention activities, making it part of the agency's mission. Continued funding, efforts to make sure that the intervention is not undercut by other activities, and the integration of implementation activities into routine job duties can lead to institutionalization. All members of the intervention team should participate in planning, training, and program improvement. If needed, an agency may access technical assistance to further their goals. This process further enhances the transfer of research programs to prevention services. It involves the program manager, facilitators, stakeholders, and communities to successfully implement a program that best meets the needs of those that depend on your services.

Quality Assurance

Quality assurance is the process in which someone familiar with the intervention observes it being delivered and provides feedback and documentation on implementation issues.

Quality assurance answers questions such as those listed below.

- Were the session goals achieved? Why or why not?
- Did the facilitators practice good group facilitation skills?
- Were the sessions conducted with fidelity in accordance with **Healthy Relationships'** Core Elements?

The responsibility of quality assurance falls to the program manager. Periodically, he or she needs to observe different sessions offered by the intervention team. After each observation, a debriefing with the intervention team gives them the opportunity to receive feedback, practice improving challenging areas, or talk of further training or technical assistance needs. Quality assurance tools for documentation are included in Appendix IV. These tools should be shared with the intervention team prior to the observation, giving them the opportunity to be aware of the areas in which they are held accountable.

The results of the quality assurance reviews should be discussed with the facilitators after each review. If necessary, additional training or technical assistance may be requested. It is very important that the quality assurance process be continuous to ensure the high quality of the intervention delivery.

Evaluation

In 2003, The Centers for Disease Control and Prevention (CDC) implemented a new evaluation framework. Prevention agencies across the nation will be responsible for accurately reporting evaluation data to a common database. Material presented here corresponds with CDC's evaluation framework in relationship to **Healthy Relationships**. An Evaluation Field Guide and various evaluation tools for **Healthy Relationships** are available for download on the **Healthy Relationships** page under "More Information/HR Resources & Tools" at www.effectiveinterventions.org (the DEBI website). Other questions need to be directed to stakeholders who are better able to address issues specific to your intervention.

During pre-implementation an agency is encouraged to develop an evaluation plan. This plan is implemented throughout the delivery of **Healthy Relationships**. The evaluation plan consists of formative evaluation, process monitoring and evaluation, and outcome monitoring. An agency does not need to be concerned with conducting an outcome evaluation because **Healthy Relationships** has been previously tested with a control group. Prior demonstration of effectiveness is an advantage to implementing an evidence-based intervention.

The implementation of the evaluation plan during the intervention will result in several sets of data to be reviewed and analyzed.

The process monitoring data are best collected in some type of spreadsheet, since they are primarily numerical and are reviewed by looking at progress over time. Program managers may also want to look at the number of people attending sessions, for example, for each target population, at each location, by facilitator team, or session by session.

The process evaluation procedure documents fidelity to Core Elements and the adapting done to meet the needs of the populations and the resources and capability of the agency. These data are primarily descriptive and should be reviewed by the Program Manager at the end of each series. Another type of process evaluation involves comparing the process monitoring data to the corresponding planned or anticipated numbers of people contacted, recruited, and attending the sessions, for example. The results of this comparison can expose areas for further review and improvement as well as areas of achievement.

The outcome monitoring process is more complex and beyond the scope of this brief section. Agencies should have an evaluation specialist on staff, consult with such a specialist, or seek technical assistance to analyze outcome results.

APPENDIX I
Risk Continuum Cards 

How to Create Cards:

The package contains a Risk Continuum Banner. The cards for each version of the exercise are in this appendix for you to duplicate, after you adapt or add to the cards as appropriate for your target population. You can change the text electronically or by printing the blank cards and writing in your text, if you prefer.

Once you have made any desired changes, you can prepare the cards for use with the Risk Continuum Banner by copying the cards on heavy paper or card stock, and cutting them out. Instructions are found below. For durability, you may want to laminate them four to a sheet, leaving space in between the cards. Trim cards so the space around them is fairly even (approximately 1/2 inch). You can attach your adhesive of choice to the back of each card in advance or let participants do that during the Risk Continuum Banner activities.

Each page of the cards is marked with a number in the upper right-hand corner. This number corresponds to the Risk Continuum Banner activity in which they are used. The exercise about disclosure to family and friends is #1, disclosure to sex partners is #2, and sexual behaviors is #3. Cards for #1 are found on pages 2-9, for #2 on pages 11-16, and for #3 on pages 18-22. These page numbers include a sheet of blank cards for each set. Page 24 is a key for the correct locations of the sexual behavior cards on the final completed banner.

The CD in your package has copies of these cards and other materials you may want to adapt reformatted without the section and page number information contained in the footer. With the electronic version of these cards, a computer, and almost any word processing program, you can change the text on any of these cards or add text to the blank page provided. Simply insert the cursor inside the card, and highlight any text there. Hit the delete button. Add any desired text. Adjust font size, if needed. As mentioned earlier, you can also make copies of the blank cards, and write the terms appropriate for your population on them.

If you prefer to make changes in the electronic version of this appendix, you can delete the appendix and page numbers if you wish. In most programs, go to the main menu, and select "View". In the drop-down menu, choose "Header and Footer." Beginning on the first page, look at the bottom of each page for the text and numbers you wish to delete. In most instances, if you highlight and delete information about a particular section, the deletion will take effect for that whole section.

Father

Brother

Mother

Sister

Son

Employer

Daughter

Co-Worker

Friend

Doctor

Acquaintance

Religious
Leader

Grandmother

Aunt

Grandfather

Uncle

Babysitter

Nurse

Beautician

Midwife

Cousin

Father-in-law

Best Friend

Mother-in-law

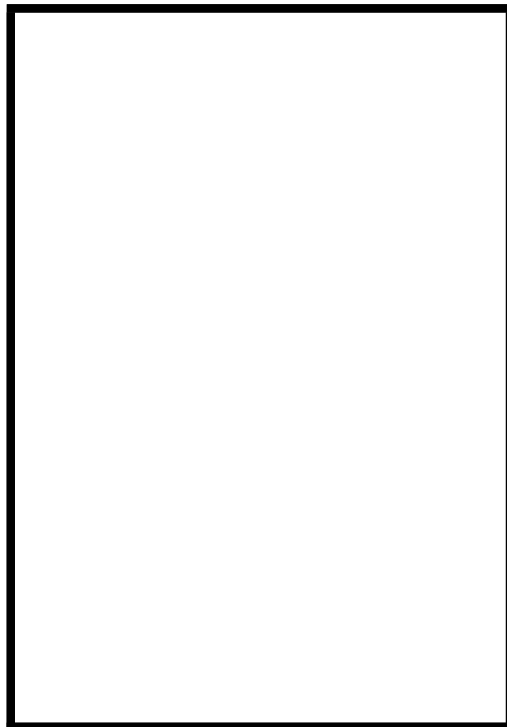
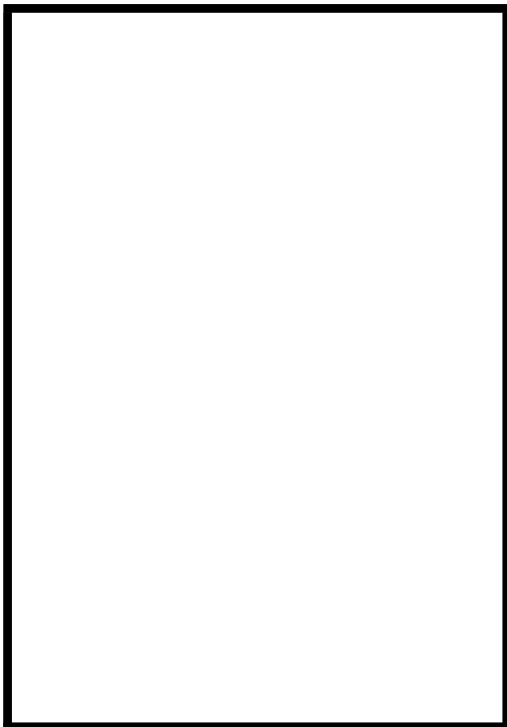
Sister-in-law

Stepdaughter

Brother-in-law

Stepson

Linkage
Coordinator



Risk Continuum Cards 1: Disclosing to Family and Friends

1. Mother
2. Father
3. Sister
4. Brother
5. Daughter
6. Son
7. Co-worker
8. Employer
9. Acquaintance
10. Friend
11. Religious leader
12. Doctor
13. Grandfather
14. Grandmother
15. Uncle
16. Aunt
17. Beautician
18. Babysitter
19. Midwife
20. Nurse
21. Best friend
22. Cousin
23. Mother-in-law
24. Father-in-law
25. Brother-in-law
26. Sister-in-law
27. Stepson
28. Stepdaughter
29. Linkage Coordinator

First Date

Long-time
Partner

One-time
Partner

Fourth Date

Abuser

Past Partner

Mate

HIV+ Date

Anonymous
Partner

Husband

Commercial
Sex Worker

Wife

Monogamous
Partner

Hustler

Sex Party
Participant

Trick

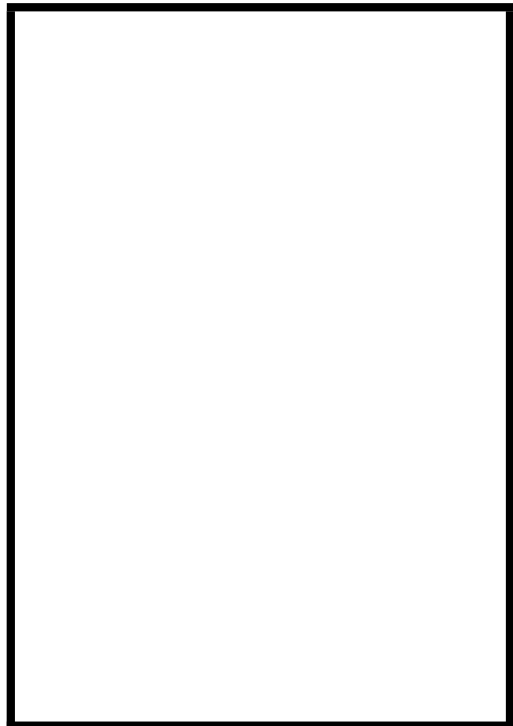
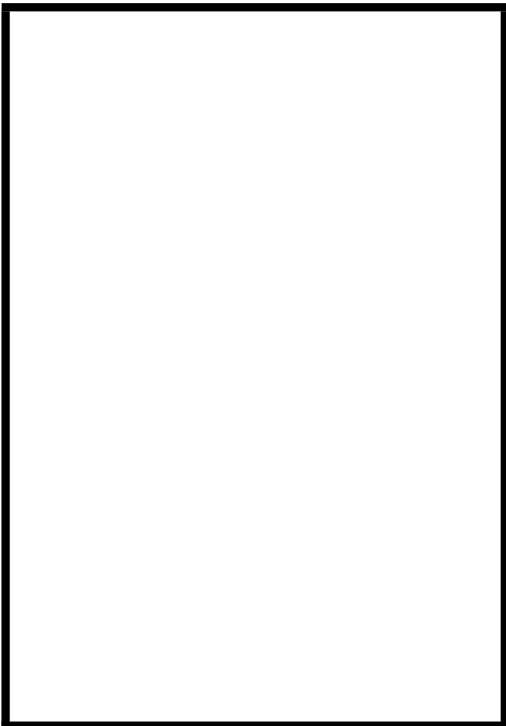
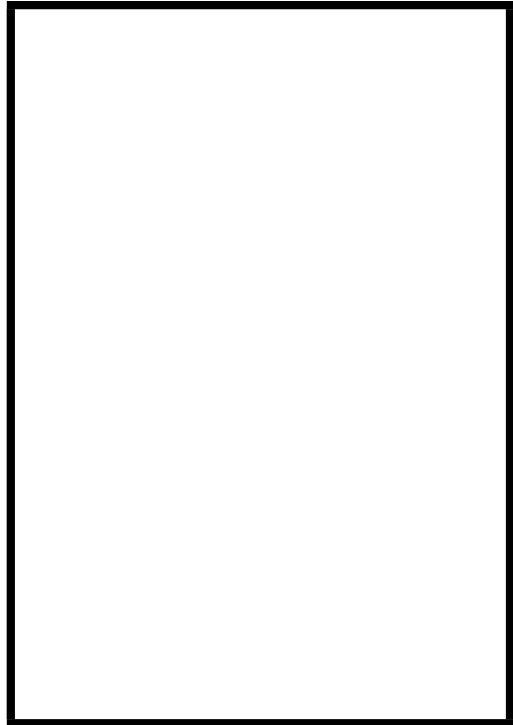
Girlfriend

Potential
Partner

Boyfriend

Online
Partner

HIV – Date
on PrEP



Risk Continuum Cards 2: Disclosing to Sex Partners

1. One-time partner
2. First date
3. Fourth date
4. Long-time partner
5. Mate
6. Abuser
7. HIV+ date
8. Past partner
9. Commercial sex worker
10. Anonymous partner
11. Wife
12. Husband
13. Sex party participant
14. Monogamous partner
15. Trick
16. Hustler
17. Boyfriend
18. Girlfriend
19. Online partner
20. Potential partner
21. HIV – date on PrEP

Anal Sex
Without
Condom

Anal Sex With
Condom

Oral Sex
Without
Condom or
Latex Dam

Oral Sex with
Condom or
Latex Dam

Vaginal Sex
With Condom

Hugging

Vaginal Sex
Without
Condom

Kissing

Back Rubs

Abstinence

Fantasizing

Self
Masturbation

Showering
With Partner

Fingering

Mutual
Masturbation
With Shared
Sex Toys

Frottage

Condomless
vaginal sex with
someone on PrEP

Condomless
receptive anal sex
with someone on
PrEP

Barrierless oral
sex with
someone on
PrEP

Condomless
insertive anal sex
with someone on
PrEP

Risk Continuum Cards 3: Sexual Behaviors

1. Anal sex without condom
2. Anal sex with condom
3. Oral sex without condom or latex dam
4. Oral sex with condom or latex dam
5. Vaginal sex without condom
6. Vaginal sex with condom
7. Kissing
8. Hugging
9. Fantasizing
10. Back Rubs
11. Self masturbation
12. Abstinence
13. Mutual masturbation with shared sex toys
14. Showering with partner
15. Frottage
16. Fingering
17. Condomless receptive anal sex with someone on PrEP
18. Condomless insertive anal sex with someone on PrEP
19. Condomless vaginal sex with someone on PrEP
20. Barrierless oral sex with someone on PrEP

Key of Risk Levels for Risk Continuum Cards #3: Sexual Behaviors

High Risk:

- Anal sex without condom
- Vaginal sex without condom

Moderate Risk: (on sliding scale but higher risk than oral sex with a condom or latex dam):

- Oral sex without a condom or latex dam
- Barrierless oral sex with someone on PrEP (giving)
- Condomless vaginal sex with someone on PrEP
- Condomless receptive anal sex with someone on PrEP

Between Moderate and Low Risk:

- Anal sex with condom
- Vaginal sex with condom
- Oral sex with condom or latex dam
- Mutual masturbation with shared sex toys
- Barrierless oral sex with someone on PrEP (receiving)
- Condomless insertive anal sex with someone on PrEP

Low Risk:

- Abstinence
- Back rubs
- Fantasizing
- Fingering
- Frottage
- Hugging
- Kissing
- Self masturbation
- Showering with partner

APPENDIX II
Easel Chart Guides

List of Easel Chart Guides

Note: the page numbers after each title refers first to the page in this appendix followed by the page number in the Facilitator’s Handbook section of the Implementation Manual where that Easel Chart Guide is referenced.

1-a: Introductions and Group Rules.....	(II-4/49)
1-b: Getting to Know You: Interview Pairs.....	(II-5/53)
1-c: Dealing with Stress Factors.....	(II-6/54)
1-d: Communicating Effectively.....	(II-7/56)
1-e: Personal Feedback Report/PFR-A.....	(II-8/58)
1-f: Stress and Disclosure.....	(II-9/60)
1-g: Risk Continuum Banner: Disclosing to Family and Friends.....	(II-12/62)
2-a: Awareness Skills.....	(II-13/72)
2-b: Listening for Meaning.....	(II-14/74)
2-c: Triggers and Barriers.....	(II-15/76)
2-d: Problem-solving.....	(II-16/80)
2-e: Decision-making and Action.....	(II-17/83)
2-f: The Discussions.....	(II-18/87)
3-a: Personal Feedback Report/PFR-B.....	(II-20/101)
3-b: Risk Continuum Banner: Disclosing to Sex Partners.....	(II-21/103)
3-c: Telling Sex Partners.....	(II-22/105)
3-d: Dealing with Disclosure to Sex Partners.....	(II-23/106)

4-a: Deciding About Disclosure to Sex Partners..... (II-32/124)

4-b: Disclosure Risk Assessment..... (II-33/125)

4-c: Key Points About Disclosure Decisions..... (II-34/125)

4-d: Relationships with Positive and Negative Partners..... (II-37/126)

4-e: Personal Feedback Report/PFR-C..... (II-38/128)

**4-f: Risk Continuum Banner:
Safer Sex/Risk Reduction..... (II-39/130)**

4-g: Where Do People Get Their HIV Risk Information..... (II-40/133)

4-h: How Can Sex Be Made Safer..... (II-41/134)

5-a: The Pros and Cons of Condoms..... (II-43/143)

5-b: Condom Practice..... (II-44/143)

5-c: Negotiating Safety..... (II-45/144)

5-d: Dealing with Safer Sex/Risk Reduction..... (II-46/145)

Notes on Revised Easel Chart Guides

The first guide (Guide 1-a) is a template showing where to insert information appropriate for your agency. Each agency should create its own version of this guide by replacing the italicized text and deleting “(template)” from the title. Keep information brief and focused on what participants will get out of attending the sessions. If your agency decides on an alternate title for “Group Rules,” replace “Group Rules” with the new title on this guide.

For Sessions One, Three, and Four, guides have been added to include a sample of each of the three blank Personal Feedback Reports (PFRs). These are to be used to review each of the PFRs as they are passed out to the participants. Due to this addition, guide numbers for these sessions have been adjusted here and in the Facilitator’s Handbook.

Guides 2-f, 3-d, and 5-d originally included multiple pages and were set up in “Dutch door” format (the pages were to be cut to reveal the questions related to facilitating the clips). In this revised version, each clip has its own full length page which includes the questions. The new guides also include additional questions and visuals to help with the facilitation of clips process.

Also in this version, there are three versions of Guides 1-f, 3-d, 4-d, and 5-d: one each for women (W), men who have sex with women (MSW), and men who have sex with men (MSM). These guides are marked with the abbreviation listed in the previous sentence; these markings can be deleted when producing the guides, if desired. Guide 2-f is marked with “all,” because the same Clips #2-1 and #2-2 are used by all three groups; this marking can also be deleted, if desired. The guides also include a set-the-scene for the original clips used with each population. If your agency uses any replacement clips, the related pages will need to be revised.

Guide 5-d/page 5 is for an optional clip for MSM. It is included to be available if a participant wanted to discuss or role-play what to do in an anonymous sex situation. If your agency wants to use this clip, **it should not be the final one** (see Appendix VI), but it could be used as the first or second one in Session Five. In that case, adjust the clip and page numbers for Guide 5-d.

This version uses some graphics to break up the text and make the guides more visually interesting. Your agency can choose new and/or additional graphics, move the graphics around, or delete some or all of the graphics. You can also make any other changes that will make the guides more effective tools for you. In any case, consider what will make the guides most appealing to your **Healthy Relationships** participants.

Guide 1-a (template)

Introductions and Group Rules

(name of agency)... (brief definition of the organization and why they are implementing this intervention)

Why Meet in Groups?

Bringing people together to share

Why is the group closed to new members?

Confidentiality of the group comes first.

Am I required to talk in the group?

Right to pass and freedom to speak

Right to not participate in activities

Respect for each other

No put downs or judgments

The main goal of the group is to learn something new and have fun doing it!

Guide 1-b

Getting to Know You: Interview Pairs

Select a partner... get to know each other



Questions:

1. Who are you?
2. What is one thing you find stressful and how do you cope (or deal) with it?
3. If this was your day and you could do anything you wanted, what would you be doing?

Guide 1-c

Dealing with Stress Factors

Some stressors are minor; others are major.

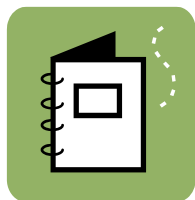
HIV/AIDS can be a long-term stressor.

HIV/AIDS is a different stressor for different people.



Healthy Relationships focuses on the stress of telling others about one's HIV status and safer sex/risk reduction.

The goal of the project is for people to deal better with stress through activities, discussions, and learning from each other.



Resources for dealing with stress

Guide 1-d

Communicating Effectively

Effective communication =

Better decisions about disclosure =

Reduced stress regarding disclosure

After listening for the other person's thoughts & feelings...

Use "I" statements to express your feelings, thoughts, needs

I feel _____ (*emotion*)

when you _____ (*recent specific act by listener*)

because _____ (*reason*)

I want/need _____ (*future specific act by listener*)

because _____ (*reason*)

Timing can be everything...listening helps

Listening for meaning

- What people say
- How they say it
- Body language
- Restating
- Open-ended questions

Guide 1-e

Personal Feedback Report/PFR-A

During the survey and interview you completed before attending the group sessions, you answered several questions regarding your experiences and your feelings. Below is a list of things that you said you find most stressful.

Going on disability	Sexual dysfunction	Major loss of income
Death of a friend	Money problems	Change of viral load
Ending a relationship	Discrimination	Finding social services
Finding treatment	Telling a friend	Starting a relationship
Change in health	Telling a partner	Loneliness/abandonment
Substance abuse	Recovery	Waiting for test results
Religion/spirituality	Being hospitalized	Telling a family member
Accessing health care	Transportation	Lack/increased sexual drive
Poor health	Child care/custody	Infecting a partner
Taking medications	Work	Uncertainty of the future
Change in T cells	Fatigue	Depression
Treatment side effects	Housing	

Of the following family members, you said the following know of your HIV status.

Mother	Father	Brother/Sister
Grandparent	Aunt/Uncle	Cousin
Partner/Spouse	Children	Grandchildren
Nephew/Niece	In-laws	Other

About disclosing your status... Below is a summary of your responses to some of the survey and interview questions.

You said that you have disclosed your status to (#) family members and (#) friends.

For those (#) people who you have disclosed to, you said that (#) responded in a positive and supportive manner.

Guide 1-f (W)

Stress and Disclosure

Why focus on stress from disclosure and safer sex?



Clip #1-1: “Too Many Friends”

This scene shows a woman talking about not disclosing the fact that her son's living with HIV.



Watch and think about the stress she reveals related to this lack of disclosure.

- ❖ What do you think this woman was feeling? What was the most stressful thing for her? What kind of reaction do you think she expected if she did disclose?
- ❖ What were **your** feelings when you last thought about disclosing to a family member or friend? What things have stopped you from disclosing?
- ❖ If you have disclosed to a family member or friend, what were the most stressful things for **you**? What kind of reaction did you get? Was it what you expected?

Guide 1-f (MSW)

Stress and Disclosure

Why focus on stress from disclosure and safer sex?



Clip #1-1: “Let’s Talk”

This scene shows a man, who is living with HIV, trying to disclose his HIV status to a woman he slept with.



Watch and think about reasons why the disclosure is stressful for him.

- ❖ What do you think this man was feeling? What was the most stressful thing about this situation for him? What kind of reaction do you think he expected?
- ❖ What were **your** feelings when you last thought about disclosing? What things have stopped you from disclosing?
- ❖ If you have disclosed to a family member or friend, what were the most stressful things for **you**? What kind of reaction did you get? Was it what you expected?

Guide 1-f (MSM)

Stress and Disclosure

Why focus on stress from disclosure and safer sex?



Clip #1-1: “Snapshot of Disclosure”

This scene shows a man, who is living with HIV, talking about disclosing his sexual orientation when a child.



Watch and think about the stress related to this disclosure experience.

- ❖ What do you think this man was feeling? What was the most stressful thing about this situation for him? What kind of reaction do you think he expected?
- ❖ What were **your** feelings when you last thought about disclosing? What things have stopped you from disclosing?
- ❖ If you have disclosed to a family member or friend, what were the most stressful things for **you**? What kind of reaction did you get? Was it what you expected?

Guide 1-g

Risk Continuum Banner: Disclosing to Family and Friends

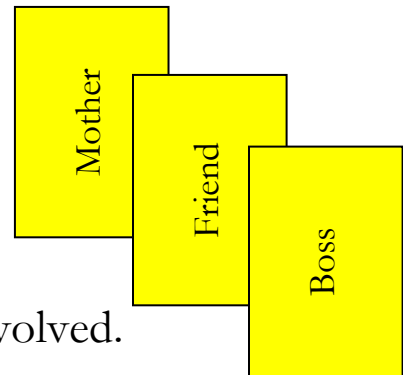
When can disclosing be risky – or not risky?

Risk of disclosure is a very individual matter and differs from person to person.

For each card:

Think about type of person listed.

Think about the kind of relationship involved.



Both disclosing and not disclosing can be stressful.

Guide 2-a

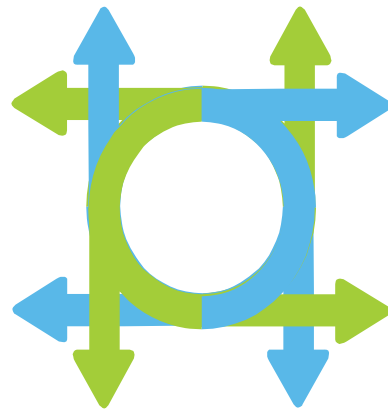
Awareness Skills

Awareness:

A key step to coping with disclosure

What is awareness?

- Ability to read/understand your surroundings
- Ability to read/understand yourself
- Noticing outside and inside
- In short...
 - Check around you
 - Check your heart
 - Check your stomach



Use “I” statements and active listening

Guide 2-b

Listening for Meaning

Speakers

Listeners

Observers

Share a good experience where you told a friend or family member you were living with HIV/AIDS.



Watch for

- Restating
- Open-ended questions
- Body language

Speaker: Did you feel heard/understood? Why or why not?

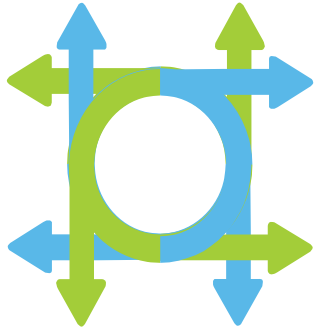
Observer: What did the listener do well? Something to improve?

Listener: What seemed easy or hard?

Guide 2-c

Triggers and Barriers

Awareness reveals...



Triggers: things about situations that encourage an action

Barriers: things about situations that discourage an action

People...

Trigger = someone you like

Barrier = someone who is scared of people living with HIV

Places...

Trigger = a private, safe place

Barrier = a public, open place

Feelings...

Trigger = feeling lonely

Barrier = feeling depressed

Substances...

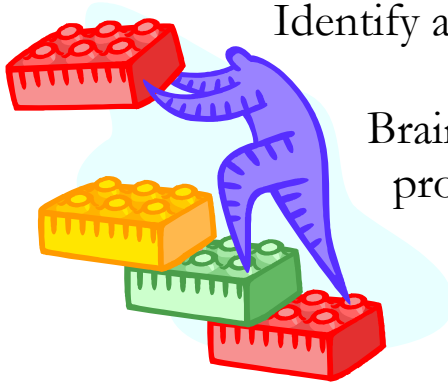
Trigger = lower inhibitions

Barrier = hard to make decision

Guide 2-d

Problem-solving

Identifying triggers and barriers empowers you to deal with them!



Identify a problem (trigger or barrier).

Brainstorm possible options to deal with the problem.

Identify the results you want – both short-term and long-term.

Example...

You are feeling lonely, so you go and visit someone you recently met who does not know you have HIV/AIDS.

Guide 2-e

Decision-making and Action

Deciding to disclose or not to disclose is a balancing act.

	Pros	Cons
To Tell (Do)		
Not to Tell (Don't)		

A healthy decision...

- Is realistic
- Is fair and balanced
- Meets the needs of all the participants
- Considers the future

Choose a plan!
Take action!

Guide 2-f/page 1 (All)

The Discussions



Clip #2-1: "Telling Mom and Dad"

This movie scene shows a young man telling his parents that he is gay and living with HIV/AIDS.



Awareness?

Triggers for disclosing?
Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?
 What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 2-f/page 2 (All)

The Discussions



Clip #2-2: "I Need A Lawyer"

This scene shows a man, who is living with HIV/AIDS, seeking legal advice from a lawyer he had met before.



Awareness?

Triggers for disclosing?
Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?

What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 3-a

Personal Feedback Report/PFR-B

During the survey and interview you completed before attending the group sessions, you answered questions about your experiences and your feelings about disclosing your status to sex partners. Below is a summary of your responses.

You said that you had (#) sex partners in the past 6 months who you did not tell you were positive.

You indicated that you were (very sure, sure, undecided, unsure, or not sure at all) that you could make effective decisions of whether to tell a partner that you were positive.

You indicated that you were (very sure, sure, undecided, unsure, or not sure at all) that you could know whether it is safe to tell a partner that you are positive.

The following are your answers to five questions.

If I were unsure of a person's status, I could decide about telling them my status before having sex.

Strongly Disagree Disagree Undecided Agree Strongly Agree

I am certain that I can discuss my status with a new sex partner.

Strongly Disagree Disagree Undecided Agree Strongly Agree

I feel confident telling someone that I am dating about my status.

Strongly Disagree Disagree Undecided Agree Strongly Agree

I am certain that I could decide about disclosing my status to a new partner, even if I had been drinking and/or doing drugs.

Strongly Disagree Disagree Undecided Agree Strongly Agree

I feel confident in refusing to have unsafe sex if pressured by my partner to be unsafe.

Strongly Disagree Disagree Undecided Agree Strongly Agree

Guide 3-b

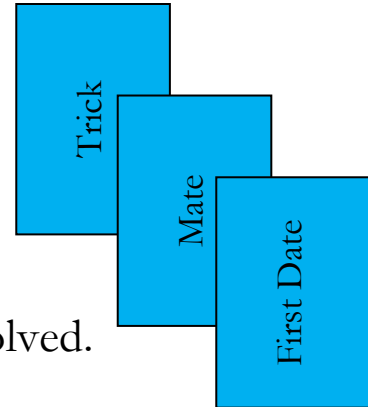
Risk Continuum Banner: Disclosing to Sex Partners

When can disclosing be risky – or not risky?

For each card:

Think about type of person listed.

Think about the kind of relationship involved.



Risk of disclosure is a very individual matter and differs from person to person.

Both disclosing and not disclosing can be stressful.

What is different about disclosing to sex partners?

Guide 3-c

Telling Sex Partners

Dealing with disclosure to partners...

Think of a high-risk disclosure situation.

Awareness

Inside

Outside

Identifying triggers and barriers

People-Places-Feelings-Substances

Problem-solving

Problem?

Options?

Results?

Effective decision-making

Pros/Cons...To Tell/Not To Tell

Realistic?

Fair and balanced?

Meets needs of all?

Considers future?

Taking action... or not

Guide 3-d/page 1 (W)

Dealing with Disclosure to Sex Partners



Clip # 3-1: “Time to Go”

The woman in this scene is feeling pressured to tell her long-term partner that she is living with HIV because he wants to make a commitment to her. She is at the point where she feels it is time to disclose.



Awareness?

Triggers for disclosing?
Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?

What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 3-d/page 1 (MSW)

Dealing with Disclosure to Sex Partners



Clip # 3-1: “Roller Coaster Feelings”

In this scene, a young man has just learned that he tested positive for HIV and is feeling very upset. He seeks comfort from his long-term girlfriend who does not yet know about the HIV test.



Awareness?

Triggers for disclosing?
Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?
 What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 3-d/page 1 (MSM)

Dealing with Disclosure to Sex Partners



Clip # 3-1: "My Mysteries"

In this scene, Zack (the man in the white shirt) is confused about telling his new partner that he has HIV. He wants to have sex with him and does not want to lose him.



Awareness?

Triggers for disclosing?

Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?

What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 3-d/page 2 (W)

Dealing with Disclosure to Sex Partners



Clip # 3-2: "First Date"

This scene features a woman, who is living with HIV, trying to postpone sex and disclosure with a new partner of unknown HIV status.



Awareness?

Triggers for disclosing?

Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?

What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 3-d/page 2 (MSW)

Dealing with Disclosure to Sex Partners



Clip # 3-2: "First Date"

This scene features a man, who is living with HIV, considering disclosure with a new partner of unknown HIV status.



Awareness?

Triggers for disclosing?
Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?
What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 3-d/page 2 (MSM)

Dealing with Disclosure to Sex Partners



Clip # 3-2: "Indiscretion"

In this scene, a man named Bobby is very upset, and his long-term partner tries to comfort him. This leads to Bobby disclosing an affair, and he wonders if he should also reveal his HIV status.



Awareness?

Triggers for disclosing?

Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?

What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 3-d/page 3 (W)

Dealing with Disclosure to Sex Partners



Clip # 3-3: “You’re Beautiful When I’m Drunk”

In this scene a woman, who is living with HIV/AIDS, is struggling with her intoxication and passion as she tries to disclose to her partner on their first real date.



Awareness?

Triggers for disclosing?

Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?

What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 3-d/page 3 (MSW)

Dealing with Disclosure to Sex Partners



Clip # 3-3: “No Stopping Her”

In this scene, a man is trying to not have sex because he is living with HIV/AIDS, but, on their first date, his partner is making it very hard.



Awareness?

Triggers for disclosing?
Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?
 What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 3-d/page 3 (MSM)

Dealing with Disclosure to Sex Partners



Clip # 3-3: “Swearing Off Sex”

The man in this scene named Steve is living with HIV. Steve is very attracted to someone he recently met, but the other man is so afraid of getting HIV that he has sworn off dating and sex.



Awareness?

Triggers for disclosing?
Barriers to disclosing?

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?
 What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of disclosing and not disclosing? Use the grid.

	Pros	Cons
To Tell (Do)		
Not To Tell (Don't)		

Take action. Role-play this scene. What would you say/do differently?

Guide 4-a

Deciding About Disclosure to Sex Partners

Stress of deciding when and if to disclose

People, places, feelings, and substance use can make disclosure easier or more difficult.

Understanding your personal risk for disclosure



Think about how to reduce the stress of making decisions about disclosure to...

- HIV + partners
- HIV - partners

Group discussion: review your own personal risks for disclosing to various types of partners.

Guide 4-b

Disclosure Risk Assessment



What negative things can happen?

Are there risks of...

Abandonment?

Violent reactions?

Others finding out?

Are there warning signs or triggers for negative reactions?

Do you have a safety plan in case things do go negative?



When is choosing not to tell an acceptable option?

Guide 4-c

Key Points About Disclosure Decisions



The decision is personal and very individual.



Anticipate reactions.



Problem-solve possible negative reactions.



Set personal priorities for disclosure.



Choosing not to disclose is an option...
but when and how?

Guide 4-d (W)

Relationships with Positive and Negative Partners

Let's talk about relationships...Mixed-status couples



Clip #4-1: “Partner Revelations”

In this scene, a woman talks about how discovering that she was living with HIV affected her husband, who was not.



Watch and think about what you would do in a similar situation.

What are the unique issues in couples where both have HIV?
Advantages? Disadvantages?

What are the unique issues in mixed status couples?
Advantages? Disadvantages?

Disclosure issues with sex partners ...
Old versus new
Casual versus steady
Ways to tell their status (reliable or not?)

What are the safer sex issues for mixed status couples?

Guide 4-d (MSW)

Relationships with Positive and Negative Partners

Let's talk about relationships...Mixed-status couples



Clip #4-1: "It's Not You, It's Me"

In this scene, a woman, who is not living with HIV, has a dream about her long-term partner disclosing his status.



Watch and think about what you would do in a similar situation.

What are the unique issues in couples where both have HIV?
Advantages? Disadvantages?

What are the unique issues in mixed status couples?
Advantages? Disadvantages?

Disclosure issues with sex partners ...
Old versus new
Casual versus steady
Ways to tell their status (reliable or not?)

What are the safer sex issues for mixed status couples?

Guide 4-d (MSM)

Relationships with Positive and Negative Partners

Let's talk about relationships...Mixed-status couples



Clip #4-1: “Dinner with Jeffrey”

Remember the scene with Steve and Jeffrey that we saw last session? In this new scene, Jeffrey is the one who chases after Steve.



Watch and think about what you would do in a similar situation.

What are the unique issues in couples where both have HIV?
Advantages? Disadvantages?

What are the unique issues in mixed status couples?
Advantages? Disadvantages?

Disclosure issues with sex partners ...

Old versus new

Casual versus steady

Ways to tell their status (reliable or not?)

What are the safer sex issues for mixed status couples?

Guide 4-e

Personal Feedback Report/PFR-C

During the survey and interview you completed before attending the group sessions, you answered questions about your experiences and your feelings about practicing safer sex. Below is a summary of your responses.

You said that you were (*very sure, sure, undecided, unsure, or not sure at all*) that you could bring up the need to practice safer sex.

You said that you were (*very sure, sure, undecided, unsure, or not sure at all*) that you could refuse to have unsafe sex if your partner pressured you to be unsafe.

You said that you had (#) partners in the past 6 months.

Below are sexual activities you said you practiced in the past 6 months.

Anal intercourse without a condom, you were top (#) times.

Anal intercourse without a condom, you were bottom (#) times.

(If applicable) You said condoms were used (*always, almost always, half of the time, almost never, never*) during anal intercourse.

Oral intercourse received without a condom/latex dam (#) times.

Oral intercourse performed without a condom/latex dam (#) times.

Vaginal intercourse without a condom (#) times.

(If applicable) You said condoms were used (*always, almost always, half of the time, almost never, never*) during vaginal intercourse.

Below are drug-using behaviors you said you practiced.

You said you have used the following drugs before or when you have sex:

If you said you have injected drugs/medications before, you indicated using the following: _____

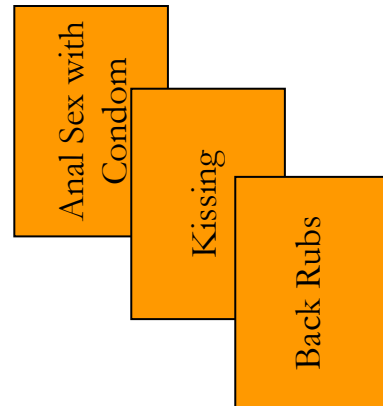
If you said you have injected drugs/medicines before, you indicated using the following kinds of needles: (*new, bleached, reused your own, shared [someone used before you], shared [someone used after you], origin unknown*) _____

Guide 4-f

Risk Continuum Banner: Safer Sex/Risk Reduction

When sex can be risky – or not risky

Continuum of sexual behavior risks



This is about facts, not personal feelings and opinions.

Guide 4-g

Where Do People Get Their HIV Risk Information?



Clip #4-2: “When Men Talk About AIDS”
A Brief HIV Risk Review

Where do people get their information on what’s safe and what’s not? This video gives the facts.

Myths and misinformation

When sex can be risky – or not risky

Guide 4-h/page 1

How Can Sex Be Made Safer?

A Review of:

Awareness

Inside

Outside

Identifying Triggers and Barriers

People-Places-Feelings-Substances

Problem-solving

Identify the problem.

Brainstorm possible options.

Identify short-term and long-term results you want.

Guide 4-h/page 2

How Can Sex Be Made Safer?

Decision-making

- Realistic?
- Fair and balanced?
- Meets needs of all?
- Considers future?

Condoms

	Pros	Cons
Safer Sex		
Unsafe Sex		

Action

Guide 5-a

The Pros and Cons of Condoms



Things people often say about condoms:

Condoms are uncomfortable for both partners.

It's embarrassing to be seen getting condoms.

Condoms ruin the mood.

To suggest using condoms communicates mistrust.

Condoms interrupt foreplay.

Condoms just remind about HIV/AIDS.

Guide 5-b

Condom Practice



Clip #5-1: “It’s All About Condoms”

Since using condoms correctly is an important part of a healthy relationship, let’s make sure we all have the same information and skills.



Watch the video.



Watch us... Facilitators give it a try...

It’s in the technique...Everyone practice!

Remember these key points...

Removing air from reservoir tip

Rolling condom all the way down

Using a water-based lubricant

Using the condom from start to finish

Removing it while the penis is still erect

Sharing ideas to make condoms easier

Guide 5-c

Negotiating Safety

Taking personal control in situations for maximizing pleasure
AND staying in your safer sex comfort zone

The roles of...

Awareness

Identifying triggers and barriers to negotiating safer sex

Problem-solving

Safer sex decision-making

Action

Guide 5-d/page 1 (W)

Dealing with Safer Sex/Risk Reduction



Clip #5-2: “Love Me, Love My Dog”
Building healthier relationships

The woman in this scene, who is living with HIV, is not going to have sex without a condom. Her new boyfriend has one but encounters difficulties with her dog.



Awareness?

Triggers for negotiating safer sex? **Barriers?**

	Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?

What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 1 (MSW)

Dealing with Safer Sex/Risk Reduction



Clip #5-2: “Pick Up Tricks”
Building healthier relationships

Here we see a woman come in to a bar and appear to try to pick up a stranger. He is living with HIV and does not encourage her.



Awareness?

Triggers for negotiating safer sex? **Barriers?**

	Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?

What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 1 (MSM)

Dealing with Safer Sex/Risk Reduction



Clip #5-2: "The Touch"
Building healthier relationships

In this scene, a man living with HIV is visiting a friend whose HIV status he doesn't know and who doesn't know his status. They've never had sex before, but things heat up after he finds that the spare bed is too small for him.



Awareness?
Triggers for negotiating safer sex? **Barriers?**

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...
What could have been said/done and how?
What would you have said/done and how?
Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 2 (W)

Dealing with Safer Sex/Risk Reduction



Clip #5-3: “Got To Go Now”
Building healthier relationships

In this scene, a woman, who is living with HIV, is considering leaving town to avoid negotiating safer sex with a new man she’s met.



Awareness?

Triggers for negotiating safer sex? **Barriers?**

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?
What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 2 (MSW)

Dealing with Safer Sex/Risk Reduction



Clip #5-3: "Dancing and Dilemmas"
Building healthier relationships

In this scene, a man wants to have sex with a woman he just met at a convention without telling her that he is living with HIV.



Awareness?
Triggers for negotiating safer sex? **Barriers?**

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...
What could have been said/done and how?
What would you have said/done and how?
Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 2 (MSM)

Dealing with Safer Sex/Risk Reduction



Clip #5-3: "Freak Out"
Building healthier relationships

In this scene, the African American man, who is living with HIV, is confronted by a former lover, who is trying to seduce him.



Awareness?
Triggers for negotiating safer sex? **Barriers?**

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...
What could have been said/done and how?
What would you have said/done and how?
Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 3 (W)

Dealing with Safer Sex/Risk Reduction



Clip #5-4: “Sex for Money”
Building healthier relationships

In this scene, a woman, who is living with HIV/AIDS, really needs money right away and uses her body to get it.



Awareness?
Triggers for negotiating safer sex? **Barriers?**

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...
What could have been said/done and how?
What would you have said/done and how?
Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 3 (MSW)

Dealing with Safer Sex/Risk Reduction

NO CLIP #5-4 FOR MSW (SKIP TO CLIP #5-5)

Guide 5-d/page 3 (MSM)

Dealing with Safer Sex/Risk Reduction



Clip #5-4: “Stealthy Seduction”
Building healthier relationships

In this scene, a man, who is living with HIV/AIDS, goes to get a glass of milk in the middle of the night. A newly met house guest, whose HIV status he does not know, seduces him.



Awareness?
Triggers for negotiating safer sex? **Barriers?**

	Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...
What could have been said/done and how?
What would you have said/done and how?
Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 4 (W)

Dealing with Safer Sex/Risk Reduction



Clip #5-5: “Let’s Make Up”
Building healthier relationships

In this scene, a man is working late, when his long-term girlfriend comes to make up after a fight. She hasn’t told him she is living with HIV/AIDS, even though she knows he is not.



Awareness?
Triggers for negotiating safer sex? **Barriers?**

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...
What could have been said/done and how?
What would you have said/done and how?
Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 4 (MSW)

Dealing with Safer Sex/Risk Reduction



Clip #5-5: "Let's Make Up"
Building healthier relationships

In this scene, a man is working late, when his long-term girlfriend comes to make up after a fight. He hasn't told her he is living with HIV/AIDS, even though he knows she is not.



Awareness?
Triggers for negotiating safer sex? **Barriers?**

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...
What could have been said/done and how?
What would you have said/done and how?
Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 4 (MSM)

Dealing with Safer Sex/Risk Reduction



Clip #5-5: "Let's Make Up"
Building healthier relationships

In this scene, a man is working late, when his long-term girlfriend comes to make up after a fight. He hasn't told her he is living with HIV/AIDS, even though he knows she is not.



Awareness?
Triggers for negotiating safer sex? **Barriers?**

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...
What could have been said/done and how?
What would you have said/done and how?
Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

Guide 5-d/page 5 (MSM-optional)

Dealing with Safer Sex/Risk Reduction



Clip #5-6: "Cruising"
Building healthier relationships

In this scene, a man, who is living with HIV/AIDS, is feeling frustrated and lonely. He goes out cruising and picks up a stranger who wants to have sex with him.



Awareness?
Triggers for negotiating safer sex? **Barriers?**

Triggers	Barriers

Problem-solve:

- ❖ Trigger/barrier that is a problem?
- ❖ Options for dealing with the trigger/barrier?
- ❖ Short- and long-term results you want?



Pause...

What could have been said/done and how?

What would you have said/done and how?

Finish the scene.

Make a decision. What are the pros and cons of practicing and not practicing safer sex? Use the grid.

	Pros	Cons
Safer Sex		
Unsafe Sex		

Take action. Role-play this scene. What would you say/do differently?

APPENDIX III
Participant Forms

Participant Forms

We recommend interviewing participants before assigning them to a **Healthy Relationships** session, since not all potential participants are a good fit for this type of group. The participant interview form can be used as a starting point for questions to ask, but each agency should customize the questions to be most appropriate for their implementation. This form was not used in the research study, because they accepted anyone who was living with HIV/AIDS and willing to participate in the intervention.

The next form is the Initial Assessment Survey (IAS), followed by the Personal Feedback Report (PFR) forms that are created based on the survey. Each PFR form has a key form following it in the Appendix; these keys relate the information on the PFR to the appropriate question on the initial assessment survey. All of these forms can be adapted to obtain additional information or be otherwise more appropriate for your target audience. However, the questions on the IAS that are used for the PFR forms should not be deleted.

Handout 5-1
Healthy Relationships
Initial Assessment Survey (Amended/Full Version)

Please answer the following questions as truthfully as possible; there are no right or wrong answers. Please take your time and read each section carefully. Some sections require you to provide numbers. Others require you to circle the appropriate response and still others require complete sentences. The questions are designed to assess stress levels and your willingness to disclose your HIV status. All answers will remain confidential to the extent allowed by law.

Participant ID Code: _____ **Today's Date:** ____/____/____

Gender: _____ (Male, Female, or Transgender)

Age: _____ **Birthdate:** ____/____/____

Ethnicity:

Hispanic/Latino/Latina

Not Hispanic or Latino/Latina

Race:

Mark your primary race first.

If you identify with more than one, please mark a secondary choice.

	Primary	Secondary
American Indian/Alaskan Native	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>
African American/Black	<input type="checkbox"/>	<input type="checkbox"/>
White	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian/Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>

1. Have you visited a doctor about your HIV? **Please circle your answer.**

Yes No *(If no, skip to question 9.)*

2. How many times have you visited this doctor **in the last 12 months?** **Please circle your answer.**

0 times 1 time 2 times 3 or more times

3. Has this doctor prescribed antiretroviral therapy (HIV medications) for you? **Please circle your answer.**

Yes No *(If no, skip to question 8.)*

4. How often do you take these medications? **Please circle your answer.**

Every day Most days Some days Never/have not filled prescription

5. If you do not take these medications every day, why not? **Please circle as many as apply.**

Too expensive Side effects Afraid others will see me Forget

Other (please list) _____

6. Is your viral load suppressed? **Please circle your answer.**

Yes No Don't know

7. When was the last time you had your viral load checked? **Please circle your answer.**

Within the last 3-6 months Between 6-12 months Over 12 months ago

8. Have you talked with your doctor about antiretroviral therapy? **Please circle your answer.**

Yes No *(Skip to question 10.)*

9. Why have you not visited a doctor? **Please circle as many as apply.**

Nervous Too busy Don't want people to discover my status

Don't like doctors Concerned about how I will be treated Too expensive

Don't know who to contact Other (**please list**) _____

10. Which of the following would you say **create stress** in your daily life? **Please circle as many as apply.**

- | | | |
|------------------------|-----------------------|-----------------------------|
| Going on disability | Sexual dysfunction | Major loss of income |
| Death of a friend | Money problems | Change of viral load |
| Ending a relationship | Discrimination/stigma | Finding social services |
| Finding treatment | Telling a friend | Starting a relationship |
| Change in health | Telling a partner | Loneliness |
| Substance Abuse | Recovery | Waiting for test results |
| Religion/spirituality | Being hospitalized | Telling a family member |
| Accessing health care | Transportation | Lack/increased sexual drive |
| Poor health | Child Care/Custody | Infecting a partner |
| Taking meds every day | Work | Uncertainty of the Future |
| Depression | Fatigue | Change in CD4-/T-cells |
| Treatment side effects | Housing | Rejection/abandonment |

Please answer the following questions as they relate to talking about your HIV status to others (disclosing). **Please answer as accurately as possible.**

11. Of the following family members, which ones know of your HIV status? **Please circle as many as apply.**

- | | | |
|----------------|------------|----------------|
| Mother | Father | Brother/Sister |
| Grandparent | Aunt/Uncle | Cousin |
| Partner/Spouse | Children | Grandchildren |
| Nephew/Niece | In-laws | Other |

12. Of the following groups, **how many** people have you told about your HIV status? *(If you have told no family members or friends, put zeros in the blanks and skip to question 17.)*

of _____ family members # of _____ friends

13. Of the people who know your HIV status, **how many** of them responded well to this information? **Please put the appropriate number in each of the blanks.**

of _____ family members who responded well

of _____ friends who responded well

14. Who was it most important to tell about your HIV status? **Please list.** What made you choose this/these person/people?

15. Who was it most difficult to tell about your HIV status? **Please list.** What made it difficult?

16. Who was it easy to tell about your HIV status? **Please list.** What made it easy?

17. If you have not told anyone your HIV status, what is your major worry about doing so?

Please answer the following questions about your experiences and feelings about disclosing your HIV status to sex partners. **Please answer as accurately as possible.**

18. How many sex partners in the past 6 months did you **not tell about** your HIV status, but practiced **safer sex**? _____

19. How many sex partners in the past 6 months did you **not tell about** your HIV status, but practiced **unsafe sex**? _____

Below each of the following statements, **please circle the response** that most closely matches your feelings. **Please circle only one response.**

20. How sure are you that you could decide to tell a family member or friend that you are positive?

Very sure Sure Undecided Unsure Not sure at all

21. How comfortable are you about telling a family member or friend that you are positive?

Very comfortable Comfortable Undecided Uncomfortable Very uncomfortable

22. Of the people you know, how many would support you in your decisions about disclosure and safer sex?

Everyone Most Undecided Some Very few

23. How sure are you that you could decide to tell a partner that you were positive?

Very sure Sure Undecided Unsure Not sure at all

24. How sure are you that you could know whether it is safe to disclose your status to a partner?

Very sure Sure Undecided Unsure Not sure at all

25. If I were unsure of a person's status I could decide about telling them my status before having sex.

Strongly Disagree Disagree Undecided Agree Strongly Agree

26. I feel confident telling someone that I am dating about my status.

Strongly Disagree Disagree Undecided Agree Strongly Agree

27. I am certain that I can discuss my status with a new sex partner.

Strongly Disagree Disagree Undecided Agree Strongly Agree

28. I am certain that I could decide about telling a new partner about my status even if I had been drinking and/or doing drugs.

Strongly Disagree Disagree Undecided Agree Strongly Agree

29. How sure are you in talking about the need for safer sex practices with your sexual partners?

Very sure Sure Undecided Unsure Not sure at all

30. How sure are you in refusing to have unsafe sex if pressured by your partner to be unsafe?

Very sure Sure Undecided Unsure Not sure at all

31. How confident are you that you can use a condom correctly?

Very confident Confident Undecided Not confident Not confident at all

32. How much risk is there that you will transmit HIV to someone else through sex?

Very low risk Some risk Undecided High risk Very high risk

Please answer the following questions about your sexual activities during the **past 6 months**.
Please answer all that apply.

33. How many sex partners have you had during the **past 6 months**? _____ (*If none, skip to question 43a.*)

34. How many times did you put your penis in someone's anus without using a condom?
_____ (**# of times**)

35. How many times did someone put their penis in your anus without using a condom?
_____ (**# of times**)

36. How often were condoms used during anal intercourse? Please circle one.

Always Almost always Half of the time Almost never Never NA

37. How many times did you receive oral intercourse without a condom/latex dam?
_____ (**# of times**)

38. How many times did you perform oral intercourse without a condom/latex dam?
_____ (# of times)

39. How often were condoms/latex dam used during oral intercourse? Please circle one.

Always Almost always Half of the time Almost never Never NA

40. How many times did you put your penis in someone's vagina without using a condom? _____ (# of times)

41. How many times did someone put their penis in your vagina without using a condom? _____ (# of times)

42. How often were condoms used during vaginal intercourse? Please circle one.

Always Almost always Half of the time Almost never Never NA

43a. Has a Health Care Provider ever told you that you had a sexually transmitted disease (STD)? Please circle as many as apply. (If none apply, skip to question 44a.)

Syphilis

Hepatitis C

Chlamydia

Human Papilloma Virus (HPV/Genital Warts)

Gonorrhea

Herpes

Hepatitis B

Other (please list) _____

43b. Have you been treated for the STD(s)?

____ Yes ____ No ____ Don't Know

44a. Have you ever used drugs or alcohol before or during sexual activities?

____ Yes ____ No (If no, skip to question 45a.)

44b. If yes, which of the following drugs have you ever used before or during sexual activities? Please circle all that apply.

Crack

Amyl Nitrate (Poppers)

Marijuana

Cocaine

Ecstasy

Alcohol

Heroin

Special K

Other _____

GHB

Amphetamines (speed, crystal)

45a. Have you ever injected any drugs or medications? ____Yes ____No
(If no, skip to end of survey.)

45b. If yes, which of the following drugs or medications have you ever injected? Please circle all that apply.

Heroin	Cocaine/Crack	Steroids
Amphetamines (Speed, Crystal)	Insulin	Hormones
Vitamins	Depo-Provera (birth control)	
Prescription drugs (Codeine, Morphine)	Other_____	

45c. If you have injected drugs or medications, what kind of needles did you use? Please circle all that apply.

New	Bleached	Shared (someone used before me)
Reused my own	Origin unknown	Shared (someone used after me)

That's it! Thank you for completing this assessment.

Handout 5-2
Personalized Feedback Report Form A

During the survey and interview you completed before attending the group sessions, you answered several questions regarding your experiences and your feelings. Below is a summary of some of your responses about your HIV medical care.

You said that you had visited a doctor for HIV care _____ times.

You said that you take your HIV medications...

Daily Most days Some days Never/Prescription not filled Not prescribed NA

You said that the status of your viral load is _____.

Below is a list of things that you said you find most stressful.

Going on disability	Sexual dysfunction	Major loss of income
Death of a friend	Money problems	Change of viral load
Ending a relationship	Discrimination/stigma	Finding social services
Finding treatment	Telling a friend	Starting a relationship
Change in health	Telling a partner	Loneliness
Substance Abuse	Recovery	Waiting for test results
Religion/spirituality	Being hospitalized	Telling a family member
Accessing health care	Transportation	Lack/increased sexual drive
Poor health	Child Care/Custody	Infecting a partner
Taking meds every day	Work	Uncertainty of the Future
Depression	Fatigue	Change in CD4-/T-cells
Treatment side effects	Housing	Rejection/abandonment

About disclosing your status... Below is a summary of your responses to some of the survey and interview questions.

You said that you have disclosed your status to _____ family members and _____ friends.

For those _____ people who you have disclosed to, you said that _____ responded in a positive and supportive manner.

Handout 5-3

Key for Creating PFR-A From Initial Assessment Survey (IAS) Full Version

During the survey and interview you completed before attending the group sessions, you answered several questions regarding your experiences and your feelings. Below are some of your responses about your HIV medical care.

(from IAS question #1 and #2) You said you had visited a doctor for HIV care (0 times, 1 time, 2 times, 3 or more times, never) .

(from IAS question #3 and #4) You said that you take your HIV medications ...

Daily Most days Some days Never/Prescription not filled Not prescribed NA

(from IAS question #6) You said that the status of your viral load is (suppressed/ not suppressed/ unknown) .

(from IAS question #10) Below is a list of things that you said you find most stressful.

Going on disability	Sexual dysfunction	Major loss of income
Death of a friend	Money problems	Change of viral load
Ending a relationship	Discrimination/stigma	Finding social services
Finding treatment	Telling a friend	Starting a relationship
Change in health	Telling a partner	Loneliness
Substance Abuse	Recovery	Waiting for test results
Religion/spirituality	Being hospitalized	Telling a family member
Accessing health care	Transportation	Lack/increased sexual drive
Poor health	Child Care/Custody	Infecting a partner
Taking meds every day	Work	Uncertainty of the Future
Depression	Fatigue	Change in CD4-/T-cells
Treatment side effects	Housing	Rejection/abandonment

About disclosing your status... Below is a summary of your responses to some of the survey and interview questions.

(from IAS question #12) You said that you have disclosed your status to (#) family members and (#) friends.

(from IAS question #13) For those (#) people who you have disclosed to, you said that (#) responded in a positive and supportive manner.

Handout 5-4
Personalized Feedback Report Form B

During the survey and interview you completed before attending the group sessions, you answered questions about your experiences and your feelings about disclosing your status to sex partners. Below is a summary of your responses.

You said that you had _____ sex partners in the past 6 months who you did not tell you were positive.

You indicated that you were _____ that you could make effective decisions of whether to tell a partner that you were positive.

You indicated that you were _____ that you could know whether it is safe to tell a partner that you are positive.

The following are your answers to 5 questions.

If I were unsure of a person's status, I could decide about telling them my status before having sex.

Strongly Disagree Disagree Undecided Agree Strongly Agree

I am certain that I can discuss my status with a new sex partner.

Strongly Disagree Disagree Undecided Agree Strongly Agree

I feel confident telling someone that I am dating about my status.

Strongly Disagree Disagree Undecided Agree Strongly Agree

I am certain that I could decide about disclosing my status to a new partner, even if I had been drinking and/or doing drugs.

Strongly Disagree Disagree Undecided Agree Strongly Agree

I am _____ I could refuse to have unsafe sex if pressured by my partner to be unsafe.

Handout 5-5

Key for Creating PFR-B From Initial Assessment Survey (IAS) Full Version

During the survey and interview you completed before attending the group sessions, you answered questions about your experiences and your feelings about disclosing your status to sex partners. Below is a summary of your responses.

(from IAS questions #18 & #19, totaled) You said that you had ___ (#) ___ sex partners in the past 6 months who you did not tell you were positive.

(from IAS question #23) You indicated that you were ___ (#) ___ that you could make effective decisions of whether to tell a partner that you were positive.

(from IAS question #24) You indicated that you were ___ (*very sure, sure, undecided, unsure, not sure at all*) ___ that you could know whether it is safe to tell a partner that you are positive.

The following are your answers to 5 questions.

(from IAS question #25) If I were unsure of a person's status, I could decide about telling them my status before having sex.

Strongly Disagree Disagree Undecided Agree Strongly Agree

(from IAS question #27) I am certain that I can discuss my status with a new sex partner.

Strongly Disagree Disagree Undecided Agree Strongly Agree

(from IAS question #26) I feel confident telling someone that I am dating about my status.

Strongly Disagree Disagree Undecided Agree Strongly Agree

(from IAS question #28) I am certain that I could decide about disclosing my status to a new partner, even if I had been drinking and/or doing drugs.

Strongly Disagree Disagree Undecided Agree Strongly Agree

(from IAS question #30) I feel ___ (*very sure, sure, undecided, unsure, not sure at all*) ___ I could refuse to have unsafe sex if pressured by my partner to be unsafe.

Handout 5-6
Personalized Feedback Report Form C

During the survey and interview you completed before attending the group sessions, you answered questions about your experiences and your feelings about practicing safer sex. Below is a summary of your responses.

You said that the last time you had your viral load checked was:

Within the last 3-6 months Between 6-12 months Over 12 months ago

You said that you were _____ that you could bring up the need to practice safer sex.

You said that you were _____ that you could refuse to have unsafe sex if your partner pressured you to be unsafe.

You said that you had _____ partners in the past 6 months.

Below are sexual activities you said you practiced in the past 6 months.

Anal intercourse without a condom, you inserted your penis in someone _____ times.

Anal intercourse without a condom, you received someone's penis _____ times.

You said condoms were used _____ during anal intercourse.

Oral intercourse received without a condom/latex dam _____ times.

Oral intercourse performed without a condom/latex dam _____ times.

Vaginal intercourse without a condom _____ times.

You said condoms were used _____ during vaginal intercourse.

Below are drug using behaviors you said you practiced.

You said you have used the following drugs before or when you have sex:

If you said you have injected drugs/medications before, you indicated using the following:

If you said you have injected drugs/medicines before, you indicated using the following kinds of needles:

Handout 5-7

Key for Creating PFR-C From Initial Assessment Survey (IAS) Full Version

During the survey and interview you completed before attending the group sessions, you answered questions about your experiences and your feelings about practicing safer sex. Below is a summary of your responses.

(from IAS question #7) You said that the last time you had your viral load checked was:

Within the last 3-6 months

Between 6-12 months

Over 12 months ago

(from IAS question #29) You said that you were _____ (*very sure, sure, undecided, unsure, not sure at all*) _____ that you could bring up the need to practice safer sex.

(from IAS question #30) You said that you were _____ (*very sure, sure, undecided, unsure, not sure at all*) _____ that you could refuse to have unsafe sex if your partner pressured you to unsafe.

(from IAS question #33) You said that you had _____ (#) _____ partners in the past 6 months.

Below are sexual activities you said you practiced in the past 6 months.

(from IAS question #34) Anal intercourse without a condom, you were the insertive partner (put your penis in someone's anus) _____ (#) _____ times.

(from IAS question #35) Anal intercourse without a condom, you were the receptive partner (received someone's penis in your anus) _____ (#) _____ times.

(from IAS question #36) You said condoms were used _____ (*always, almost always, half of the time, almost never, never, NA*) _____ during anal intercourse.

(from IAS question #37) Oral intercourse received without a condom/latex dam _____ (#) _____ times.

(from IAS question #38) Oral intercourse performed without a condom/latex dam _____ (#) _____ times.

(from IAS question #40 & #41, totaled) Vaginal intercourse without a condom _____ (#) _____ times.

(from IAS question #42) You said condoms were used _____ (*always, almost always, half of the time, almost never, never, NA*) _____ during vaginal intercourse.

Below are drug using behaviors you said you practiced.

(from IAS question #44b) You said you have used the following drugs before or when you have sex: _____

(from IAS question #45b) If you said you have injected drugs/medications before, you indicated using the following: _____

(from IAS question #45c) If you said you have injected drugs/medicines before, you indicated using the following kinds of needles: _____

Handout 5-8
Healthy Relationships
Initial Assessment Survey (Amended/Short Version)

Please answer the following questions as truthfully as possible; there are no right or wrong answers. Please take your time and read each section carefully. Some sections require you to provide numbers. Others require you to circle the appropriate response and still others require complete sentences. The questions are designed to assess stress levels and your willingness to disclose your HIV status. All answers will remain confidential to the extent allowed by law.

Participant ID Code: _____ **Today's Date:** ____/____/____

Gender: _____ (Male, Female, or Transgender)

Age: _____ **Birthdate:** ____/____/____

Ethnicity:
Hispanic/Latino/Latina Not Hispanic or Latino/Latina

Race:
Mark your primary race first.
If you identify with more than one, please mark a secondary choice.

	Primary	Secondary
American Indian/Alaskan Native	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>
African American/Black	<input type="checkbox"/>	<input type="checkbox"/>
White	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian/Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>

1. Have you visited a doctor about your HIV? **Please circle your answer.**

Yes No *(If no, skip to question 7.)*

2. How many times have you visited this doctor **in the last 12 months?** **Please circle your answer.**

0 times 1 time 2 times 3 or more times

3. Has this doctor prescribed antiretroviral therapy (HIV medications) for you? **Please circle your answer.**

Yes No *(If no, skip to question 7.)*

4. How often do you take these medications? **Please circle your answer.**

Every day Most days Some days Never/have not filled prescription

5. Is your viral load suppressed? **Please circle your answer.**

Yes No Don't know

6. When was the last time you had your viral load checked? **Please circle your answer.**

Within the last 3-6 months Between 6-12 months Over 12 months ago

7. Which of the following would you say **create stress** in your daily life? **Please circle as many as apply.**

- | | | |
|------------------------|-----------------------|-----------------------------|
| Going on disability | Sexual dysfunction | Major loss of income |
| Death of a friend | Money problems | Change of viral load |
| Ending a relationship | Discrimination/stigma | Finding social services |
| Finding treatment | Telling a friend | Starting a relationship |
| Change in health | Telling a partner | Loneliness |
| Substance Abuse | Recovery | Waiting for test results |
| Religion/spirituality | Being hospitalized | Telling a family member |
| Accessing health care | Transportation | Lack/increased sexual drive |
| Poor health | Child Care/Custody | Infecting a partner |
| Taking meds every day | Work | Uncertainty of the Future |
| Depression | Fatigue | Change in CD4-/T-cells |
| Treatment side effects | Housing | Rejection/abandonment |

Please answer the following questions as they relate to talking about your HIV status to others (disclosing). **Please answer as accurately as possible.**

8. Of the following groups, **how many** people have you told about your HIV status? *(If you have told no family members or friends, put zeros in the blanks and skip to question 10.)*

of _____ family members # of _____ friends

9. Of the people who know your HIV status, **how many** of them responded well to this information? **Please put the appropriate number in each of the blanks.**

of _____ family members who responded well

of _____ friends who responded well

Please answer the following questions about your experiences and feelings about disclosing your HIV status to sex partners. **Please answer as accurately as possible.**

10. How many sex partners in the past 6 months did you **not tell about** your HIV status, but practiced **safer sex**? _____

11. How many sex partners in the past 6 months did you **not tell about** your HIV status, but practiced **unsafe sex**? _____

Below each of the following statements, **please circle the response** that most closely matches your feelings. **Please circle only one response.**

12. **How sure are you that you could decide to tell a partner that you were positive?**

Very sure Sure Undecided Unsure Not sure at all

13. **How sure are you that you could know whether it is safe to disclose your status to a partner?**

Very sure Sure Undecided Unsure Not sure at all

14. **If I were unsure of a person's status I could decide about telling them my status before having sex.**

Strongly Disagree Disagree Undecided Agree Strongly Agree

15. **I feel confident telling someone that I am dating about my status.**

Strongly Disagree Disagree Undecided Agree Strongly Agree

16. **I am certain that I can discuss my status with a new sex partner.**

Strongly Disagree Disagree Undecided Agree Strongly Agree

17. **I am certain that I could decide about telling a new partner about my status even if I had been drinking and/or doing drugs.**

Strongly Disagree Disagree Undecided Agree Strongly Agree

18. **How sure are you in talking about the need for safer sex practices with your sexual partners?**

Very sure Sure Undecided Unsure Not sure at all

19. How sure are you in refusing to have unsafe sex if pressured by your partner to be unsafe?

Very sure Sure Undecided Unsure Not sure at all

Please answer the following questions about your sexual activities during the **past 6 months**. **Please answer all that apply.**

20. How many sex partners have you had during the past 6 months? _____ *(If none, skip to question 43a.)*

21. How many times did you put your penis in someone's anus without using a condom?
_____ **(# of times)**

22. How many times did someone put their penis in your anus without using a condom?
_____ **(# of times)**

23. How often were condoms used during anal intercourse? Please circle one.

Always Almost always Half of the time Almost never Never NA

24. How many times did you receive oral intercourse without a condom/latex dam?
_____ **(# of times)**

25. How many times did you perform oral intercourse without a condom/latex dam?
_____ **(# of times)**

26. How many times did you put your penis in someone's vagina without using a condom?
_____ **(# of times)**

27. How many times did someone put their penis in your vagina without using a condom?
_____ **(# of times)**

28. How often were condoms used during vaginal intercourse? Please circle one.

Always Almost always Half of the time Almost never Never NA

29a. Have you ever used drugs or alcohol before or during sexual activities?
___Yes ___No (If no, skip to question 30a.)

29b. If yes, which of the following drugs have you **ever** used before or during sexual activities? **Please circle all that apply.**

Crack	Amyl Nitrate (Poppers)	Marijuana
Cocaine	Ecstasy	Alcohol
Heroin	Special K	Other_____
GHB	Amphetamines (speed, crystal)	

30a. Have you ever injected any drugs or medications? ___Yes ___No
(If no, skip to end of survey.)

30b. If yes, which of the following drugs or medications have you **ever** injected? **Please circle all that apply.**

Heroin	Cocaine/Crack	Steroids
Amphetamines (Speed, Crystal)	Insulin	Hormones
Vitamins	Depo-Provera (birth control)	
Prescription drugs (Codeine, Morphine)	Other_____	

30c. If you have injected drugs or medications, what kind of needles did you use? **Please circle all that apply.**

New	Bleached	Shared (someone used before me)
Reused my own	Origin unknown	Shared (someone used after me)

That's it! Thank you for completing this assessment.

Handout 5-9

Key for Creating PFR-A From Short Initial Assessment Survey (IAS)

During the survey and interview you completed before attending the group sessions, you answered several questions regarding your experiences and your feelings. Below are some of your responses about your HIV medical care.

(from IAS question #1 and #2) You said you had visited a doctor for HIV care (0 times, 1 time, 2 times, 3 or more times, never) .

(from IAS question #3 and #4) You said that you take your HIV medications ...
Daily Most days Some days Never/Prescription not filled Not prescribed Not applicable

(from IAS question #5) You said that the status of your viral load is (suppressed/not suppressed/unknown) .

(from IAS question #7) Below is a list of things that you said you find most stressful.

Going on disability	Sexual dysfunction	Major loss of income
Death of a friend	Money problems	Change of viral load
Ending a relationship	Discrimination/stigma	Finding social services
Finding treatment	Telling a friend	Starting a relationship
Change in health	Telling a partner	Loneliness
Substance Abuse	Recovery	Waiting for test results
Religion/spirituality	Being hospitalized	Telling a family member
Accessing health care	Transportation	Lack/increased sexual drive
Poor health	Child Care/Custody	Infecting a partner
Taking meds every day	Work	Uncertainty of the Future
Depression	Fatigue	Change in CD4-/T-cells
Treatment side effects	Housing	Rejection/abandonment

About disclosing your status...Below is a summary of your responses to some of the survey and interview questions.

(from IAS question #8) You said that you have disclosed your status to (#) family members and (#) friends.

(from IAS question #9) For those (#) people who you have disclosed to, you said that (#) responded in a positive and supportive manner.

Handout 5-10

Key for Creating PFR-B From Short Initial Assessment Survey (IAS)

During the survey and interview you completed before attending the group sessions, you answered questions about your experiences and your feelings about disclosing your status to sex partners. Below is a summary of your responses.

(from IAS questions #10 & #11, totaled) You said that you had (#) sex partners in the past 6 months who you did not tell you were positive.

(from IAS question #12) You indicated that you were (#) that you could make effective decisions of whether to tell a partner that you were positive.

(from IAS question #13) You indicated that you were (very sure, sure, undecided, unsure, not sure at all) that you could know whether it is safe to tell a partner that you are positive.

The following are your answers to 5 questions.

(from IAS question #14) If I were unsure of a person's status, I could decide about telling them my status before having sex.

Strongly Disagree Disagree Undecided Agree Strongly Agree

(from IAS question #16) I am certain that I can discuss my status with a new sex partner.

Strongly Disagree Disagree Undecided Agree Strongly Agree

(from IAS question #15) I feel confident telling someone that I am dating about my status.

Strongly Disagree Disagree Undecided Agree Strongly Agree

(from IAS question #17) I am certain that I could decide about disclosing my status to a new partner, even if I had been drinking and/or doing drugs.

Strongly Disagree Disagree Undecided Agree Strongly Agree

(from IAS question #19) I feel (very sure, sure, undecided, unsure, not sure at all) I could refuse to have unsafe sex if pressured by my partner to be unsafe.

Handout 5-11
Key for Creating PFR-C From Short Initial Assessment Survey (IAS)

During the survey and interview you completed before attending the group sessions, you answered questions about your experiences and your feelings about practicing safer sex. Below is a summary of your responses.

(from IAS question #6) You said that the last time you had your viral load checked was:

Within the last 3-6 months

Between 6-12 months

Over 12 months ago

(from IAS question #18) You said that you were (very sure, sure, undecided, unsure, not sure at all)
that you could bring up the need to practice safer sex.

(from IAS question #19) You said that you were (very sure, sure, undecided, unsure, not sure at all)
that you could refuse to have unsafe sex if your partner pressured you to unsafe.

(from IAS question #20) You said that you had (# partners in the past 6 months.

Below are sexual activities you said you practiced in the past 6 months.

(from IAS question #21) Anal intercourse without a condom, you were the insertive partner (put your penis in someone's anus) (# times.

(from IAS question #22) Anal intercourse without a condom, you were the receptive partner (received someone's penis in your anus) (# times.

(from IAS question #23) You said condoms were used (always, almost always, half of the time, almost never, never, NA) during anal intercourse.

(from IAS question #24) Oral intercourse received without a condom/latex dam (# times.

(from IAS question #25) Oral intercourse performed without a condom/latex dam (# times.

(from IAS question #26 & #27, totaled) Vaginal intercourse without a condom (# times.

(from IAS question #28) You said condoms were used (always, almost always, half of the time, almost never, never, NA) during vaginal intercourse.

Below are drug using behaviors you said you practiced.

(from IAS question #29b) You said you have used the following drugs before or when you have sex: _____

(from IAS question #30b) If you said you have injected drugs/medications before, you indicated using the following: _____

(from IAS question #30c) If you said you have injected drugs/medicines before, you indicated using the following kinds of needles: _____

APPENDIX IV
Facilitator Materials

Facilitator Materials

The facilitators should fill out a copy of the Session Evaluation forms on the next four pages at the end of each **Healthy Relationships** session. The Facilitator's Session Outline forms, one for each session, can also be used to assure completion of all content items. This set of forms can be used to help with the debriefing sessions and process evaluation.

The next two Facilitator Evaluation forms look at personal characteristics and group process skills. These forms are designed for use when selecting new facilitators or re-evaluating current ones.

At the end of this appendix is a section on group facilitation skills and tips. This is intended as an introduction to good group facilitation. It should not be considered a substitute for facilitation training, practice, and experience.

Session Evaluations

Date of session: _____ Session #: _____ Location: _____

of participants attending: _____ # of participants missing: _____

If participants missed this session, list any information you have on why they were not there.

What went well in the session?

What could have been done better in the session?

List any memorable “quotes” from the session.

The objectives of each session are listed below. Select the appropriate session and put a check mark by each objective met. If there were objectives that were not met or problems meeting an objective, explain.

Session One Objectives:

- Introduce the goals and expectations of the program.
- Establish group cohesiveness and trust.
- Introduce connection of stress and HIV/AIDS
- Introduce disclosure to family and friends as a potential stressor.
- Identify personal disclosure to family and friends risk continuum.

Session Two Objectives:

- Explore the elements of disclosure to family and friends.
- Introduce and practice awareness skills.
- Introduce and practice identification of triggers and barriers.
- Introduce and practice problem-solving.
- Introduce and practice decision-making and how it leads to action.

Session Three Objectives:

- Introduce disclosure to sex partners as a potential stressor.
- Identify personal disclosure to sex partners risk continuum.
- Review skills building: awareness, trigger and barrier identification, problem-solving, decision-making, and action.
- Practice skills as related to disclosure to sex partners.

Session Four Objectives:

- Explore disclosure to sex partners.
- Explore relationships with positive and negative partners.
- Introduce safer sex/risk reduction.
- Identify personal safer sex/risk reduction continuum.
- Review the Five Coping Skills as related to safer sex/risk reduction.

Session Five Objectives:

- Build condom skills and alternatives to unsafe sex.
- Identify the pros and cons of condoms, and problem-solve cons.
- Practice the Five Coping Skills as related to safer sex/risk reduction.

List any other items that need follow-up at the next session.

How engaged or involved (or not) were the majority of the participants?

Very

Somewhat

Not Very

Not At All

List any triggers or barriers to involvement or participation.

List any suggestions for increasing involvement.

List any signs of attitude change in the participants, particularly related to the three life areas.

List any signs of behavior change in the participants, particularly related to the three life areas.

List any referrals or additional information requested by the participants.

Healthy Relationships Session One Facilitators' Session Outline

Element	Comments/Notes
Before Session:	
Set up for session (including Easel Chart Guides, Risk Continuum Banner, video)	
Welcome participants; (if applicable) give out prize ticket	
During Session:	
Introduce facilitators and agency	
Introduce purpose	
Set up group rules	
Conduct "Interview Pairs" activity	
Guide discussion of dealing with stress factors related to HIV/AIDS	
Distribute and introduce Resource Packets	
Introduce communication skills	
Distribute and guide discussion of PFR-A	
Set-up, show, and guide discussion of Clip #1-1	
Conduct Risk Continuum Banner activity (family and friends), and guide related discussion	

Healthy Relationships Session One Facilitators' Session Outline (page two)

Element	Comments/Notes
End of Session:	
Recap session concepts	
Set-up and show Clips #1-2 and #1-3	
Thank participants for coming	
Remind participants about Resource Packet	
Remind participants of next meeting	
Conduct prize drawing (if applicable)	
After Session:	
Fill out Session Evaluation	
Attend debriefing	

Healthy Relationships Session Two Facilitators' Session Outline

Element	Comments/Notes
Before Session:	
Set up for session (including Easel Chart Guides, video)	
Welcome participants; (if applicable) give out prize ticket	
During Session:	
Thank participants for coming	
Note and inquire about missing participants	
Review group rules	
Do overview and guide discussion of awareness skills	
Conduct Listeners-Speakers-Observers activity	
Do overview and guide discussion of triggers and barriers identification skills	
Segue into and do overview and guided discussion of problem-solving skills	
Do overview and guide discussion of effective decision-making and action	
Demonstrate the Decision-making Grid	
Set-up and show Clip #2-1, relate to Five Coping Skills and disclosure to family and friends, guide discussion, and conduct role-play	
Set-up and show Clip #2-2, relate to Five Coping Skills and disclosure to family and friends, guide discussion, and conduct role-play	

Healthy Relationships Session Two Facilitators' Session Outline (page two)

Element	Comments/Notes
End of Session:	
Recap session concepts (Five Coping Skills)	
Thank participants for coming	
Remind participants about Resource Packet	
Remind participants of next meeting	
Conduct prize drawing (if applicable)	
After Session:	
Fill out Session Evaluation	
Attend debriefing	

Healthy Relationships Session Three Facilitators' Session Outline

Element	Comments/Notes
Before Session:	
Set up for session (including Easel Chart Guides, Risk Continuum Banner, video)	
Welcome participants; (if applicable) give out prize ticket	
During Session:	
Thank participants for coming	
Note and inquire about missing participants	
Review group rules	
Distribute and guide discussion of PFR-B	
Conduct Risk Continuum Banner activity (sex partners), and guide related discussion	
Review Five Coping Skills as related to disclosure to sex partners	
Set-up and show Clip #3-1, relate to Five Coping Skills and disclosure to sex partners, guide discussion, and conduct role-play	
Set-up and show Clip #3-2, relate to Five Coping Skills and disclosure to sex partners, guide discussion, and conduct role-play	
Set-up and show Clip #3-3, relate to Five Coping Skills and disclosure to sex partners, guide discussion, and conduct role-play	

Healthy Relationships Session Three Facilitators' Session Outline (page two)

Element	Comments/Notes
End of Session:	
Recap session concepts (Five Coping Skills as related to disclosure to sex partners)	
Thank participants for coming	
Remind participants about Resource Packet	
Remind participants of next meeting	
Ask participants to think about how disclosure to HIV- partners is different than to HIV+ partners	
Conduct prize drawing (if applicable)	
After Session:	
Fill out Session Evaluation	
Attend debriefing	

Healthy Relationships Session Four Facilitators' Session Outline

Element	Comments/Notes
Before Session:	
Set up for session (including Easel Chart Guides, Risk Continuum Banner, video)	
Welcome participants; (if applicable) give out prize ticket	
During Session:	
Thank participants for coming	
Note and inquire about missing participants	
Review group rules	
Guide discussion of personal disclosure risks with various types of sex partners	
Introduce and guide discussion of disclosure risk assessment	
Summarize key points of disclosure decisions	
Set-up and show Clip #4-1	
Guide discussion, based on Clip #4-1, of issues related to sero-discordant couples	
Distribute and guide discussion of PFR-C	
Conduct Risk Continuum Banner activity (sexual behaviors), and guide related discussion	
Set-up and show Clip #4-2 (HIV/AIDS education video) or otherwise present information	

Healthy Relationships Session Four Facilitators' Session Outline (page two)

Element	Comments/Notes
Review Five Coping Skills as they relate to safer sex/risk reduction	
End of Session:	
Thank participants for coming	
Remind participants about Resource Packet	
Remind participants of next meeting and that it will be the last session	
Conduct prize drawing (if applicable)	
After Session:	
Fill out Session Evaluation	
Attend debriefing	

Healthy Relationships Session Five Facilitators' Session Outline

Element	Comments
Before Session:	
Set up for session (including Easel Chart Guides, video)	
Welcome participants; (if applicable) give out prize ticket	
During Session:	
Thank participants for coming	
Note and inquire about missing participants	
Review group rules	
Review Five Coping Skills	
Guide discussion of pros and cons of condom use	
Set-up and show Clip #5-1 (condom demos)	
Demonstrate proper condom use	
Conduct condom practice	
Discuss negotiating safer sex	
Set-up and show Clip #5-2, relate to Five Coping Skills and safer sex/risk reduction, guide discussion, and conduct role-play	
Set-up and show Clip #5-3, relate to Five Coping Skills and safer sex/risk reduction, guide discussion, and conduct role-play	
Set-up and show Clip #5-4, relate to Five Coping Skills and safer sex/risk reduction, guide discussion, and conduct role-play	

Healthy Relationships Session Five Facilitators' Session Outline (page two)

Element	Comments/Notes
Set-up and show Clip #5-5, relate to Five Coping Skills and safer sex/risk reduction, guide discussion, and conduct role-play	
End of Session:	
Recap concepts from all sessions	
Give participants opportunity to share what they gained from the sessions	
Guide discussion of action plans	
Thank participants for coming	
Remind participants about Resource Packet	
Present participants with certificate, award and acknowledgement	
Ask participants to fill out post-group evaluation	
Conduct prize drawing (if applicable)	
After Session:	
Fill out Session Evaluation	
Attend debriefing	

Facilitator Evaluation					
Facilitator:			Evaluator:		
Date of Session:	Number of Participants:				
Personal Characteristics	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Able to build rapport	5	4	3	2	1
Creates warm and welcoming environment	5	4	3	2	1
Authentic	5	4	3	2	1
Trustworthy	5	4	3	2	1
Flexible	5	4	3	2	1
Active listener	5	4	3	2	1
Good observer	5	4	3	2	1
Understanding and non-judgmental	5	4	3	2	1
Dynamic and friendly	5	4	3	2	1
Empathetic and supportive	5	4	3	2	1
Patient	5	4	3	2	1
Interested in working with groups	5	4	3	2	1
Not chemically dependent, sober, or in recovery	5	4	3	2	1
Respectful of others and their opinions	5	4	3	2	1
Respect for confidentiality	5	4	3	2	1

Facilitator Evaluation					
Facilitator:			Evaluator:		
Date of Session:		Number of Participants:			
Group Process Skills	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Good knowledge of group process	5	4	3	2	1
Knowledge of HIV/AIDS	5	4	3	2	1
Ability to promote communication	5	4	3	2	1
Understanding of group dynamics	5	4	3	2	1
Ability to manage and control problems	5	4	3	2	1
Ability to work with people where they are	5	4	3	2	1
Maintains eye contact	5	4	3	2	1
Uses humor effectively and appropriately	5	4	3	2	1
Ability to adapt to changing dynamics in the group	5	4	3	2	1
Ability to adjust agenda times to meet the needs of the group	5	4	3	2	1
Focuses on group needs instead of own personal agenda	5	4	3	2	1
Ability to make appropriate referrals to services	5	4	3	2	1
Follows up on identified needs	5	4	3	2	1
Willingness to learn from the group	5	4	3	2	1

Skills and Tips for Facilitating Groups

What is group facilitation?

Group facilitation is the process where group facilitators:

- Help participants to assign meaning to their goals and expectations for the sessions
- Guide participants in discussion that creates an opportunity for them to learn from one another
- Coach participants in the learning and practice of new skills

Group facilitation is not the same as counseling or instructing a group of participants. In brief interventions such as Healthy Relationships, one of the main objectives in facilitating a group is for the participants to take responsibility for the direction the group takes within the context of the session goals and objectives.

Why do you need group facilitation skills?

Being skilled in guiding the group process is important because the facilitator is responsible for making sure that:

- The goals of the group sessions are met
- Participants in the group feel safe and comfortable to contribute to the discussion
- Discussion topics raised by participants in the session are addressed sufficiently

If a participant raises a matter that is not appropriate for the group to address, the facilitator should know how to refer the participant to additional services or to table the matter for a more appropriate time while also keeping the general group session on target.

What are group facilitation skills?

Good facilitation skills can be learned. Some of those skills include, but are not limited to, modeling skills for participants to practice, provide constructive feedback on the role-plays, the ability to establish trust, help create bonding among participants, keep participants involved in the discussions, create a sense of shared ownership in their input, keep discussions on track and on time, maintain an open climate, maintain a safe environment, maintain respect among participants, and manage different personality types.

Tips for modeling skills for participants

Modeling skills for participants is an important part of facilitating groups. When group facilitators model skills, learning the proper way to perform a skill can be enhanced among the participants. When modeling, group facilitators should be well-prepared and familiar with the material in advance of the groups. Apart of being prepared is being comfortable in using the skills taught in a particular session. If the skill requires two persons to model, practice the skills in advance with your co-facilitator so you can develop a rhythm for modeling to the participants.

Tips for providing constructive feedback on role-plays

Encouraging and correcting participants' performance of role-plays through constructive feedback is an important skill to develop as a group facilitator. As mentioned earlier, one of the purposes of group facilitation is to help the participant learn and practice new skills. Implied in participants learning and practicing new skills is that participants will learn new skills properly through feedback from the facilitators.

Constructive feedback should be offered in an open and respectful manner. For example, group facilitators can offer feedback on a role-play performance by using the goals of the exercise as a tool for asking the observer or the participants if the necessary features of the skill are being performed and ask the other group members what can be done differently. If necessary, the group facilitator can model the performance to ensure that the participants are clear on how to perform the role-play.

Tips for establishing trust

Trust is a belief that participants' sharing their life experiences and opinions are important to the other participants and to the facilitators. An important characteristic of trust is the belief that other participants and the facilitators will treat the information shared in the group with respect and not judge the participant for sharing or repeat the information to others outside the group sessions. In Healthy Relationships, ground rules are established early in the groups. Facilitators can establish trust among the participants by establishing the ground rules collectively, emphasizing the importance of each participant not judging one another based on information shared, and keeping information shared within the group confidential. Following the ground rules consistently throughout each session helps to establish a group norm. It also reduces the chances that facilitators interact with participants with favoritism and maintains the facilitators' roles as neutral. A facilitator can review the purpose of the sessions and the group rule about privacy at the beginning of each meeting. Also, opening the group session by checking in with participants and asking them what their goals and expectations are for the session can help build trust.

Trust can be weakened when the facilitators allow individual needs or interests of a given participant to take priority over the group's interests. Facilitators inconsistently following the agreed upon ground rules may appear as though the facilitators favor one participant over another or that there is no structure by allowing certain behaviors to take place. If facilitators notice that group trust is beginning to weaken, using a structured exercise that encourages teamwork and bonding can help re-establish trust among the participants and facilitators. Verbally acknowledge to the group if you have not been consistently following the group rules and state that they are an important tool for you to use to help ensure each member is experiencing what they came to the session to experience. State that from this point on, you all will be attentive to the rules and your co-facilitator will help you refer to them if you or the participants become distracted with the group activities.

Tips for creating bonding among participants

Bonding is the relationship that develops among participants as a result of shared experience and trust being established. Built into the intervention, are different types of exercises facilitators can use to help participants get to know one another a little more. These activities can help participants meet one another, lighten the tone of the session, and refocus their attention on the topic. They can be organized so that participants work in pairs or smaller groups and learn more about one another. Another way to help participants bond is through the use of scheduled breaks with snacks. This can create “free” time where participants talk among themselves and take a break from the topic at hand. A facilitator also can help participants bond by using humor to lighten the discussion. When addressing personal topics such as disclosure of HIV status and sexual risk behaviors, sometimes the discussion can turn into a heavy conversation. Appropriate use of humor to introduce session activities or exercises can set the tone in which the group discusses issues and create opportunities to for participants to learn various aspects of one another’s personality. Facilitators can also create bonding among the participants by appropriately disclosing some information about themselves at the right time. This decision requires good judgment; however, facilitators who choose to share personal information about themselves can do so by using just a few words or engaging body language that suggests they identify with what the participants are experiencing without offering too much detailed information about their own experiences. When disclosing, remember that the session time is for the participant’s self-development not the facilitators’.

Finally, checking in with the participants’ expectations for the session and comfort level, or “taking the group’s temperature” periodically throughout each session can establish bonding. Checking in early in each session can help determine what their expectations and goals are for the session. In doing so, other participants may identify similar experiences and goals and be encouraged to share their own expectations with the group. Checking in mid-way through each session can provide opportunities for participants to stop and think about what they have experienced so far and begin to assess whether or not they feel that they are reaching their goals. Sharing their thoughts about the session up to that point can be useful for other participants to understand their own experiences and help them feel connected to others who give similar feedback. Checking in mid-way also gives the facilitators a chance to address any issues developing around a specific topic or activity and offers time to correct any misinformation or misunderstandings. Finally, similarly to other opportunities for checking in, checking in at the end of each session helps participants summarize what they have experienced. The facilitator summarizing the participants’ observations helps participants bond.

Bonding can be derailed by the facilitators not paying attention to the participant’s non-verbal and verbal cues. These cues can indicate whether participants are understanding the discussion, if they are bored, or whether or not they agree with the issues raised. A facilitator can re-establish bonding among participants by engaging the group for more feedback on what they wish to experience, and what they are experiencing, write down the participant’s feedback on ease paper, and create a specified amount of time either in the current session or the next session to continue working toward the stated goals and expectations.

Tips for keeping participants involved in the discussion

Involvement in group discussion takes place when the majority of the group's participants feel comfortable enough to sincerely and openly share their thoughts. A good group facilitator helps participants feel comfortable in sharing their experiences and opinions in the sessions while balancing conversation among the group participants. A facilitator can make participants feel comfortable in sharing by remaining neutral in their opinions, making participants feel good about what they share, and creating ways where each participant has a chance to speak, if they wish.

As mentioned previously, facilitators can also create good group discussion by consistently following the ground rules. Checking in with the participants throughout the sessions to ensure they understand the activities and they are getting something meaningful out of the sessions. Facilitators can use a structured exercise conducted in smaller groups or in pairs as a tool for generating good discussion around a topic. This can help participants think about the scenario from their own experience, and share their perspectives. If time does not allow for an exercise, facilitators can ask the participants to internalize the scenario and reflect upon what they would do if they were in that current situation.

As mentioned before, facilitators can make a participant feel good about sharing by: checking back with the group to see what participants think about the topic and the discussion. As mentioned earlier, this process maybe referred to as "taking the group's temperature." Engage the participants by making eye contact when you speak to them and when they are speaking to the group. If you are writing on easel paper or preparing the room for an exercise, wait until you have finished before you begin to address the participants. Finally, people often take their cues from other people in the room. If the facilitator is not at ease introducing a topic or conducting an exercise, the participants may sense this discomfort. Be prepared in advance of the group session for the topic and exercises so you do not need to refer to your notes throughout the sessions. If after preparing for the session you feel uncomfortable in the session or you lose your place in facilitating the group, your co-facilitator can help remind you of the next exercise or activity. If your co-facilitator is not able to help you refocus the group discussion, take a short break and give yourself time to meet with your co-facilitator and either change facilitation roles or refocus your thoughts and activities for the remaining time of the session.

A good group discussion can be interrupted by the facilitators not being familiar with the session material or making awkward transitions into the next activity or exercise. Facilitators can help one another get back on track by quickly checking in with participants to see if they are feeling comfortable with the discussion up to that point. If the participants are not comfortable, facilitators can use a limited amount of time to explore what the participants would like to experience in the remaining time of the session. Try to be as responsive to their needs as you can while following the agenda. It is not necessary to have full closure on every issue raised by the end of a session. An issue raised can be addressed to some extent and then tabled for another time, for example after the group, for more discussion.

Tips for creating a sense of shared ownership in their input

Shared ownership is when participants feel as though they can be involved in group activities, exercises and discussions while helping to maintain group rules among one another. Facilitators help group participants feel as though they own a part of the group process that is taking place. This is important because when people feel as though they are active participants in activities or conversation, they may be more likely to be more honest and frank about their experiences and help one another follow the group rules. This openness adds value to the group discussions.

A facilitator can create a sense of shared ownership among participants by establishing ground rules collectively and getting most of the participants to agree to them. Shared ownership also is created when facilitators help participants see the value of the session or the activities. This can be done as each session is opened and participants are thinking about what they want to experience and what their goals are for the sessions. When facilitators help participants identify whether or not they are achieving their goal, a sense of ownership in the group sessions can be created.

Non-verbal communication can express messages of approval or disapproval to the participants and can make them feel included or excluded from the process. As the facilitator, be aware of your own body language, tone of voice, and facial expressions. Facilitators talking too much throughout the session can also interfere with creating a sense of shared ownership and may alienate some of the participants. Similarly, participants sharing too much can make other participants feel as though their experiences are not as valid and can interfere with the other participants feeling as though they share ownership in the group. If you notice that you maybe expressing opinions through your body language or verbally dominating the discussions, refocus the group participants by acknowledging the behavior with the group and re-establishing a neutral role. To re-establish a neutral role state that the process is for the participants to learn from one another and that your role as a facilitator is mainly to ensure that the session goals are met within the specified time period and that the participants feel free to share their experiences. As stated before, the facilitator can also re-establish a sense of shared ownership by “taking the group’s temperature” and checking in to see if they are feeling as the discussion is beneficial for them.

Tips for keeping discussions on track and on time

Keeping on track and on time is staying focused on the session agenda and within the allotted amount of time. This is important because each session is designed to shape personal behaviors and teach certain skills through different exercises and activities. Each exercise and activity has a set time in which to complete them. If the facilitators are not paying attention to the time and omit exercises and activities to help manage time, the participants may not understand the information covered in the sessions. If you find yourself or the participants moving away from the discussion topic, either one of the facilitators can summarize what has been covered so far or ask one of the participants to summarize for the group the main points covered. Then move into the next activity or exercise.

If you find yourself or the participants going beyond the time set for an activity, acknowledge that you want to respect everyone's time by not going over and that you want to make sure the main points of the session are covered. Then ask the group if they are okay with moving on to the next activity. This will help maintain your role as a neutral and fair person helping everyone gain something positive from the discussions.

Also, the co-facilitator can help keep the group discussions and activities on time by giving a discrete signal to the other facilitator that time to close is approaching. If the participants are working in pairs or smaller groups, both facilitators can circulate the room and remind participants of the time.

Tips for maintaining an open climate

An open climate is a tone, established by both facilitators and other group participants, that welcomes honest and sincere sharing of life experiences and opinions. As mentioned earlier, checking in with the group can help facilitators to achieve a number of goals. Checking in with the group can also help create an open climate by getting the participant's feedback on what they understand, and what they expect to experience in the duration of the session. Sometimes, participants can make comments or ask questions that alienate other participants and interfere with the group process. If this happens, facilitators can help re-establish an open climate by referring to the ground rules and restate the purpose of the session in general is for everyone to benefit from the information shared. Point out that in order for learning to take place, everyone has to feel as though they are apart of the discussions. Then, acknowledging and address the issue for a certain allotted time. If after discussing how participants feel, you sense that more time maybe needed to answer questions or address comments immediately, you can suggest that the group takes a short break and the facilitators can speak with the participant(s) outside of the session. If facilitators feel the matter can wait, then suggest to the group to address the issue after the session has completed.

Tips for maintaining a safe environment

There are different ways an environment can be safe for participants. Group facilitators can maintain participants' physical safety in the rare event a fight or physical altercation erupts in the sessions by following their agency's protocol for situations like this. They should clear the room so other participants are not at risk of being harmed and have a charged cellular phone with them to call for help, if necessary. After the altercation, they should dismiss the group until another time to be determined. This gives the agency time to evaluate the event and determine if the group should be re-convened.

A safe environment can also be created by group facilitators' protection of the participants' privacy. In Healthy Relationships, both facilitators sign disclosure forms that ensure the participants' right to privacy. It is important that in addition to the facilitators protecting the participants' privacy, that other participants' protect one another's privacy as well. To help remind participants' how important this is, refer to the group rules and emphasize that everyone has the right to share or not to share in each session. If information has been disclosed about a participant, address the matter with the participant whom the information was shared and give them the option to either stay in the group or change groups, or remind them that they do have the right to not participate in the intervention if they feel too uncomfortable in the sessions.

Tips for maintaining respect among participants

A facilitator should maintain respect among the participants for each others' ideas, choices, and life experiences. This can be done by sincerely listening to the discussion and validate the experiences participants share. This not only models for the participants how to respect one another, but it also demonstrates to them your respect for the topics being discussed and adds credibility to your role as the facilitator. Mutual respect established among the participants can be weakened when facilitators allow participants to make verbal comments or non-verbal gestures that may make others feel uncomfortable. If mutual respect is weakened by a group participant, the facilitator can refer to the ground rules and then give the participant a chance to express their opinion in a respectful way. Use some time to talk through peoples feelings around what was stated or suggested. If the facilitator(s) weakened, the facilitators should acknowledge their behavior immediately and state that group rules apply to the facilitator as well. The facilitators should also check-in with the group to see what their feelings are about the issue before moving into the next exercise or activity.

Tips for managing different personality types

One of the things that makes group discussions interesting and fun are the mix of personalities the participants show. As a facilitator, striking a balance among the various personalities to ensure the session goals are met is very important. Too much of any given personality dominating the groups can be a problem. Some of the types of personalities that could be in a group include a: gatekeeper, encourager, information giver, summarizer, and a blocker.

Gatekeeper: A gatekeeper is typically someone who involves various group members in the conversation or activities. Sometimes having a person who is not facilitating the group take on this role can be distracting. One of the ways you can include this person without breaking the group bonding process is to acknowledge the importance for everyone to share. In doing so, remind the group of any ground rules that may have been agreed to before the session and include a statement that people should feel free to either participate or not at any time and as group members we should respect someone else's choice not to share.

A facilitator can also include gatekeepers in the process by getting feedback from them during the session breaks. This can help you stay connected to what their thoughts are and help them stay focused on the purpose of the meeting without alienating them or making them feel as though their input is not valued.

- Let these participants help you keep the group discussion going; this also ensures they participate as well.

Encourager: An encourager is typically someone who supports others in their participation. An encourager usually is not a problem unless the group participants do not wish to take part at that time. As a facilitator you want participants to feel open enough to share and to acknowledge when they do make a positive contribution to the group, without being insincere or making the person feel as though they are being mocked. One way to manage an encouraging person is to remind the group that some of

the choices people have to make around disclosure and safer sex are very personal and depend on the situation they are at that time. We can support people, but we should be aware of the issues around the experience they are sharing or deciding not to share.

A facilitator can re-establish the tone of the group by referring to the ground rules, pointing out that the group sessions are to be non-judgmental and open for participants to share when they are comfortable.

Sometimes participants, who encourage others to share, miss the opportunity to talk about their own opinions and feelings.

- Try to include the participant in the discussions
- Ask them to volunteer in a role-play or some other type of exercise

Information Giver: An information giver is typically someone providing facts about a topic. While facts can be helpful, they may not be an appropriate response to the matter being discussed or the “facts” may not be accurate. As a facilitator, it is important to respectfully point out what types of support other than information are appropriate and offer an example, such as financial support or emotional support. If a participant begins to provide information, respectfully remind the participants that there is a resource packet used in the Healthy Relationships intervention.

- Use the information packet to correct any misinformation presented or introduce the packet to prevent misinformation being presented.

Summarizer: A summarizer is typically someone who listens to input and offers feedback highlighting what they understand the speaker is saying. Sometimes this feedback can distract the group from clearly understanding the points you want made or can interrupt the sharing that is taking place. As a facilitator, it is important to recognize the value in summarizing information shared among the participants, but to assume the role of summarizing relative to the sessions or activity. You can point out to the group that each person’s thoughts are welcomed and the information shared in the group is rich. However, as the facilitator you want to be sure the group does not lose the key points made so you will summarize at the end of each discussion. This should help review key points in case any one is not clear.

- Try to keep the participant summarizing engaged in the group discussion.

A facilitator can manage this personality type by staying in your role. As facilitators, you possess the power to create and maintain different characteristics of the group. It is important to recognize your role as a neutral person in the group sessions and the power that comes with your role. As facilitators it is important to interact with the group without becoming a participant in the group. One way facilitators can help maintain their neutral role is by not giving your power to the group. Power can be given to the group when facilitators allow the participants to oversee the group process more than participate in the group process. Participants summarizing the sessions along with the facilitator stating their observations can help provide structure to the feedback process and is one way to maintain power as the group leader. You can restate that because it is important for everyone to be clear about the purpose of the sessions and not miss any of the rich discussion, you will review the highlights before closing out each session. You

can also redirect the discussion away from that person and open the topic up to the larger group, if time permits.

As the facilitator, you can assign a person who summarizes information a role. They can help in the group process by reviewing the activity or exercise goals for smaller group members and offering feedback to the larger group. The facilitator can allow the participant to summarize while working through the activities or exercise and review the main points at the close of the session.

Acknowledge the importance of reviewing key discussion topics, without being defensive or attacking. This can help maintain respect between you and the participants.

Blocker: A blocker is typically someone who is not open to new ideas or opinions. As a facilitator, it is important to set the right tone of the group where everyone is open to share without making others feel shut-out. If a participant makes comments that silence the discussion, disagrees with others' point of view, or is not open to being apart of the group work, facilitators should remind people that in all of the sessions, participants have a choice to come. Everyone has an opportunity to speak, but without criticizing the intervention activities or one another.

One way to turn the blocker into a helpful participant is to ask them what their opinions are on the topic and refer to the group rules emphasizing the sessions are non-judgmental then open the discussion back up to the group. As a facilitator you should make yourself available after group sessions to talk through any left over matters one-on-one to be sure participants feel as though they were heard and not ignored.

Another way to manage the Blocker personality is to find out at the beginning of the sessions what participants are expecting to experience in the sessions. This can help in preventing a Blocker personality from dominating the discussions as well as manage this personality if they persist in dominating the group.

Finally, if there are concerns being raised about the exercises or activities throughout the sessions, as stated earlier, acknowledge them and allot a limited amount of time to address those concerns and then move into the next activity or exercise. If time does not allow for you to continue the discussion, table the topic until either after the session or the next session.

Dominator: A dominator is someone who controls the floor in the groups. One way to manage this personality is to refer to the group rules emphasizing that everyone should have a chance to talk. Asking this participant to put themselves in the position of someone with a different opinion or life experience and discuss the topic from that perspective, can help the Dominator gain from the group discussion, as well as opening the discussion to others.

Information Seeker: An information seeker is typically someone asking questions or looking for input from others. Sometimes their questions may break the flow of the discussion. As a facilitator you can write down questions on the easel paper to address at

the end of the session. Tell the group that there will be time for everyone to share their thoughts and ask for questions at this time.

Use your judgment, if the information being sought is directly related to the session and it is not appropriate to wait to address the matter later in the session, do not ignore or dismiss the issue. Ask the group how they wish to handle the matter and agree to how much time will be spent discussing the matter, then refocus on the session activities.

For more information on facilitating groups, there are resources listed below.

Resources

Florida State University

<http://med.fsu.edu/education/FacultyDevelopment/small%20group%20skills.asp>

W. Brendan Reddy (1994). Intervention Skills: Process Consultation for Small Groups and Teams. Pfeiffer.

Corey, G. (2000). Theory & Practice of Group Counseling. 5th Ed. Brooks/Cole Thomson Learning.

APPENDIX V
Resources

HIV Websites

These are a few of the websites that might be of interest to you or your participants.

<http://aids.gov/>

www.aids-ed.org

www.aidsmeds.com

www.aidsmeds.com/espanol/

www.aegis.com

www.amfar.org

www.thebody.com

www.cdc.gov/nchstp/od/nchstp.html

www.gmhc.org

<http://hivinsite.ucsf.edu>

www.hivpositive.com

<http://www.hivtest.org/>

<http://www.nineandahalfminutes.org/>

www.nmac.org

www.projinf.org

Disclaimer of Liability and Endorsement

For non-federal websites listed below, the U.S. Centers for Disease Control and Prevention does not warrant or assume any legal liability or responsibility for the accuracy, completeness, or usefulness of any information, apparatus, product, or process disclosed.

The U.S. Centers for Disease Control and Prevention does not endorse or recommend any commercial products, processes, or services. The views and opinions of authors expressed on the Websites do not necessarily state or reflect those of the U.S. Government, and they may not be used for advertising or product endorsement purposes.

Finding Videos

Here are a few of the websites that may be helpful when searching for videos.

www.allmovie.com

www.amazon.com

www.bestvideo.com

www.blockbuster.com

www.ccvideo.com

www.ebay.com

www.formovies.com

www.frys.com

www.fye.com

www.half.com

www.hollywoodvideo.com

www.imdb.com

www.netflix.com

www.paramount.com

www.rarevideo.com

www.suncoast.com

Some of the websites on the previous page have information about HIV/AIDS-specific videos.

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The U.S. Centers for Disease Control and Prevention does not endorse or recommend any commercial products, processes, or services. The views and opinions of authors expressed on the Websites do not necessarily state or reflect those of the U.S. Government, and they may not be used for advertising or product endorsement purposes.

APPENDIX VI
Video and Movie Clips 

Clip Essence Tables

Explanation of tables:

There are a variety of types of clips shown in the five sessions of **Healthy Relationships**: personal statements, HIV/AIDS information, condom demonstration, and, most importantly, clips from popular movies. We will use the term “clips” to refer to all of these and “video” to refer to sources (such as movies or documentaries). The term “movie-quality” means that the clip has high production values. The following tables are designed to assist implementers in selecting appropriate clips to use in the intervention. Many of the clips used in the original study are useable or even recommended, but all clips should be selected based who the group participants are.

First are tables with information on each clip; the two-digit clip number appears just before the table. The first digit is the session in which the clip is used. The second digit reflects the order in which the clips are used in that session. For example, the second clip used in Session Three would be listed as Clip #3-2.

Column 1: (Purpose) lists what is to be accomplished by showing the clip. It will also refer to which life area should be related to the clip.

Column 2: (Essential Ingredients) lists what must be included in the clip selected.

Column 3: (Options) gives options that might increase the effectiveness of a clip or make it more effective for a particular population.

Column 4: (Original Video and Recommendations) lists the source of the original clip(s) with the target population, the title (if applicable), a brief description, and the number of the related sample “set-the-scene” in column 5. It also lists any recommendations related to the selection of that clip.

Column 5: (Sample “Set-the-scenes”) contains one or more sample scenarios based on the clip(s) that the original study used.

After these individual clip tables, there is another table which categorizes the original clips by target population (Women, MSW, and/or MSM), counter times, length of clip, ethnicity of cast, and purchase information. For the original clips, place an order at <http://www.effectiveinterventions.org/go/interventions/healthy-relationships/hr-dvd-clips-order-form>. For questions, contact cbac@utsouthwestern.edu.

Abbreviations: MSW = men who have sex with women, MSM = men who have sex with men

Notes:

Always use clips as appropriate to the target audience as possible. The majority of participants in the original research were African-American, and you will see that reflected in many of the clip selections.

The facilitators need to introduce all clips prior to viewing in such a way as to relate the scenes to HIV/AIDS and to act as springboards to discussion around disclosure and safer sex/risk reduction. See Facilitator's Handbook for specific procedures. A few of the clips used in the original study were from movies about HIV/AIDS and/or included characters who were living with HIV/AIDS. If these clips are used, they may need slightly less explanation.

In general, for movie clips participants are told to ignore anything they may already know about the movie and concentrate on how the scene is described or "set" by the facilitator. Set up the context for the movie clips along these lines:

"You may have seen this movie (*tell them the title*), but now forget anything you know about it. For our purposes, the (*add description, like 'main female' or 'repairman'*) character is living with HIV." (*Add "set-the-scene"; see sample "set-the-scenes" or Easel Chart Guides for examples*). If the scene is about disclosure, add that the character living with HIV has not disclosed their status to the others in the clip. If the scene is about sexual partners, add that the partner's HIV status is either negative or unknown and that there has been no disclosure prior to the scene by the person living with HIV. It is also helpful to designate the type and length of relationship.

When creating the Easel Chart Guides, you can choose to insert a "title" for the clips you select; the guides in Appendix II have such titles. For example, for the clip used for sample "set-the-scene" #1, the title is "Too Many Friends."

Questions for many of the movie clips are the same, as they tie back to the Five Coping Skills being taught in the group. Frame your "set-the-scene" so you can talk about "what would you have said or done?" or "what could be done to make this situation safer?"

Arrange clips in Sessions Three and Five in order from the easiest to role-play around to the most difficult. Generally, the more talk there is in the scene, the easier the situation is to deal with; the more passion and less talk, the harder.

See Appendix V for a list of where else to find these films. You can also search on the internet for more movie-related websites.

Clip #1-1

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To introduce the concept of using clips as part of the sessions</p> <p>To act as spring-board to discussion around disclosure to family and friends</p>	<ul style="list-style-type: none"> * Show the difficulty/stress involved in disclosure * Include some emotional elements * Give hint of “what would people say?” * Involve communication issues 	<p>Can be clip from a popular movie or a personal statement</p> <p>Create “in-house” video with personal statement from someone from the target population</p> <p>Can include any combination of a number of different emotional elements (embarrassment, fear, pain, guilt, anger, frustration, etc.)</p> <p>Can show:</p> <ol style="list-style-type: none"> 1) lack of understanding 2) myths about HIV/AIDS 3) support, rejection, or fear of rejection from church, family, friends, etc. 4) dealing with interruptions or the other person not listening 5) disclosure of sexual orientation, not HIV/AIDS (for MSM groups) 	<p><u>For Women:</u> from <i>Absolutely Positive</i>, personal statement. A woman talks about the fact that she has not disclosed her son’s HIV status, #1.</p> <p><u>For MSW:</u> from <i>Batman</i>. Batman tries to disclose his status as a super hero to a girlfriend, #2.</p> <p><u>For MSM:</u> from <i>Billy’s Hollywood Screen Kiss</i>. A young man recalls childhood experience of disclosing his sexual orientation, #3.</p> <p>Optimum Length: Between 1 and 3 minutes</p>	<p>Sample “Set-the-scene” #1: This scene shows a woman talking about not disclosing the fact that her son's living with HIV.</p> <p>Watch and think about the stress she reveals related to this lack of disclosure.</p> <p>Sample “Set-the-scene” #2: This scene shows a man, who is living with HIV, trying to disclose his HIV status to a woman he slept with.</p> <p>Watch and think about reasons why the disclosure is stressful for him.</p> <p>Sample “Set-the-scene” #3: This scene shows a man, who is living with HIV, talking about disclosing his sexual orientation when a child.</p> <p>Watch and think about the stress related to this disclosure experience.</p>

Clip #1-2

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample "Set-the-scenes"
<p>To end session on "up note"</p> <p>To motivate participants to return for next session</p>	<ul style="list-style-type: none"> * Humorous * Contain at least one element that can be tied to the life areas or skills that will be addressed in upcoming sessions 	<p>Can revolve around disclosure of anything, not just sexual orientation or HIV status</p> <p>Create "in-house" video of men and their lines to update the concept used in <i>She's Got to Have It</i>, and use for any groups, including MSMs.</p>	<p><u>For Women and MSW</u>, from <i>She's Gotta Have It</i>: A number of men demonstrate some of the worse pick-up lines ever tried, #4.</p> <p><u>For MSM</u>, from <i>The Bird Cage</i>: In these scenes a gay man tries to help his lover learn to act "like a man", #4.</p> <p>Recommendations: Use <i>The Bird Cage</i> or similar movie clip with all groups, unless you have participants with severe homophobia, since it is so funny to most people. Do cut the scenes to make it shorter.</p> <p>Optimum Length: Between 3 and 4 minutes</p>	<p>Note: For Clips #1-2 and #1-3, only one contextual "set the scene" is necessary, since the clips should be run back-to-back.</p> <p>Sample "Set-the-scene" #4: Before you leave, we'd like to show you a couple of funny clips about the difficulties caused by trying to hide things about ourselves.</p>

Clip #1-3

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To end session on “up note”</p> <p>To motivate participants to return for next session</p>	<p>* Humorous</p> <p>* Contain at least one element that can be tied to the life areas or skills that will be addressed in upcoming sessions</p>	<p>Can introduce idea of listening to prevention professionals</p> <p>Can show:</p> <ol style="list-style-type: none"> 1) “what you see isn’t necessarily what you get” 2) the stress of not having a condom with you when you want to have sex 3) concept of prior partners 	<p><u>For all groups</u>, from <i>Robert Tommsend: Partners in Crime, Vol. 1</i>: A man considers having sex without a condom, and the “Surgeon General” pays him a visit, #4.</p> <p>Recommendations: While somewhat dated, many audiences still find this clip funny. For younger audiences especially, consider other options that illustrate the importance of safer sex in a humorous way.</p> <p>Optimum Length: Between 2 and 3 minutes</p>	<p>See previous “Set-the-scene”.</p>

Clip #2-1

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around disclosure to family and friends</p> <p>To set-up role-plays where participants can practice the Five Coping Skills learned in this session (awareness, trigger/barrier identification, problem-solving, decision-making, and action) as related to disclosure to family and friends</p>	<p>* Show people disclosing or thinking about disclosing their status</p> <p>* Provide discussion points about the stress of being open (or not) about HIV status</p> <p>* Show importance of support (whether taken advantage of or not)</p> <p>* Bring up stigma</p>	<p>Can compare and contrast:</p> <ol style="list-style-type: none"> 1) between someone who discloses and someone who doesn't 2) people at different levels of openness <p>Can show:</p> <ol style="list-style-type: none"> 1) disclosure of sexual orientation, not HIV/AIDS (for MSM groups) 2) unusual ways to disclose (use films to prompt discussion, etc.) 3) dealing with people who can't cope with your disclosure 4) different levels of support 	<p><u>For Women</u>, from <i>Absolutely Positive</i>, 2 personal statements: A woman talking about how she disclosed her HIV status to her young daughter, and the woman from Clip #1-1 talking more about her experiences related to not disclosing her son's HIV status, #5.</p> <p><u>For MSW</u>, from <i>HIV/AIDS Infecting and Affecting Our Community</i>, personal statements: A variety of men, who are all living with HIV/AIDS, talk about the reactions of other people to learning about their status, #5.</p> <p><u>For MSM</u>, from <i>An Early Frost</i>: A man, living with HIV/AIDS, discloses his status and sexual orientation to his parents, #6.</p> <p>Recommendations: Use <i>An Early Frost</i> or similar movie clip with all groups. It illustrates well the concept of awareness and listening, is about HIV/AIDS, and has lots of ways to tie it to the skills in this session.</p> <p>Optimum Length: Between 2 and 3 minutes</p>	<p>Sample “Set-the-scene” #5: This scene shows a person (or people), who is (are) living with HIV/AIDS, talking about disclosing their status.</p> <p>Sample “Set-the-scene” #6: This movie scene shows a young man telling his parents that he is gay and living with HIV/AIDS.</p>

Clip #2-2

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around disclosure to family and friends</p> <p>To set-up role-plays where participants can practice the Five Coping Skills learned in this session (awareness, trigger/barrier identification, problem-solving, decision-making, and action) as related to disclosure to family and friends</p>	<ul style="list-style-type: none"> * Be movie-quality * Be able to be tied to the skills learned in the session * Be suitable for discussion and stimulating role-plays around disclosure to family and/or friends 	<p>Can show:</p> <ol style="list-style-type: none"> 1) silent clues of rejection 2) stigma and myths about HIV/AIDS 3) example (model) of someone who is very open about disclosure 4) discussion point around appropriate times (or not) to disclose 5) higher level of stress on part of person who is not living with HIV/AIDS than on part of person who is 	<p><u>All groups</u>, from <i>Philadelphia</i>: A man discloses to a lawyer the fact he has AIDS, #7.</p> <p>Recommendations: Use <i>Philadelphia</i> with all groups. While filmed in 1993, it illustrates very well the concept of listening, is about HIV/AIDS, and can be tied to the skills in this session in many ways.</p> <p>Optimum Length: 1 minutes, 38 seconds</p>	<p>Sample “Set-the-scene” #7: This scene shows a man, who is living with HIV/AIDS, seeking legal advice from a lawyer he had met before.</p>

Clip #3-1

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around disclosure to sex partners</p> <p>To set up role-plays where participants can practice the Five Coping Skills learned in the previous session (awareness, trigger/barrier identification, problem-solving, decision-making and action) as related to disclosure to sex partners</p>	<ul style="list-style-type: none"> * Be movie-quality * Be able to be tied to the skills learned in the previous session * Be suitable for discussion and stimulating role-plays around disclosure to sex partners 	<p>Can show:</p> <ol style="list-style-type: none"> 1) misunderstandings and stress in relationships when one or more partners are not honest about HIV status or sexual orientation 2) how HIV status is viewed 3) example (model) of someone who is struggling with disclosure (whether of HIV status or sexual orientation) 4) appropriate and inappropriate times to disclose 	<p><u>For Women</u>, from <i>Eve’s Bayou</i>: A woman and man discuss his desire to marry her, #8.</p> <p><u>For MSW</u>, from <i>Boyz n the Hood</i>: A young man who is distressed talks with his girlfriend about their relationship, #9.</p> <p><u>For MSM</u>, from <i>Making Love</i>: Two men try to get each other to disclose sexual orientation, #10.</p> <p>Recommendations: Select a more current MSM movie as the clip is extremely dated.</p> <p>Optimum Length: Between 2 and 3 minutes</p>	<p>Sample “Set-the-scene” #8: The woman in this scene is feeling pressured to tell her long-term partner that she is living with HIV because he wants to make a commitment to her. She is at the point where she feels it is time to disclose.</p> <p>Sample “Set-the-scene” #9: In this scene, a young man has just learned that he tested positive for HIV and is feeling very upset. He seeks comfort from his long-term girlfriend who does not yet know about the HIV test.</p> <p>Sample “Set-the-scene” #10: In this scene, Zack (the man in the white shirt) is confused about telling his new partner that he has HIV. He wants to have sex with him and does not want to lose him.</p>

Clip #3-2

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around disclosure to sex partners</p> <p>To set-up role-plays where participants can practice the Five Coping Skills learned in the previous session (awareness, trigger/barrier identification, problem-solving, decision-making and action) as related to disclosure to sex partners</p>	<ul style="list-style-type: none"> * Be movie-quality * Be able to be tied to the skills learned in the previous session * Be suitable for discussion and stimulating role-plays around disclosure to sex partners * Be a harder situation for disclosure than the last clip 	<p>Can show:</p> <ol style="list-style-type: none"> 1) misunderstandings and stress in relationships when one or more partners are not honest about HIV status or sexual orientation 2) stress and pain in relationships when one or more partners discloses something 3) how HIV status is viewed 4) example (model) of someone who is struggling with disclosure (whether of HIV status or sexual orientation) 5) appropriate and inappropriate times to disclose 	<p><u>For Women and MSW</u>, from <i>Love Jones</i>: A couple is having trouble ending their first date, #11 (Women) and #12 (MSW).</p> <p><u>For MSM</u>, from <i>Love! Valour! Compassion!</i>: Two gay men, one older, are in bed together when one expresses love, then the other discloses an “indiscretion”, #13.</p> <p>Optimum Length: Between 1 and 2 minutes</p>	<p>Sample “Set-the-scene” #11: This scene features a woman, who is living with HIV, trying to postpone sex and disclosure with a new partner of unknown HIV status.</p> <p>Sample “Set-the-scene” #12: This scene features a man, who is living with HIV, considering disclosure with a new partner of unknown HIV status.</p> <p>Sample “Set-the-scene” #13: In this scene, a man named Bobby is very upset, and his long-term partner tries to comfort him. This leads to Bobby disclosing an affair, and he wonders if he should also reveal his HIV status.</p>

Clip #3-3

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around disclosure to sex partners</p> <p>To set-up role-plays where participants can practice the Five Coping Skills learned in the previous session (awareness, trigger/barrier identification, problem-solving, decision-making and action) as related to disclosure to sex partners</p>	<ul style="list-style-type: none"> * Be movie-quality * Be able to be tied to the skills learned in the previous session * Be suitable for discussion and stimulating role-plays around disclosure to sex partners * Be a harder situation for disclosure than the last clip 	<p>Can show:</p> <ol style="list-style-type: none"> 1) misunderstandings and stress in relationships when one or more partners are not honest about HIV status or sexual orientation 2) example (model) of someone who is struggling with disclosure (whether of HIV status or sexual orientation) 3) appropriate and inappropriate times to disclose 4) added problems of trying to disclose while influenced by drugs/alcohol 	<p><u>For Women</u>, from <i>Boys on the Side</i>: A drunk/high couple are on the edge of having sex, #14.</p> <p><u>For MSW</u>, from <i>Boomerang</i>: A man pretends to not want to have sex in order to get some, #15.</p> <p><u>For MSM</u>, from <i>Jeffrey</i>: Steve, a man living with HIV, wants to date Jeffrey, who has sworn off dating and sex because of fears of HIV/AIDS, #16.</p> <p>Note: Originally there were four clips for MSM for Session Three, including the one used for Clip #3-1 for women. We did not list it here for MSM, since it features a heterosexual couple.</p> <p>Optimum Length: Between 1 and 2 minutes</p>	<p>Sample “Set-the-scene” #14: In this scene a woman, who is living with HIV/AIDS, is struggling with her intoxication and passion as she tries to disclose to her partner on their first real date.</p> <p>Sample “Set-the-scene” #15: In this scene, a man is trying to not have sex because he is living with HIV/AIDS, but, on their first date, his new partner is making it very hard.</p> <p>Sample “Set-the-scene” #16: The man in this scene named Steve is living with HIV. Steve is very attracted to someone he recently met, but the other man is so afraid of getting HIV that he has sworn off dating and sex.</p>

Clip #4-1

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around disclosure to sex partners, especially in sero-discordant relationships</p>	<p>* Be able to be tied to the skills learned in previous sessions</p> <p>* Be suitable for discussion around disclosure to sex partners, especially in sero-discordant relationships</p>	<p>Can show:</p> <ol style="list-style-type: none"> 1) how HIV status is viewed 2) misunderstandings and stress in sero-discordant relationships 3) stress and pain in relationships when one or more partners discloses their HIV status 4) example (model) of someone who discloses 5) appropriate and inappropriate times to disclose 6) how alcohol/drugs can “trigger” a disclosure 7) example (model) of a negative partner deciding that the relationship is more important than HIV/AIDS 8) example (model) of a negative partner demanding safer sex 9) reality of HIV/AIDS not “going away” 	<p><u>For Women</u>, from <i>Absolutely Positive</i>. The woman from Clip #1-1 gives another personal statement, this one about her HIV negative husband’s reactions, #17.</p> <p><u>For MSW</u>, from <i>Absolutely Positive</i>. This is a personal statement from a Hispanic couple who tell how she found out he was living with HIV, #18.</p> <p><u>For MSM</u>, 2nd scene from <i>Jeffrey</i>: Jeffrey sets up a seduction scene for Steve, #19.</p> <p>Recommendations: If using scene from <i>Jeffrey</i>, cut to keep it under 4 minutes.</p> <p>Optimum Length: Between 2 and 3 minutes</p>	<p>Sample “Set-the-scene” #17: In this scene, a woman talks about how discovering that she was living with HIV affected her husband, who was not.</p> <p>Sample “Set-the-scene” #18: In this scene, a woman, who is not living with HIV, has a dream about her long-term partner disclosing his status.</p> <p>Sample “Set-the-scene” #19: Remember the scene with Steve and Jeffrey that we saw last session? In this new scene, Jeffrey is the one who chases after Steve.</p>

Clip #4-2

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To ensure all participants have the same factual information about HIV/AIDS and risky behaviors</p> <p>To act as springboard to discussion around safer sex/risk reduction</p>	<p>* Include accurate and current information on HIV/AIDS</p>	<p>Any accurate and up-to-date educational video that has been approved by a literature review committee and that is not longer than the original video</p>	<p><u>For all groups</u>, <i>When Men Talk About AIDS</i>, an AIDS education video, #20</p> <p>Recommendations: This video was used with all groups successfully, but the material is somewhat dated. Other videos can be used for the educational element, but make sure they present accurate information and are appropriate for your group participants.</p> <p>Optimum Length: Between 15 and 20 minutes</p>	<p>Sample “Set-the-scene” #20: Where do people get their information on what’s safe and what’s not? This video gives the facts.</p>

Clip #5-1

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around safer sex/risk reduction and condoms</p>	<p>* Include accurate and up-to-date information about condoms (e.g., does not recommend non-oxynol 9)</p>	<p>Any condom educational videos that are not longer than the original videos</p>	<p><u>For Women and MSW, <i>It’s All About Condoms</i></u> and the Reality Condom marketing video, #21</p> <p><u>For MSM, <i>It’s All About Condoms</i></u>, #21</p> <p>Recommendations: <i>It’s All About Condoms</i> was used with all groups successfully. Other videos can be used for the condom education, but make sure they are appropriate for your group participants. The package includes one option: a short animated film <i>Safe in the City</i>.</p> <p>Optimum Length: Between 8 and 12 minutes</p>	<p>Sample “Set-the-scene” #21: Since using condoms correctly is an important part of a healthy relationship, let’s make sure we all have the same information and skills.</p>

Clip #5-2

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around safer sex/risk reduction</p> <p>To set-up role-plays where participants can practice the Five Coping Skills (awareness, trigger/barrier identification, problem-solving, decision-making and action) as related to building healthier/safer relationships</p>	<ul style="list-style-type: none"> * Be movie-quality * Be able to be tied to the skills learned in previous sessions * Be suitable for discussion and stimulating role-plays around safer sex/risk reduction and building healthier relationships 	<p>Can show:</p> <ol style="list-style-type: none"> 1) situations with lots of humor 2) problems with using condoms that might not be anticipated 3) misunderstandings and stress in new relationships 4) misunderstandings and stress where HIV status is unknown 5) example (model) of someone who demands condom use 6) example (model) of people who impose standards on their choice of partners 7) example (model) of a partner demanding safe sex 8) how choices can survive the influence of alcohol/drugs/passion 	<p><u>For Women</u>, from <i>Booty Call</i>: A man and a woman are about to have sex, but she refuses to do it without a condom, #22.</p> <p><u>For MSW</u>, from <i>Dead Air</i>: A couple of strangers in a bar become friends because of similar attitudes, #23.</p> <p><u>For MSM</u>, from <i>Billy’s Hollywood Screen Kiss</i>: Two friends end up sharing a bed and almost have sex, #24.</p> <p>Optimum Length: Between 2 and 3 minutes</p>	<p>Sample “Set-the-scene” #22: The woman in this scene, who is living with HIV, is not going to have sex without a condom. Her new boyfriend has one but encounters difficulties with her dog.</p> <p>Sample “Set-the-scene” #23: Here we see a woman come in to a bar and appear to try to pick up a stranger. He is living with HIV and does not encourage her.</p> <p>Sample “Set-the-scene” #24: In this scene, a man, living with HIV is visiting a friend whose HIV status he doesn’t know and who doesn’t know his status. They’ve never had sex before, but things heat up after he finds that the spare bed is too small for him.</p>

Clip #5-3

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around safer sex/risk reduction</p> <p>To set-up role-plays where participants can practice the Five Coping Skills (awareness, trigger/barrier identification, problem-solving, decision-making and action) as related to building healthier/safer relationships</p>	<ul style="list-style-type: none"> * Be movie-quality * Be able to be tied to the skills learned in previous sessions * Be suitable for discussion and stimulating role-plays around safer sex/risk reduction and building healthier relationships * Be a harder situation to negotiate than the last clip 	<p>Can show:</p> <ol style="list-style-type: none"> 1) situations with lots of humor 2) problems with maintaining condom use 3) misunderstandings and stress in sero-discordant relationships 4) stress and pain in relationships when one or more partners resists healthy behaviors 5) how alcohol/drugs and passion can “trigger” risky behavior 6) example (model) of a negative partner deciding that the relationship is more important than HIV/AIDS 	<p><u>For Women</u>, from <i>Set It Off</i>: A couple is discussing the woman’s desire to leave, but he encourages her to stay. Kisses lead to sex, #25.</p> <p><u>For MSW</u>, 2nd scene from <i>Boomerang</i>: The same man from the 1st scene (Clip #3-3) goes dancing with a woman and later seduces her, #26.</p> <p><u>For MSM</u>, from <i>The Closet, Season I</i>: Two men had a previous relationship, but now one wants to take advantage of the other’s difficulties with his current partner, #27.</p> <p>Optimum Length: Between 1 and 3 minutes</p>	<p>Sample “Set-the-scene” #25: In this scene, a woman, who is living with HIV, is considering leaving town to avoid negotiating safer sex with a new man she’s met.</p> <p>Sample “Set-the-scene” #26: In this scene, a man wants to have sex with a woman he just met at a convention without telling her that he is living with HIV.</p> <p>Sample “Set-the-scene” #27: In this scene, the African American man who is living with HIV is confronted by a former lover, who is trying to seduce him.</p>

Clip #5-4

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around safer sex/risk reduction</p> <p>To set-up role-plays where participants can practice the Five Coping Skills (awareness, trigger/barrier identification, problem-solving, decision-making and action) as related to building healthier/safer relationships</p>	<ul style="list-style-type: none"> * Be movie-quality * Be able to be tied to the skills learned in previous sessions * Be suitable for discussion and stimulating role-plays around safer sex/risk reduction and building healthier relationships * Be a harder situation to negotiate than the previous clip 	<p>Can show:</p> <ol style="list-style-type: none"> 1) division of power in relationships 2) exchange of sex for money or drugs 3) problems with maintaining condom use 4) misunderstandings and stress in sero-discordant relationships 5) stress and pain in relationships when one or more partners resists healthy behaviors 6) how alcohol/drugs and passion can “trigger” risky behavior 7) example (model) of a negative partner deciding that the relationship is more important than HIV/AIDS 	<p><u>For Women</u>, 2nd scene from <i>Set It Off</i>: A woman needs money immediately, and a man demands sex in exchange, #28.</p> <p><u>For MSW</u>, no clip for this slot</p> <p><u>For MSM</u>, from <i>Love! Valour! Compassion!</i>: This is a virtually non-verbal scene where a blind man is seduced as he gets a late night glass of milk, #29.</p> <p>Optimum Length: Between 1 and 3 minutes</p>	<p>Sample “Set-the-scene” #28: In this scene, a woman, who is living with HIV/AIDS, really needs money right away and uses her body to get it.</p> <p>Sample “Set-the-scene” #29: In this scene, a man, who is living with HIV/AIDS, goes to get a glass of milk in the middle of the night. A newly met house guest, whose HIV status he does not know, seduces him.</p>

Clip #5-5

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around safer sex/risk reduction</p> <p>To set-up role-plays where participants can practice the Five Coping Skills (awareness, trigger/barrier identification, problem-solving, decision-making and action) as related to building healthier/safer relationships</p>	<ul style="list-style-type: none"> * Be movie-quality * Be able to be tied to the skills learned in previous sessions * Be suitable for discussion and stimulating role-plays around safer sex/risk reduction and building healthier relationships * Be a harder situation to negotiate than the previous clip 	<p>Can show:</p> <ol style="list-style-type: none"> 1) resistance being overcome 2) how much can be said without words 	<p><u>For all groups</u>, from <i>Jason’s Lyric</i>: A woman reconciles with her boyfriend after a fight without words but with lots of passion, #30 (Women) or #31 (MSW and MSM).</p> <p>Recommendations: Strongly consider using this clip, at least with Women and MSW groups. This scene so powerfully depicts the level of passion that has no words that, while it features a heterosexual couple, it was used successfully with all groups. This type of clip with the most difficult safer sex/risk reduction negotiation situation should be used as the final clip.</p> <p>Optimum Length: 1 minute, 32 seconds</p>	<p>Sample “Set-the-scene” #30: In this scene, a man is working late, when his long-term girlfriend comes to make up after a fight. She hasn’t told him she is living with HIV/AIDS, even though she knows he is not.</p> <p>Sample “Set-the-scene” #31: In this scene, a man is working late, when his long-term girlfriend comes to make up after a fight. He hasn’t told her he is living with HIV/AIDS, even though he knows she is not.</p>

Alternate Clip #5-6 (MSM Only)

Purpose	Essential Ingredients	Options	Original Video and Recommendations	Sample “Set-the-scenes”
<p>To act as springboard to discussion around safer sex/risk reduction</p> <p>To set-up role-plays where participants can practice the Five Coping Skills (awareness, trigger/barrier identification, problem-solving, decision-making and action) as related to building healthier/safer relationships</p>	<ul style="list-style-type: none"> * Be movie-quality * Be able to be tied to the skills learned in previous sessions * Be suitable for discussion and stimulating role-plays around safer sex/risk reduction and building healthier relationships * Must not be the final clip in Session Five 	<p>Can show:</p> <ol style="list-style-type: none"> 1) ability to change mind 2) what loneliness can lead to 3) mixed feelings 	<p><u>For Women and MSW</u>, none</p> <p><u>For MSM</u>, from <i>Making Love</i>: A man goes cruising for companionship (sex) but changes his mind when it materializes, #32.</p> <p>Recommendations: This scene was not used in every implementation. It was included to be available if a participant wanted to discuss or role-play what to do in an anonymous sex situation. Use discretion if you decide to include this clip for MSM groups, but still put Clip #5-5 last.</p> <p>Optimum Length: Between 1 and 2 minutes</p>	<p>Sample “Set-the-scene” #32: In this scene, a man, who is living with HIV/AIDS, is feeling frustrated and lonely. He goes out cruising and picks up a stranger who wants to have sex with him.</p>

Details About Clips Used In The Original Study

Note: For non-movie clips, starting counter is the beginning of the video. Starting counter for movies assumes the beginning of the movie as 0:00:00. This is to allow for different editions of the movies with different introduction times. Every effort has been made to be as accurate as possible on these counter times, but anyone using this table to create their intervention video should use their own judgment about the precise moment to start and end their clips.

The following clips are included in the package on one DVD: *HIV/AIDS: Infecting and Affecting Our Community*, *When Men Talk About AIDS*, and a short animated film about condom use, *Safe in the City*. The counter times for *HIV/AIDS: Infecting and Affecting Our Community* presume that 0:00:00 is the beginning of this video. The complete video is included, since it contains other scenes that some agencies might also want to use in their sessions. *When Men Talk About AIDS* is played in its entirety; therefore, counter times are not listed. *Safe in the City* was not a part of the original research study, but it is included in the package because the original condom education tapes were not available. For some groups *Safe in the City* also may be appropriate to use for Clip #5-1 in place of a longer condom demonstration tape.

For the original clips, place an order at <http://www.effectiveinterventions.org/go/interventions/healthy-relationships/hr-dvd-clips-order-form>. For questions, contact cbac@utsouthwestern.edu.

Two of the original clips are not generally available except on the original clips DVD. *It's All About Condoms* and *Reality Condom Marketing Video* were used for Clip# 5-1 for Women and MSW groups. When discussing male condom use, we recommend that facilitators replace these tapes by choosing an appropriate condom demonstration video or using *Safe in the City*. When discussing female condoms, the facilitators can distribute information sheets showing how to insert the condom. They can also demonstrate how to insert the condom using a female anatomical model. The last unavailable clip (title unknown) was used for Clip #5-3 with MSM. In its place we provide information on the clip used on the original clips DVD; this clip meets the criteria listed under "Purpose" and "Essential Ingredients" in the Clip Essence Tables.

Total time refers to the time of the clip as played straight through once. It does not include additional viewings.

The ethnic/gender breakdown refers to the main character(s) featured in the clip.

There are five tables, one for each session of **Healthy Relationships**.

Abbreviations: MSW = men who have sex with women, MSM = men who have sex with men

Details About Clips Used In The Original Study: Session One

Clip #	Title	Target	Starting Counter	Ending Counter	Total Time	Ethnic/Gender Breakdown	Purchase Information
1-1	<i>Absolutely Positive</i> (1990)	Women	0:42:52	0:44:20	1 minute, 28 seconds	African-American woman	Amazon.com
1-1	<i>Batman</i> (1989)	MSW	1:18:10	1:20:57	2 minutes, 47 seconds	White man and woman	Commercial video and film outlets
1-1	<i>Billy's Hollywood Screen Kiss</i> (1998)	MSM	0:23:18	0:26:08	2 minutes, 50 seconds	White man	Commercial video and film outlets
1-2	<i>She's Gotta Have It</i> (1986)	Women and MSW	0:14:27	0:16:08	1 minute, 41 seconds	African-American woman and men	Commercial video and film outlets
1-2	<i>The Bird Cage</i> (1996)	MSM	0:49:37 0:53:09 1:10:05	0:52:41 0:54:16 1:11:03	5 minutes, 9 seconds	White men	Commercial video and film outlets
1-3	<i>Robert Townsend: Partners in Crime, Vol. 1</i> (1987)	All	0:34:13	0:36:46	2 minutes, 33 seconds	African-American man and woman and White man, mostly African-American extras	Commercial video and film outlets

Details About Clips Used In The Original Study: Session Two

Clip #	Title	Target	Starting Counter	Ending Counter	Total Time	Ethnic/Gender Breakdown	Purchase Information
2-1	<i>Absolutely Positive</i> (1990)	Women	A: 0:35:17 B: 0:37:09	A: 0:36:17 B: 0:39:08	A: 1 minute, 1 second B: 1 minute, 59 seconds	A: White woman B: African-American woman from Clip #1-1	See #1-1 (Women).
2-1	<i>HIV/AIDS Infecting and Affecting Our Community</i> (1996)	MSW	0:05:04	0:07:56	2 minutes, 52 seconds	African-American men	Only available on HR Original Clips DVD
2-1	<i>An Early Frost</i> (1985)	MSM	0:29:17	0:31:21	2 minutes, 4 seconds	White men and women	Commercial video and film outlets
2-2	<i>Philadelphia</i> (1993)	All	00:22:10	00:23:48	1 minute, 38 seconds	African-American man and White man	Commercial video and film outlets

Details About Clips Used In The Original Study: Session Three

Clip #	Title	Target	Starting Counter	Ending Counter	Total Time	Ethnic/Gender Breakdown	Purchase Information
3-1	<i>Eve's Bayou</i> (1997)	Women	1:07:51	1:08:50	59 seconds	African-American man and woman	Commercial video and film outlets
3-1	<i>Boyz N the Hood</i> (1991)	MSW	1:13:40	1:17:18	3 minutes, 38 seconds	African-American man and woman	Commercial video and film outlets
3-1	<i>Making Love</i> (1982)	MSM	0:46:03 0:49:14	0:48:15 0:51:16	4 minutes, 14 seconds	White men	Commercial video and film outlets
3-2	<i>Love Jones</i> (1997)	Women and MSW	0:30:04	0:31:40	1 minute, 36 seconds	African-American man and woman	Commercial video and film outlets
3-2	<i>Love! Valour! Compassion!</i> (1997)	MSM	1:00:39	1:01:54	1 minute, 15 seconds	White men	Commercial video and film outlets
3-3	<i>Boys On The Side</i> (1995)	Women	1:04:00	1:06:02	2 minutes, 2 seconds	White man and woman	Commercial video and film outlets
3-3	<i>Boomerang</i> (1992)	MSW	0:13:41	0:14:34	53 seconds	African-American man and woman	Commercial video and film outlets
3-3	<i>Jeffrey</i> (1995)	MSM	0:25:03 0:34:49	0:28:36 0:35:19	4 minutes, 3 seconds	4 White men, 1 African-American man, extras of various ethnicities	Commercial video and film outlets

Details About Clips Used In The Original Study: Session Four

Clip #	Title	Target	Starting Counter	Ending Counter	Total Time	Ethnic/Gender Breakdown	Purchase Information
4-1	<i>Absolutely Positive</i> (1990)	Women	0:48:42 0:55:59	0:49:23 0:57:37	2 minutes, 19 seconds	African-American woman from #1-1	See #1-1 (Women).
4-1	<i>Absolutely Positive</i> (1990)	MSW	0:51:09	0:52:58	1 minutes, 49 seconds	Hispanic man and woman	See #1-1 (Women).
4-1	<i>Jeffrey</i> (1995)	MSM	1:21:44	1:28:21	6 minutes, 37 seconds	4 White men, 1 African-American man, extras of various ethnicities	See #3-4 (MSM).
4-2	<i>When Men Talk About AIDS</i> (1996)	All	use whole tape	use whole tape	25 minutes	African-American woman, men of various ethnicities	Created by Dr. Seth Kalichman, included in package

Details About Clips Used In The Original Study: Session Five

Clip #	Title	Target	Starting Counter	Ending Counter	Total Time	Ethnic/Gender Breakdown	Purchase Information
5-1	<i>Reality Condom Marketing Video</i> (date unknown)	Women and MSW	not available	not available	4 minutes, 28 seconds	Women of various ethnicities	Only available on HR Original Clips DVD
5-1	<i>It's All About Condoms</i> (date unknown)	All	not available	not available	8 minutes	African-American man and woman	Only available on HR Original Clips DVD
5-2	<i>Booty Call</i> (1997)	Women	0:27:28 0:28:47	0:28:07 0:29:13	1 minute, 5 seconds	African-American man and woman	Commercial video and film outlets
5-2	<i>Dead Air</i> (1994)	MSW	0:09:56	0:11:11	1 minute, 15 seconds	African-American man and woman	Not easily available. It gets shown on Black STARZ! sometimes. Try African-American used video and film outlets or Amazon.com.
5-2	<i>Billy's Hollywood Screen Kiss</i> (1998)	MSM	0:56:33	1:00:24	3 minutes, 51 seconds	White men	See #1-1 (MSM).
5-3	<i>Set It Off</i> (1996)	Women	1:16:40	1:17:40	1 minute	African-American man and woman	Commercial video and film outlets
5-3	<i>Boomerang</i> (1992)	MSW	00:48:10	00:50:34	2 minutes, 24 seconds	African-American man and woman	See #3-3 (MSW).
5-3	<i>The Closet, Volume I, "Decisions, Decisions..."</i> * (2006)	MSM	00:41:50	00:42:50	1 minute, 1 second	African-American man and White man	Commercial video and film outlets *-Note: this episode is sometimes known as Episode 1 and sometimes as Episode 3.

Details About Clips Used In The Original Study: Session Five (continued)

Clip #	Title	Target	Starting Counter	Ending Counter	Total Time	Ethnic/Gender Breakdown	Purchase Information
5-4	<i>Set It Off</i> (1996)	Women	0:15:33	0:18:00	2 minutes, 27 seconds	African-American man and woman and extras	See #5-3 (Women).
5-4	<i>Love! Valour! Compassion!</i> (1997)	MSM	0:39:19	0:40:14	55 seconds	White men	See #3-2 (MSM).
5-5	<i>Jason's Lyric</i> (1994)	All	1:15:12	1:16:44	1 minute, 32 seconds	African-American man and woman	Commercial video and film outlets
5-6	<i>Making Love</i> (1982)	MSM	0:18:10	0:19:31	1 minute, 21 seconds	White men	See #3-1 (MSM).

APPENDIX VII

Research Article

Reprinted from the American Journal of Preventive Medicine, Volume 21 (2), Seth C. Kalichman, et al, Effectiveness of an Intervention to Reduce HIV Transmission Risk in HIV-Positive People, Pages 84-92, Copyright 2001, with permission from the American Journal of Preventive Medicine.

Effectiveness of an Intervention to Reduce HIV Transmission Risks in HIV-Positive People

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Background: As many as one in three HIV-positive people continue unprotected sexual practices after learning that they are HIV infected. This article reports the outcomes of a theory-based intervention to reduce risk of HIV transmission for people living with HIV infection.

Methods: Men ($n=233$) and women ($n=99$) living with HIV-AIDS were randomly assigned to receive either (1) a five-session group intervention focused on strategies for practicing safer sexual behavior, or (2) a five-session, contact-matched, health-maintenance support group (standard-of-care comparison). Participants were followed for 6 months post-intervention.

Results: The intervention to reduce risk of HIV transmission resulted in significantly less unprotected intercourse and greater condom use at follow-up. Transmission-risk behaviors with non-HIV-positive sexual partners and estimated HIV transmission rates over a 1-year horizon were also significantly lower for the behavioral risk-reduction intervention group.

Conclusions: This study is among the first to demonstrate successful HIV-transmission risk reduction resulting from a behavioral intervention tailored for HIV-positive men and women.

Medical Subject Headings (MeSH): adaptation, psychological; health behavior; HIV; mental health; primary prevention (Am J Prev Med 2001;21(2):84-92) © 2001 American Journal of Preventive Medicine

Introduction

Studies show that a significant minority of people living with HIV/AIDS continue to practice sexual behaviors that place their partners and themselves at-risk for HIV and other sexually transmitted infections (STIs).¹⁻⁴ Across a wide range of U.S. geographic areas, populations, and settings, the overall rate of continued unprotected intercourse is approximately 33% among people with HIV infection.⁵ Given the potentially grave consequences of continued unprotected sexual intercourse among HIV-positive people, there is an urgent need for prevention interventions designed for people living with HIV infection. Thus far, efforts to reduce HIV-transmission risk behavior have concentrated on strategies adapted from interventions for uninfected populations with disappointing results,⁶ and HIV antibody testing and counseling results in only modest

behavior change in HIV-positive people.⁷⁻⁹ However, research does suggest that social support and mental health counseling interventions may have unanticipated positive effects on sexual transmission risk behaviors. For example, Coates et al.¹⁰ found that a stress management program for HIV-seropositive men in San Francisco surprisingly reduced numbers of sexual partners. Kelly et al.¹¹ also reported reductions in sexual risk behaviors following three different mental health treatments.

In the current study, we tested a behavioral intervention designed to assist people living with HIV infection to reduce HIV-transmission risk behaviors. Our intervention model was grounded in Social Cognitive Theory,¹² emphasizing the importance of building behavioral skills, enhancing self-efficacy for practicing risk-reduction behaviors, promoting intentions to change risk behaviors, and developing strategies for behavior change. We tailored our experimental intervention for HIV-positive people and framed the intervention content within the context of managing stress related to HIV disclosure and practicing safer sexual behavior. Because there is evidence that social support groups can affect risk behavior, we used a social support group model as a standard-of-care comparison intervention in a randomized effectiveness trial design. We hypothe-

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The full text of this article is available via AJPM Online at www.elsevier.com/locate/ajpmonline.

Table 1. Baseline demographic and health characteristics for risk-reduction and health maintenance–control conditions

	Transmission risk-reduction intervention (n=185)		Health maintenance–control condition (n=143)	
	N	%	N	%
Male	125	67	105	73
Female	60	32	38	26
Transgender	2	1	2	1
Income <\$20,000	165	89	126	88
Relationship status				
Not in an exclusive relationship	109	59	85	59
In a relationship <6 months	27	14	30	21
In a relationship >6 months	50	27	30	21
Sexual orientation				
Homosexual	97	52	77	53
Heterosexual	21	11	16	11
Bisexual	68	36	52	36
Currently taking antiretroviral medications	176	95	134	93
Drug use in the past 3 months				
Alcohol	86	47	67	47
Marijuana	38	21	37	26
Cocaine	14	8	20	14
Inhalants	7	4	14	10
Injection drugs	2	22	1	11
Other drugs	2	1	4	3
	M	SD	M	SD
Age	40.4	7.0	40.9	7.5
Years education	12.7	2.1	13.3	2.3

M, mean; SD, standard deviation

sized that the behavioral risk-reduction intervention would demonstrate less sexual risk behavior, particularly risks posed to HIV-negative sexual partners, compared to the social support group condition.

Methods

Recruitment and Randomization

Men and women were recruited from AIDS services and infectious disease clinics in Atlanta, Georgia. Flyers announcing the study opportunity were posted in these locations, and providers were asked to refer clients to the study. To increase the external validity of the study, the only eligibility criteria for participation were: (1) living with HIV/AIDS, and (2) voluntary willingness to complete the study activities. Participants were informed that their HIV status would be verified by presenting a photo identification and proof of their HIV status; this procedure was followed for all participants at the time of enrollment. Informed consent was obtained in accordance with Institutional Review Board guidelines. Participants completed an in-depth, sexual behavior interview over the telephone to maximize participant convenience and reduce potential response biases.¹³ Following completion of the baseline assessment, the enrollment coordinator drew a randomly generated group assignment in a sealed envelope to determine each participant's intervention condition.

Participants

Participants were 230 HIV-positive men and 98 HIV-positive women. The mean age was 40.1 years (standard deviation [SD]=7.0); and 52% of the sample identified as gay, 9% bisexual, and 39% heterosexual. The sample was 74% African American, 22% white, and 4% of other ethnicities. Approximately half (48%) had completed ≤12 years of education, 56% had annual incomes <\$10,000, and 53% currently received disability benefits (see Table 1).

Measures

Participants completed measures at baseline, immediate post-intervention, and at 3 months and 6 months following the intervention. Assessments consisted of: (1) self-administered surveys to assess demographic and health characteristics, Social Cognitive Theory constructs, and treatment satisfaction; and (2) detailed structured interviews that focused on sexual-risk and protective behaviors.

Demographic and health characteristics. Participants reported their age, ethnicity, sexual orientation, employment status, current income, highest level of education, whether they had received mental health treatment or been incarcerated in jail, the date they first tested HIV positive, whether they had been diagnosed with an AIDS-related condition, and their most recent CD4 cell count (coded as above or below 200 cells/mm³) and viral load (coded as undetectable if under 400 copies/ml).¹⁴

Table 2. Self-efficacy of transmission risk–reduction and behavioral intentions immediately following risk–reduction and health maintenance–control conditions

	Transmission risk–reduction intervention (N=155)		Health maintenance–control condition (N=126)		<i>F</i> ^a	<i>p</i>
	M	SD	M	SD		
Self-efficacy for						
Suggesting condoms with new partners	3.5	0.7	3.4	0.8	3.6	.05
Using condoms when intoxicated	3.1	0.9	3.2	0.9	0.1	.91
Satisfying partner with safer sexual behavior	3.6	0.6	3.3	0.8	7.9	.01
Satisfying self with safer sexual behavior	3.5	0.6	3.3	0.8	6.0	.02
Intentions to						
Keep condoms nearby	5.5	1.2	5.2	1.4	0.3	.56
Consider the costs and benefits of HIV status disclosure to partners	5.1	1.4	4.5	1.8	7.9	.01
Refuse unsafe sex	5.3	1.3	5.0	1.6	0.7	.37
Practice safer sexual behavior with undisclosed partners	3.8	1.9	3.5	1.9	4.3	.04

^a *F* values for ANCOVAs comparing treatment groups while controlling for baseline rates of behaviors, participant age, gender, and randomization block.

M, mean; SD, standard deviation

Social Cognitive Theory constructs. Participants completed measures of self-efficacy, behavioral intentions, and behavior-change strategies relevant to the risk reduction adapted from previous studies.^{12,15} (See Table 2 for items.) Self-efficacy was assessed for four HIV risk-reduction behaviors keyed to intervention components via a 4-point scale (1=strongly disagree, 4=strongly agree). For behavioral intentions, participants indicated how likely they would be to engage in four actions to reduce HIV-related risks in a situation that they might feel tempted or pressured to engage in unprotected intercourse via a 6-point scale (1=definitely will not do, 6=definitely will do). Finally, participants were asked at the 3-month and 6-month follow-ups whether they had practiced four intervention-related, risk-reduction actions linked to the behavioral intention items over the past 3 months.

Treatment satisfaction survey. Participants completed a 12-item measure of treatment perceptions at the end of the final intervention session. Seven items assessed perceptions of the group environment (e.g., “There was a feeling of togetherness in the group”; $\alpha=0.95$), and five items assessed perceptions of the group facilitators (e.g., “The group leaders cared about the community”; $\alpha=0.92$). Responses were measured via a 4-point scale (1=strongly disagree, 4=strongly agree).

Sexual transmission risk and protective behaviors. Participants completed individual interviews to ascertain the HIV status of their sexual partners and rates of sexual practices. The interview first elicited whether participants had any sexual partners in the previous 3-month period.¹⁶ Participants who indicated that they did not have any sexual partners in the past 3 months were probed to ensure accuracy of their response, with confirmation of having no sexual partners ending the sexual behavior section of the interview ($n=106$, 32%). For sexually active participants, we conducted partner-by-partner interviews to ascertain: (1) each partner’s HIV status, and (2) sexual practices and condom use for each partner over the 3-month retrospective period. For each of up

to four sexual partners, interviewers asked participants to recount the number of times they engaged in vaginal, anal, and oral intercourse. For men who have sexual intercourse with men, anal intercourse was assessed for receptive and insertive acts separately. Participants with five or more partners in the past 3 months ($n=23$, 7%) reported cumulative rates of sexual activities with all additional partners. Rates of unprotected and total occasions of anal, vaginal, and oral intercourse were aggregated across partners. Unprotected oral intercourse was analyzed separate from anal and vaginal intercourse. We also computed the proportion of anal and vaginal intercourse occasions protected by condoms using the formula: condom protected acts / total acts. HIV transmission risks to non-HIV-positive partners were modeled using procedures described in the results section.

Intervention Procedures

Several elements were controlled across the experimental and comparison conditions. Group sessions for both conditions consisted of six to ten participants and one male and one female community-based group facilitator, one of which was an HIV-positive peer counselor. We crossed group facilitators with intervention conditions to remove potential differential facilitator effects. Facilitator adherence to intervention protocols and protection against drift and contamination were monitored and closely supervised. Specifically, all group sessions were audiotaped and reviewed by a clinical supervisor. In addition, a doctoral-level clinical supervisor held debriefing meetings with group facilitators after each session as well as weekly supervision meetings to review study protocols and intervention sessions. Groups were conducted with men and women separately. Both interventions were delivered in five 120-minute sessions, with two sessions per week over 2.5 weeks. Finally, all participants were reimbursed US\$10 for each group session attended and US\$35 for completing each assessment.

Intervention to Reduce HIV-Transmission Risk

The experimental condition consisted of a skills-based behavior-change intervention. Grounded in Social Cognitive Theory,¹² our intervention was aimed at: (1) developing skills to effectively cope with HIV-related stressors and sexual risk-producing situations, (2) enhancing effective decision-making skills for self-disclosing HIV serostatus to sexual partners, and (3) facilitating the development and maintenance of safer sexual practices.

The first three sessions were committed to building self-efficacy for decisions to disclose HIV serostatus to people in one's life, including sexual partners. Disclosure situations with positive and negative outcomes and strategies that did and did not work were generalized to situations involving disclosure of HIV status to sexual partners. Participants listed the barriers to disclosing their HIV serostatus to sexual partners in several types of relationship contexts. Potential adverse outcomes of disclosure, including violence and rejection, were explored with rehearsal of active coping responses. We used brief scenes (2 to 3 minutes) edited from popular films as realistic and engaging scenarios for participants to rehearse HIV-status disclosure in role-play activities.¹⁶ Participants practiced identifying barriers to disclosure, assessing partner reactions, and strategies for disclosing and not disclosing.

Sexual transmission risks in relationships with HIV-positive and HIV-negative partners were the focus of the remaining two intervention sessions. Hazards of co-infection with other STIs as well as HIV transmission risks were highlighted in the context of maintaining safer sexual practices over the long term of HIV infection. Participants were given a personalized feedback report concerning their own risk practices extracted from baseline assessments.¹⁶⁻¹⁹ Group facilitators reviewed the general content of the feedback report using an enlarged blank form. Participants were not asked to share the content of their feedback reports, although some chose to do so. Groups discussed strategies for maintaining satisfying relationships while also protecting oneself and one's partner. The facilitators provided opportunities for participants to explore negative attitudes toward condoms and conducted in-session practice with male and female condoms on anatomical models. Scenes edited from popular films were again used for participant rehearsal of risk-reduction and communication skills. Using the movie scenes, participants identified and applied problem-solving strategies to risk antecedents (triggers) and barriers to practicing safer sexual behavior. The intervention ended with the completion of individualized sexual health and relationship plans, which included personal decision criteria for disclosing HIV serostatus to potential sexual partners and strategies for maintaining safer sexual practices.

Health Maintenance Comparison Intervention

The control condition was a time- and contact-matched, social support group for people living with HIV infection modeled after support groups offered in the community.^{20,21} This condition provided a service while not introducing cognitive and behavioral skills components hypothesized to change high-risk sexual behaviors. The sessions included information updates on HIV disease, management of health

problems, medication adherence, healthcare and health insurance concerns, and nutrition. Each participant also developed a personalized health maintenance plan at the end of the final group session.

Preliminary Analyses and Statistical Procedures

We inspected all outcome variables for skewed distributions and outliers. Variables that were significantly skewed were transformed using the formula $\log_{10}(x+1)$ with nontransformed observed values presented in the tables.²² Male and female participants were evenly distributed across conditions, with 67% male and 33% female participants in the risk-reduction intervention and 76% male and 24% female participants in the comparison condition. Of the 328 participants enrolled in the trial, 281 (86%) completed immediate post-intervention assessments, 277 (84%) completed at least three of the five intervention-group sessions, 271 (82%) were retained at the 3-month follow-up, and 256 (78%) completed the 6-month follow-up; 10 participants died during the follow-up period.

To test for differential attrition across conditions, a 2 attrition (lost vs retained) \times 2 condition (risk-reduction skills intervention vs comparison) contingency table, chi-square test was performed; 44 of 187 (24%) participants in the experimental condition and 33 of the 145 (23%) comparison-intervention participants were lost at follow-up, a nonsignificant difference. We also conducted attrition analyses for differences on baseline measures using 2 (attrition) \times 2 (condition) analyses of variance,²³ where: (1) an attrition effect signals differences between participants lost and retained, (2) an intervention effect indicates a breakdown in randomization, and (3) an attrition \times condition interaction indicates differential loss between conditions. Results indicated a main effect for attrition on participant age: participants lost to follow-up were younger ($M=37.9$) than those retained ($M=40.7$). No other differences between lost and retained participants were significant, there were no significant differences between intervention conditions on baseline variables, and the attrition by intervention-group interactions were not significant. We also tested for intervention-group differences in treatment satisfaction, specifically, perceptions of the group environment and group facilitators, with results failing to show significant differences. Finally, we found that the 12 study interviewers were evenly distributed across intervention conditions and there were no differences among interviewers on any outcome variables.

For the main study outcome analyses, we conducted 2(condition) \times 2 (follow-up assessment point) analyses of covariance for continuous variables and logistic regressions for categorical variables reporting odds ratios (ORs) with 95% confidence intervals. For all analyses, we used an intent-to-treat approach by including all participants who were enrolled in treatment regardless of the number of intervention sessions completed. Consistent with an intent-to-treat analysis and to increase the external validity of the study, participants who were not sexually active at baseline were included in the outcome analyses for sexual-risk behavior by assigning the value zero (0) for all behaviors. We also controlled baseline rates of behavior to test for group differences over and above pre-intervention rates. Because participant age differed for participants lost to attrition and because the intervention

Table 3. Strategies to reduce transmission risk at 3-month and 6-month follow-ups among risk-reduction and health maintenance–control conditions

	Transmission risk-reduction intervention <i>n</i> (%)	Health maintenance–control condition <i>n</i> (%)	Adjusted OR^a	<i>p</i>
Kept condoms nearby				
3-month follow-up	137 (91)	104 (86)	1.3	0.69
6-month follow-up	135 (92)	105 (95)	0.3	0.06
Considered the costs and benefits of disclosure				
3-month follow-up	93 (62)	61 (50)	2.2	0.02
6-month follow-up	87 (59)	60 (55)	0.7	0.24
Refused unsafe sexual practice				
3-month follow-up	77 (51)	67 (55)	0.4	0.01
6-month follow-up	87 (59)	53 (48)	2.0	0.05
Practiced safer sexual behavior without disclosing HIV status				
3-month follow-up	67 (44)	50 (41)	0.7	0.4
6-month follow-up	62 (42)	37 (33)	1.7	0.1

^a Odds ratios (OR) adjusted for participant age, gender, randomization block, and baseline intentions to perform specified behavior. Cell sizes for 3-month follow-up: risk-reduction intervention *n*=150, control intervention *n*=121. Cell sizes for 6-month follow-up: risk-reduction intervention *n*=146, control intervention *n*=110.

content was tailored for gender, both age and gender were controlled. Finally, randomization to treatment groups occurred within 14 blocks of participants recruited over the study period, so we included randomization block as a factor in the analyses. For all analyses, cell sizes and degrees of freedom vary slightly due to missing data.

Results

Social Cognitive Theory Constructs

Results of MANCOVA testing for intervention effects on risk-reduction self-efficacy indicated significant differences between conditions (Wilks' lambda=0.95, $F [5, 242]=2.57$, $p<0.05$); risk-reduction intervention participants reported greater self-efficacy for suggesting condom use with new sexual partners and being able to satisfy sexual partners and oneself by practicing safer sexual behavior (see Table 2). Similar results occurred for the MANCOVA analyzing risk-reduction intentions (Wilks' lambda=0.96, $F [4, 247]=2.46$, $p<0.05$); participants in the risk-reduction intervention reported stronger intentions to consider the pros and cons of disclosing their HIV status to partners, and to practice safer sexual behavior with partners who are unaware of their HIV status.

Analyses at the 3-month and 6-month follow-up for behavioral risk-reduction strategies indicated significant differences between conditions (see Table 3). After adjusting for participant age, gender, randomization block, and baseline intentions to perform the respective strategies, we found that risk-reduction intervention participants were significantly more likely to have considered the pros and cons of HIV status disclosure to sexual partners. Unexpectedly, comparison–intervention participants were significantly more likely to have refused unsafe sexual practices at the 3-month follow-up. However, this finding was reversed

at the 6-month follow-up, with risk-reduction participants reporting significantly greater rates of refusing unsafe sexual practices.

Sexual Behaviors Across Partners

Analyses conducted between intervention conditions controlling for covariates did not indicate differences between intervention conditions for number of sexual partners reported at the 3- or 6-month follow-up assessments (see Table 4). Rates of unprotected intercourse and total number of sexual intercourse occasions across all partners did not differ between conditions at the 3-month follow-up. However, we did find significant differences between conditions for rates of unprotected intercourse, total number of intercourse occasions, and percentage of intercourse occasions protected by condoms at the 6-month follow-up. Differences among conditions for unprotected oral sex were not significant at either time point. Participants in the risk-reduction intervention condition were significantly less likely than participants in the comparison condition to report non–HIV-positive sexual partners 6 months following the intervention.

Sexual Behaviors with Partners of Unknown or Known HIV-Negative Serostatus

Analyses comparing intervention groups on sexual practices with non–HIV-positive partners showed that participants in the risk-reduction intervention demonstrated significantly less unprotected intercourse and total rates of sexual intercourse with non–HIV-positive sexual partners at both the 3-month and 6-month follow-ups (see Table 5). Differences between intervention conditions for proportion of intercourse occasions protected by condoms and for unprotected oral sex

Table 4. HIV-risk and protective sexual behaviors for all partners among risk-reduction and health maintenance-control conditions 3 months and 6 months following intervention

	Transmission risk-reduction intervention		Health maintenance-control condition		<i>F</i> ^a	<i>P</i>
	M	SD	M	SD		
Number of sex partners						
Baseline	1.6	2.4	1.7	3.3		
3-month follow-up	1.3	2.3	1.2	1.5	0.3	.60
6-month follow-up	1.2	1.9	1.3	1.9	0.3	.60
Unprotected vaginal and anal intercourse						
Baseline	2.7	9.1	1.7	6.4		
3-month follow-up	1.7	7.6	2.2	6.3	1.2	.20
6-month follow-up	1.2	4.5	3.4	10.9	4.9	.02
Total vaginal and anal intercourse						
Baseline	7.5	18.5	5.8	12.8		
3-month follow-up	4.4	9.6	7.4	14.9	2.2	.10
6-month follow-up	3.6	6.3	8.2	16.2	7.7	.01
Percentage condom use for vaginal and anal intercourse						
Baseline	75.5	35.9	57.1	45.0		
3-month follow-up	79.9	36.8	62.8	45.3	3.4	.07
6-month follow-up	71.7	39.5	54.6	48.5	3.8	.05
Unprotected oral sex						
Baseline	7.1	10.1	10.2	21.1		
3-month follow-up	4.1	8.9	6.8	11.5	0.5	.46
6-month follow-up	5.5	21.2	8.4	15.0	0.2	.59
	N	%	N	%	OR ^b	<i>p</i>
Reported non-HIV-positive partners						
Baseline	57	31	42	29		
3-month follow-up	48	32	36	39	1.3	.62
6-month follow-up	50	34	46	42	2.7	.04

^a *F* values for ANCOVAs comparing treatment groups controlling for baseline rates of behaviors, participant age, gender, and randomization block.

^b Odds ratios and associated *p* values adjusted for baseline rates, participant age, gender, and randomization block. Cell sizes for 3-month follow-up: risk-reduction intervention *n*=150, control intervention *n*=121. Cell sizes for 6-month follow-up: risk reduction intervention *n*=146, control intervention *n*=110.

M, mean; SD, standard deviation

with non-HIV-positive partners were not significant at either follow-up assessment.

Intervention Effects on Estimates of HIV Transmission

We used the secondary HIV transmission rate model developed by Pinkerton et al.²⁴ to examine differences between conditions in HIV transmission risks to HIV-negative sexual partners. HIV transmission risk was estimated by the formula:

$$p = 1 - (1 - \alpha_n)^n (1 - \alpha_k)^k,$$

where *n* and *k* are transmission risk behaviors (e.g., receptive anal and vaginal intercourse for women, or receptive and insertive anal intercourse for gay men) and α_n and α_k are the associated per-act transmission probabilities.^{24,25} Estimates of HIV transmission risks were summed across partners and extrapolated to a 12-month time horizon (see Table 6). The transmission rate can thus be viewed as an estimate of the approximate number of partners who would become HIV infected during the 12-month time horizon (see Table

6 for estimated transmission rates). Because transmission rates were only computed for people reporting any unprotected acts with uninfected partners, cell sizes for female-to-male transmission risks (*n*=9) did not allow for reliable statistical tests. Analyses of covariance for male-to-male transmission at the 6-month follow-up (*F* [1, 48] 4.9, *p*<0.05), and for male-to-female transmission at the 3-month follow-up (*F* [1, 19] 9.9, *p*<0.01), showed that the risk-reduction intervention resulted in lower HIV transmission rates from male participants to male and female uninfected partners compared to the health maintenance group.

Tests for Moderators of Intervention Effects

To examine potential moderators of the observed intervention effects, participant gender, sexual orientation, psychiatric history, incarceration history, current drug use, and history of injection drug use were tested for main effects and interactions with intervention conditions on unprotected sexual acts at each follow-up. No main effects or interactions were significant,

Table 5. Risk and protective sexual behaviors for non-HIV-positive partners among risk-reduction and health maintenance conditions 3 months and 6 months following intervention

	Transmission risk-reduction intervention		Health maintenance-control condition		<i>F</i> ^a	<i>p</i>
	M	SD	M	SD		
Unprotected vaginal and anal intercourse						
Baseline	0.9	4.9	0.4	4.3		
3-month follow-up	0.3	1.9	0.5	2.2	4.7	.03
6-month follow-up	0.2	1.1	1.0	6.9	4.2	.04
Total vaginal and anal intercourse						
Baseline	3.9	16.3	3.3	8.7		
3-month follow-up	1.8	4.6	2.8	7.6	4.4	.03
6-month follow-up	1.1	2.7	4.4	13.2	11.5	.01
Percent condom use for vaginal and anal intercourse						
Baseline	89.6	58.3	72.5	43.3		
3-month follow-up	81.2	39.3	80.1	36.7	0.10	.60
6-month follow-up	94.6	48.9	69.6	46.4	1.5	.23
Unprotected oral sex						
Baseline	6.4	7.6	9.2	15.6		
3-month follow-up	5.9	8.6	7.4	8.9	0.1	.82
6-month follow-up	8.3	17.7	9.5	12.7	0.5	.48

^a *F* values for ANCOVAs comparing treatment groups controlling for baseline rates of behaviors, participant age, gender, and randomization block. Cell sizes for 3-month follow-up: risk-reduction intervention *n*=150, control intervention *n*=121. Cell sizes for 6-month follow-up: risk-reduction intervention *n*=146; control intervention *n*=110. M, mean; SD, standard deviation

suggesting that the intervention did not have differential outcomes for these subgroups.

Discussion

This study is among the first to demonstrate positive effects of a theory-based behavioral intervention designed to reduce HIV sexual-transmission risks among men and women living with HIV infection. The risk-

reduction intervention resulted in lower rates of anal and vaginal intercourse across all sexual partners, and reduced potential exposures of HIV to sexual partners with unknown and known HIV-negative statuses relative to a standard-of-care comparison intervention. In addition, modeling the behavioral outcomes on HIV transmission rates showed that the risk-reduction intervention resulted in lower rates of HIV transmission from

Table 6. Differences among conditions in estimated rates for HIV transmission from infected participants to uninfected partners over a 12-month horizon at the 3-month and 6-month follow-ups

Sexual dyad	<i>n</i> ^a	Risk behaviors and transmission rate parameters				Risk-reduction intervention	Health maintenance-control condition
		<i>n</i>	α_n	<i>k</i>	α_k	Mean	Mean
Male participant-male partner	49	Receptive anal intercourse	0.02	Insertive anal intercourse	0.0006		
3-month follow-up						0.0015	0.0010
6-month follow-up						0.0057	0.0311*
Female participant-male partner	9	Vaginal intercourse risk to uninfected male partner	0.0006	Anal intercourse risk to uninfected male partner	0.000		
3-month follow-up						0.0	0.0
6-month follow-up						0.0	0.0006
Male participant-female partner	20	Vaginal intercourse risk to uninfected female partner	0.001	Anal intercourse risk to uninfected female partner	0.02		
3-month follow-up						0.0006	0.0022*
6-month follow-up						0.0004	0.0047

* *p* < 0.05

^a *n* = number of participants with unprotected noninfected partners included in analysis.

^b *n* and *k* = transmission risk behavior parameters, and α_n and α_k represent base rates for estimated HIV transmission obtained from published studies

HIV-positive men to uninfected male and female partners over a 1-year time horizon compared to the health maintenance condition. HIV transmission risks may also be suppressed in the risk-reduction intervention group by potential reductions in other STIs.²⁶ Therefore, the HIV risk-reduction intervention tailored for people who are HIV positive reduced exposures to STIs for participants and their partners, as well as risks for transmitting HIV to uninfected partners.

Although the risk-reduction intervention demonstrated greater risk-reduction outcomes than a health maintenance comparison group, it is important to note that some of these differences emerged at the longer-term follow-up. This finding is not surprising because previous research shows risk-behavior changes occur in response to interventions similar to our comparison condition.^{10,11}

A limitation of this study was its reliance on self-reported sexual behaviors, given the potential for self-report biases. Although we performed standardized telephone interviews and we equalized some of the sources of demand characteristics across conditions by using a time-matched, contact control group, self-reported sexual behaviors are susceptible to under-reporting. However, the control condition did not include brief risk-reduction messages to control for additional demand characteristics. Rates of HIV-transmission risk behaviors reported in this study should, therefore, be considered a lower bound and condom use should be considered an upper-bound estimate. Although we did not find evidence for effects of moderator variables, these analyses lacked statistical power to detect differences. In addition, our measures of self-efficacy were limited by not assessing this construct for specific behaviors under conditions of varied difficulty. This study also used only a 6-month follow-up to assess longer-term risk reduction. Therefore, future intervention trials are being planned that will follow participants over longer periods of time. Future intervention studies with HIV-positive people of diverse ethnic groups and injection drug use histories are also needed.

This study was motivated by the urgent need for interventions to reduce HIV-transmission risk for HIV-positive people.²⁷ We tested an intervention that was delivered by community-based paraprofessionals and mental health counselors in the context of a community-based service agency that could implement the intervention as a community program. Given the efficiency of preventing HIV transmission from known infected to uninfected people, we conclude that behavioral interventions should be integrated into care systems for people living with HIV infection. For example, case management and support groups can integrate cognitive and behavioral skills building intervention components into existing services. Successful implementation of risk-reduction interventions for HIV-in-

fectured people will also require removing barriers to discussing HIV-transmission risks and eliminating the social stigmas that preclude people from disclosing their HIV status. In the context of a growing population of people living with HIV-AIDS, the potential for transmitting HIV treatment-resistant virus,²⁸ and the absence of a preventive vaccine, increasing access to theory-based, behavioral risk-reduction interventions offers our greatest hope for preventing HIV infections.

Intervention manuals are available upon request. We are grateful to the staff of AIDS Survival Project and Positive Impact Inc. of Atlanta for their assistance. This research was supported by National Institute of Mental Health (NIMH) grant R01-MH57624.

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APPENDIX VIII
Evaluation Forms

Evaluation Forms

Each agency's funding source will have different requirements for process monitoring, process evaluation, and outcome monitoring. The following forms are supplied as suggestions. Each can be modified to fit your agency's requirements, target population, resources, and needs.

The Process Monitoring Form that is presented is meant to serve as a supplement to the normal data collection of how many people attended, what were their gender, race/ethnicity/risk behavior/age, etc.

The Process Evaluation Form can aid your agency in determining how closely you implemented the Core Elements and documenting the adapting you did for your population and agency. The Participant Feedback Form can be used to receive structured comments from your participants as part of intervention improvement.

Outcome Monitoring, when required and appropriate, can be conducted by having the participants complete the Post Assessment Survey and then comparing the results to the data from the Initial Assessment Survey on outcome variables.

**HEALTHY RELATIONSHIPS
PROCESS MONITORING FORM**

Series #: _____ Target population: _____

Facilitators: _____ Location: _____

Date of first session of this series: _____

1. How many people were contacted as part of the session recruitment?

Contacted: _____

Where/How were they contacted and by whom:

2. How many of those people contacted, agreed to attend the sessions?

Agreed to attend: _____

3. How many people were re-contacted to assure their attendance?

Re-contacted: _____

- a) Of these re-contacted participants, how many times were they contacted?
- b) By what means were these participants re-contacted? (check all that apply)

phone email case manager
 face-to-face other _____

4. Total number of participants who attended each session?

Session One: # attended: _____

Session Two: # attended: _____

Session Three: # attended: _____

Session Four: # attended: _____

Session Five: # attended: _____

5. Any new participants added after start and in which session?

Session Two: _____

Session Three: _____

Session Four: _____

Session Five: _____

If the # for a session is lower than a previous session, were you able to determine the reason for the participant no-show? How did you do that, and what was the reason?

6. Number of contacts between each session to maintain attendance?

contacted between each session: _____

a) By what means were these participants contacted between each session?
(check all that apply)

phone email case manager

face-to-face other _____

Did you have to cancel a session due to lack of attendance? How many and which session(s)?

**HEALTHY RELATIONSHIPS
PROCESS EVALUATION FORM**

Listed below are the Core Elements of the intervention as outlined in the manual. Using the list below, please answer Questions 1-4.

- (#1) Defining stress and reinforcing coping skills with people living with HIV/AIDS across three life areas:
 - Disclosing to family and friends
 - Disclosing to sexual partners, and
 - Building healthier and safer relationships

- (#2) Using modeling, role-play, and feedback to teach and practice skills related to coping with stress.

- (#3) Teaching decision-making skills around the issue of disclosure of HIV status.

- (#4) Providing participants with Personal Feedback Reports, based on the Initial Assessment Survey, to motivate change of risky behaviors and continuance of protective behaviors.

- (#5) Using movie-quality clips to set up scenarios around disclosure and risk reduction to stimulate discussions and role-plays.

1. Has your organization dropped any of the Core Elements listed above?

- Yes
- No

(1a) If yes, and by referring to the numbered Core Elements above, please indicate *which* Core Element(s) were dropped.

- #1 #4
- #2 #5
- #3

(1b) If yes, please indicate *why* each was dropped.

2. Have you modified any of the Core Elements as listed on the previous page and described in the intervention manual?

- Yes
- No

(2a) If yes, and by referring to the numbered Core Elements above, please indicate *which* ones (if any) were modified.

- #1
- #2
- #3
- #4
- #5

(2b) If yes, please indicate how each was modified. Indicate *which* Core Element(s).

(2c) If yes, please indicate why each was modified. Indicate *which* Core Element(s).

3. Rate how closely your organization implemented the Core Elements exactly as outlined in the intervention manual.

- Not very closely at all
- Not very closely
- Somewhat closely
- Closely
- Very closely

This next section deals with the changes or adaptations you made to Healthy Relationships.

4. How did you change Healthy Relationships to fit your agency and its circumstances for this intervention cycle? List all changes as they relate to the following areas, and indicate how successful you feel they were and why:

a. number of sessions

b. length of sessions

c. facilitators

d. participants

e. videos and other clips

f. guided discussion

g. role-playing

h. Easel Chart Guides

i. Resource Packets and other handouts

j. condom skills

k. snacks

l. incentives

m. other

5. How did you change Healthy Relationships to fit your target population for this intervention cycle? List all changes as they relate to the following areas, and indicate how successful you feel they were and why:

a. number of sessions

b. length of sessions

c. facilitators

d. participants

e. videos and other clips

f. guided discussion

g. role-playing

h. Easel Chart Guides

i. Resource Packets and other handouts

j. condom skills

k. snacks

l. incentives

m. other

HEALTHY RELATIONSHIPS: Participant Feedback Questions

Participant ID Code: _____

1. What did you like most about the **Healthy Relationships** group sessions?
2. How do you feel you benefited from participating in the **Healthy Relationships** group?
3. Did you feel comfortable sharing your experiences with members of the group? Was there anything that the facilitators could have done to help you be more comfortable?
4. How do you feel that tension or conflict within the group was handled by the facilitators? Was there anything that the facilitators could have done differently to handle conflict or tension?
5. Were there some topics that needed more time for discussion?
6. Were there some topics that you would have liked to have been in the sessions that were not covered?

THANK YOU FOR YOUR HELP!

**HEALTHY RELATIONSHIPS
POST ASSESSMENT SURVEY
OUTCOME MONITORING**

Please answer the following questions as truthfully as possible; there are no right or wrong answers. Please take your time, and read each section carefully. Some sections require you to provide numbers. Others require you to circle the appropriate response and still others require complete sentences. The questions are designed to assess stress levels and your skills in making decisions about disclosing your HIV status or having safer sex. All answers will remain confidential to the extent allowed by law.

Participant ID Code: _____ **Today's Date:** ____/____/____

Please answer the following questions as they relate to talking about your HIV status to others (disclosing). **Please answer as accurately as possible.**

1. How sure are you that you could decide to tell a family member or friend that you are positive? Please circle one.

Very sure Sure Undecided Unsure Not sure at all

2. How comfortable are you about telling a family member or friend that you are positive? Please circle one.

Very comfortable Comfortable Undecided Uncomfortable Very uncomfortable

3. How sure are you that you could decide to tell a partner that you were positive? Please circle one.

Very sure Sure Undecided Unsure Not sure at all

4. How sure are you that you could know whether it is safe to disclose your status to a partner? Please circle one.

Very sure Sure Undecided Unsure Not sure at all

Below each of the following statements, **please circle the response** that most closely matches your feelings.

5. If I were unsure of a person's status I could decide about telling them my status before having sex.

Strongly Disagree Disagree Undecided Agree Strongly Agree

6. I feel confident in making a decision about telling someone that I am dating about my status.

Strongly Disagree Disagree Undecided Agree Strongly Agree

7. I am certain that I can make a decision about discussing my status with a new sex partner.

Strongly Disagree Disagree Undecided Agree Strongly Agree

8. I am certain that I could decide about telling a new partner about my status even if I had been drinking and/or doing drugs.

Strongly Disagree Disagree Undecided Agree Strongly Agree

9. How sure are you in talking about the need for safer sex practices with your sexual partners?

Very sure Sure Undecided Unsure Not sure at all

10. How sure are you in refusing to have unsafe sex if pressured by your partner to be unsafe?

Very sure Sure Undecided Unsure Not sure at all

11. How confident are you that you can use a condom correctly?

Very confident Confident Undecided Not confident Not confident at all

12. How much risk is there that you will transmit HIV to someone else through sex?

Very low risk Some risk Undecided High risk Very high risk

13. Of the people you know, how many would support you in your decisions about disclosure and safer sex?

Everyone Most Undecided Some Very few

Please answer the following questions about your sexual activities during the **past** _____
(fill in time period for this assessment). Please answer all that apply.

14. During the **past** _____, how many sex partners have you had? _____ *(If none, skip to the end.)*

15. How many times did you put your penis in someone's anus without using a condom?
_____ (# of times)

16. How many times did someone put their penis in your anus without using a condom?
_____ (# of times)

17. How often were condoms used during anal intercourse? Please circle one.

Always Almost always Half of the time Almost never Never NA

18. How many times did you put your penis in someone's vagina without using a condom?
_____ (# of times)

19. How many times did someone put their penis in your vagina without using a condom?
_____ (# of times)

20. How often were condoms used during vaginal intercourse? Please circle one.

Always Almost always Half of the time Almost never Never NA

That's it! Thank you for completing this assessment.

APPENDIX IX
CDC Required Materials



Nonoxynol-9 Spermicide Contraception Use --- United States, 1999

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (1), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (2--4); one trial showed an increased risk (3). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (5,6), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%--18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%--5% of all women attending Title X clinics

reported using N-9 contraceptives (other than condoms) as their primary method of contraception ([Table 1](#)). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9--lubricated ([Table 2](#)). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that N-9--containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

Reported by: *The Alan Guttmacher Institute, New York, New York. Office of Population Affairs, U.S. Dept of Health and Human Services, Bethesda, Maryland. A Duerr, MD, C Beck-Sague, MD, Div Reproductive Health, National Center Chronic Disease and Public Health Promotion; Div of HIV and AIDS Prevention, National Center HIV/AIDS, STDs, and TB Prevention; B Carlton-Tohill, EIS Officer, CDC.*

Editorial Note:

The findings in this report indicate that in 1999, before the release of recent publications on N-9 and HIV/STDs ([4,6,7](#)), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9--lubricated; this is consistent with trends in condom purchases among the general public ([8](#)). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV infection and other STDs ([7](#)). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continue to be distributed provided the condoms have not passed their expiration date. The amount of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the studies in Africa and the use of N-9--lubricated condoms is preferable to using no condom at all. In the future, purchase of condoms lubricated with N-9 is not recommended because of their increased cost, shorter shelf life, association with urinary tract infections in young women, and lack of apparent benefit compared with other lubricated condoms ([7](#)).

Spermicidal gel is used in conjunction with diaphragms ([1](#)); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year ([1](#)).

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of 49% of all pregnancies were unintended (9). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (1). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (2,7). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

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Table 1

TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contraception, by Title X Family Planning Region — United States, 1999

Region*	No. of women served	Male condoms		N-9 products†	
		No.	(%)	No.	(%)
I	179,705	27,726	(15)	1,251	(1)
II	404,325	73,069	(18)	21,515	(5)
III	487,502	73,088	(15)	4,807	(1)
IV	1,011,126	93,011	(9)	29,630	(3)
V	522,312	61,756	(12)	2,489	(1)
VI	478,533	40,520	(8)	11,212	(2)
VII	238,971	15,949	(7)	1,386	(1)
VIII	133,735	15,131	(11)	4,885	(4)
IX	672,362	109,678	(17)	14,547	(2)
X	186,469	17,320	(9)	1,275	(2)
Total	4,315,040	527,248	(12)	92,997	(2)

* Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, Virgin Islands; Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee; Region V=Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin; Region VI=Arkansas, Louisiana, New Mexico, Oklahoma, Texas; Region VII=Iowa, Kansas, Missouri, Nebraska; Region VIII=Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming; Region IX=Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, Palau; Region X=Alaska, Idaho, Oregon, Washington.

† Primary method of contraception reported by these women was one of the following: spermicidal foam, cream, jelly (with and without diaphragm), film, or suppositories.

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Table 2

TABLE 2. Number of nonoxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/territories, 1999

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods					
		Condoms with N-9	Condoms without N-9	Gel	Vaginal			Jelly	Foam
					Film	Insert			
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841	2,400	
New York†	283,200	1,936,084	NA	0	73,788	NA	3,112	23,830	
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200	9,900	
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760	25,920	
Tennessee	111,223	2,865,160§	717,088	0	94,500	12,528	756	2,758	
Michigan	166,893	631,000	254,000	0	0	NA	1,000	1,200	
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200	0	
Oregon	57,099	151,900	276,000	345	25,764	2,074	272	3,007	

* Not available.

† 41 of 61 grantees responded.

§ Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.

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Notice to Readers: CDC Statement on Study Results of Product Containing Nonoxynol-9

During the XIII International AIDS Conference held in Durban, South Africa, July 9--14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (1). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, <http://www.cdc.gov/hiv>; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

1. van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9--14, 2000, Durban, South Africa.

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<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4931a4.htm>



CONTENT OF AIDS-RELATED WRITTEN MATERIALS, PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS (Interim Revisions June 1992)

Basic Principles

Controlling the spread of HIV infection and AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can fully protect themselves from acquiring the virus. These methods include abstinence from the illegal use of IV drugs and from sexual intercourse except in a mutually monogamous relationship with an uninfected partner. For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages can be controversial. These principles are intended to provide guidance for the development and use of educational materials, and to require the establishment of Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

- a. Written materials (e.g., pamphlets, brochures, fliers), audio visual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.

Written materials, audiovisual materials, and pictorials should be reviewed by Program Review Panels consistent with the provisions of Section 2500 (b), (c), and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c), and (d), as follows:

"SEC. 2500. USE OF FUNDS.

(b) CONTENTS OF PROGRAMS. - All programs of education and information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such

activities.

(c) LIMITATION. - None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.

(d) CONSTRUCTION. - Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to, or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene."

c. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

d. Messages provided to young people in schools and in other settings should be guided by the principles contained in "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (MMWR 1988;37 [suppl. no. S-2]).

Program Review Panel

b. Each recipient will be required to establish or identify a Program Review Panel to review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or another CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:

(1) Understand how HIV is and is not transmitted; and

(2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for

which materials are intended.

The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or procedure of the recipient organization or local governmental jurisdiction.

Applicants for CDC assistance will be required to include in their applications the following:

(1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review panel, except as provided in subsection (d) below. In addition:

(a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either through representation on the panels or as consultants to the panels.

(b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a State or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.

(c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.

(d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.

(2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:

(a) Concurrence with this guidance and assurance that its

provisions will be observed;

(b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multi state), or statewide in scope, or that plan to distribute materials as described above to other organizations on a national, regional, or statewide basis, must establish a single Program Review Panel to fulfill this requirement. Such national/regional/State panels must include as a member an employee of a State or local health department, or an appropriate designated representative of such department, consistent with the provisions of Section 2.c.(1). Materials reviewed by such a single (national, regional, or state) Program Review Panel do not need to be reviewed locally unless such review is deemed appropriate by the local organization planning to use or distribute the materials. Such national/regional/State organization must adopt a national/regional/statewide standard when applying Basic Principles 1.a. and 1.b.

When a cooperative agreement/grant is awarded, the recipient will:

- (1) Convene the Program Review Panel and present for its assessment copies of written materials, pictorials, and audiovisuals proposed to be used;
- (2) Provide for assessment by the Program Review Panel text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals which are under development;
- (3) Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the Program Review Panel specifying the vote for approval or disapproval for each proposed item submitted to the panel; and
- (4) Provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

Filling out CDC Form 0.113 for Written Educational Materials on HIV/AIDS

In conjunction with the Centers for Disease Control and Prevention's (CDC's) efforts to increase awareness and use of evidence-based effective HIV prevention interventions, we are distributing copies of CDC form 0.113 (see attached). The following provides rationale and instructions on how to complete form 0.113.

Form 0.113 asks you to list the names and other identifying information for the individuals who make up your Program Review Panel. A Program Review Panel is a group of at least five people, representing a cross section of the population in a given area, who review written materials intended for HIV/AIDS educational programs. The Program Review Panel represents local standards and judgment as to what materials are appropriate for selected local audiences.

Should you need to form a Program Review Panel, see CDC's "Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs (Interim Revisions June 1992)." Following are a few key points from that document:

- Written educational materials on HIV prevention should use language or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices regarding HIV transmission.
- Such materials should be reviewed by a Program Review Panel.
- Whenever possible, CDC-funded community-based organizations (CBOs) are encouraged to use a Program Review Panel formed by a health department or other CDC-funded organizations rather than establish a new one.

To complete the enclosed form 0.113:

1. List the name, occupation, and affiliation (organization, business, government agency, etc.) of each member of the Program Review Panel you are using. There must be at least five members of this panel. If there are more, list them on the back of the form.
2. List the name of your organization, your grant number (if known), and ensure the form is signed by both your project director and an authorized business official. Have each person date the form after signing it.
3. If you are not developing any new HIV/AIDS related materials and therefore do not need to use a Program Review Panel, complete the second page, "Statement of Compliance with Content of HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Educational Sessions." This states that your organization is using materials previously approved by the local Program Review Panel.

Please note that form 0.113 is currently undergoing revision. The revised version will soon be available. A key change in the new form is that it requires, rather than recommends, that CBOs use the Program Review Panel established by the local or state health department rather than forming a new one. Please contact us if you have questions or need technical support.

Once you have completed form 0.113, please return it to your Project Officer or maintain it in your files if you are not directly funded by CDC.

Condoms and STDs:

Fact Sheet for Public Health Personnel



Consistent and correct use of male latex condoms can reduce (though not eliminate) the risk of STD transmission. To achieve the maximum protective effect, condoms must be used both consistently and correctly. Inconsistent use can lead to STD acquisition because transmission can occur with a single act of intercourse with an infected partner. Similarly, if condoms are not used correctly, the protective effect may be diminished even when they are used consistently. The most reliable ways to avoid transmission of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are to abstain from sexual activity or to be in a long-term mutually monogamous relationship with an uninfected partner. However, many infected persons may be unaware of their infections because STDs are often asymptomatic or unrecognized.

This fact sheet presents evidence concerning the male latex condom and the prevention of STDs, including HIV, based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies assessing condom use and STD risk. This fact sheet updates previous CDC fact sheets on male condom effectiveness for STD prevention by incorporating additional evidence-based findings from published epidemiologic studies.



Sexually Transmitted Diseases, Including HIV Infection

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS. In addition, consistent and correct use of latex condoms reduces the risk of other sexually transmitted diseases (STDs), including diseases transmitted by genital secretions, and to a lesser degree, genital ulcer diseases. Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer.

There are two primary ways that STDs are transmitted. Some diseases, such as HIV infection, gonorrhea, chlamydia, and trichomoniasis, are transmitted when infected urethral or vaginal secretions contact mucosal surfaces (such as the male urethra, the vagina, or cervix). In contrast, genital ulcer diseases (such as genital herpes, syphilis, and chancroid) and human papillomavirus (HPV) infection are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical and empirical basis for protection. Condoms can be expected to provide different levels of protection for various STDs, depending on differences in how the diseases are transmitted. Condoms block transmission and acquisition of STDs by preventing contact between the condom wearer's penis and a sex partner's skin, mucosa, and genital secretions. A greater level of protection is provided for the diseases transmitted by genital secretions. A lesser degree of protection is provided for genital ulcer diseases or HPV because these infections also may be transmitted by exposure to areas (e.g., infected skin or mucosal surfaces) that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing risk of STD transmission among condom users with nonusers who are engaging in sexual intercourse. Accurately estimating the effectiveness of condoms for prevention of STDs,



however, is methodologically challenging. Well-designed studies address key factors such as the extent to which condom use has been consistent and correct and whether infection identified is incident (i.e., new) or prevalent (i.e. pre-existing). Of particular importance, the study design should assure that the population being evaluated has documented exposure to the STD of interest during the period that condom use is being assessed. Although consistent and correct use of condoms is inherently difficult to measure, because such studies would involve observations of private behaviors, several published studies have demonstrated that failure to measure these factors properly tends to result in underestimation of condom effectiveness.

Epidemiologic studies provide useful information regarding the magnitude of STD risk reduction associated with condom use. Extensive literature review confirms that the best epidemiologic studies of condom effectiveness address HIV infection. Numerous studies of discordant couples (where only one partner is infected) have shown consistent use of latex condoms to be highly effective for preventing sexually acquired HIV infection. Similarly, studies have shown that

condom use reduces the risk of other STDs. However, the overall strength of the evidence regarding the effectiveness of condoms in reducing the risk of other STDs is not at the level of that for HIV, primarily because fewer methodologically sound and well-designed studies have been completed that address other STDs. Critical reviews of all studies, with both positive and negative findings (referenced here) point to the limitations in study design in some studies which result in underestimation of condom effectiveness; therefore, the true protective effect is likely to be greater than the effect observed.

Overall, the preponderance of available epidemiologic studies have found that when used consistently and correctly, condoms are highly effective in preventing the sexual transmission of HIV infection and reduce the risk of other STDs.

The following includes specific information for HIV infection, diseases transmitted by genital secretions, genital ulcer diseases, and HPV infection, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.



HIV, the virus that causes AIDS

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS

HIV infection is, by far, the most deadly STD, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual transmission of HIV is both comprehensive and conclusive. The ability of latex condoms to prevent transmission of HIV has been scientifically established in “real-life” studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of HIV.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as urethral and vaginal secretions, blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate that the consistent use of latex condoms provides a high degree of protection.

Other Diseases transmitted by genital secretions, including Gonorrhea, Chlamydia, and Trichomoniasis

Latex condoms, when used consistently and correctly, reduce the risk of transmission of STDs such as gonorrhea, chlamydia, and trichomoniasis.

STDs such as gonorrhea, chlamydia, and trichomoniasis are sexually transmitted by genital secretions, such as urethral or vaginal secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against diseases such as gonorrhea, chlamydia, and trichomoniasis by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of STDs such as chlamydia, gonorrhea and trichomoniasis.



Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Consistent and correct use of latex condoms reduces the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. Condom use may reduce the risk for HPV infection and HPV-associated diseases (e.g., genital warts and cervical cancer).

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through “skin-to-skin” contact from sores/ulcers or infected skin that looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/secretions. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are covered (protected by the condom) as well as those areas that are not.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms provide limited protection against syphilis and herpes simplex virus-2 transmission. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers associated with increased condom use in settings where chancroid is a leading cause of genital ulcers.

Condom use may reduce the risk for HPV-associated diseases (e.g., genital warts and cervical cancer) and may mitigate the other adverse consequences of infection with HPV; condom use has been associated with higher rates of regression of cervical intraepithelial neoplasia (CIN) and clearance of HPV infection in women, and with regression of HPV-associated penile lesions in men. A limited number of prospective studies have demonstrated a protective effect of condoms on the acquisition of genital HPV.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer, nor should it be a substitute for HPV vaccination among those eligible for the vaccine

Selected References are available at:

www.cdc.gov/condomeffectiveness/references.html

