



**A
Community-Level
STD/HIV
Prevention
Intervention**

**Implementation Manual
and
Technical Assistance Manual**

Draft 11/1/04



How to use this manual

This implementation manual contains information and resources to help agencies decide if Community PROMISE is right for them and, if so, to guide agencies in planning, implementing, and evaluating the intervention.

This section provides an overview of the content and format of the manual.

The manual is composed of six modules, each addressing a major component of Community PROMISE.

Module 1: **Introduction and Core Elements.** Reviews the development and theoretical basis for the intervention. Introduces the four core elements: community identification process, role model stories, peer advocates and evaluation. Also provides guidance for deciding if the intervention is right for your agency and, if so, what resources and skills are needed for implementation.

Module 2: **Community Identification Process.** Discusses why and how your agency should become familiar with the community's needs before implementing the intervention. Presents key assessment tools and techniques and provides guidance on how to use the resulting information in this specific community-level intervention. Also discusses the role of community mobilization in the design and implementation of PROMISE.

Module 3: **Role Model Stories.** Presents the key components and procedures for identifying possible role model story community peers/interviewees, conducting interviews, and writing and producing role model stories.

Module 4: **Peer Advocates.** Contains information on the methods for identifying, accessing, training, organizing, and mobilizing community advocates for the selection and distribution of intervention materials. Also discusses how to involve other community organizations, businesses, and networks to assist in the distribution of risk-reduction information, and role model stories as well as the distribution of other prevention materials, such as condoms and bleach kits.

Module 5: **Evaluation.** Discusses why and how to evaluate the intervention, and offers practical guidelines and tools for conducting process monitoring and evaluation and outcome monitoring.

Module 6: **Management.** Guides agencies in managing the human resources, finances, materials, and process of planning for and implementing the intervention.



A few of these modules, such as Community Identification Process, Role Model Stories and Peer Advocates, contain “good,” “better,” and “best” options for implementation. The purpose of these options is to assist agencies in developing an appropriate implementation plan that corresponds to their resources. The decision about which option to use will depend upon the resources available to your agency. The “good” option is what is minimally needed for Community PROMISE to be effective. The next option, “better,” provides further key characteristics that, if added, will improve the intervention. The “best” option depicts the ideal program. If your agency’s resources allow, try to implement the “best” of Community PROMISE, especially regarding the community assessment as well as the role model story development.

Appendices, containing resources that correspond to each of the 6 modules and important information from the Centers for Disease Control and Prevention, are located at the end of the manual after tab 7.

A Technical Assistance Guide is located after tab 8.



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MODULE 1: Introduction and Core Elements

What is Community PROMISE?

Description

Community PROMISE is an effective community-level STD/HIV prevention intervention that relies on role model stories and peers from the target population of your community. Community PROMISE is successful because it is created anew each time it is implemented in collaboration with a specific community.

“PROMISE” is an acronym for “Peers Reaching Out and Modeling Intervention Strategies.” The “community” in Community PROMISE refers to two fundamental factors. First, members of an at-risk community generate the specific intervention content from their own experience. This content includes the true risk-reduction stories shared by the intervention community itself—stories that model risk-reduction strategies for friends and associates (members of the same target population) within that same community. The second community element refers to the broad risk community that is impacted by the intervention. Not only do the active intervention participants change their behaviors, but so do members of the broader risk community as a result of peer influence.

Community PROMISE is based upon the experience of the AIDS Community Demonstration Project (ACDP). Funded by the Centers for Disease Control and Prevention (CDC), the Project found Community PROMISE to be effective in five cities across the United States. Community PROMISE was developed in response to an urgent need for effective community-level interventions that could be reasonably implemented by local health departments and service organizations.

Target Populations

Community PROMISE can serve any community or population, since the messages come from and are communicated within the community. The intervention has been tested primarily with African American, Caucasian, and Latino communities, including injection drug users (IDUs) and their sex partners, non-gay identified men who have sex with men (MSM), high risk youth, female sex workers, and high risk heterosexuals. Community PROMISE has since been used with other populations, such as Native Americans, Asians and Pacific Islanders and individuals living with HIV. The community can be defined as a particular group of people who share a risk behavior or as a geographic or social community with many members who engage in high risk behaviors. The important element is that the people your agency is trying to reach are part of a social network, since the role model story messages and peer influence move through such networks to influence behavior.

Community: a particular group of people who share a risk behavior or as a geographic or social community with many members who engage in high risk behaviors.



Core Elements

Core elements refer to the features in the intent and design of an intervention that are responsible for the effectiveness of the intervention. They are elements of the intervention that must be maintained in order for the intervention to remain effective.

The four core elements of Community PROMISE are:

1. **Community identification process**
2. **Role model stories**
3. **Peer advocates**
4. **Evaluation**

A brief description of each core element follows. More detailed information on implementing the core elements is found in modules 2: Community Identification Process, 3: Role Model Stories, 4: Peer Advocates, and 5: Evaluation.

Core Element 1: Community identification process

Effective interventions always begin with an up-to-date assessment of the targeted community. This provides information about what drives the risk-taking as well as risk-reducing behaviors of the group you want to influence and the locations and environments where risk behaviors take place.

The community identification (CID) process used in Community PROMISE involves multiple methods, including individual interviews with in-house staff and outreach workers (internal staff), staff of agencies providing services to the population or people whose work puts them in close contact with the target population (external sources of information), community members who control access to the target population (gatekeepers), and articulate members of the target population (key participants).

In addition, the CID process is likely to include focus groups of the target population members to elaborate on the information obtained through individual interviews. An agency will also do observations of the community in which the target population lives or where they engage in high risk behaviors to expand on the context of the target behaviors. Descriptions of these methods and how, why, and when they are used will be found in Module 2.

CID is a formative evaluation process to collect important information and learn from the perspective of the community itself about:

- why people engage in risk behaviors,
- what barriers exist to changing behaviors,
- what will encourage them to change behaviors,
- locations where members of the community may engage in risk behaviors, and,
- other key information.



Core Element 2: Role model stories

Role model stories comprise the “heart” of printed materials distributed throughout the target community. They are brief publications that depict personal accounts from individuals in the target population who have made or are planning to make a risk-reducing behavioral change. Role model stories are discussed in detail in Module 3. Depending on which populations they are meant to reach and what behaviors they are trying to influence, the stories may include examples of people who have started carrying condoms with them, have talked to a partner about condom use, use condoms consistently, avoid sharing needles, etc.

Role model stories are brief publications that depict personal accounts from individuals in the target population who have made or are planning to make a risk-reducing behavioral change.

In the stories, “role models” explain how and why they took steps to practice HIV risk-reduction behaviors and the positive effect it has had on their lives. The role models are not required to demonstrate perfect risk-reduction behavior, but they must show some action or movement towards reducing HIV risk such as carrying condoms, discussing prevention with a partner, or using condoms part of the time or with certain partners. These are just a few examples.

Core Element 3: Peer advocates

The messages in the role model stories are reinforced by interpersonal communication with trained peer advocates. Peer advocates are volunteers from the target population who help distribute the role model stories and other materials. Recruitment, training, and the role of the peer advocates are further discussed in detail in Module 4. In their interactions with the target population, the peer advocates encourage either peers to read and talk about the stories within their own network of friends. By doing this, peer advocates assist their peers in more immediately relating to the content of the role model stories and help encourage peers to engage in risk-reduction or health-enhancing behaviors.

Effective training of the peer advocates is vital to the success of the intervention, since the advocates will be asked to distribute role model stories through their own social networks. Equally important are the ideas for retention of advocates, since recognition of the role of peer advocates in the intervention will maintain their active participation.

Peer advocates are volunteers from the target population who help distribute the role model stories and other materials.

Prevention materials are distributed by the peer advocates to help achieve the intervention goals. The type of materials distributed depends upon the target population and the risk behavior the intervention is trying to change. If the goal is to increase condom use, condoms and lubricant should be readily available. If the target population is sex workers whose work may involve oral sex, some of the condoms should be non-lubricated. If the target population consists of gay men, it is desirable to distribute water-based lubricants with the condoms. If the target population is



IDUs and the goal is safer injecting, information regarding clean needles or a needle-exchange program would be appropriate for distribution. Materials or coupons for discounted purchase of the items are distributed individually. Other times these items are pre-packaged with the role-model story publications. The target population decides which mix of distribution methods works best for them and this information is often revealed during the CID process.

Core Element 4: Evaluation

Evaluation of behavioral interventions such as Community PROMISE is an important program management tool. As an “effective intervention,” Community PROMISE is understood to be effective in achieving a set of goals for your community. Evaluation can provide evidence of effectiveness in achieving a certain outcome and can also reveal whether or not the process of implementing the intervention was correct and efficient. Evaluation provides valuable information to improve Community PROMISE in your agency.

There are many different stakeholders that will benefit from and even require information provided by evaluation of Community PROMISE. These include the obvious: the funding agency that provides the financial support for the program, the prevention planning group that makes recommendations to the funding agency, and the political body that ultimately decides the fate of the funding. Agency employees working on the program will also be interested in knowing how their work on Community PROMISE is proceeding and if that work is having a positive outcome.

Evaluation can provide evidence of effectiveness in achieving intervention objectives, reveal whether or not the process of implementing the intervention was correct and efficient, and provides valuable information to improve the intervention in your agency.

Equally important is the target population, which will want to know that your intervention into their environment is effective and appropriate toward promoting their health and safety. Residents of the broader community (beyond the community of target population members) may also want to know that you are implementing an effective intervention.

To summarize, the four core elements of Community PROMISE are interdependent and not implemented in a strict linear process. Figures 1-3 illustrate how the four core elements and related activities are interrelated.

Many of the interrelated activities occur during the **Community Identification Process**. While conducting interviews in the community, staff identify **Peer Advocates**. Also, staff identify advisory board members and gradually build referral networks. **Evaluation** activities begin with CID, at the beginning of the project. **Formative evaluation** begins when staff interview people who provide services to the population (systems people interviews), interact with the population (interactor interviews) and gatekeepers. Staff set up **process monitoring and evaluation** systems at the start of CID as well. In addition, staff design and administer their **outcome monitoring** instrument in order to create a baseline of data on attitudes or behaviors of the population, or their current stage of change. Later on in the project, these baseline data will be used to measure change in the target population.



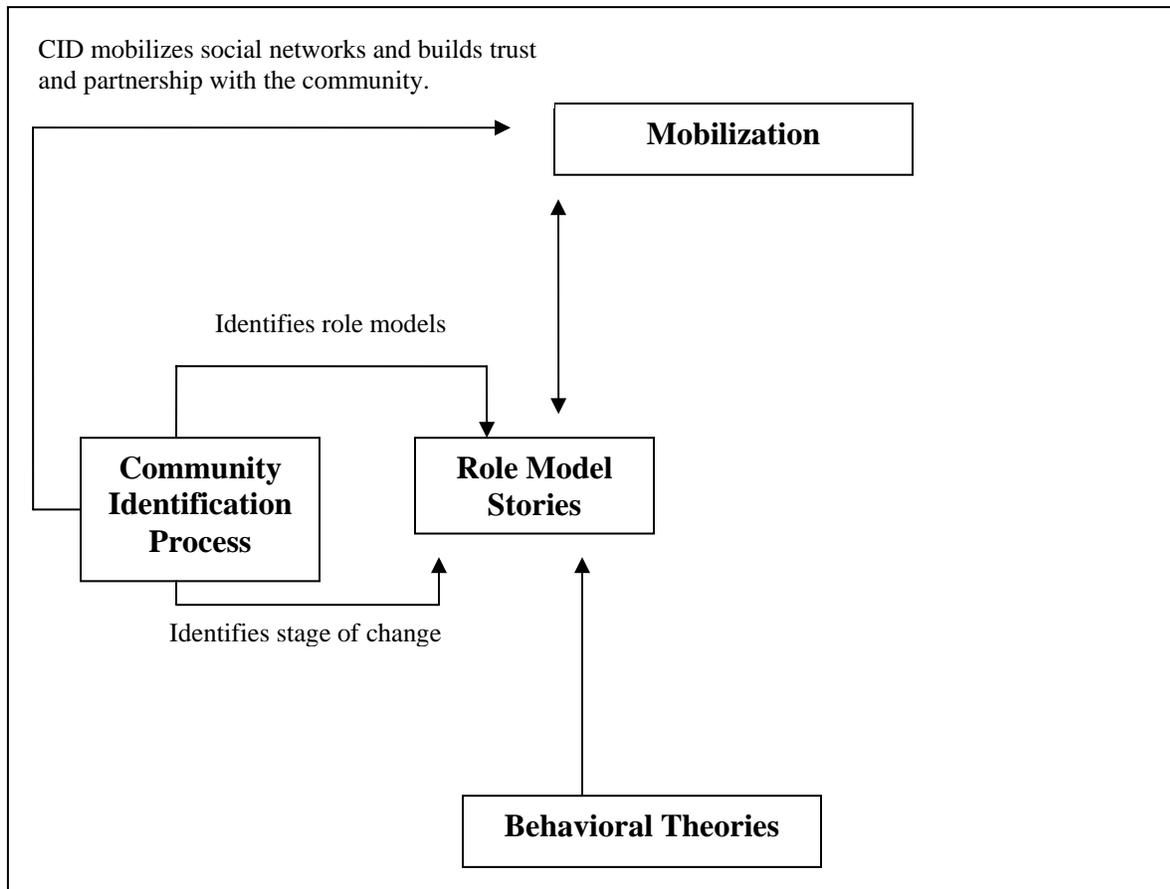
While writing **Role Model Stories**, **Peer Advocates** work with staff and members of the target population to confirm the validity of the story. As peer advocates and staff work on the street, they continue to build referral networks to help operationalize the intervention. Staff consult advisory board members and other community agencies to approve the content of the stories for distribution. **Process monitoring** activities continue. Developing relationships with community members and collecting **formative data** can also continue throughout all intervention stages.

Peer Advocates are vital to the success of Community Promise. Peer advocates work hours, go places and meet with members of the target population that are off limits to outreach staff. They are the frontline and public representatives of the project, with high profile both in the office and on the streets. They increase community awareness and **mobilize the community** to participate in the intervention. As they interact with members of the target population, they build the **network of referrals** of those who may wish to participate or contribute to the project by donating time, supplies or other resources. The main duty of peer advocates is to **distribute role model stories**. **Management** and coordinating outreach staff and peer advocates emerges as a top priority in the core element and work of peer advocates. The activities of another core element, **evaluation** are also interdependent with the Peer Advocate core element. **Process monitoring** is underway, and peer advocates keep logs of the number of **role model stories** and other materials they distribute.

Evaluation is a core element that is interdependent with the core elements of community identification, role model stories and peer advocates. Evaluation takes place at each stage of the intervention. After the intervention has been implemented for several months, **process monitoring** data are reviewed, and **process evaluation** takes place. Staff and peer advocates will conduct **outcome monitoring** to determine if the stage of the target population has changed, or if there has been a change in attitudes or behaviors. In outcome monitoring, the data collected in the **community identification** process stage are compared to data collected in the **evaluation** stage. These data are used to help improve programs, inform administrators and funders of the progress and success or limitations of the work.



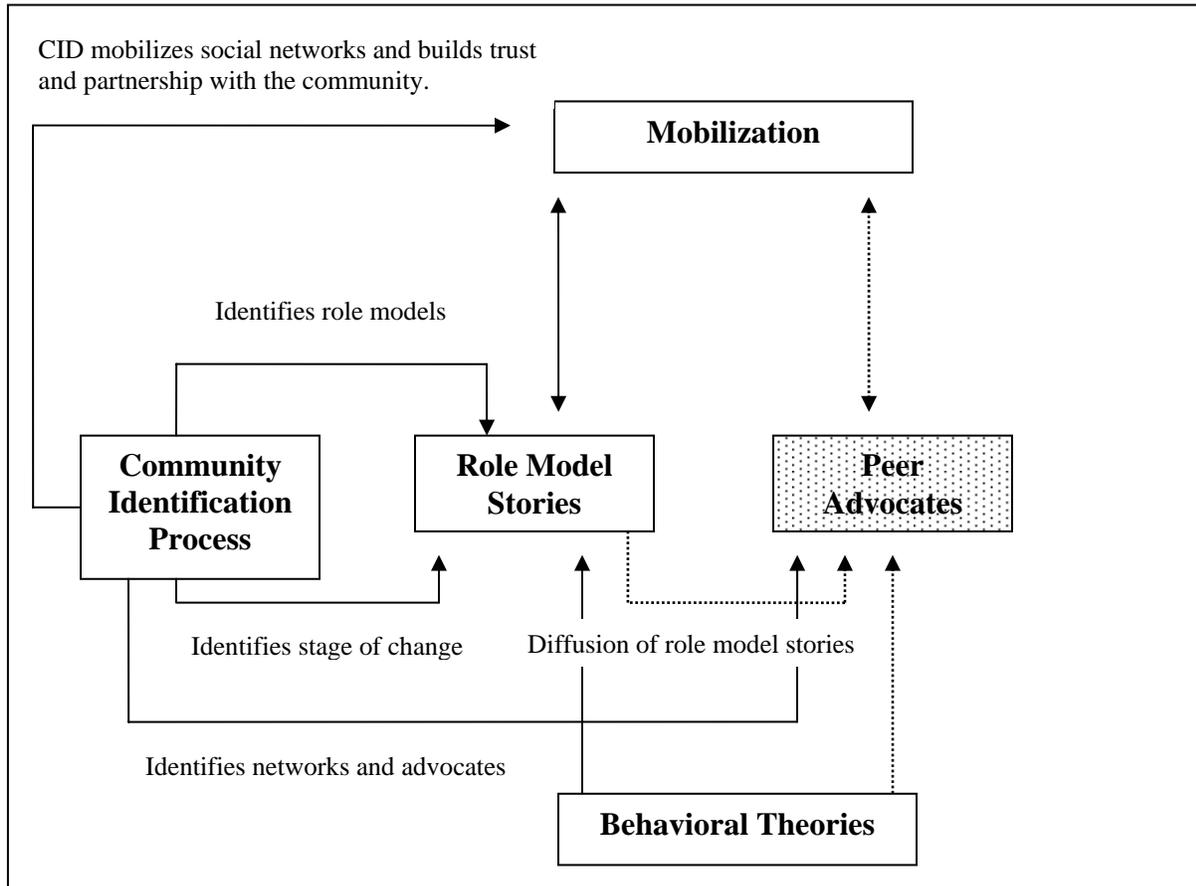
Figure 1: Interrelationship of Two Core Elements, Mobilization, and Behavioral Theories



CID contributes to community mobilization by accessing and engaging social networks and building trust and partnership with the community. CID also contributes to role models stories by identifying potential role models and determining the predominant stage of change and specific target behavior in the community. Role model stories are grounded in Stages of Change and other behavioral theories.

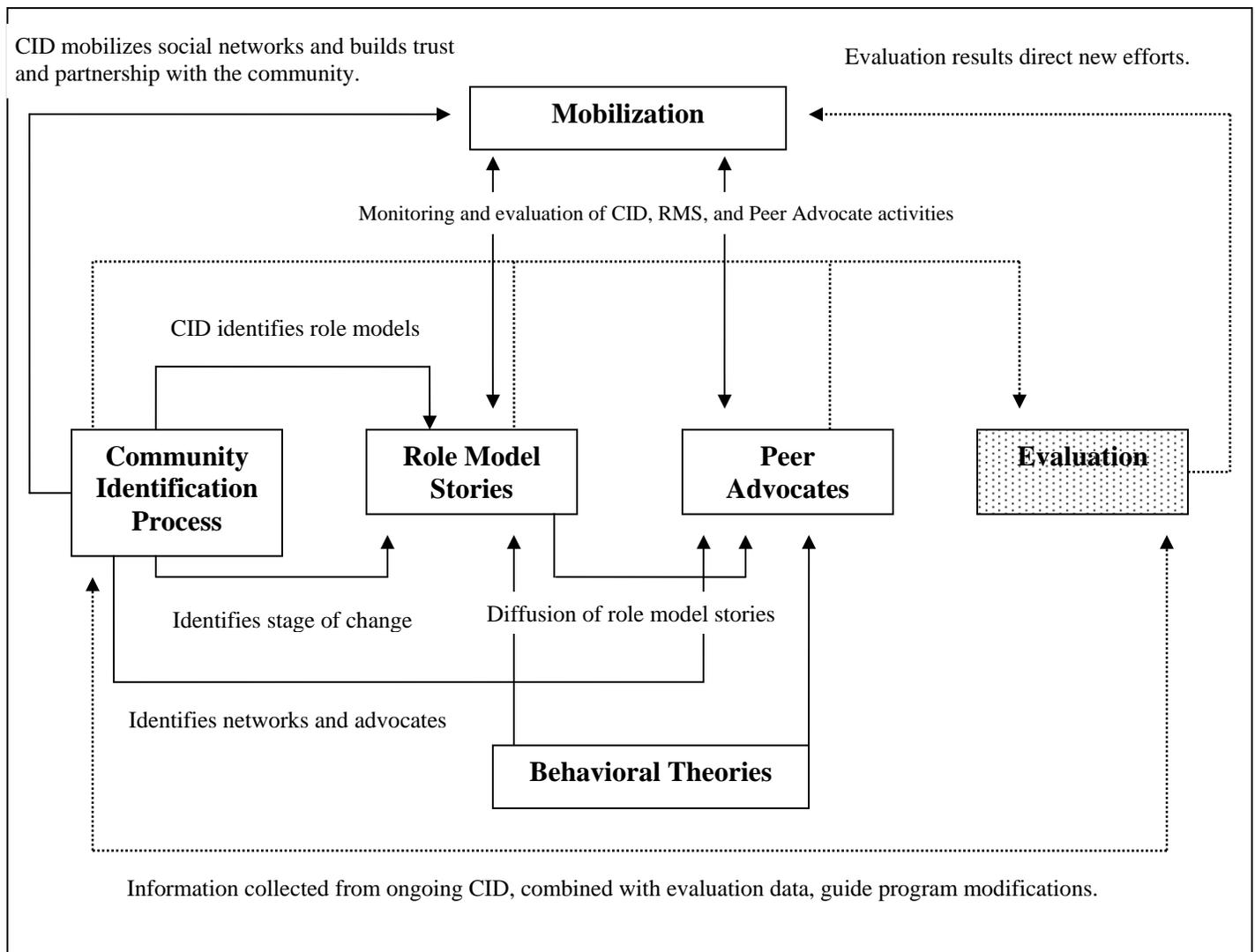


Figure 2: Interrelationship of Three Core Elements, Mobilization and Behavioral Theories



Social networks and potential peer advocates are identified through CID. The role model stories, which are based on specific behavioral theories, are distributed by peer advocates. Engaging role models and peer advocates strengthens mobilization efforts.

Figure 3: Interrelationship of the Four Core Elements, Mobilization and Behavioral Theories



Process monitoring and evaluation data **are** collected for CID, role model story and peer advocate activities. **Ongoing CID** provides information that, in conjunction with evaluation data, informs program modifications.

Development of Community PROMISE

Community PROMISE is based on the AIDS Community Demonstration Project that was tested and proven to be effective in a research study. See [Appendix A](#) for a research article on the Project and [Appendix B](#) for more detailed information on demonstration sites and researchers. The goals of the intervention were to increase the consistency of condom use for anal and vaginal intercourse with main and “other” (non-main, paying, occasional, casual, or regular)



partners, and to increase consistent use of bleach for cleaning needles. The target populations with whom the intervention was tested were IDUs, their female sex partners, female commercial sex workers, street youth, and non-gay identified MSM. These individuals included mostly White, African Americans, and Latinos, but Asian and Pacific Islanders and Native Americans also participated. The Project outcomes at the community level included movement toward consistent condom use with main and non-main partners and increased carrying of condoms. At the individual level, the Project outcomes included increased condoms carrying and higher stage-of-change scores for condom and bleach use.

Understanding the theory behind Community PROMISE

An intervention is theoretically-based if its activities are consistent with a particular set of systematic assumptions about cause and effect. One advantage of using theoretically-based interventions is that theories are supported by reasoning and logical hypotheses. In addition, many theories about behavior have been supported by findings from experiments designed to test whether the theory can apply to many situations.

Behavioral theories suggest how and why individuals behave as they do. Community PROMISE is based upon the idea that an individual's behavior is influenced by a variety of factors, which appear in the behavioral theories that are part of this intervention. The influencing factors are listed below:

Seven Influencing Behavioral Factors

1. Perceived personal risk (susceptibility and severity)
2. Perceived effectiveness of risk-reduction behavior (response efficacy)
3. Perceived self-efficacy
4. Belief about what people who are important to you want you to do (subjective norms)
5. Beliefs about the extent to which peers typically perform the behavior (perceived social norms)
6. Beliefs about the positive consequences of performing the behavior
7. Beliefs about the decreased negative consequences of performing the behavior

Theories in Community PROMISE

Community PROMISE is based on established models and theories of behavior change. No single theory adequately describes the complexity of sex- and drug-related risk behavior or ways to motivate change among groups of individuals affected by and/or at risk for HIV. Consequently, this intervention incorporates five theoretical models, which are described below:

Health Belief Model

According to the Health Belief Model, three main factors can influence an individual to change his or her behavior in order to effectively reduce the risk of contracting HIV. First, the individual must think he or she is personally at risk of contracting the disease. Second, the disease must be perceived as having severe or dire consequences. Third, the individual must believe (1) that changing his or her behavior will be effective in reducing the risk of contracting the disease; and



(2) that the benefits of the preventative action outweigh its perceived costs (Becker, 1974, 1988; Janz & Becker, 1984).

Theory of Reasoned Action

The Theory of Reasoned Action suggests that there is one primary predictor of specific behavior change: an individual's intention to perform that behavior. This intention is determined by two other factors: (1) the individual's attitude toward performing the behavior based on his or her beliefs about its consequences; and (2) the individual's perception of the social pressure put upon him or her to perform the behavior. This theory suggests that people change behaviors if people who are important to them think that they should adopt a particular behavior, subjective norms. (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975).

Social Cognitive Theory

The Social Cognitive Theory argues that three factors influence the likelihood of an individual to change his or her behavior. First, the individual must believe that the benefits of performing the new behavior will outweigh its costs. Second, the individual must have confidence in his or her ability to perform the specific preventive behavior (self-efficacy). The individual must believe he or she has the skills and abilities necessary to perform the new behavior in a variety of circumstances. This theory also suggests that the necessary skills and confidence to perform a new behavior can be learned by observing that behavior in others. Third, there must be reinforcement of positive behavior changes from persons who are important. (Bandura, 1986, 1991)

Diffusion of Innovations Theory

Diffusion of Innovations Theory refers to the process by which an innovation is communicated over time through members of a social network. Diffusion consists of four elements: (1) the innovation, idea, practice, or object that is thought of as new; (2) communication or the exchange of messages; (3) a process of dissemination or diffusion that occurs over time; and (4) a social system, structure, or group of individuals that interact. This theory suggests that HIV prevention, when viewed as an innovation, will be successful or adopted by individuals when the innovation is diffused or distributed through communities of those at risk. (Rogers, 1994)

Stages-of-Change/Transtheoretical Model

The Stages-of-Change Model was designed to describe the stages individuals go through when changing behaviors. The stages are described below:

1. **Pre-contemplation** is, as its name suggests, the stage “before thinking” about changing a behavior. This occurs when the individual has no intention of adopting a recommended protective behavior and is not even thinking of changing their current behavior.
2. **Contemplation** is the stage at which an individual is thinking about choosing the new behavior but has not yet begun to perform that behavior.



3. **Preparation or Planning** is when there is some attempt to change a current behavior accompanied by a firm intention to accomplish change in the immediate future. Consistent performance of the new behavior has not yet been achieved.
4. **Action** occurs when the new behavior is being performed consistently but not for more than six months.
5. **Maintenance** is the stage that defines the practice of the new behavior for a period of six months or more. During this phase, the individual continues to work to prevent relapse.

Relapse is an important element in this theory and a reality that may occur between any of the stages. The stages are meant to be thought of as cyclical and not linear, and a person can cycle through them in various combinations before reaching maintenance.

According to this model, different intervention activities are necessary depending upon where the individual is on the stage continuum (Prochaska & DiClemente, 1986, 1992).

Below is a summary of the behavioral theories and how they appear in the intervention:

- 1.) People change their behaviors gradually, in stages, over time. Community PROMISE highlights people in various *stages of change* in the role model stories, and also periodically measures participants' stage of change in order to assess the community and our progress (*Transtheoretical Stages of Change Model*).
- 2.) People change behaviors when they have skills to perform the new behavior. Community PROMISE shows role-models developing and using these skills, such as keeping condoms or bleach handy or negotiating condom use (*Social Cognitive Theory*).
- 3.) People change their behavior when they are clear about a specific behavioral goal. Community PROMISE shows only one, clearly expressed behavioral goal in each role model story, and expresses the role model's *attitudes and beliefs* about performing the specific behavior (*Theory of Reasoned Action*).
- 4.) People change behavior and learn how to perform a new behavior when they see others like themselves adopting those behaviors. Community PROMISE shows people from the target population overcoming obstacles to changing the behavior and emphasizes modeling, vicarious learning, and relevance in their lives (*Social Cognitive Theory*).
- 5.) People change behaviors if they see others like them or close to them changing those behaviors creating a perception of social norms, and if people who are important to them think that they should adopt a particular behavior, subjective norms. Community PROMISE shows people becoming aware of important norms and learning what an "important other" wants them to do (*Theory of Reasoned Action*).



6.) People tend to adopt behaviors if they are reinforced or rewarded for doing so. Community PROMISE tells the positive outcomes of adopting the behavior such as feeling good about oneself, believing that you can perform the behavior, or being praised by others (*Social Cognitive Theory*).

7.) People change their behaviors depending on their beliefs about the behaviors or about the consequences of the behaviors (*Theory of Reasoned Action*). These beliefs fall into several categories:

a.) perceived susceptibility; the belief that you are at risk for acquiring a certain disease. Community PROMISE has role models identify or become aware of their risk (*Health Belief Model*).

b.) perceived severity; the belief that HIV is a serious disease with serious consequences (*Health Belief Model*).

c.) self efficacy; the belief that you can adopt the behavior despite the obstacles you might encounter. Community PROMISE shows how people overcome these obstacles (*Social (Cognitive) Learning Theory*).

d.) response efficacy, the belief that taking the recommended action will work to protect oneself from disease (*Social (Cognitive Learning Theory)*).

8.) People also change behavior based on the attitudes that they have about the behavior and its consequences, and those attitudes – positive or negative – come from their beliefs (*Theory of Reasoned Action*). A subset of attitudes is cost-benefit analyses that we all do, which asks if the outcome of the behavior change is worth the cost to me? (*Health Belief Model*) This is similar to outcome expectancies (*Social Cognitive Learning Theory*).

9.) People are more likely to change behavior if they have an intention to do so. Community PROMISE shows what people go through to develop an intention to change behavior (*Theory of Reasoned Action*).

10.) These messages gain credibility if they are diffused throughout the target community by appropriate peers or respected members of that community, so we recruit peer advocates to do the distribution as well as provide content for the role model stories. They distribute the stories within their own social networks (*Diffusion of Innovation*).

11.) The messages are also enhanced if they are repeated, that is if the role model stories in brochures or flyers also appear on posters, condom or bleach kits, etc. Multiple role model stories can carry the same message expressed in different ways, so that while the message is repeated (“Buy Volkswagen!”), the medium varies (flyers, brochures, posters, different stories).

As this summary suggest, these theoretical concepts form the heart of Community PROMISE and guide the project.



Deciding if Community PROMISE is right for you

In making a decision about whether or not your agency is interested, willing and able to commit to implementing Community PROMISE, it is important to review the following considerations:

Community PROMISE is right for you if:

1. *Explicit material about sexual and drug practices can be used in your population.*

In order for role model stores to be effective, they must allow the readers to identify with the characters depicted. Role model stores are the real-life experiences of members of the target population as expressed in their own words. Because the role model stores are as realistic as possible, they will contain graphic language used to describe risk behaviors. If the decision makers in your community believe such materials are not appropriate for your target population, then Community PROMISE may not be appropriate for your agency. For example, if you conduct outreach to middle-school children, graphic language about sex and condoms may not be viewed as acceptable by those who control access to that population.

2. *You have an outreach component in your program.* Community PROMISE requires outreach into the community. At the core of the intervention are peer advocates, working under the guidance of outreach workers, who distribute the role model stores to members of the target population. If your agency does not have an outreach component, you do not have the necessary tools to launch Community PROMISE effectively. Keep in mind that, if Community PROMISE will be the first outreach activity administered by your program, your timeline for implementing the intervention will be longer because you will need extra time to establish the outreach component.

3. *You can maintain the confidentiality of the people you interview.* Role model stores are the experiences of real people. If you are unable to maintain the confidentiality of the individuals you interview, you would be violating the trust necessary to do Community PROMISE. For example, if your agency requires you to report illegal activities—such as substance use—to authorities, or prohibits you from working with someone who is actively using drugs, then you will not be able to offer the confidentiality necessary to get the complete true-life story. Such constraints will limit the success of Community PROMISE.



4. *You can be specific about the target population or its risk behaviors.* Community PROMISE was developed to target a specific population and its well-defined risk behaviors. The intervention will not be effective for use in a general population, where the risk behaviors are many and varied. For example, women (in general) may not be an appropriate target population as compared to women who are practicing a specific risk behavior. Among women in general, sexual and drug-using behaviors vary quite a bit. Women who don't use drugs may be offended at the suggestion that they do, while women who are not sexually active outside of a primary relationship might not want to be classified with women who are. Community PROMISE is appropriate for identifiable, specific sub-populations of women such as IDUs, runaways, or sex workers.

Likewise, the message for behavior change must be specific. It is not enough to say, "Practice safer sex." In Community PROMISE, the behavior you are trying to modify must be made explicit. For example, instead of telling someone to "protect yourself," it is more effective to recommend a specific behavior change such as using condoms with main and/or non-main sexual partners or using clean needles. If it isn't possible to be this specific, try another type of intervention, or change your goal to raising the awareness of risk if that is indicated for your population.

What does an agency need to make this program work?

If your agency possess the following six conditions, your chance of success with a community-level intervention such as Community PROMISE will be much greater.

1. *Access to the target population.* To collect the preliminary information needed to develop the intervention effectively, you must have access to the target population. This means you must have some idea where to reach them and what are their issues and risks. Your agency must be able to overcome obstacles to reaching the target population.
2. *Outreach workers.* An existing outreach program will simplify efforts to establish this intervention. If your agency must recruit, hire, and train an outreach staff, you will add months of "up-front" time and expense to your effort. A staff experienced in outreach can save you much necessary training and orientation. Even more useful is an outreach staff experienced with the same population you intend to target for the intervention.
3. *An existing HIV prevention program in your organization.* It takes time and effort to train existing staff in HIV prevention behavior change. An agency with an existing HIV prevention program will have a head start on this process even if the program currently focuses on HIV information and education rather than motivating risk behavior change.
4. *Commitment to conduct a preliminary CID process.* This program will be effective only if it is tailored to the specific population whose behavior is being addressed.



Your agency must make a commitment to learn about the community and resist the tendency to think planners know everything they need to know about the target population. Although planners or staff members may already be associated with the target population through social contact, ethnic ties, current or past behavioral association, sexual orientation, or a combination of these, they should never assume that those associations provide all the knowledge needed about the population in order to implement Community PROMISE (or any other prevention intervention). The preliminary CID process allows for a much better understanding of the structural, environmental, behavioral, and psychological facilitators and barriers to HIV risk reduction in your target population.

5. *The talent and motivation to write the role model stories.* This does not mean that you have to hire professional writers. Training is available to develop role-model writing skills. Ultimately, however, the writer of the stories must not only display good writing skills but also have a firm grasp of the theory behind behavior change. Though the stories will come from professional, structured interviews, it is important that the writer know the theoretical underpinnings of the intervention. The writer must not only be able to condense a long interview into an interesting short story but must also have a firm understanding of the purpose and intent of the stories. This is why not all outreach workers—or program managers—succeed at writing role model stories. But many can be taught the skill.
6. *The resources to publish the stories.* Publications can be produced inexpensively but not for free. The agency must have either a budget to pay for the publications or contacts that will do the job for next to nothing. Publications can be duplicated on the office copier, printed in four-color slick brochures, or anything in between. Adding artwork—photos, drawings, or computer graphics—will give life to the publication but will require additional resources if you don't already have access to them. Someone with design experience will be useful in the publication of the role model stories.

More information on resources required to implement Community PROMISE is found in Module 6.

An important note about fidelity and adaptation

Community PROMISE is a community-level intervention that relies on the participation of peer advocates and the stories of target population members. As such, it is naturally adapted and tailored to each unique community environment to best fit the community's needs, culture, etc. In addition, agency resources will determine how the intervention is implemented and what modifications, if any, need to be made to fit within budget limits. For example, it may be appropriate for role model stories to be distributed openly in a social setting in one community, yet more appropriate to be distributed discretely in another community. Resources may permit production of glossy color stories in one agency, black and white photocopies in another. These are typical adaptations of the intervention to the agency and community reality. The manual even



presents different options and levels of implementation that were discussed in the preceding section: “How to use this manual.”

However, there are limits to how the intervention can be modified. Community PROMISE is effective at promoting a community-wide increase of risk-reduction behaviors, based upon research and demonstration of the intervention in its entirety, with all four core elements. In order for your agency to expect such effectiveness from the intervention, the four core elements of Community PROMISE must be implemented with fidelity. Fidelity refers to how faithfully and accurately you implement the four core elements of the intervention as they are outlined in this manual. You should access the technical assistance provided by the Community PROMISE program and other sources to assist you with questions regarding adaptation and fidelity.

Reminder:

Maintain fidelity to the Four Core Elements of Community PROMISE:

- 1 Community identification process
- 2 Role model stories
- 3 Peer advocates
- 4 Evaluation

Summary

This comprehensive module presented information on how Community PROMISE was developed, the role of theory in the intervention, the four core elements, decision-making factors regarding whether or not to implement the intervention, and agency resources required for implementation. It also noted the importance of maintaining fidelity to the intervention. The next module presents the core element, CID process, and guides you through why and how to assess your community prior to implementing Community PROMISE.



MODULE 2: Community Identification Process

Obtaining Critical Information about the Target Population

A critical first step in any STD/HIV prevention program is becoming familiar with the target population. As mentioned in Module 1, a program will be effective only if it is tailored to the specific population whose behavior is being addressed. This requires an understanding of the behaviors that put the population at risk, the meaning of those behaviors to population members, and the context in which the risk behavior occurs. Since every sub-group of people is comprised of persons who are similar to one another in some ways and different in others, a clear understanding of the general and specific characteristics of the target population is necessary.

A second reason for learning more about the target population is based on the history of such programs. In the past, programs have been implemented without involvement of the people to be served. Many of these programs have either failed or had negative unintended consequences. The success of social programs can be compromised because of a lack of understanding of the targeted population and the omission of the “insiders” perspective in the program development.

Although a program planner or other staff members may already be familiar with the target population through social contact, ethnic ties, shared sexual orientation, current or past behavioral association, or a combination of these, it should not be assumed that those associations provide all the knowledge needed. There is always something more that can be learned and sub-populations that can be discovered and added to the picture.

Using a discovery process like CID described in this Module, much time and work will be saved in the long run, and the planner will obtain a much better understanding of what is needed to develop, implement, and evaluate Community PROMISE. The importance of a CID process cannot be stressed enough (Tashima et al., 1996).

To successfully conduct Community PROMISE, you must understand the target population and their behaviors, from their perspective.

CID is a formative evaluation process to gather helpful information for the planning of a service and its delivery to a particular group of people. In this case, CID is important for identifying and describing structural, environmental, behavioral, and psychological factors that can facilitate or act as barriers to STD/HIV risk-reduction. It is important to remember that, throughout the CID process, the planner’s essential objective

Community identification (CID) is a formative evaluation process to gather helpful information for the planning of a service and its delivery to a particular group of people.

In the context of Community PROMISE, CID is important for identifying and describing structural, environmental, behavioral, and psychological factors that can facilitate or act as barriers to HIV risk-reduction, and for accessing and understanding the target population.

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must be to listen to and learn from those who have knowledge of the target population. Many of the CID methods discussed in this module will be used throughout implementation of Community PROMISE. For example, before distributing your role-model stories, you will want to “pre-test” them, or get feedback from community members about the stories’ appropriateness and acceptability. The techniques described here will be critical in helping you prepare your materials.

With the ultimate goal of understanding the target population from the insiders’ viewpoint, the CID process has **seven basic objectives**:

1. To develop a clear understanding of the composition of the target population and its subgroups.
2. To identify specific risk behaviors and the contexts in which they occur as well as the current stage of change in each (sexual practices, substance use, injection practice, disclosure, counseling and testing).
3. To identify the barriers to behavior change faced by the target population and how those barriers might be overcome.
4. To establish a presence in the community and to build trust with target population members. This can be accomplished by following the process of referrals that will be described and capitalizing on the relationships others have established.
5. To learn what members of the population believe are appropriate and relevant risk-reduction messages, methods, and materials.
6. To develop a plan for accessing at-risk members of the target population by identifying the gatekeepers (informal leaders within a target population whose endorsement or disapproval will facilitate or thwart the population’s acceptance of your staff and program) and important points and methods of access to the population.
7. To elicit support and cooperation from other agencies and to learn about the services provided by other agencies and organizations.

These objectives can be accomplished through the CID process. This module presents different levels of conducting CID. What differentiates “best” from “better” and “better” from “good” CID is the breadth and depth of both the effort required and the information obtained, not simply the use of different methods. You may choose the combination that best meets your needs or fits your resources. We encourage you to spend the time necessary to conduct as complete a CID process as possible.

Good

- Define your target population
- Survey internal staff
- Conduct gatekeeper interviews
- Conduct key participant interviews
- Conduct focus groups
- Conduct community observation



Better

- Define your target population
- Survey internal staff
- Conduct gatekeeper interviews
- Conduct key participant interviews
- Conduct focus groups
- Conduct community observation

PLUS

- Survey external sources of information

Best

- Define your target population
- Survey internal staff
- Conduct gatekeeper interviews
- Conduct key participant interviews
- Conduct focus groups
- Conduct community observation
- Survey external sources of information

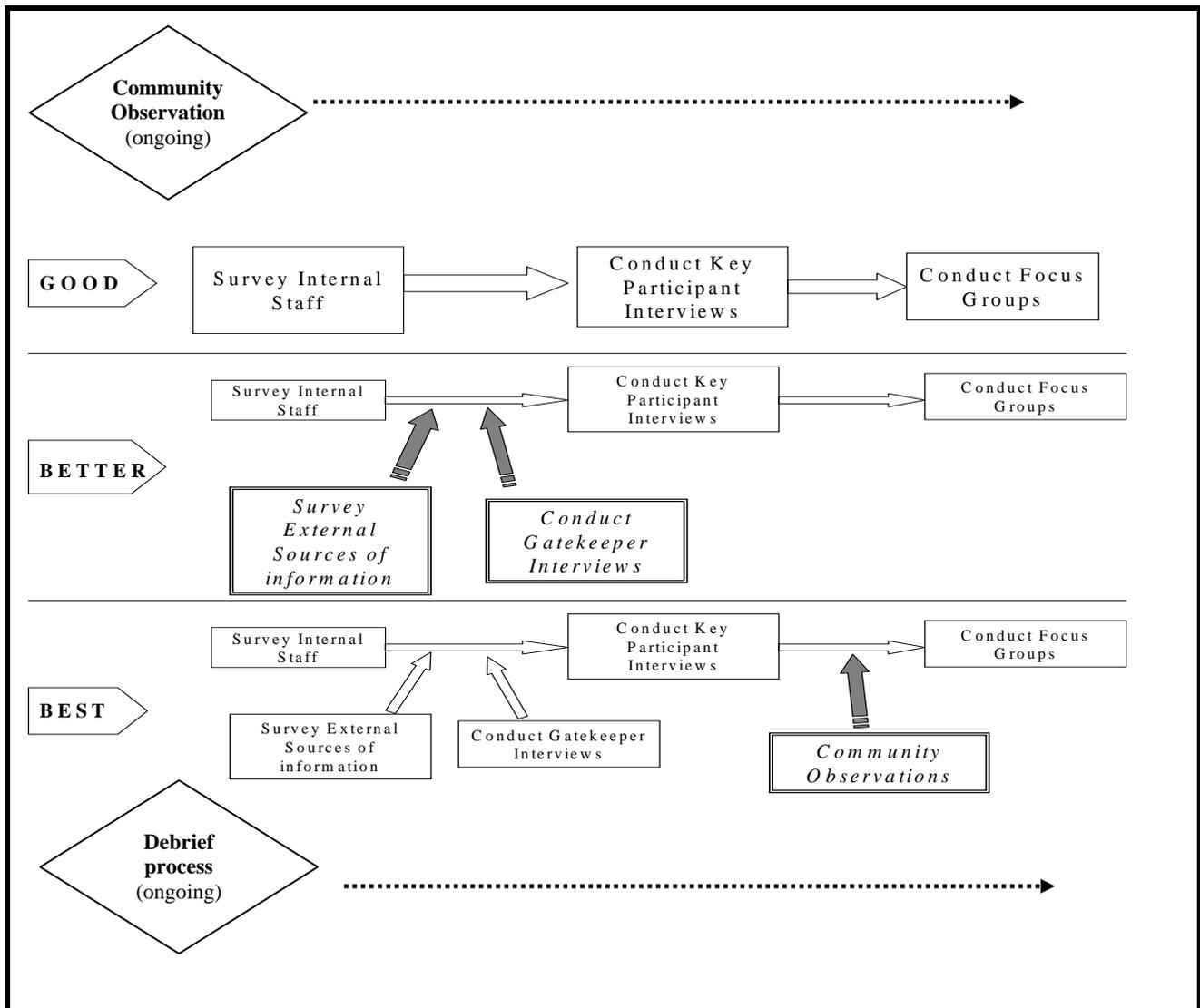
PLUS

- Conduct additional external and gatekeeper interviews
- Conduct additional key participant interviews
- Make additional community observations

Below is a graphic model to illustrate the different “good,” “better,” and “best” approaches to implementing the CID process of Community PROMISE. Please note: these activities do not necessarily have to occur in the order they appear.

In Appendix D1, you will find a CID worksheet to help in planning to conduct the CID process.





With this map as a guide for the different CID process activities, we can now go into more detail regarding the various activities.

Define the Target Population

The CID process can help you define and learn more about your target population. There are many subgroups to any population and defining those subgroups is important in targeting your message. For example, the CID process in one demonstration site revealed five subgroups of sex workers: (1) female street prostitutes, (2) female cantina workers, (3) “call girls,” (4) male street prostitutes,

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and (5) “call boys.” Information about other potential subgroups, such as Asian women brought into the United States to work in illegal brothels, indicated that these groups were relatively small or inaccessible to outsiders. Interviewees provided a wide range of estimates regarding the number of sex workers in the Long Beach area: from 30 to 2,000, with an average estimate of around 300. The largest of the sex worker segments was believed to be female street prostitutes. Therefore, although the role-model stories targeted the risk population of commercial sex workers, the majority of the stories had female street prostitutes as the main character. This decision was based on the size of the population subgroup, the subgroup’s accessibility, and the subgroup’s HIV risk.

In defining your target population, you should have information on ethnicity, age range, language, education levels, clothing styles, geographical setting, community organization and structure, target audience members, risk behaviors, and slang/terminology. You should also learn about the target population’s risk behavior, factors influencing risk behavior, and factors that may hinder as well as foster positive behavior change. Identifying, defining and understanding your target population will assist you in appropriately carrying out the following CID methods and in suitably tailoring the intervention to that population.

Survey Internal Staff

The goal of surveying or interviewing your own staff is to document what you already know about the target population while also developing a list of contacts outside of your agency. Staff interviews can be conducted in a group or individually. Internal staff includes outreach workers and program staff, as well as agency staff who may not work directly on the project (such as administrators, custodians, clerks, volunteers).

The task for internal staff is to brainstorm and write down everything they know about the target population. The list should include but not be limited to ethnicity, age range, language, educational levels, clothing styles, geographic settings, community organization and structure, estimated numbers, names of people you know who are part of, have access to, or work with the population, risk behaviors, slang related to risk behaviors, where and how to access the population, barriers to access, ways to overcome or eliminate barriers, perceived risk, actual risk, factors that influence risk, people who are gatekeepers, informal networks within the population, internal resources, and other outside groups serving the population.

Don’t forget to ask for names and contact information of others who could be interviewed about the population. Surveying internal staff will greatly enrich your knowledge base and provide information that you may have never obtained otherwise. You may also identify staff resources you didn’t know you had.

From the information you have collected, you can prepare a guided interview format to then collect information from people in the community. Guided interview formats will help you collect the same types of information from each person you talk to. Based on emerging data, you can always revise the interview questions to reflect new types of information you wish to obtain. [Appendix D2](#) contains a sample survey to be used with staff, external agencies, interactors and gatekeepers.

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Appendices H1- H3 contain resources on interviewing, including a sample interview questionnaire and key observer interview form.

Survey External Sources

It is important to access available outside sources, such as service providers (also known as systems people), that have regular contact with the target population such as community-based agencies, the health department, health care providers, the justice system, other social service agencies, etc. Information gained from external sources helps to further define sub-groups in the target population and is also useful in identifying potential strategies for accessing target population members. Often, external sources are able to identify specific locations where target population members may be found, and they can assist in identifying potential barriers to HIV prevention among target population members.

Surveying external sources also helps to establish relationships with other community agencies. These contacts will make the agencies aware of your plans to conduct outreach in the community and provide a way for you to see who is and who is not supportive of the effort. You also will establish a network of resources and referrals to help the target population members with whom you and your staff interact.

Example of potential barriers described by external sources:

- A sense of invulnerability: the target population believes that if they have not been infected, they must not be susceptible to the disease.
- A belief that risk of HIV is associated only with homosexuality or injecting drugs.
- A belief that one's sex or needle-sharing partners are not HIV infected. This sense of false security may be based on the nature of the relationship or of the person (how long he or she has known the partner, if a potential partner is neatly groomed, etc).
- The risk of HIV infection may be considered to be less severe or less likely compared to threats associated with violent crime, poverty, and drug addiction.
- Individuals engaging in illegal activities (such as drug use or prostitution) and undocumented immigrants are extremely suspicious of anyone outside of their social networks, particularly government workers.



There are three categories of sources for external information:

1. *Materials*: Sources of written or visual information about the target population or sub-groups of the target population, such as books, videos, articles, reports, and Internet sites.
2. *Systems or Service Providers*. Individuals providing services to the population. These include members of other service agencies, community-based organizations, law enforcement, the judicial system, health care providers, teachers, recreation service providers, drug treatment, or youth agencies, for example.
3. *Interactors*. Those who interact with the target population but are not members of either the formal system (such as the legal or social service system) or of the target population. Depending on your target population, interactors might include shopkeepers, taxi drivers, hairdressers, park attendants, bus drivers, motel clerks, bartenders, liquor and convenience store clerks, or former target population members.

Interviews with staff members of other agencies or with some of the individuals who interact with the target population can be conducted in person or via telephone. The interviews should answer many questions about the target population, including: (1) the existence, size and types of population sub-groups, (2) estimates of HIV awareness, (3) risk practices, (4) locations and strategies to reach the population, (5) potential barriers to accessing population members, (6) literacy level, and (7) the names, addresses, and telephone numbers of others who could be interviewed, with permission to use the name of the person who supplied the new name. If you identify a number of people at a given agency who are familiar with the target population, you may wish to conduct a group interview.

To conduct complete internal and external interviews, you should continue with the interviews at each stage until one of two events become clear: you are only being referred to people with whom you have already spoken or you are only getting answers you have already heard. The redundancy is proof that you have reached a point of saturation in that level of interviews.

Conduct Community Observations

Throughout the CID process, you can gather valuable information through field observations at the sites where outreach may take place. Conducting field observations allows you to document the characteristics and activities of target population members such as how a commercial sex worker solicits a date, or how drug users interact with each other. Observations tell you about the community, such as the physical layout, the relationships of people in and moving through the area, the activities occurring that you can see, and the general “feel” of the area. Field observations establish the presence of outreach staff members, which earns the trust of the target population. They also help you identify the sites where the largest number of target population members can be reached, so you can plan the best locations for outreach and distribution of role model stories.

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Conducting community observations can also be an on-going activity which will allow you to be aware of changes in locations of high risk behavior, type of activities in the area, law enforcement efforts, new people in the community, etc.

Although useful in producing rich and varied data, observation can be affected by a number of factors:

- The observer's interests, experience and expectations
- The observer jumping to conclusions
- The length of time an observer waits until writing up notes—the longer he or she waits to complete a write-up, the less likely these notes are to be accurate and perceptive
- Being observed may lead to individuals changing their normal pattern of behavior

In order to provide a complete picture of the activity that takes place at a certain site, observations should be done at all times of day and every day of the week. Although as an observer you will be noticed, you should try to fit in as much as possible by assuming a casual approach and dressing similarly to the specific group being observed. At first, observers may want to limit or avoid interaction with the individuals present, keeping conversations low-key in order to allow people to get used to their presence. If asked, be honest about what you are doing and your organization. This allows trust to form. Carry identification but little or no money or jewelry. A list of safety guidelines for field staff is included in [Appendix D3](#). These guidelines are also useful for conducting key participant interviews and any time you and your staff are in the field.

What is observation?

The most natural and obvious way to collect information is to simply watch, listen, and record what is happening. Observation is unlike other methods that rely on self-reported behavior or other data sources. Instead, it allows the observer to gain first-hand experience of the meanings, relationships, and contexts of behavior. The observer learns by being present, by seeing what people do and how they interact, by listening to what they say, and noticing the sounds, smells, and seemingly insignificant details of the environment.

Community observation can be conducted through the entire CID process.

At an *early* stage of the CID process, observations may be used to:

- highlight areas for materials distribution, map key areas, establish means of accessing the target population, identify key informants
- gain an understanding of local behaviors, vocabulary and customs

During the *middle* stage of the CID process, observations may be used to:

- confirm findings from other methods and data sources
- explore specific topics or behaviors further

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At the *ongoing* stage of the CID process, observations may be used to:

- confirm findings from other methods and data sources
- assess the representative nature of the your findings (this could be through repeating observations with different groups in different areas)
- outline potential problems and possible solutions for recruiting advocates and distributing materials

What can be observed?

Almost anything can be observed during community observations. However, this does not mean that observers should conduct observations that observe *everything*. An inexperienced observer may make the mistake of trying to record or remember every detail of a situation because he or she is worried that something important will be missed or is unsure what is actually of interest.

Rather, observers should concentrate their observations on *specific aspects* of a situation. To help ensure that observations are undertaken systematically and consistently among observers, the following elements should be considered.

Elements of observation:

<u>Settings</u>	Where does the observation take place? When? What is the physical layout? What kinds of physical characteristics are present?
<u>People</u>	Who is present? Numbers? Sex, age, ethnicity?
<u>Activities</u>	What is going on? What activities are the people involved in?
<u>Signs</u>	Are there any clues that provide evidence about meanings and behaviors?
<u>Acts</u>	What are people doing?
<u>Events</u>	Is this a regular occurrence? Or is it a special event such as a meeting or a disagreement?
<u>Time</u>	In what order do things happen? Is there a reason for this?
<u>Goals</u>	What are people trying to accomplish?
<u>Connections</u>	How do the people know one another? Is their relationship social or organized on a commercial basis? Does the relationship change over time?

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Not all of these elements can or should be observed at one time. Where observers feel that there are an overwhelming number of aspects that could be observed, they should:

- Prioritize each element in terms of its importance to the CID process and deal with these in turn. This is normally done when a situation is unlikely to be repeated or could end at any moment.
- Ask co-workers to help. This is only possible when the situation under observation would not be disturbed or interrupted by additional observers.
- Observe a limited number of aspects and try to repeat the observation at a later date. This can be useful where a situation is frequently repeated such as interactions at a needle exchange program.

Where and when should observations be conducted?

Observers should try to conduct observations where the most important behaviors and activities are likely to occur. This may involve gaining access to “difficult to reach” populations. Sometimes the observer may accidentally come across interesting situations, but it is better to anticipate when and where relevant behaviors and events are likely to occur.

- Observation can aid and improve knowledge through mapping the community and listing items/events observed.
- Knowledge from such mapping and listing exercises can benefit further observations. This is particularly useful for distinguishing between *regular* and *unusual* events.

Where and when should observation not be conducted?

Some observers may wish to observe all kinds of behaviors and events. However, some of these might be better investigated using other methods. There are also certain times and places when observations should not be used. These include situations where an observer may place themselves, participants being observed, their key informants or the larger CID process in a vulnerable or compromised position. This could involve:

- becoming actively or mistakenly involved in illegal activities such as being in a public sex environment without identification during a police sweep
- undertaking a course of Identification which is *ethically* inappropriate, e.g., asking a target population member to approach someone and ask for sex in exchange for drugs to observe the result
- endangering the safety and security of the participants being observed, the observer, and others, e.g., by interrupting a drug deal



**Community observation experience
from a project targeting men in public sex environments**

"We spent time in parks and other such places looking for evidence of active sex sites: old condoms and condom wrappers. The wrappers, which are plastic, aren't biodegradable, so they last a long time. Therefore, their presence doesn't indicate that where they are found is an active sex site. But at the same time, their condition may give some indication to that issue: if all the wrappers are old, crummy and dirty, it may not be an active sex site. If there are new and fresh wrappers, it may be an active sex site. Since condoms are biodegradable, their presence (for example, in bushes) probably indicates that the site is an active sex site. Another indication of an active sex site is the presence of napkins. They are oftentimes an indication of oral sex going on. They're sometimes used if condoms are not. Napkins are quite biodegradable, so their presence usually indicates an active sex site."

Community and micro-site mapping.

Maps are one product of community observations. The maps you will create are both of physical elements of the areas in which you will be working as well as of the locations where different subpopulations seem to cluster. Later in the intervention, you will use the maps to mark locations where advocates are located, where they are doing their materials distribution, where your business advocates are located, etc. These maps give you a quick and visual snapshot of the area in which you are working and the work you are doing. Maps are useful as they can provide graphic representations of often complex information. See figures A and B for photographs of sample maps. There are four main steps in mapping an area.

1. *Obtain an up-to date map of the locality.* If a map is not available, draw your own. This need not be drawn to scale. However, it should be large enough to allow sufficient details to be recorded. Note all streets, alleys, buildings, other landmarks.
2. *Walk through the area a number of times.* You should note important features, check the layout, make rough sketches, and add detail to the map. Add names of businesses, locations of high activity, gathering spots, social service agencies, churches, etc.
3. *Talk through the area.* As you talk with interactors and gatekeepers you can add to the information on your maps. You will learn of new gathering spots, new social networks, and potential advocates.

Mapping is a *continual* process. New locations and areas of interest will arise during the CID process and these can also be mapped. As the map becomes more detailed and access to particular locations increases, you could produce maps of individual *micro-sites*. These are small but important areas such as shooting galleries, treatment clinics, drug dealing points, and hotels

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frequented by sex workers. Here, the spatial layout and organization of the location should be noted.

Figure A: sample map 1



Figure B: Sample map 2



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Debriefing, Data Reduction and Summarizing

Staff members should participate in debriefing sessions on a regular and as-needed basis to process the CID experience. This session, which can be facilitated by a key staff member, should include questions such as: What were your expectations prior to the community observation or interview and how did your experience meet or differ from those expectations? What was your impression of the non-verbal messages from the person you were interviewing? Would they be important to talk to again, to recruit for the Advisory Group or as an advocate? Did you feel her/she was giving you the full story? What new things did you learn? What seemed to be missing from what he/she told you? Did anything he/she said contradict earlier information? What observations were most memorable or striking to you? Did anything you saw or heard disturb you? Staff should feel supported and comfortable sharing their experiences. They should also continually be encouraged to separate their impressions from the words or observations, and from the inferences they make based on those words and observations.

From the debriefings, additional entries can be made on the maps to indicate points of access, places to recruit advocates, etc. Another part of the process is reducing the data. Data reduction occurs after each set of interviews or continually, if possible. Reduction means taking the results of interviews, focus groups, and observations and adding it to the existing data by category of data. For example, the answers to each of the questions from the external, interactor, and gatekeeper interviews can be compiled as the interviews progress. When a response is given by more than one person it can be noted so some measure of the strength of the answer can be created. The debriefing process can identify places where there seem to be gaps in knowledge which can then be addressed in later surveys. Discrepancies in the data from different sources can be examined and explored in future interviews. Data reduction allows you to look at the results of many interviews in a compact fashion. This does not need to be computerized. You can do a simple listing on butcher paper just as effectively.

The third step is summarizing the data. Summarization allows you to compact the results to present it to others. It allows the findings and conclusions drawn from the various data collection methods to be compared in a written report. This will serve as an historical document, describing what was done, learned, and evaluated. It also provides an important rationale and justification for the intervention activities you will undertake. Finally, it can help convince your funding sources of your expertise and commitment.

The transcripts or notes from the different types of interviews conducted (internal, external, gatekeeper, key participant, and focus groups), as well as the information gained from community observations and other external sources of information, can be used to produce a summary report that covers these areas:

- sources of STD/HIV information
- sources of other community information
- social connections
- service utilization
- knowledge and awareness of STD/HIV
- sexual practices
- substance use and injection practices
- other STD/HIV risks
- community stage of change
- community access points

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By integrating and organizing all of the information into one report, you will be able to review all of the information gained from the CID process. You will also be able to identify where information is incomplete or missing and whether additional identification work is needed. All of the information gained from the CID process is invaluable in assisting you to plan the best implementation of Community PROMISE with your particular target population.

Conduct Gatekeeper Interviews

Gatekeepers are individuals within a given target population who can allow or prevent an outsider's entrance into a community. They are often informal leaders who are respected or admired. Their endorsement can facilitate the acceptance of staff members who are not part of the target population. The purposes of gatekeeper interviews are: (1) to gain access to target population members, (2) to learn more about the HIV risk and perceptions of the target population, and (3) to introduce Community PROMISE to that population through its highly regarded members.

The CID process will create a list of people who are perceived as gatekeepers in the target community. You will be able to contact them and say that you have been referred to them by a person you have already interviewed, someone with whom the gatekeeper has an established relationship of trust. This referral process will greatly increase the chances that the gatekeeper will be willing to speak with you about your project. A well-connected gatekeeper will already know that you are in the community. Be sure to send your best people to see gatekeepers – staff who can clearly speak about the purposes and activities of the project, the role for the gatekeeper, and the importance of working with the community. These gatekeepers can make significant contributions to the success of your program or cause its failure.

Gatekeeper interviews take place following surveys of internal staff and other agencies but usually before key participant interviews or focus groups. During the survey of internal staff, some gatekeepers most likely will be identified. These individuals can be approached and, after the project and its purpose is explained, asked for an interview. It is important to familiarize them with your project and its goals before meeting with gatekeepers. Often, gatekeepers will serve as access points into the community, and gaining their trust and respect is fundamental. Let them know they are an important part of the program.

Gatekeeper interviews are typically conducted in field settings. Often, gatekeepers introduce staff members to the places frequented by the target population and the people they know in the area. Gatekeepers can also help to identify key participants to interview. Gatekeepers can be among the most valuable advocates for the outreach project by spreading program awareness and helping to secure more participants. Gatekeepers can become Advisory Group members, can recruit peer advocates, and identify initial role models.



Conduct Key Participant Interviews

This interviewing stage is very important for the development of a program that will truly address the needs of its target population. Interviews with selected members of the target population called “key participants” will provide a great deal of important information about their lives, how they view their HIV risk, and what they have done about it, all from the insider perspective. It is this insider perspective that will help you get at the factors that influence behaviors. Your role model stories can then address these factors, making them more immediately relevant.

These interviews are guided by a set of predetermined questions, but spontaneous questions can and should also be asked to follow up on interesting points and to provide participants the freedom to describe their experiences in their own way. We want to emphasize that, even though the interview format is fairly structured and there is a questionnaire involved, it is not to be completed by the key participant him- or herself. This is a private interaction, almost a discussion, between the interviewer, who is a person on your staff, and an interviewee, the key participant.

The program manager has the responsibility of determining which topics are the most important and determining how to focus the discussions on those topics. It is important not to be too controlling throughout the interview. Dominating a discussion may limit what is said, which will hinder your information-gathering process. On the other hand, a certain amount of control must be exercised to remain on topic and to assure that neither the interviewer nor respondent will become fatigued before the essential information is obtained.

You’ll ask the key participant many of the same questions you asked your staff and all the others you have talked with:

- What are the patterns of behavior in the target population?
- What are the informal networks that have been established?
- What are the concerns and needs of the target population?
- What barriers do they face in accessing prevention materials?
- What barriers will you face in accessing them for your program?

Two valuable pieces of information that you’ll gain from the key participants are (1) an idea of the stage of change the community is in with regard to the specific risk-reduction goals you would like them to adopt, and (2) the best places, times, and methods to access the target population. Knowing which stage of change the community is in will allow you to plan and develop role-model stories that are relevant to the community. For example, if the community is at the contemplation stage, stories about how someone moved from the preparation to the action stage will not be relevant. Rather, in this example, stories will be more relevant and have a greater impact on the community if they focus on how someone moved from contemplation to preparation. In addition, the key participant will help you determine the best places to access the target population. This information is critical in identifying potential community advocates so that all such high activity locations and networks are covered by the activities of sufficient advocates. In addition, you will receive

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important information regarding the factors which influence the target population to practice risk behavior and to move from one stage to the next.

A list of questions to consider asking during a key participant interview is included in [Appendix D4](#). These and other questions can be asked of a target population member in a key participant interview. Try to interview at least eight to 12 key participants from each target population or subpopulation.

One way to do these interviews is to tape record and transcribe the interview so that the interviewer can concentrate his or her attention on the person, not on writing down responses. This also ensures that the richness of the information will not be lost. However, not all agencies have the resources to have tapes transcribed. Taping and then reviewing the tapes for the summarizing process can be done. If tape recording is not possible, and in some cases these interviews will be done on the street where tape recording is impractical, careful notes can be taken and then reviewed immediately after the interview for additions and corrections.

Again, these interviews are very important, so take the time and effort to do them well.

Key participant interviews are a good opportunity to identify the target population's predominant stage of change. They can be done with a short series of questions about a target risk behavior. For example, if through your CID process activities you are learning that the target population may be engaging in unprotected anal sex with paying partner, you can measure the population's stage of change on that behavior by asking:

- 1) How often would you say you use condoms when you have sex with paying partners?
- 2) Depending on the response, you would ask a follow up question about how likely it is that they will begin using condoms or, if they do use, for how long have they been using.

At the end of Module 5, Evaluation, you will find a staging instrument that illustrates the above example in further detail and can help you in identifying stage of change for a particular target behavior. You can substitute any target risk reduction behavior into the instrument and modify the questions accordingly.

Focus Groups

Focus groups are group interviews where a moderator raises topics while a small group of interviewees discusses them in comfortable terms. Ideally, focus groups are composed of six to 10 individuals who come from similar backgrounds. One or two well-trained and experienced moderators work from a predetermined set of discussion topics. The essential data will be what the participants in the group say during their discussions. The interview is usually recorded on audio and/or video, and note-takers may be assigned to record observations.

Focus groups are extremely important because they create lines of communication among the participants. Just as important, however, are the lines of communication that connect the project

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team with the participants. Therefore, the focus group itself is actually the second step in a three-part process of gathering information. First, the project team determines what it needs to learn from the participants. Second, the moderator creates a topical conversation among the participants. Third, the moderator and members of the team summarize what they have learned from the participants. If you do not have staff in-house with focus group expertise, you should seek external resources.

In Community PROMISE, focus groups are used in the CID stage and again during the pre-test of the developing role-model stories. Module 3 on Role Model Stories will discuss this further.

There are four basic steps for designing a successful focus group. A checklist to help prepare the day of the focus group is included in Appendix D5.

1. *Planning*

- a. Determine what information is needed with a clear, specific list of objectives.
- b. Determine how to divide groups. Sometimes it may be appropriate to divide participants of different genders, racial/ethnic backgrounds, and educational levels into separate groups.
- c. Determine how many focus groups you want to conduct. As a general rule, conduct at least two to three group interviews with each population segment. Never have only one group per target population or subpopulation.
- d. If the target group is spread out over a wide area, consider conducting focus groups in multiple locations.
- e. Determine the duration of the focus group. 1 ½ to 2 ½ hours is usual.
- f. Determine how many moderators will be necessary given the number of groups you will be conducting. Also, moderators should have similar backgrounds to the population being interviewed. At the very least, they should be comfortable interacting with them.
- g. Prepare a realistic time line. For example, if you have not recruited for a focus group before, or if you are relying on other organizations to assist in recruiting, allow yourself at least three weeks for the recruiting phase.
- h. Budget appropriately. Approximate costs for each focus group (these vary from locality to locality):
 - Honorarium to organizations or individuals assisting in recruiting: \$100–500
 - Transportation for recruiters: \$0.31–0.37 per mile
 - Focus group facility rental fee: \$350–400
 - Audio-visual equipment and tapes: \$100
 - Food for focus group participants: \$100
 - Incentives for focus group participants: \$15–35 per person (teens can often be recruited for \$5; physicians typically require an incentive of \$100).
 - Transportation for group participants: \$5–30 per person
 - Transcriber: \$100

These costs are estimates. Depending on your agency's resources and the

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situation of your target population and your agency's facilities and other resources, focus groups may be conducted for much less.

2. *Recruiting*

- a. Develop eligibility and exclusion criteria for individual participants.
- b. Develop the screening specifications, including how many participants to screen and invite to the groups and the demographics of each group.
- c. Develop a screening questionnaire for help in determining which individuals meet the eligibility criteria.
- d. Develop a one-page flyer explaining the project and promoting participation.
- e. Determine a recruitment strategy. Will you rely on the program staff's own networks? Will the program staff get assistance from outside referrals but do all the screening themselves? Will program staff delegate some screening to outside referral sources, such as volunteers or another agency (not recommended; try to avoid if you can)?
- f. Once the strategy has been determined, complete the recruitment plan.
 - Identify where and when to contact the target population.
 - If appropriate, identify outside referral sources for possible assistance.
 - If the referral source needs permission to assist you, identify permission givers and specify who will approach them.
 - Allow at least three weeks for recruiting.
 - Be aware that posters, leaflets, and announcements are likely to be insufficient for recruiting focus group participants. People who respond to them may be unqualified for the group in some fashion, may develop fake qualifications to make themselves seem eligible for the incentive, or may have a personal characteristic that you would have screened out had you interviewed them in advance.
 - Contact prospective participants who have responded to the posters and announcements individually. They should be screened and invited to participate once it appears they meet the qualifications (for instance, sufficiently verbal but not uncontrollably verbose, willing to discuss intimate topics, etc).
 - Once an eligible individual agrees to participate, a confirmation letter should be sent (if possible and appropriate) and reminder calls can be made.

While recruiting, you should obtain periodically reports of how recruiting is going so problems can be quickly identified and solved. One problem you will face is participants failing to show up to the focus group. Over-recruiting will minimize this. If you are looking for eight people in each group, it is wise to recruit 15 to 16. Anticipate barriers to attendance and ways to overcome those barriers such as providing childcare or transportation. If more than the needed number of people present for the group, thank those who arrive last, pay them the incentive for coming, and invite them to attend a future group, if appropriate.

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3. *Moderating.* Included in Appendices D6 and D7 is an outline to assist the moderator in preparing for the focus group discussion and sample focus group questions.
 - a. Listen carefully and use active listening techniques. Be interested in the participants and show positive regard.
 - b. Be a moderator, not a participant. Do not express your own opinions.
 - c. Control your reactions and never evaluate responses, not even in facial expression or body language.
 - d. Use words to reward thoughtful, relevant responses.
 - e. Encourage group cohesion and interaction in the first 15-20 minutes of the group:
 - (i) pose provocative questions that ask for people’s opinions
 - (ii) pose questions to the group, not individuals
 - (iii) use silence to signal that group interaction is wanted
 - (iv) avoid eye contact with participants who persist in interacting with the moderator in a one-on-one fashion
 - (v) get nonparticipating group members to speak through the use of eye contact or by calling on them directly
 - f. Discourage individuals from interrupting each other by saying, “Let’s let ___ finish.”
 - g. Discourage side conversations.
 - h. Watch time carefully. Constantly monitor the discussion for relevance.
 - i. Be flexible. If one question doesn’t work, try another.
 - j. Probe for both clarification and motivation; probing should be simple and specific.
 - k. Ask for feelings directly if you want to discuss them. Participants may be reluctant to offer their feelings without being asked.
 - l. Intervene as gently and as infrequently as possible as a general rule.
 - m. Never answer substantive questions or play the role of the expert. If the discussion depends on a minimum level of participant knowledge, introduce the information through written materials.
Avoid taking notes.

4. *Analysis.* As shown in the analysis continuum below, the data from the focus group are analyzed to obtain the information needed to develop the program. Probably the least manageable report of the focus group is the one that contains only raw data. A report with only raw data consists of transcripts that present the exact statements of focus group participants as they responded to specific questions or topics. This may be useful for knowing the exact words of the participants, but informing program development will require further analysis of the data.



The Analysis Continuum

Raw Data → Description → Interpretation → Recommendations

Next on the analysis continuum is description, which provides summary statements of the participants' comments. When using this type of analysis, a brief description of the theme of the responses is provided, followed by verbatim quotes that illustrate the theme. The quotes selected are determined by the purpose of the report. If the purpose of the report is to describe the range and diversity of comments, then examples will be selected accordingly. Other times, the purpose may be to provide insight into the typical or common response, in which case typical or common quotes will be selected. While the presentation of raw data usually entails reporting all responses, the descriptive analysis simplifies the reader's task by presenting themes and providing examples of quotes.

Interpretation is a more complex form of analysis. It builds on the descriptive analysis, and then suggests what the findings mean. While the descriptive analysis results in a summary, interpretation aims to provide understanding of the findings. To interpret focus group findings, the reader is required to consider the frequency (how often was it said), extent (how many people said it), intensity (how strong was the opinion), and meaning of the comments made by participants.

Recommendations are made after the interpretations. Recommendations place greater emphasis on obtaining multiple perspectives of the raw data as well as generating ideas regarding future courses of action. Depending on the information provided by the focus group participants, recommendations might be made regarding the topic area—for example, where and how should recruitment of the target population take place, or what beliefs about HIV risk-reduction should be addressed in the intervention?

Ongoing CID

CID does not end when the intervention begins. The process of interviewing key participants, gatekeepers, and interactors needs to continue throughout the intervention to keep current the information on access points, new social networks, language, risk behaviors, and movement in the community's stage of change. The last of these is especially important since it is the key input into each round of role model story development. If the majority of the community starts in the contemplative stage you will be developing stories that show a movement to preparation. As the community moves to preparation, the stories need to switch to show a movement to action. It is the CID efforts that provide this warning. CID can also assist in some of the process evaluation efforts, particularly whether or not the community members are reading the materials. As noted in the role

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model story section, individual interviews with Advisory Group members or others or focus groups with community members will provide input into the format of the story publications.

Community Mobilization

Now that you've completed the initial snapshot of the community, it is important to strategically consider the role of the community in the implementation of your intervention.

The primary purposes of community mobilization or participation are to facilitate positive response to media modeling campaign, create opportunities for community involvement, create project identity, encourage community ownership and use the power of the community to initiate and maintain behavior change.

Community mobilization requires the establishment of a network for interpersonal communication, for the distribution of media packages and for distribution of facilitating materials such as condoms. This network then can grow to include other community members who are key observers, advisory group members, contributors of resources to community events, etc. Growing out of the network, usually in a secondary phase of the campaign, community participation may also be organized to support environmental or regulatory change, i.e., increasing social or drug treatment services, improving law enforcement practices, establishing needle exchange, broadening condom distribution, etc.

Theory-based rationale for mobilization

The conceptual rationale for the mobilization of the community network is drawn from Social Learning Theory (Bandera, 1986) and from theories of mass communication and the diffusion of innovations (Rogers, 1983). In the approach employed here, the main functions of interpersonal communication are the expression of social reinforcement, cues and prompt to observe and imitate modeling information from the media campaign, and, appropriate distribution of the condoms, bleach, treatment vouchers and other materials.

Community mobilization aims to:

- ~facilitate positive response to media modeling campaign,
- ~create opportunities for community involvement,
- ~create project identity,
- ~encourage community ownership, and,
- ~use the power of the community to initiate and maintain behavior change.

The network members or "change agents" may also provide direct modeling of risk-reducing behaviors. The recruitment and deployment of indigenous "change agents" has been demonstrated in political organization, agricultural and other economic innovation and in numerous programs to promote preventive medical care (Rogers, 1983; Puska, et al., 1987). For involving community members in

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environmental change, there are well-developed models for goal-setting and empowerment through political and economic processes (Bracht, 1990; Olson, 1965).

Community Advisors

When implementing a new program, it is imperative that community members be involved in planning the proposed activities. Through the CID process you will have identified key community members, especially those who are known as experts in issues related to health. These individuals can serve as community advisors and their buy-in to your program can facilitate the community's acceptance of the program. By involving the community advisors early and telling them about your program in advance, they will be much more likely to support it when it becomes public. Their support can in turn facilitate the community's acceptance of and participation in the program. In addition, the community advisors can provide you with important guidance and insight. Ways to involve them might include asking them to help set priorities and to identify related health concerns. Through their participation, community advisors may become committed to the program and can be helpful in unleashing the voluntary energy that is to be tapped through the interpersonal network that will be organized.

These advisors are also sources of ideas about how to improve implementation and more effectively reach the desired groups, and they may be invited to focus groups and involved in pre-testing of materials. Community advisors can be a source of resources such as staff, space and incentives for program participation. They may also be the first program participants, i.e., by providing a role model story or becoming a member of the volunteer network.

When interviewing or meeting with community advisors, notes should be taken and a record should be made of the advisors' formal statements of support for the project and their priorities for STD/HIV prevention, with their expressed permission in advance. Community advisors may make suggestions about peer advocates or suggest people for role models. Related health and social priorities should also be discussed and ideas, suggestions and possible resources provided noted. Recommended contacts should be recorded.

You may consider organizing community advisors into an Advisory Group. The Advisory Group can serve as a resource for tailoring the effort to the local situation, eliciting participation and engendering a sense of ownership. An Advisory Group can assist coordination with and between existing programs. More importantly such a group can provide ongoing advice, linkages to community members, insight into community actions and reactions, as well as becoming the "voice" of the community when seeking resources for program activities. This group does not necessarily constitute a ruling body and formal group meetings may not be necessary.

Advisory Group notes should be taken during each interview or discussion with members. A record should be made of the Advisors' formal statements of support for the project and their priorities for HIV prevention, with their expressed permission in advance. Advisory Group members may make suggestions about peer advocates or suggest people for role models. Related health and social priorities should also be discussed and ideas, suggestions and possible resources provided noted.

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Recommended contacts should be recorded. An example of a form for Advisory Group records is given in [Appendix D8](#).

Peer Advocates and Role Models

All the people who participate in PROMISE are part of the community mobilization effort. They each become representatives of the project, carriers of the behavior change message, and forces for change in community norms. As such they are important players, whose contributions are invaluable. Part of the mobilization is to recognize those contributions and demonstrate to the community that each person who participates in whatever way is valued and appreciated. Recognition events that are described more fully in the peer advocate section can provide this recognition as can small tokens of appreciation, public acknowledgement, and simply the opportunity to work with the paid staff on the project. The peer advocates distribute role model stories and materials as well as reinforcing behavior change. The role models provide the real life examples of the behavior change. Both are key to Community PROMISE and the mobilization effort to change community norms and behaviors.

Community Events

Community events are an important community mobilization tool that serve multiple purposes: they recruit people to become involved in the project as peer advocates, role models, business advocates or providers of incentives; they build visibility of the project and create a feeling of community ownership; provide recognition of peer advocates; and encourage the creation of informal networks that can lead to advocacy groups.

Advocacy and environmental change

Depending upon the particular program community and its local circumstances, there are various possible objectives for advocacy and environmental or regulatory change. From a theoretical perspective, environmental changes may either motivate, as when new rewards or incentives are provided, or facilitate, as when barriers are removed. For example, some community clinics provide small gifts or financial assistance to women who accept prenatal care. This concept may include any effort to reduce the cost of an important health or social service, as well as any facilitative action to increase access to services, e.g., a mobile health screening unit. Other examples are needle-exchange programs and wider distribution of condoms, e.g., through schools.

Approaches to Social Change

Strategies for social change have been reviewed in detail in several sources (e.g., Bracht, 1990; Rice and Paisley, 1981; Olson, 1965).



Four primary approaches may be considered:

1. Direct advocacy and "lobbying" of decision-makers, i.e., going to people with the power to make the change and asking them to do it. This may involve the enlistment of sympathetic mutual acquaintances, family members, etc.
2. Marshalling public opinion to put pressure on decision-makers, e.g., organizing a demonstration to stress the need for new services or policies. Tactics of "media advocacy" (Atkin and Wallack, 1990) include any kind of publicity stunt that engenders sympathy and interest among persons important to the decision-makers.
3. Political activism which uses electoral processes to influence government agencies and legislative representatives,
4. Economic actions which put financial pressure on individuals and institutions. This includes boycotts, strikes, etc., as well as positive actions such as charitable donations.

Based on specific needs and capabilities, community participants may involve one or more of these strategies of action. In any case, the critical task in empowerment is the establishment of a sense of individual and collective self-efficacy (Zimmerman and Rappaport, 1988). A general recommendation is to start "small," with clearly winnable goals. Rather than immediately tackling an objective that might require adversarial relations, participants may identify a useful community service such as neighborhood cleanup. This type of initial activity can provide a success experience and serve to emphasize community spirit and local pride as a starting point for social change.

Participation in the access network has a similar function; providing a "doable" first step toward more ambitious long-term goals. Topics of leadership development and creation of indigenous community organization are beyond the scope of this guide. Complete presentations of those topics are available in other sources (Reiff and Reissman, 1965; Meyer, et al., 1980). It must be noted that health departments are themselves local agencies, and organizational rules or political considerations may limit formal staff involvement in controversial issues.

Summary

The CID process is a critical element in preparing to conduct a community level intervention such as Community PROMISE. This module discussed the key steps and issues regarding this process, which provides an understanding of the practices that put the population at risk, the meaning of those practices to population members, and the context in which the risk behavior occurs. Also addressed was the importance of mobilizing community participation in and support for Community PROMISE. The next module introduces role model stories and discusses how to conduct interviews and develop stories from those interviews that contain key content components.



MODULE 3: Role Model Stories

What are role model stories?

A role model story is a brief publication that depicts the actual or planned behavior change of a specific target population member or “role model”. The story delivers a risk reduction message, based upon the experiences of target population members in their efforts to reduce their risk behaviors. Since members of the target population provide the content of the stories through interviews, the stories product is relevant and sensitive to the language and cultural nuances of the target population. The stories are distributed and reinforced by peers from the target population who have been recruited and trained for that purpose. These peer advocates, described in Module 3, are the messengers or the risk reduction messages in the stories.

Role model stories are effective HIV prevention tools in that they model a risk-reducing behavior, suggest alternatives to risky situations, and, illustrate positive outcomes of taking steps towards self-protection.

Role model stories have three goals:

1. To show how a role model moved from one stage of change with a specific HIV prevention behavior to the next stage (movement of only one stage) and the obstacles overcome throughout that process of change
2. To be genuine, acceptable, interesting, and to capture the reality of the population member whose life is depicted
3. To motivate movement toward the desired behavioral goal (for example, condom use)

The stories are community-tailored and designed to:

- model the risk-reducing behavior of a specific target population
- describe the positive consequences of making a particular behavior change
- communicate a message with which the target population can identify
- make use of the target population’s own expressions and phrasing
- be at the literary level of the target population
- portray real situations with which the people can identify

Role model stories can be produced as flyers, brochures, handouts, comic strips, novellas or other media such as videos or audio tapes. They can range from simple black and white flyers to glossy, colored products. The format and style of the stories will depend on your agency’s resources and what is appropriate for your target population, as identified during the CID process.

Role model stories & your program

There are a few ways you can use role model stories in your program, depending on the resources of your agency and what you learn in the CID process. As with the CID process, what differentiates “best” from “better” and “better” from “good” role model stories is the breadth and



depth of both the effort required and the information obtained, not simply the use of different strategies.

Good—Use a generic role model story that has no local references.

- Some role model stories have already been developed for different populations. They are available from:

The California AIDS Clearinghouse
1443 N. Martel Ave.
Los Angeles, CA 90046
(888) 611-4CAC
www.hivinfo.org

Better—Use a generic role model story that has local references or “flavor” added.

- A better option is to take the role model stories obtained from the AIDS Clearinghouse or other sources and add local references, landmarks, or other aspects to the story that would give it a local flavor. For example, substitute the word “bar” with the name of a local bar; however, the story may still lack the uniqueness of the target population in your area. Remember, the final decision regarding whether to add local references will depend upon what you learn from pre-testing your materials. If during the pre-test you learn that local references are not acceptable (e.g., bar owner protests the use of the bar name in the story), then you may need to create other ways to add local flavor to the story— for example, using a popular local phrase to describe something in the story.

Best—Develop your own role model story with local references or flavor using real people from your target population.

- Developing your own role model story will ensure that your program is most relevant and sensitive to the population you target.
- This Module will discuss the seven steps in the development of a role model story, which are:

1. Specify a target population and behavior
2. Recruit and screen a role model
3. Interview the role model
4. Transcribe the interview
5. Write the story
6. Pre-testing and editing
7. Produce role model publication



Below are two examples of role model stories:

Finding the Right One!

Hey guys! My name's Andre. I'm 21 and I've been out since I was 16. I moved to Denver about seven months ago. I love the party scene here. Lots of cool clubs and hot guys! You can usually find me at the Compound or the Wave.

I seem to meet a lot of guys and it's pretty easy for me to get laid. Sometimes if I meet a guy at a club and we've been partying, it's harder for me to use condoms. Especially if I'm on top. I always have trouble keeping it hard. But I recently met this guy from the Health Project and we started talking. I told him about this and he gave me some suggestions like using lube on the inside of the condom. He also gave me some condoms that have more room at the top. He said this helped increase the feeling. You know what? He was right. I got the chance to try them a couple months ago and I kept it hard the whole time. I also kept the condom on the whole time. It felt so good to have great sex and still feel protected! These condoms are it! **I guess it's just a matter of finding the right one!**

I still have a couple of these condoms. In fact I'm going to get some more of them. I know that they will protect me from getting infected with HIV so why risk it?

Tricks for my Tricks

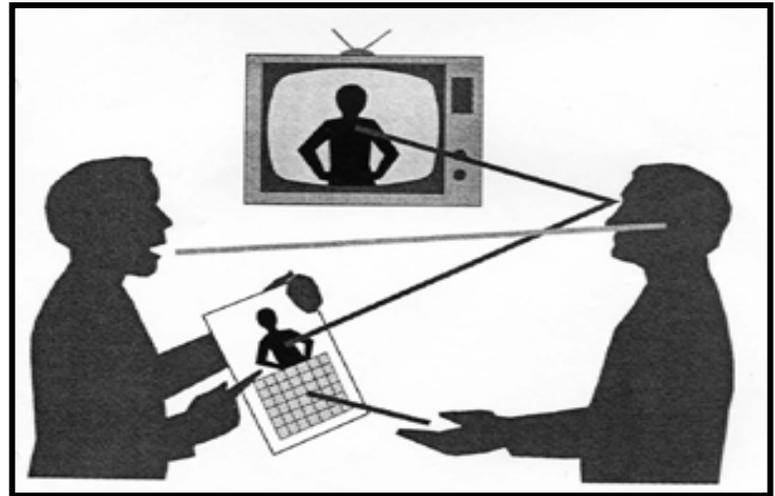
I've been hanging out around 11th and Anaheim turning tricks for a living. I got into the scene a couple years ago and have been making a steady living since – a lot more money than I made waiting tables. My name's Shauna, but my johns know me as Sugar. That's because I'm known for being hot and sweet! I know I should use condoms with all of my guys if they're gonna screw me, but I make so much more cash if I don't. My girlfriend is really concerned that I'm going to catch something so she has been showing me ways to make condoms sexier. She says that with the right technique and the right condom all of her men are more than satisfied. She uses them all the time and still rakes in the dough. I know I could do that! **I've learned some knew tricks for my next trick!**



Before discussing how you can develop your own role model story, let's review how theory plays a role in the stories

The diagram below illustrates the concepts from Social Cognitive Theory that are being used in the role model story process and other parts of Community PROMISE. The role model story is handed to a member of the target population and he/she also discusses it with the peer advocate. He/she is then able to take the story away, re-read it and think about it, share it with others, and use it to model his/her own behavior in an attempt to overcome the same or similar barriers in the same way as the role model. The next module will discuss the peer advocate's part in this process, which includes drawing attention to and reinforce the risk reduction message of the story, and providing the reinforcement for positive behavior change.

The television in this diagram represents the mass or large media (radio, television, newspapers) that you can also use to provide further reinforcement for imitation of the role models. Depending on your community and target population you can write role model stories that can be put on the radio or in the newspaper. If the audiences for those media are too broad for your intervention, you can produce posters or small neighborhood billboards that highlight the headline of your story and draw people's attention to it.



Then your outreach staff, peer advocates, and business advocates can ask people, “Have you seen the poster about Art and Sandra? Well, I have the full story to share with you.” Such repeated exposure to some elements of the story also serves to reinforce the message – a person who has received the story will see the poster and remember what the story said. This may be just enough to remind him/her about the new plan he/she wants to try the next time. So, all these pieces work together to form the intervention.

Developing your own role model story

In order to develop your own role model story, there are a series of seven steps you should follow. These steps are listed and then further described below.

1. Specify a target population and behavior
2. Recruit and screen a role model
3. Interview the role model
4. Transcribe the interview
5. Write the story
6. Pre-testing and editing
7. Produce role model publication



Step 1: Gather Information

To gather information for your own stories, you will have to do the following:

Specify population & behavior. To be credible, role model stories must contain elements of racial, cultural, and socioeconomic experiences common to individuals in the target population. For this reason, it is very important to elicit stories from actual members of the specific targeted population in geographical areas in which the stories will be distributed. For instance, if Community PROMISE is targeting young Latino men who have sex with men, then the story should come from a young Latino man who has sex with men.

Also, each role model story should target only one behavior. If you want to increase condom use, the story should only be about condom use, not condom use and reducing the number of sexual partners.

Once you have specified your population and target behavior, the next characteristics to identify are the gender, ethnicity, and age range of the individual needed for the role model story.

Recruit a role model. Good role models do not have to practice the target behavior perfectly. A good role model is someone from the target population who has made a positive change regarding the specific behavior to be modeled. Role models are not just the individuals who use condoms 100% of the time, but also those who have only started using condoms, or who have used them with one partner or one type of partner.

An outreach worker can recruit the role model by using his or her established, trusting contacts in the community. Your first role models may come from your contacts made in the CID process. Often, an outreach worker who is experienced with the target population knows the extent to which some members of that population have had success with behavior change. Outreach workers should screen potential role models to make sure the individuals are part of the target population. The outreach worker can question a potential role model either directly (“Do you shoot up?”) or indirectly (“Do you need information regarding needle exchange programs?”) Good rapport and a trusting relationship between the outreach worker and potential role model will help to ensure that the role model will be willing to speak openly to the person conducting the interview

Screen the potential role model. Because the outreach worker and the role model have established a relationship, the role model may not want to disappoint or shock the outreach worker; therefore, he or she may be less truthful about the story. Likewise, the role model may want to impress or “show good” for the outreach worker. To minimize the possibility of the role model altering his or her story, someone other than the outreach worker can conduct the role model’s interview. This person could be the program coordinator or other project staff person.



However, if your agency has limited staff resources, you may use an outreach worker for the interview.

Prior to the final selection, the interviewer should personally screen the potential role models, judging whether the individuals can provide worthwhile material for the stories. Although a potential role model may fit the desired description, there are also other factors that must be examined. During the screening, the interviewer should keep the following concerns in mind:

- Does the role model's experience fit with the target goals of the role model story (e.g., appropriate stage of change of the targeted behavior)?
- Does the role model practice (or to what degree is there an intention to practice) risk-reducing behaviors in order to prevent the spread of STD/HIV rather than for another reason, such as to prevent pregnancy?
- Is the role model able to recall specific details about past and present risk and goal behaviors, and can those experiences be described?
- Is the role model willing to share detailed personal experiences about relevant, intimate aspects of his or her life, including sex- and drug-related behaviors?
- Does the role model understand how the information will be used and that the interview will be recorded, either by tape recorder or notes?
- Does the role model agree to give the time needed for the interview?

Your agency can decide whether or not to pay role models. The advantages include showing appreciation and value for the role models information and increasing their cooperation and eagerness to participate. However, the disadvantages include that this will cost your agency additional money and your agency might have a policy to giving cash. An alternative is to provide non-monetary incentives such as movie coupons, food coupons, T-shirts, water bottles. etc.

Interview the role model. The video on "Conducting a Role model Story Interview" contained in your Community PROMISE package gives you detailed instructions about how to conduct a role model story interview. Please review the video before conducting any interviews. The video demonstrates the technique of a structured interview that is tape recorded. Some demonstration sites conducted less structured interviews in their storefront locations or even on the street. The objectives of the interview are to capture the elements needed for the story and to record the person's own words that describe the experience and the circumstances surrounding the behavior change.

Remember, the role model story is the core of this intervention, and the interview is critical to develop an effective, quality story.



Where to conduct the interview

Ideally, the interview should be conducted in a private room. However, other settings may be used if a private space is not available. Public or “field-based” locations that offer some privacy are options. The key is to provide a safe environment with minimal distraction, where the interviewee feels comfortable disclosing personal information.

How to conduct the interview

There are different methods for capturing the interview, depending on resources and what is appropriate and comfortable for the interviewee. To assure accuracy and to allow the interviewers to best focus on the interview, a tape recorder can be used. Taping and transcribing the interview will provide the writer of the role model story with exact words and expressions, which is especially helpful in writing the stories. The recording will also allow the interviewer to review the interview repeatedly and at a comfortable pace.

If a tape recorder is not available or appropriate, the interviewer can take notes during the interview. The interviewer might conduct the interview without any tools, and later record the interview from memory. This option is least ideal, since the interviewer may not recall the interview completely or correctly.

Consent

In all methods of interviewing, consent should be received from the interviewee. If a signed consent form is not currently a requirement of your agency, it is a good idea to develop one. A sample can be found in [Appendix E1](#). Review the consent form verbally with the potential role model before you begin the actual interview. The role model should sign the form before the interview and be given a copy to keep. Also, remember to record the role model's name and any nicknames he or she may have when you conduct the interview. By also recording the nicknames, you avoid accidentally using any of these names in any of the stories that comes from the interview, assuming the person does not want you to use their real name or nickname. If they want to remain anonymous in the story, the real name and any nicknames are kept confidential.

The role model should also be shown a copy of the publication in which the story will appear. This ensures full understanding of how the information will be used, and it also prevents misunderstandings after the story is published. This also allows the role model to feel comfortable and know that nothing in the story will reveal his or her true identify unless he/she has given permission. You should also obtain consent for any photography of role models or others, to be used in role model story publications. A sample consent form for photography is in [Appendix E2](#).

Interview delivery

During the interview with the role model, questions should be posed clearly and concisely using simple words and phrases. A role model interview guide can be



found in [Appendix E3](#). The interview questions should be designed to elicit responses that will make up the elements of a role model story (discussed in “Step 2”).

There are four parts to the role model story interview:

1. Background Information,
2. Planning and Starting Behavior Change,
3. Taking Action, and,
4. Effectiveness and Social Support.

When asking questions, it is important that the interviewer not lead the role model in a certain direction by communicating his or her own ideas. See the interview tip below for an example. Ask open-ended questions that allow the role model to tell his or her own story, and try to obtain as much relevant detail as possible.

The interviewer must not attempt to counsel the role model or provide feedback during the interview. After the interview is completed, the interviewer should correct any misinformation the role model gives, furnish information about STDs, HIV and AIDS, and provide referrals if needed. Again, it's the interviewer's responsibility to address practices that may place the role model at risk for STD/HIV infection.

Interview Tip

An interviewer could influence a role model's response by asking, for instance, “How often do you use condoms?” before asking whether condoms are used at all. This assumes that the role model does use condoms and clearly tells the role model what the expected answer should be. While it may be the behavior you wish to model, the information should emerge because the role model has experienced it, not because the interviewer is priming him or her for it.

Often, a single interview can yield enough information for several role model stories. It may be possible to create a series of stories that follows one individual through his or her own behavior change process. This series may chronicle the individual's initial reluctance to change, his or her development of a commitment to change, the first attempts at change, and eventual consistent adoption of the risk-reduction behavior.

Step 2: Write the Role model Story

There are eight key content components, which must appear in the role model story. They can appear in any order.

- 1) Characterization
- 2) Membership in target population
- 3) Risk behavior
- 4) Goal



- 5) Stage of change
- 6) Influencing factors
- 7) Barriers to change and methods to overcome them
- 8) Positive outcome

Component 1: Characterization is a short description about the role model and the circumstances of his or her life. It ranges from one or two sentences to not more than a short paragraph. The characterization makes the role model real, adds credibility to his or her experience, and brings the story to life.

Sample: Characterizations

Sherry has been on the streets since she had her last baby. The baby was taken away from her because she was high on crack when he was born. She’s been living mostly in her sister’s garage, and she smokes as much crack as she can afford to.

“I’m a people person. I try my best to satisfy. Mainly I deal with street people. People who are into narcotics.”

“To be honest, during the course of my day I do anything it takes to get money, and most of my money is spent on drugs.”

Component 2: Membership in target population. Often, the characterization of the role model’s life situation will identify clearly his or her membership in the target population as it does in the example above. If it does not, that membership should be made explicit early in the story since it helps the reader identify with the role model.

Sample: Target Population Membership

“I’m Felicia. I wouldn’t really say I’m a prostitute. But I do depend on prostitution a lot to get my money.”

“I’ve been living here in Long Beach for six years. I came here when my folks kicked me out when I was 14 because they found out I was gay. Since then, I’ve been hangin’ out here and there...”

Component 3: Risk behavior. Many individuals have more than one risk behavior. It is important that the risk behavior central to the story is clear to the reader. The context in which the behavior occurs should also be included. If the target behavior is condom use, an important factor in identifying the context is recognizing the type of



sexual partner. An example of this would be: “I sell my body to guys on their way to work each morning, and I hardly ever asked them to use a rubber until...”

Component 4: Goal. Each story should contain only one goal. Since a single risk behavior could have a number of different goals, it is important that the only one goal be selected and included in the story. That goal must also be precise. For example, while “reducing HIV risk” is not a precise goal, “not sharing injection equipment,” or “using a condom during anal sex with a main partner” are more precise goals. Using a condom is not a very precise enough goal. The reasons why people use condoms vary by the type of partner and the type of sex they are having. The stage a person may be in for condom use also varies by these same circumstances. So it is important to be specific as to partner type (main, casual, sex trading) and type of sex (vaginal, oral, anal).

Below are many examples of behavioral goals related to the prevention of HIV that you may wish to use. (Remember, only one per story).

<u>Examples of Behavior Change Goals</u>	
<i>Categories:</i>	<i>Specific Behavior Change Goals:</i>
Abstinence, monogamy	Not having penetrative sex Delaying the onset of sexual activity Having sex with only one partner who is similarly committed to having sex only with you
Oral sex	Using condoms for oral sex with main partner Using condoms for oral sex with regular but non-main partners (including paying partners, “just for sex” partners, etc.) Using condoms for oral sex with casual partners
Vaginal sex	Using condoms for vaginal sex with main partner Using condoms for vaginal sex with regular but non-main partners Using condoms for vaginal sex with casual partners
Anal sex	Using condoms for anal sex with main partner Using condoms for anal sex with regular but non-main partners (including paying partners, “just for sex” partners, etc.) Using condoms for anal sex with casual partners
Substance use	Not having sex when drunk or high Not getting drunk or high when intending to have sex Not sharing any part of one’s injection equipment Using new, sterile injection equipment each time Using needle exchange Substituting another method of drug administration for injecting Seeking treatment for substance abuse
Related behaviors	Getting tested for HIV, and receiving counseling if appropriate Obtaining information on early intervention if HIV-positive and linkages to care Seeking counseling if depressed or out-of-control Disclosure of HIV status

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The goal featured in the story should also reflect movement from one behavior change stage to the next, as discussed below. In CID, the stage of change that predominates in the target community will have been identified for each specific behavior. Consequently, the role model story can be written to describe an appropriate and achievable goal that is relevant for many members of the target population. The story should be written to show a movement from the community predominant stage to the next stage. For example: from contemplation to preparation. Ultimately, the story will facilitate the target population's movement towards consistent adoption of the desired behavioral goal.

It is important to note that not every individual in the target population is at the same stage of change. Most of your role model stories will reflect the behavior change stage of the majority of the target population. If resources allow, a range of stories should be produced to reflect the varying readiness of other target population members to adopt risk-reducing practices.

For example, if most sex workers in a community are in the contemplation stage in their condom use with main partners, the majority of the stories should be written about how role models moved from the contemplation to the preparation stages. This encourages readers to move in the direction of adopting condom use. In this case, the majority of the stories should not focus on the maintenance stage because that stage is too far along the continuum and represents an unrealistic immediate goal for most individuals.

Component 5: Stage of change. The story should also illustrate movement from one stage of behavior change to another. There should be movement only from one stage to the next stage. The story should not illustrate movement of more than one stage. For example, the story should not show someone moving from pre-contemplation (thinking about whether the behavior should be changed) to action (practicing the new behavior). There are only three shifts (from one stage to the next) that you can show in a role model story:

- Pre-contemplation to Contemplation
- Contemplation to Preparation
- Preparation to Action

The last shift possible in the Stages of Change model, Action to Maintenance, does not make good stories because the only difference between these two stages is the passage of time.

The reality of relapse should be addressed if relevant to the story. Relapse can occur at any stage and can be a move back one or several stages.



The work you have done in the CID process will tell you what stage of behavior change the majority of the target population is in for the behavior you are addressing. The stories you begin with need to show a change from that stage to the next stage. As you continue to implement Community PROMISE, your ongoing CID process and your evaluation work will show how the target population members are changing their behavior. As this shift occurs you can switch the stage of the stories you distribute to show movement from the new stage of behavior to the next higher stage. You can also address relapse issues at any point.

Reviewing the Stages of Change Model

Pre-contemplation: the individual has no intention of adopting a Recommended protective behavior and is not even thinking of changing their current behavior.

Contemplation: the individual is thinking about choosing the new behavior but has not yet begun to perform that behavior

Preparation or Planning: the individual makes some attempt to change a current behavior accompanied by a firm intention to accomplish change in the immediate future.

Action: the individual is performing the new behavior consistently for less than six months.

Maintenance: the individual is practicing the new behavior for a period of six months or more.

Component 6: Influencing factors. Each story should describe only one or two factors that influenced the role model to change his or her behavior. As discussed in module 2, these influencing factors typically are specific beliefs or attitudes that make a person think or act differently. They have an impact on the way a person thinks or feels about HIV risk or performing a target behavior. The influencing factor is what motivates the role model to develop an intention to modify his or her risk behavior, adopt a new behavior, or continue with a practice that has already been adopted. These examples of influencing factors have been drawn from several theories of behavior change.

To review, the seven influencing behavioral factors in Community PROMISE are

1. Perceived personal risk
2. Perceived effectiveness of risk-reduction behavior (response efficacy)
3. Perceived self-efficacy
4. Belief about what people who are important to you want you to do (subjective norms)
5. Beliefs about the extent to which peers typically perform the behavior (perceived social norms)
6. Beliefs about the positive consequences of performing the behavior
7. Beliefs about decreased negative consequences of performing the behavior



Examples of Factors Influencing Behavior Change

Perceived risk	Your perception of being at risk for contracting HIV <i>“I never thought I could be at risk for HIV, but then I found out my boyfriend shared needles with someone who is HIV+.”</i>
Response efficacy	Your conviction that certain behaviors will protect you from contracting HIV <i>Counselor tells role model that condoms protect against HIV and other STDs</i>
Self-efficacy	Your confidence in being able to practice risk-reduction behavior <i>“I know I can get him to use a condom even when he doesn’t want to.”</i>
Subjective norms	Your perception of how others important to you want you to behave <i>“My boyfriend wants me to use condoms when I have sex with dates, and he’s pretty important to me.”</i>
Social norms	Your perception of what others are doing <i>“Other women I know who date also use condoms with their dates, and some use them with their boyfriends, too.”</i>
Positive consequences	Your perception that there are benefits to an action. <i>“I can actually last longer in sex when I’m using a specialty condom”</i>
Decreased negative consequences	Your perception that potential adverse outcomes can be reduced. <i>“I can reduce the chances of getting an STD if I use condoms with all my partners”</i>

Component 7: Barriers to change and methods of overcoming them. Each story should describe a specific barrier that the role model encountered when adopting the target behavior. For example, not having a condom available at the time of sex is clearly a barrier to condom use. The story should address this issue and describe the method used to overcome the barrier, such as carrying condoms or asking a date to stop by a store to buy them. Negative reactions or problems should be included, such as a partner becoming angry when asked to use a condom, but the resolution to this obstacle must also be presented (see *Component 8*.)



Personal experience: Writing role model stories

“One of the difficulties I had in writing a role model story is showing how the person had difficulties that they had to overcome. This is especially hard when you're interviewing people who have been successful. These people oftentimes gloss over the hard times they have experienced because, naturally, they want to talk about all of their successes. They may even say something like, ‘Oh, I woke up one day, and just did it.’ As a result, they can seem to go from the first stage to the last stage very quickly. They want to be perceived in a good light.”

Component 8: Positive outcome. Finally, the role model story should include the positive outcome that reinforces the adoption or the intention to adopt the desired behavior.

For example, using a condom during sex may reduce the worry of contracting HIV, or it may give the role model a better self-image. Even in situations where the goal was not achieved (such as the role model asking a partner to use a condom but the partner refusing), a positive outcome must be included (such as the role model feeling good about trying and having developed a new strategy for overcoming the barrier in the future).

Important note:

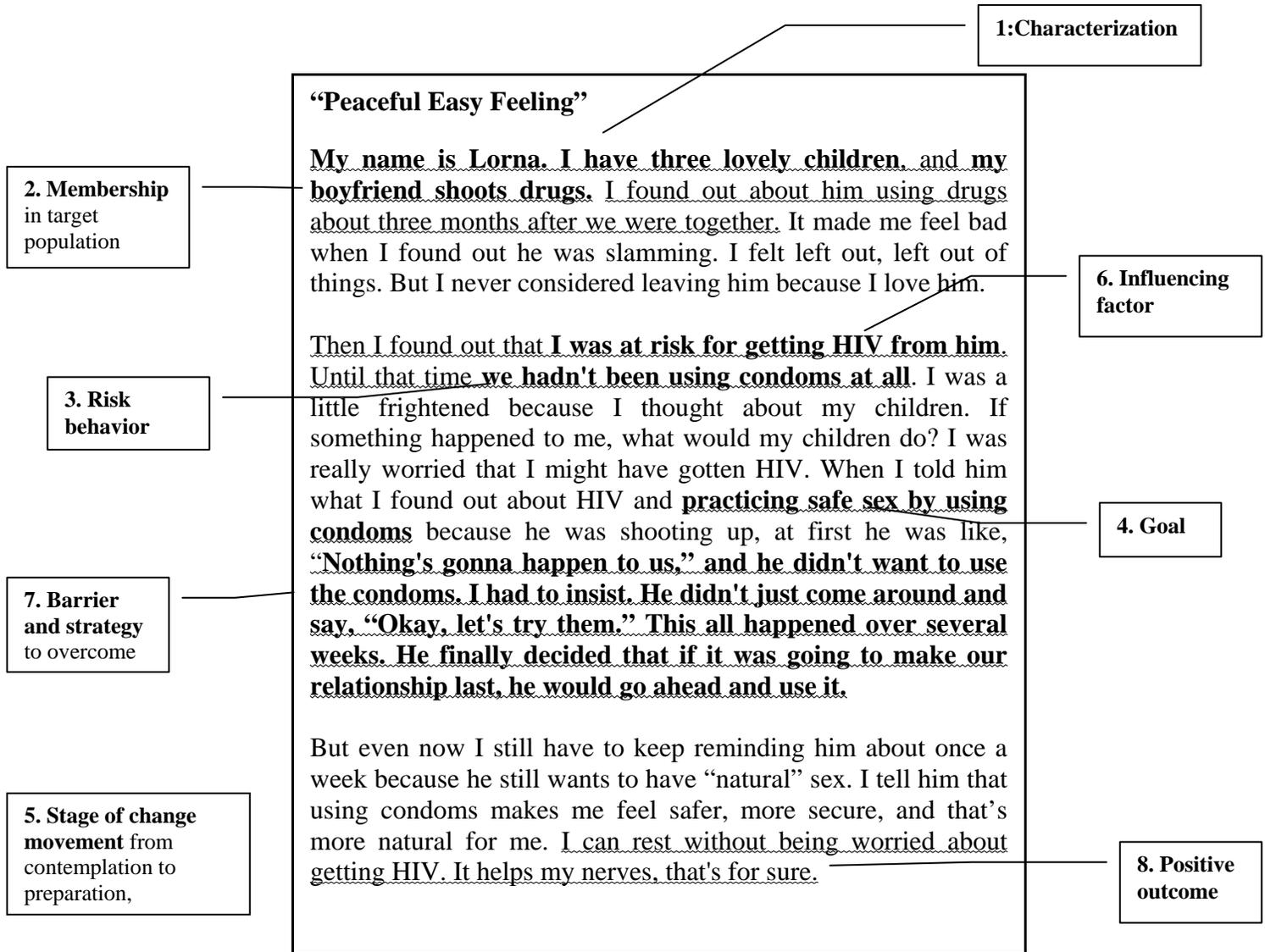
It is critical that the information about HIV and STD transmission and condom use and effectiveness provided in your role model stories be accurate. Please consult Appendix J for information on smart sexual behavior including abstinence, being faithful to a single partner and consistently using condoms, Appendix K for information on nonoxynol-9 and increased HIV risk, and Appendix L for information on the effectiveness of latex condoms in preventing transmission of HIV, hepatitis, and other sexually transmitted diseases.

Role Model Story Worksheet

In preparing the story, a worksheet may be useful. Using a worksheet can help keep the story focused and ensure it includes the necessary key content components. For this purpose, a Role model Story Content Worksheet is included in [Appendix E5](#).



Below is an example of a role model story with each key content component identified:

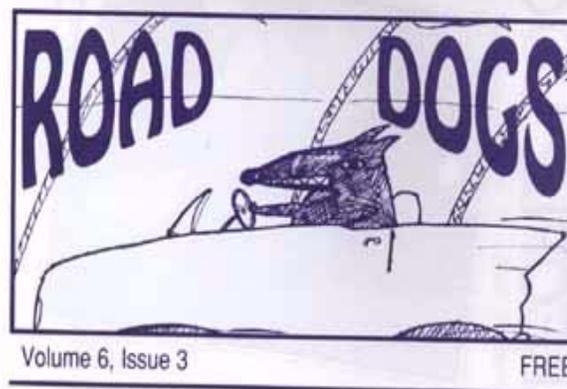


Step 3: Produce the Role model Story

As you prepare to produce the role model story, you will need to consider the following issues: size, papers and colors, artwork, program recognition, layout, editing and re-editing, printing and reproducing pre-testing and accompanying prevention materials. Your CID process results, along with your agency resources, will determine how you produce your role model story.

Format. Role model stories may be developed as short stories, photo novellas, cartoons, or newspaper articles. The publication itself may be a magazine, flyer, brochure, poster, or trading card. The story format should be selected with your target population in mind. Do they spend a lot of time reading? Would they like a pocket-sized publication, or something larger? The pre-test focus groups and interviews can address these issues. The story should be relatively brief, somewhere between one and six paragraphs.

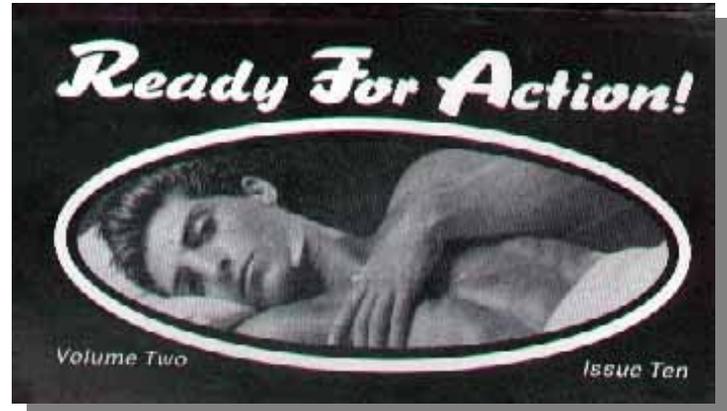
Papers & colors. Once the format of the publication is chosen, paper types and ink colors must be considered. Weight, texture, and color of stock must be selected. Glossy paper, although more visibly appealing, may not be the choice of your audience. For example, the population of injection drug users in one demonstration site preferred non-glossy paper because glossy is difficult to write on and they liked to make notes, such as recording telephone numbers, on the publications. Paper color can also help provide interest if your publication has to be photocopied. Just remember to keep a black and white original.



Artwork. Illustrations may include photographs of models or advocates from the community, drawings, cartoons, or original art pieces found in books, on the Internet or from software packages which are intended to be used for printing and reproductions. Photographic models may be offered either a small incentive or free photographs in exchange for their participation. As in interviewing role models, it is important to thoroughly explain the



context in which the photographs will be used and obtain written consent. A sample consent form for photographs is included in Appendix M. Drawings or illustrations may also be obtained from the population members or through local art classes. A small fee or a certificate of appreciation may be offered to those whose artwork is used in the publication.



Project recognition. The name of the project should be easily identifiable on the role model story materials. The repeated use of a masthead with a logo or publication name will help achieve the perception that your program is active and vital.

Building this identity will also help the target population members to recognize the program, and it will assist you in advocate recruitment and retention. Potential advocates and community members should be involved in the creation and selection of a name and logo for the program. This can be achieved through focus groups or surveys of the target population during the CID process. A contest can also be held to solicit artwork from your target audience to be used as a logo or masthead. The use of the logo on items used by staff members and advocates (t-shirts, caps, posters) will assist in creating visibility for your program.

Layout. Layout of the flyer can be done with art boards, by computer, by cutting and pasting the pieces together, or by contracting with a layout artist. Many printing companies offer layout services in addition to printing. Most, if not all, of the layout work can be done using word processing programs. It is important that the materials are readable and attractive to your audience, but they need not be overly slick or professional.

Editing and re-editing. Several other staff members should review the role model story and provide feedback about its clarity. The story should be easily understood by others. Be sure to re-edit the story if any changes are made from the initial round of feedback. This is also the time to do a reading level check. If you have typed your story in Microsoft Word you can go to Tools, Spelling and Grammar, Options and then check “Show readability statistics”. It will tell you the reading level of your text. Other software programs also have this feature.

Printing and reproducing. The manner in which you print and reproduce the stories depends on your agency’s resources. Options can range from color laser printing to black and white photocopies of the stories.

Pre-testing. Once you have developed the story, it is important to test it with target



population members or community advisors. Through focus groups or brief individual interviews with target population members and outreach staff, you will be able to: (1) gather information regarding the target population's preferences among different styles and presentation formats, (2) identify attention-getting features in messages, (3) determine how acceptable the use of local references are in your stories, and (4) get reactions about the comprehension, credibility, and perceived relevance of the role model stories as well as reactions to the publication name and sensitive issues included in the story. [Appendix E5](#) includes a script for conducting street interviews for the purpose of pre-testing materials.

In the focus groups and interviews, show the particular role model story to the participants. After giving sufficient time for review, base the discussion on these types of questions:

- What is the story trying to say?
- What is the message in the story?
- What is the point of the story?
- Are there any words that other people might not understand?
- Is there anything that might upset people about this story?
- Do you believe this; is it credible? Why or why not?
- Is this interesting? Why or why not?
- Does this suggest an action? What?
- Will people like you respond to this? Why or why not?
- How could we make this stronger, better, more effective, etc.?

Use the responses obtained in focus groups and interviews to fine-tune the story before publishing.

After you have a nearly final version this is also the time to present your story to your CDC-required Materials Review Panel or state or local review boards for their approval. Materials are presented and approved for a specific target population so be sure your Panel knows your target population and understands how the story will be distributed – one-on-one to persons you know have high risk behaviors.

Accompanying prevention materials. You may want to distribute other items, such as condoms or bleach kits, with the stories or provide useful referrals. Selecting additional materials or referrals should be based on input from the target population through focus groups and interviews, staff interviews, and the resources of the program. Finally, materials accompanying the role model stories should be tailored to the needs of the specific population targeted by the publication. For example, if sex workers are targeted, packets should include non-lubricated condoms (preferred for oral sex) as well as lubricated ones. For other populations, it may be important to include lubricant along with condoms. Materials should also include instructions for use. Don't assume, for example, that the target population knows the correct methods for the use of condoms.



Below is an example of a role model story interview transcript and the role model story that was developed from that interview.

Role Model Interview Transcript
Benito – “Andre”

This is a partial transcript of a role model story interview to be used for training purposes only. In an actual interview, much more time is spent upfront covering topics such as where the role model was recruited, who recruited them, why the interviewer is a different person and what this interview will be used for. As well, the interviewer should spend time at the beginning building rapport and setting the stage for the interview to be conducted in a conversation-like atmosphere.

THIS IS PATRICK DOING A ROLE MODEL INTERVIEW FOR THE MASSKE PROJECT.

HOW OLD ARE YOU?

I'm 21.

WHAT IS YOUR ETHNIC BACKGROUND?

Hispanic.

WHAT IS YOUR CURRENT OCCUPATION?

I'm a field site representative for a company called Icon. I travel a lot around the metro area managing my boss's sites.

HOW LONG HAVE YOU LIVED IN THE DENVER AREA?

Seven months.

WHERE ARE YOU FROM?

Seattle.

WHERE WERE YOU BORN AND RAISED?

Central Washington.

WHAT BRINGS YOU TO DENVER?

I have three sisters that I have had a long distance relationship with. And I also came to visit in February and met somebody and we kind of hit it off and I moved down here for him. That usually doesn't happen but I decided to try it once but it didn't work out so... It was fine because I had sisters here anyway. Had I not known anybody else I wouldn't have moved.

BUT YOU ARE HERE PERMANENTLY NOW?

Yes.

WHO ELSE IN YOUR FAMILY LIVES HERE?

Just my sisters.



HAVE YOU EVER BEEN LEGALLY MARRIED?

No.

WHAT IS YOUR CURRENT RELATIONSHIP STATUS?

I'm single now but I did have a boyfriend.

WHEN DID THAT END?

In June.

WHAT HAVE YOU BEEN DOING SINCE JUNE?

Kind of dating.

OK, GREAT. WE ARE GOING TO MOVE INTO YOUR FIRST SEXUAL EXPERIENECE.

Ever?

YES, JUST THINK BACK TO WHENEVER THAT WAS. AT WHAT AGE DID YOU HAVE YOUR VERY FIRST SEXUAL EXPERIENCE?

16. I had already come out by then.

WAS THAT WITH A MALE OR FEMALE?

Male.

AND BRIEFLY DESCRIBE THAT.

It wasn't anything much. It was mostly oral sex. I lived in a small town and it was the first gay guy that I had met and he was interested in me. It didn't really go any further than oral sex.

DID YOU GIVE AND RECEIVE?

Yes.

WERE CONDOMS USED?

No.

OK, SO ORAL ONLY. WHAT ABOUT YOUR FIRST VAGINAL OR ANAL SEX?

It happened probably six or seven months later and it was unprotected anal and I was giving.

JUST SO I AM CLEAR, YOU WERE ON TOP FOR ANAL SEX WITHOUT A CONDOM?

Yes.

HAVE YOU EVER HAD SEX WITH WOMEN?

No.

WHEN DID YOU FIRST NOTICE AN ATTRACTION TO OTHER MEN?



I would say fifth grade, so 10?

SO MOVING A LITTLE MORE RECENTLY, AND SPECIFICALLY IN DENVER, WHERE DO YOU GO WHEN YOU ARE IN THE MOOD TO MEET MEN FOR SEX?

Oh, the clubs, yeah.

WHAT CLUBS?

The Wave, Pure, Triangle, La Rumba, Compound. I seem to meet a lot of guys.

OK, GETTING BACK TO THE SEXUAL SIDE OF THINGS... WHEN YOU HOOK UP WITH A GUY, WHAT PERCENTAGE OF THE TIME DO YOU ENGAGE IN ANAL SEX?

Um, probably 99.9% of the time.

TOP, BOTTOM OR BOTH?

I'm versatile.

OK, AND OUT OF THE 99%, WHAT PERCENTAGE OF THE TIME WERE CONDOMS USED?

Probably 90% of the time.

SO YOU ARE ABLE TO USE CONDOMS 90% OF THE TIME?

Yeah, and when a condom *is* used I am usually the bottom. Just for the fact that I don't like the condom feel.

SO YOU ARE MORE LIKELY TO USE CONDOMS IS YOU ARE GOING TO BE THE BOTTOM PARTNER?

Yeah, I've been thinking about using them more when I'm on top. I try not to top that much because I can't keep a hard on when I have a condom on.

OK, SO SOMETIMES WHEN YOU ARE USING CONDOMS IT MESSES WITH YOUR HARD ON?

All the time.

WAS THERE EVER A TIME WHEN YOU WANTED TO USE A CONDOM WHEN YOU WERE ON TOP AND WERE ABLE TO?

Yes.

WHAT MADE THAT POSSIBLE?

I was in a bar and some guy from the Men's Health Project came up, handed me condoms and started talking to me. I told him I had been planning on using condoms but I didn't like to use them because they messed with my hard on. He told me that some of the condoms he gave me were new and had more room at the top. I guess it's just a matter of finding the right one. He also told me to try lube inside of the condom because that makes it feel better. So I did that and it worked! I kept the condom on and stayed hard the whole time! It felt so good to have great sex and still feel protected!

HOW LONG AGO WAS THAT?

About two months or so.

AND HAVE YOU CONSISTENLY USED THEM SINCE?



Yes and I still have the condoms. I'm going to get some more. And I always have lube so next time I am a top I will do it again. I know they will protect me so why risk it?

THAT'S GREAT! LET'S MOVE ON....

ROLE MODEL STORY

Finding the Right One!

Hey guys! My name's Andre. I'm 21 and I've been out since I was 16. I moved to Denver about seven months ago. I love the party scene here. Lots of cool clubs and hot guys! You can usually find me at the Compound or the Wave.

I seem to meet a lot of guys and it's pretty easy for me to get laid. Sometimes if I meet a guy at a club and we've been partying, it's harder for me to use condoms. Especially if I'm on top. I always have trouble keeping it hard. But I recently met this guy from the Health Project and we started talking. I told him that I had been planning to use condoms all the time but I had trouble staying hard. He gave me some suggestions like using lube on the inside of the condom. He also gave me some condoms that have more room at the top. He said this helped increase the feeling. You know what? He was right. I got the chance to try them a couple months ago and I kept it hard the whole time. I also kept the condom on the whole time. It felt so good to have great sex and still feel protected! These condoms are it! **I guess it's just a matter of finding the right one!**

I have been using these condoms ever since. I know that they will protect me from getting infected with HIV so why risk it?

Characterization:	I moved to Denver about seven months ago. I love the party scene here.....
Membership:	I'm 21 and I've been out since I was 16.
Risk Behavior:	Anal top without a barrier
Goal:	Consistent condom use for insertive anal sex
Influencing factor:	Self Efficacy
Barrier to Change/	Can't stay hard with a condom on
Methods to overcome:	Found the right condom and used lube inside
Positive Outcome:	Had great sex, stayed hard and felt protected
Stage of Change:	Preparation to Action

Summary

This module introduced you to role model stories and provided a step-by-step guide to developing the stories from the interview to the production. The next module discusses the role of peer advocates in distributing the stories.



MODULE 4: Peer Advocates

Distribution of Materials by Peer Advocates

The success of Community PROMISE depends on focused and frequent distribution of role model stories, real-life stories of how members of the specific target population have successfully changed their behavior in order to avoid STD/HIV, to members of the target population. These stories, usually packaged with prevention materials such as condoms and bleach kits, will encourage individuals to adopt and practice safe behavior.

The stories are distributed by peers from the target population who have been recruited and trained. The distribution through peer advocates or, in some cases outreach workers, adds to the effectiveness of the intervention. The peer advocates are chosen to represent the full variety of geographic, agency, and social networks found in the target population. These networks, as well as potential peer advocates, are identified through the CID process.

Peer advocate responsibilities

- Distribute role model stories and prevention materials to members of the target population
- Reinforce the acceptance of the stories and materials
- Discuss the stories and highlight the risk reduction message
- Encourage and reinforce positive behavior change

There are several levels of distribution of the materials, depending on agency resources:

- Good* Using paid outreach workers who have never been members of the target population but who are able to relate well with that population and gain its cooperation
- Better* Using paid outreach workers who are former members of the target population, with perhaps a few peer advocates as special assistants
- Best* Using selected peer advocates who are current members of the target population, with outreach workers to train and support them

Since most programs using Community PROMISE will already have outreach workers as part of their STD/HIV prevention efforts, this module will focus on the use and care of peer advocates. Primarily, the module will describe methods of recruiting, training, and retaining peer advocates. In addition, it will discuss outreach workers in their roles as peer managers and material suppliers. If your program can only use outreach workers to distribute role model stories, the guidance in this module for peer advocate can be adapted and applied to your outreach workers

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Peer advocates play an essential role in the success of this intervention by distributing the role model stories and the accompanying prevention materials to a specific target population. In addition, the peer advocates will interact with target population members to encourage the adoption of risk-reduction practices. In doing this, they reinforce behavior change in the target audience. While advocates typically are members of the target population, they can also be individuals with personal ties to target population members with whom they interact regularly and comfortably.

It is important that you have peer advocates that represent each of the social networks in your target population. The CID process will assist staff in identifying networks and the first group of potential peer advocates. The outreach staff will be responsible for recruiting and training the advocates.

Note on Reinforcement

When the peer advocate gives the story to a target population member and says, “I think you’ll really like this story; you should check it out,” the advocate is reinforcing accepting and reading the story. The advocate can also reinforce progress towards adopting safer sex practices by asking target population members if they have tried using condoms and making a positive comment on any attempt to carry, introduce, or use the condom (for example, “It’s good that you have started carrying one. It’s important to protect yourself.”)

There are many advantages to using carefully chosen and well-trained peer advocates, as opposed to paid outreach workers, to distribute materials:

1. Advocates often have immediate credibility with target population members—credibility that typically would be earned more slowly by program staff.
2. Advocates can distribute prevention materials at times when outreach workers may not be available (such as evenings and weekends).
3. Advocates are often present in the places where the risk behavior occurs (for example, where drugs are being used).
4. Advocates expand the reach of your program, enabling a larger number of individuals to be contacted than could be reached by paid staff alone.
5. Advocates will allow your program to reach individuals who might not otherwise access information provided by people who are identified as being part of an organization or governmental institution.
6. Peer advocate teach us about the target population.



Roles of advocates and outreach workers

The role of peer advocates.

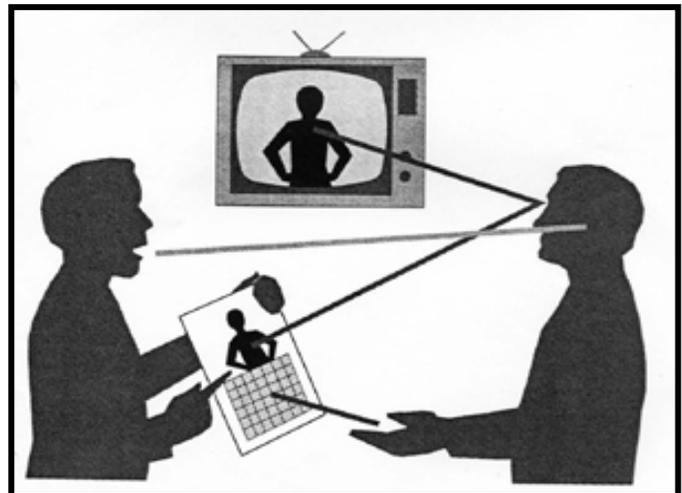
Peer advocates distribute role model stories and encourage and reinforce behavior change. There are two general types of peer advocates: (1) true peers, who are current members of the target population—for example, men who have sex with men, or a person who currently injects drugs—and (2) peer associates, who are not target population members but are individuals—such as former target population members, family members, friends, or a well-liked counselor—who interact with them regularly. While both types of peers can be effective, true peers are more likely to have credibility with the target population. They are also more likely to find themselves naturally in situations where target population members congregate and where risk behaviors occur, such as an alley where drugs are injected, a motel where other sex workers bring their customers, or a sex club.

A note of caution about former target population members

When using former target population members, it is important to pay attention to the situations they may be put in by interacting with current target population members. For example, engaging in advocate activities with current drug users may jeopardize the sobriety of an individual in recovery. Great care should also be taken in recruiting individuals who may be viewed as authority figures by target population members because their formal role (for example, principal, parole officer) may interfere with the acceptability and credibility of your program.

Let's review the graphic below from Module 3. Remember that the peer advocate's part in this process is to encourage acceptance of the stories, draw attention to the key risk reduction message of the story, make the story more relevant to the person receiving it, and provide the reinforcement for positive behavior change.

The advocate's role is not to educate people or teach them facts about HIV. The distribution of the role model stories should occur largely within the peer advocate's own social network; among the people he or she already knows who are at risk for HIV. Some advocates may also distribute prevention materials to people they do not know personally. For example, a gay male advocate may go to a public cruising area to distribute materials.



From a theoretical perspective, the objectives of interpersonal communication for community demonstration campaigns, such as the peer advocates role in Community PROMISE, are to provide:

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1. Channels for distributing materials and resources to facilitate risk reduction,
2. Encouragement and reinforcement for imitation of models or for stated intention to imitate modeled behavior, and
3. Modeling (through distribution of media materials and personally).

What's the Difference: Advocates or Volunteers?

There may be complex issues in having volunteers affiliated with your agency. Agencies may be required to cover all volunteers on an insurance policy, and when their “volunteers” are active drug users or otherwise involved in illegal activities, this becomes a problem. Some agencies or health departments, due to institutional constraints, are not allowed to have volunteers who are active drug-users affiliated with their program. Other agencies find using the term “volunteers” suggests a committed staff member who works in the agency’s office on a more-or-less dependable schedule. Using the same term to refer to someone who may be less regular in work schedule, or for someone the other workers may not want to have in the office, can be a problem. Calling these particular program volunteers “advocates” or “community advocates” can address these issues. In Community PROMISE we use “peer advocate” to refer to this particular type of volunteer. Some agencies call them “members” of a particular program.

If designating the role of the advocate in this way does not fully address the constraints on your agency, another possibility is to establish linkages with a community-based agency that is able to work with high-risk population members (for example, drug users or commercial sex workers). Consequently, Community PROMISE would be a partnership between your agency and another. Whether the partnership is formal—such as a subcontract or memorandum of understanding—or informal depends on the needs and requirements of the agencies involved.

The role of business advocates.

In addition to peer advocates, Community PROMISE relies on another type of community advocate, known as the business advocate.

Business advocates are individuals who work or are highly involved with businesses, services centers or other community-based sites, also known as interactors or drop sites. Examples include a beautician at beauty parlor, a salesperson at a liquor store, or a clerk at a motel, all of whom interact with the target population in the course of their business. The business advocates’ activities support and complement the peer advocates’ activities. Ideally, business advocates are recruited and trained individually to distribute the role model stories to the target population members they know or see on a regular basis. For example, an owner of a small liquor store located in an area where sex workers solicit “dates” could give out condoms to the women who came into the store and individually encourage them to read the role model story publication.



Business advocates can also serve an important function by making role model stories available to community members and prominently displaying posters or other prevention materials. This requires minimal effort on the part of the business advocate, yet it can increase the visibility of your program and communicate local support for STD/HIV risk-reduction as well as assist in changing the norms of the target population related to the risk behavior. The participation of the business advocates also provides the target population with regular and consistent access to the prevention materials at a known location. Remember, the activities of the business advocate are intended to supplement, not replace, the activities of the peer advocates.

Potential locations for business advocates	
Coffee houses	Liquor stores
Laundromats	Beauty/barber shops
Motels/hotels	Bars
Barber shops	Restaurants
Bookstores	Markets

When recruiting business advocates, many of the same techniques used to recruit community advocates can be used. Outreach workers should assess the business owner’s access to and attitude toward target population members by dropping in on occasion and observing their interactions with target population members. Business members selected to become advocates should be those who are viewed favorably by members of the target population. For example, if the target population doesn’t trust the business merchant, they will be less likely to enter that business and ask for prevention materials

The role of outreach workers.

In the “Better” and “Best” levels of implementing the peer advocate core element as outlined in the beginning of this module, the role of outreach workers is quite different from that of outreach workers on most HIV prevention projects. Although the outreach workers may distribute materials, their primary and crucial role is recruiting, training, supplying, and maintaining advocates. Outreach workers are also invaluable because they provide constant motivation and positive reinforcements for each advocate’s efforts. However, it is appropriate for outreach workers to distribute materials at times, including at the start-up months of this intervention, when the intervention is expanding into new areas, or when new individuals are being recruited or trained as advocates. Outreach workers also ‘debrief’ the peer advocates on a regular basis, obtaining information on the number of materials that each advocate distributes, where, and to whom.

No matter what level of implementation you select, outreach workers are invaluable in gaining access to the community and establishing the presence of your program in the community since they conduct the CID process. Outreach workers can conduct field outreach to develop a presence in the community. They will also be conducting ongoing CID tasks throughout the life of the project so information can be collected on any changes in the stage of behavior. This information allows the role model stories to change appropriately. Through repeated contact, outreach workers can gain trust of community members and begin to identify various individuals to approach about becoming advocates. It is important for outreach workers to maintain a

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consistent, reliable presence in the community. In being reliable, it is also important for outreach workers to follow through with any commitments they make to community members. If the outreach worker tells a community member he or she will be back tomorrow, they should not let the community member down. Outreach workers should be visible and easy to recognize by the target population. To make the outreach worker easier to identify, staff members can wear t-shirts or carry tote bags or backpacks bearing the program name while they conduct outreach.

Outreach workers from the target population, in comparison to individuals who are not from the target population, may be more effective when communicating risk-reduction messages. They may also be more successful in recruiting advocates. This is because they reflect cultural realities of the population.

Personal experience: Credibility as an outreach worker

“I found I was more effective in having a positive impact on target population members when I ‘stepped back’ and dealt with people from where I am now (ex-drug addict) as opposed to dealing with people as if I were still a current member of their group. The same ‘lingo, game, and talk’ that had bought me credibility and respect from target population members when I was still using drugs did not provide me the same amount of credibility and respect from people as when I represented myself as an ex-drug user. It was better when I was being myself.

Comparing responsibilities of outreach workers and peer advocates

Outreach Workers

- Gain access and establish presence in the community
- Recruit and train advocates
- Supply and maintain advocates
- Motivate and reinforce advocates
- Possibly distribute materials

Peer Advocates

- Distribute role model stories
- Reinforce others to read the role model stories
- Report the characteristics of the people stories were distributed to
- Refer others who possibly could be advocates



Advocate recruitment

The initial recruitment of advocates is one of the most challenging and important steps in this intervention. To be successful, you must: (1) establish a community presence, (2) identify recruitment areas, and (3) conduct recruitment.

Establishing a community presence

The CID process you will have initiated will assist you in establishing a community presence. Through the process of being referred from systems people to interactors and then to target population gatekeepers and members you will have built on the trust of many people and established new relationships and connections. Your staff will have been in the community for considerable periods of time, observing and talking with people. You will have established a community advisory board whose members will be providing you with helpful suggestions about recruiting advocates. You should continue to maintain an very active presence in the community, attending events, observing, talking with people on the street and at gathering places. The more you can do to make your project known and accepted, the easier the task of recruiting advocates will be.

Identifying recruitment areas

The best locations for successfully recruiting advocates will depend upon the population targeted for intervention. The CID process will tell you where to begin and may have identified potential advocates already. Areas where population members naturally congregate—such as methadone clinics, gay and lesbian community centers, coffeeshouses, public cruising sites, and adult bookstores—can be good places to initiate recruiting efforts. Locations for recruiting advocates may be identified during the formative research period through individual surveys or interviews or focus groups. Involving advocates in identifying new areas and strategies for recruiting new advocates can be helpful and can also increase an advocate’s sense of involvement. Since you are trying to recruit advocates from a variety of networks you want to look at your CID results and determine

Advocate Recruitment Sites	
<u>Youth</u>	<u>Drug Users</u>
Coffee houses	Methadone clinics
Hamburger stands	Food banks
Arcades	Liquor stores
Swap meets or malls	Needle exchange programs
	Recycling centers
<u>Gay Men</u>	<u>Sex Workers</u>
Coffee houses	Certain motels
Gay bars	Streets known for prostitution
Gay community centers	
<u>Female Sex Partners of IDUs</u>	<u>Non-Gay Identified Men</u>
Laundromats	Public sex environments
Markets	Adult bookstores
WIC clinics	

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what the agency/geographic/hangout/social networks are for your target population. Then you can begin recruitment to cover those networks. Recruiting people just through other advocates may restrict your coverage of networks.

CID data is valuable in preparing a plan for systematic utilization of formal systems, informal networks and geographic units as channels of access to the community in order to recruit peer advocates. Results of the CID process, which identified points of access into subculture networks, provide the starting point for building an effective network. For example, to reach IV drug users the staff needs to build extensive contacts with current or former IDUs who know and are accepted by the community of interest. As discussed in community mapping in Module 2: CID, staff from each site prepare forms and charts that tentatively "map" the access plan, with final mapping to be done on-site with input from local advisors and volunteers. Based on the access plan, illustrations of "ideal" advocates are generated. There are three general approaches to network organization:

1. Networks within interaction systems, agencies or private businesses
2. Networks in physical space such as residential/hangouts
3. Informal networks and other natural groups.

Recruiting potential advocates

Not every member of the target population is appropriate as an advocate. Therefore, it is important to identify the characteristics you are looking for before you begin recruiting.

Advocate characteristics. Willingness to participate and distribute role model stories should only be a small part of the criteria to be an advocate. It is more important that individuals who are selected to be advocates have non-judgmental attitudes and do not impose their own agenda on the individuals they encounter. For example, individuals who want to reform target population members by recruiting them into their own program or religious group should not be invited to become advocates.

They also need to be willing to approach people either in their own social networks or people on the street and be able to establish a non-threatening presence. Individuals selected should also have spent time or lived in the local community for more than six months with plans to remain in the area for the next year. This will ensure that they have good connections with target population members and will minimize advocate turnover. Potential advocates must have a reliable way to be contacted. This can be a permanent living situation (whether in an apartment or a regular place they stay on the streets), a regular hangout, a pager, a person to leave messages with, or a connection with other advocates who may be able to locate them.

Ideally, the outreach worker should observe the potential advocate and his or her interactions with peers in order to ascertain whether the individual is liked and would be viewed as a credible source of information by his or her peers. The outreach worker could also observe how much contact the individual has with other target population members.

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Each advocate should be asked where and to whom he/she intends to distribute materials as well as how many he/she believes can be distributed in a week. This will also allow you to plan coverage of an area or network.

Advocates do not have to be consistently engaging in risk reduction activities, but they do need to believe in the importance of protecting themselves from HIV and at least be working toward their own consistent risk-reduction practices. For example, if an advocate is known by his or her peers as someone who refuses to use condoms, then it is likely that he or she will not be a credible or effective advocate.

Positive Advocate Traits

- Non-judgmental
- Won't try to reform target population members
- Doesn't have a hidden agenda (personal or religious) that conflicts with program
- Able to establish a quick, positive impression
- Lives or spends time in target area and plans on staying in the area

It is important to be mindful of the geographical areas and social networks from which you have recruited advocates. If most of your advocates are from one geographical area, it is likely that you will saturate that area quickly and miss the opportunity to distribute stories to a diversity of areas. Likewise, if many of your advocates are friends or interact in the same social circles, the level of distribution to differing social networks will be limited. In summary, the impact that you can have on the community will be varied or limited depending upon the diversity of the advocates you recruit.

Using Target Population Members: Issues to Keep in Mind

When working with any population that uses injected drugs or other addictive substances, you should realize that it may be unrealistic to expect peer advocates to abstain from substance use while performing advocate activities. Drug and alcohol use must be accepted and not be used as an indicator of the potential effectiveness of the advocate. Any individual who displays unpredictable behavior, regardless of his or her known drug use, should not be recruited for advocate activities. Similarly, if MSM are being targeted, advocates who meet sex partners in public cruising areas cannot be expected to stop doing so when they join the program. This may conflict with some organizations' rules regarding advocate conduct. If this is the case in your organization, you may prefer to adopt a different title for this program to differentiate these advocates from others working in your agency.



Recruiting advocates can be accomplished in several ways. Advocates may be recruited in the field, through referrals from existing advocates or gatekeepers, and, if appropriate, through announcements and advertisements posted in the community or in targeted publications.

Field recruitment. Recruiting from areas frequented by target population members can be a very successful strategy, especially for street-based populations such as IDUs or commercial sex workers. When recruiting individuals to be advocates, outreach workers should begin by introducing themselves and the program immediately. The goal of the initial contact is to gain the individual's interest in the program and its goals. Developing trust and rapport between a potential advocate and an outreach worker is a slow process achieved through repeated contact. Over time, the outreach worker must use his or her own judgment about whether the individual has developed sufficient trust to disclose personal information (name, address or hang out, and telephone) necessary for the outreach worker to follow up with the individual. Some individuals may express interest in becoming an advocate after just one meeting, but most will want to be come more familiar with program and its staff before making this commitment.

When describing the program, the outreach worker may want to stress the opportunity to do something good for the community and the importance of what advocates do (e.g., saving lives, reaching people who may not otherwise learn how to avoid HIV) as well as any incentives provided for participating as an advocate. Positive encouragement from the outreach workers is particularly important in persuading individuals to become advocates. When the outreach worker has determined that the individual has a genuine interest in becoming an advocate, an advocate contact sheet should be completed, a sample of which is provided in [Appendix G4](#). The contact sheet is used to record information about the potential advocate (e.g., home address, telephone number, regular hangouts, names of friends) that will allow the outreach worker to easily locate the individual in order to schedule and remind him or her of the training date and time.

Referrals from gatekeepers and existing advocates. Informal community leaders, who are people respected or admired within the community, and existing advocates may be great sources for identifying other individuals willing to assist the program in its efforts. These individuals are in the unique position of knowing potential advocates, and they will know how well the target population will relate to them. However, it is still important for an outreach worker to screen all potential advocates to ensure that they have the potential to become effective advocates. A word of caution: don't rely entirely on referrals from existing advocates to identify new advocates. Friends of current advocates often move in the same social circles and may duplicate the efforts of the existing advocates, adding little or nothing to the breadth of distribution you desire.

Advertisements and flyers. Other methods of recruiting community advocates include:

- placing ads in newspapers and other publications read by your target population, such as school newspapers to reach youth, or local gay-oriented magazines to reach men who have sex with men

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- posting flyers in areas that your target population “hangs out,” such as laundromats, bars, and stores
- making recruiting materials available in agencies that serve your target population, such as WIC programs for female sex partners of injection drug users

These types of advertisements may also be useful when trying to reach at-risk populations who are not readily accessible on the streets or in other specific venues, such as non-gay-identified men who have sex with men. However, there may be cases in which public advertisement for advocates is not appropriate in your target population. This will be revealed during the CID process.

Advocate Training

Invitations to the advocate training sessions are given to those individuals who have the desired personal characteristics and meet the selection criteria discussed above. In order to maximize turnout at advocate trainings, it is important to provide potential advocates with a written reminder of the day, time, and location of the training. Following the initial contact, potential advocates should receive a written invitation. The written invitation can be mailed or hand-delivered on the street by the outreach worker. The invitations don’t have to be fancy. Inexpensive photocopies, which can be filled-in by hand, are sufficient. Finally, each person may be re-contacted and reminded just prior to (a day before) the training. For some populations, giving daily reminders of the upcoming training as well as offering transportation to the training site are important for improving attendance.

Advocate Training Session

A group training for potential advocates lasts from one to three hours. The training should be held at a location that is convenient and easily accessible to the target population. The primary objectives of the training are to reinforce potential advocates’ participation and to teach them to:

1. Understand and be able to explain the goals of the program
2. Identify methods of transmission of STD/HIV
3. Describe methods of HIV prevention
4. Distribute intervention materials to target population members
5. Discuss role model stories
6. Provide reinforcement to target population members

Training peer advocates

At the start of the training, each potential advocate is given a training folder consisting of a training agenda, their initial advocate contact sheet, a map of the area targeted for intervention, pen or pencil, and a few sheets of blank, ruled paper. Samples of the role model story publications with attached materials (e.g., condoms and bleach kits) are also provided to the potential advocates. Depending upon the target population members, a light snack to a complete

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meal should be served. A flip chart containing basic STD/HIV transmission and prevention information needs to be placed in front of the group, along with a TV monitor and VCR if you are going to show a videotape.

Introduction. The facilitator begins by introducing him or herself and welcoming participants to the advocate training session. Participants are then asked to help themselves to food and are encouraged to review their training folders and update the advocate contact sheet if necessary. All the staff present at the training are introduced and participants are asked to introduce themselves, stating how long they have been in the city, and why they are interested in becoming a volunteer. Participants may also be asked to discuss AIDS information or training they have received in the past. The training agenda should also be reviewed and participants advised of the topics and activities that will be covered in the session.

Overview of program. A general description of the project, its purpose, and the source of funding is then provided to the participants. The populations to be targeted by the program are described, along with the program's goal of encouraging target population members to use condoms regularly or the goal your program has chosen for behavior change. The facilitator then explains that the intervention model has been used successfully in other communities with a variety of populations at risk for STD/HIV infection.

Target area. If a certain geographic area has been targeted for intervention, a map of that area should be included in the training packet and its boundaries reviewed. The basis for selecting this area should also be discussed (e.g., an area with a high incidence of STD/HIV/AIDS, an area well-known for containing many target population members, or an area identified by the funding agency).

Target population. Participants should be encouraged to distribute materials only to persons targeted for intervention—not to everyone. Participants are asked to think about individuals they know to be target population members, and then asked how they would identify additional members. This may vary if you are working in a community with many residents who may have high risk behaviors or have close contact with people who do. In this case you and your peer advocates may be giving material to people and talking with them about sharing it within their own family or network.

Importance of advocates. Advocates are critical to the success of this model, and it is important that the participants understand the importance of their role in the program. It is also important that participants know that they as advocates have more credibility with target population members than do staff members. Individuals are more likely to listen to those they already know and respect than they are to persons working for an agency. The importance of preventing new cases of HIV infections and providing prevention messages and supplies to help people in their community should also be emphasized, as should advocate responsibilities. These responsibilities may include distributing materials to target

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population members, assembling materials for distribution, recruiting other advocates, and restocking business advocate sites.

STD/HIV/AIDS information. Basic STD, HIV and AIDS information is presented to the group.

This information may be tailored to the existing knowledge of the group being trained. For instance, if you are training youth, you may want to present basic definitions of terms of STD/HIV/AIDS and discuss the differences between HIV and AIDS. However, if you are training a group of gay men who may already know basic information about HIV and AIDS, discussions may focus on latency periods and new treatment information.

The peer advocates should also be educated about: smart sexual behavior including abstinence, being faithful to a single partner and consistently using condoms (see Appendix J); the association of nonoxynol-9 and increased HIV risk. (see Appendix K); and the effectiveness of latex condoms in preventing transmission of HIV, hepatitis, and other sexually transmitted diseases (see Appendix L).

Methods of approach and initial contact. Participants are shown several methods of approaching a person they know and people they do not know in an open, friendly, non-threatening way and establishing a comfortable conversation. They should role-play such situations. They should also practice their introduction, who they are and what they are doing, so people they approach are clear as to the purpose of the contact from the beginning.

Role model stories. Participants are shown the role model stories and asked if they have seen the publications before. They also are informed that all of the stories in the publications are true, but the people appearing in photographs may be models. The process by which target population members are recruited and interviewed for the role model stories is also discussed. Any publications should be read aloud.

Material distribution. The most important part of the advocate training is teaching the participants how to distribute the materials and reinforce risk-reduction behaviors. Once the advocates have been given information about the materials, such as whom they go to and where to pass them out, they need to know the methods used to distribute the materials. Individuals must learn what to say to the target population when distributing materials.

The advocate should learn that there are specific messages to get across when distributing the role model stories. When the material is distributed to a target population member, advocates need to encourage him/her to read the publication and discuss STD/HIV prevention. The stories should be mentioned and the move of the role model toward risk-reduction behavior emphasized. For example, an advocate may say, “Here’s a story about a woman whose old man didn’t want to use a condom. She got him to try it by getting him so turned on that he couldn’t wait to get the condom on.” Some people may not be able to or may not have the time to read the publication, so advocates need to be sure to tell

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recipients a little about the stories. Other people may not want to take the material at first. If a target population member says, “I don’t need this,” advocates can respond by saying, “Maybe you know someone who does.” The facilitator should play a role for these scenarios using examples from the current publication.

Another point to be emphasized is the use of encouragement or positive reinforcement for individuals to begin or continue positive behavior change. It is hard for people to change their behaviors, so it is good for advocates to let them know that they are doing a good job by saying something positive. The facilitator should give specific examples of positive reinforcement, such as:

- “It’s great that you’re concerned about protecting yourself from HIV.”
- “You’re doing the right thing by thinking about using condoms.”
- “More and more people are thinking that way and are starting to use condoms, too.”

Advocates should be reminded that the recipient of the materials doesn’t have to adopt the behavior in order to receive positive reinforcement. Behavior change is often a long-term process. Advocates are encouraged to respond positively in all situations, even when the person they are talking with has refused to look at or take the role model story. In such a situation, the advocate should be taught to still say something positive such as, “Well, maybe next time. Have a good day!”

Finally, advocates should be encouraged to follow-up with the people to whom they have given the role model stories. When re-contacting someone, the advocate may say something as simple as, “How did you like that story I gave you.” This kind of follow-up reinforces reading and practicing the behaviors illustrated in the stories.

Role-playing. During the training session, the staff will role-play distribution and reinforcement techniques. Individuals will be selected to participate in a role-play with a staff member or others in attendance. The facilitator should not ask for someone to volunteer for the role-play session because it gives the individuals an option of not participating. The goal is to get all the individuals in the training session to participate in at least one role-playing session.

Incentives. If used, the program’s incentives, including the schedule and qualifications, should be discussed. Incentives for the advocates should not be extensive but instead merely small rewards that indicate to participants that their hard work is appreciated. Suggested incentives include t-shirts with the program logo, fanny packs, watches, water bottles, sunglasses, hygiene kits, coffee mugs, tote bags, or back packs. Other incentives can include movie tickets, fast-food coupons, groceries or grocery vouchers, and other entertainment or gift certificates.

Closing. At the end of the training, participants will be reminded of what is expected of

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peer advocates. They are asked to evaluate whether they are willing to make a commitment to being an advocate. Participants who are interested will be informed that an outreach worker will contact them each week to make sure that they have enough materials to distribute. Advocates are not required to come to the office. Advocates should expect to be interviewed (debriefed) by an outreach worker once every three months (or more frequently at the beginning of a program) about their experiences distributing materials.

Advocates should be reminded that this is volunteer work. Any time they do not want to volunteer or for some reason they cannot continue to be an advocate, they just have to let an outreach worker know. They can quit at any time and restart as an advocate at any time. Whatever amount of time they can give is appreciated.

After completing the training, participants who agree to become advocates will sign an advocate agreement form indicating their willingness to participate. The facilitator will read the advocate agreement form aloud to be sure the participants understand its content before they sign it. Those individuals in attendance who you do not feel would be appropriate as peer advocates should be given another assignment. For example, those who do not become peer advocates could be community observers who inform staff members about community trends and reactions to Community PROMISE. Everyone in attendance at the training should feel a part of the prevention effort.

The facilitator thanks the participants for attending the training session, then welcomes the new advocates to the Advocate Network. Advocates are then given a bag of intervention materials (we advise starting new advocates out with a small amount of material), and all should be given an incentive for having participated in the training.

Further training. Before leaving the training, volunteers are encouraged to make an appointment with an outreach worker for further training in the field. The additional field training motivates new advocates to begin distributing materials immediately, and it is a good opportunity for them to view outreach workers distributing materials. Outreach workers can observe the new advocates' distribution techniques and make any corrections or review segments from the training session that may have been misunderstood or forgotten.

Training business advocates

Unlike individual advocates, business advocates can be trained individually at their workplace. Training for business advocates is an abbreviated version of the agenda outlined for the group training of community advocates. In the business training, greater emphasis should be placed on the project and its goals and on identifying individuals to receive materials; less emphasis should be placed on teaching basic STD/HIV and AIDS information. Strategies for engaging at-risk customers and encouraging them to accept and read the role model stories should also be discussed.

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Advocate retention

Training and managing advocates is very labor-intensive, but it is crucial to retaining a dedicated group of advocates. [Appendix F1](#) contains a summary of issues to deal with in managing peer advocates. In addition to recruiting and training appropriate advocates, outreach workers should meet weekly with each advocate to provide him or her with additional distribution materials when needed. When possible, incentives should also be given periodically to each advocate in appreciation of his or her efforts. In addition to the incentives already described, other incentives can include special activities such as picnics, parties, and support groups. Support groups may be particularly useful in maintaining the advocates' STD/HIV knowledge, conveying program information, and increasing advocates' participation.

Maintenance of advocates can be very time-consuming due to the lifestyle and characteristics of some target populations. Because of the advocates' busy lifestyles, some will be hard to reach. In addition, some members of specific risk groups, such as IDUs and commercial sex workers, often do not have a long-term permanent living situation. Some may live in motels, share living space with friends or relatives, live in other transitory situations, or be homeless. There are a number of strategies for outreach workers can maintain contact with advocates.

1. Maintain records of telephone numbers and addresses
 - don't throw away old or disconnected numbers—they may work later
 - keep record of as many numbers as possible (e.g., pagers, friends' pagers, cellular phone)
 - obtain a message phone number of a relative or friend who is in regular contact with the advocate
2. Check the advocate's hangouts
 - attractions—bus benches, phones, shooting galleries, alleys, abandoned buildings
 - businesses—liquor stores, restaurants, laundromats
 - connection—places where people meet or call the drug connection
3. Call around or visit contacts
 - jails or hospitals
 - members of the advocate's networks
 - neighbors and apartment managers
 - store owners
 - other outreach workers
 - parole or probation officer

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It is important to be available for your community advocates. You will need to meet the advocates where they are (on the streets). Other points of contact might include a storefront office, another agency, or local retail stores or restaurants. Setting a consistent time at another location may also be helpful. For example, you might want to arrange to always be at a local coffee shop on Thursdays from 1:00 p.m. to 4:00 p.m. A project storefront greatly facilitates regular contact with peer advocates but may not be feasible for all projects.

In addition to regular visits or phone calls from the outreach worker, other activities will increase advocate motivation and retention rates.

Monthly advocate meetings. Monthly support group meetings, sessions to review materials and information, or informational workshops can be conducted to provide additional support and reinforcement for the advocates' activities. These activities give the advocates the opportunity to meet and share their experiences with program staff and each other. In addition, advocates can describe their perceptions of the barriers to behavior change in the target population and discuss solutions to overcome these barriers. Group activities also enable staff members to solicit information from advocates about a number of issues: (1) the target population's interest in the intervention materials, (2) specific sites where outreach currently is needed, and (3) when distribution is not going well in the target area. These meetings also provide an important opportunity for staff to reinforce the role of the advocates in the project by offering additional practice of skills or role-playing. Finally, advocate meetings may include guest speakers who discuss other health-related topics.

Personal experience: Keeping advocates involved

“A way to increase participation of peer advocates in group activities or socials is to make sure that the weekly or regular contact that is made with them by the outreach workers is nurturing and supportive. Groups of people who have not had a lot of opportunity to do volunteer work (like being a peer advocate) in their lives as a whole, such as drug users and sex workers, find the novelty of being an advocate very positive. They get a lot of pride out of the experience.”

Social gatherings and community events. Picnics, community barbeques, parade participation, and other appreciation events serve as incentives for advocate participation in the program. They also provide a method of recruiting new advocates, provide additional opportunities to reinforce advocates' efforts, and provide social reinforcement for risk-reduction behaviors. Events such as parade participation may also increase program visibility as well as provide an opportunity for the advocates to participate in positive social interactions with peers and outreach workers. Advocates have the opportunity to bring their children and/or a guest to the event. Other activities at these social events may include an STD/HIV

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prevention play, advocate bingo (using prevention words), a raffle, a clothing bank, and distribution of certificates of appreciation by a local politician. Food and raffle prizes for these events may be donated by local businesses to support your prevention efforts in the community. Be sure to include games, prizes, and entertainment for the children that attend.

Incentives. Incentives such as restaurant gift certificates (fast-food), hygiene kits, t-shirts, and money may also be used to retain advocates. When feasible, the incentives should be identified by the advocates themselves. It is important to develop a concrete incentive schedule that is known by all advocates. This discourages advocates from asking for incentives every time they see an outreach worker and assists outreach workers in maintaining equality in reward distribution to all advocates.

Every advocate who has been actively distributing materials may receive an incentive. While some highly motivated groups of advocates can be given incentives on a relatively infrequent basis, it may be necessary to provide incentives more often if advocate retention becomes a problem. Keep in mind that the cost of advocate incentives is minimal compared to cost of recruiting and training new advocates or having paid staff conduct outreach. None of the items listed below costs more than \$10 per item. To increase program recognition and promote further identification with the program, the project name and logo can be inscribed on some incentive items.

Personal experience: Incentives

“Incentives are usually not the reason why peer advocates volunteer their time. While they do definitely enjoy and appreciate the incentives, some bigger rewards for them are: the prestige and respect they get in the community, the good feelings they get about themselves from volunteering, which is oftentimes simply the praise they get from the outreach worker, and going to all of the parties, meetings, and other activities associated with being a peer advocate.”

Cards & letters. Sending birthday cards to advocates from staff members expressing appreciation for their hard work and effort provides an incentive to continue advocate activities. Letters and cards containing current intervention flyers may also encourage continued advocate activities when advocates are in the hospital, jail, or prison. Advocates respond positively to all these additional social incentives, particularly the letters while in prison and jail because often this is the only correspondence they receive the entire time they are incarcerated. Advocates may also need letters verifying their advocate activities for court appearances, job references, and for their parole officers. Printed on

Suggested Items for Advocate Incentives

T-shirts	Watches	Food coupons
Backpacks	Sunglasses	Hygiene kits
Fanny packs	Coffee mugs	Tote bags
Water bottles	Movie passes	Baseball caps
Bandanas	Grab bags	Money

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agency letterhead, a letter may be very useful to advocates seeking employment or documenting their community activities.

Periodic newsletters can also be distributed among advocates to provide local information about STD, HIV and AIDS cases, program updates, referrals to local services, and acknowledgments of exceptional and new advocates. Calendars listing the program activities for the month can be included to remind advocates of upcoming project and community events.

Non-tangible motivators. There are also non-tangible rewards inherent to participating in the program. Other than the advocate's own altruistic motives, attention from staff members is often the most important factor. Providing a positive contribution to the community is also a predominate reason for participating as an advocate. A sense of belonging and contributing to a community effort is vital; therefore, fostering this feeling is very important. Giving concrete symbols of advocates' connection to the group—such as badges or T-shirts with the program logo—is an important aspect of the advocate effort.

Other opportunities. There may be other opportunities in the program for advocates to earn incentives. For example, incentives or monetary rewards may be given for assembling condom packets, being interviewed for a role model story, or participating in a focus group. Be creative—assist the advocates in organizing a block party or garage sale from which they can divide the proceeds among themselves. The advocates are great resources for ideas about the types of incentives or assistance that would be helpful.

Being an advocate with the project may also lead to employment opportunities. The advocate may gain experience sufficient to be an outreach worker with a local service agency, or an individual might gain a position at an organization through a recommendation from advocate activities.



Below is a sample interaction between a peer advocate and a member of the target population:

Peer Advocate (PA): Hey! What's up Mike?
 Mike (M): Oh, nothing much.
 PA: How are you doing?
 M: Can't complain. What about you?
 PA: I'm pretty good. I got another one of those stories for you. Did you get a chance to read the last one?
 M: Yeah, it was cool.
 PA: I thought so too. Man, this HIV shit ain't no joke. Do you mind if I ask you a couple of questions about the story?
 M: No, go ahead.
 PA: What do you think the story was focused on?
 M: Well, it was about this dude who got his old lady to use condoms.
 PA: Yea. Did it say how long they had been using them?
 M: Nah. It just said they had been using them for a while.
 PA: That's cool. I've got one last question for ya. What made him want to use condoms with his old lady in the first place?
 M: The guy from that place, what was it? Well anyway, he told him about AIDS and dude had been with a lot of other honeys. So he wanted to make sure that his girl was protected.
 PA: You got it. Does this story sound familiar?
 M: Yea. Sounds like a lot of guys I know, including myself. I know I should use them. In fact I make sure I keep them with me now.
 PA: I'm glad to here that. I'll be even more excited when you tell me you're using them every time. Here you go. Next time I see you let me know what you think about this one, ok?

Summary

This module has linked role models stories with the role of peer advocates in distributing those stories. In addition to discussing methods for identifying, accessing, training, organizing, and mobilizing community advocates for the selection and distribution of intervention materials, the module addressed the distribution of other prevention materials, such as condoms and bleach kits. The next module presents the final core element, evaluation. You will learn why evaluation of Community PROMISE is important and how to conduct process monitoring and evaluation activities, as well as outcome monitoring.

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MODULE 5: Evaluation

Evaluation of Community PROMISE, or of any other behavioral intervention, is an important program management tool. This module presents an overview of evaluation terminology and techniques and provides tools to assist you in planning and conducting the monitoring and evaluation of the process and outcome of implementing Community PROMISE in your agency.

The importance of evaluation

As an “effective intervention,” Community Promise is already understood to be effective in achieving behavior change in a community. The monitoring and evaluation your agency conducts can show that 1) you achieved your objectives with your target population, 2) you maintained fidelity to the core elements of PROMISE, and 3) you altered the stage of behavior change, attitudes, and/or norms of the community in support of reducing HIV risk. Monitoring and evaluation also can identify the need for and methods to improve your implementation activities and increase the effectiveness of your program.

Evaluation can be defined as “the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming” (*Patton, 1997*). It can also be described as collecting, analyzing, interpreting and communicating information about the effectiveness of social programs undertaken for the purpose of improving social conditions” (*Rossi et al, 1999*).

There are many different stakeholders that will benefit from and even require information provided by evaluation of Community PROMISE. These include the obvious: the funding agency that provides financial support for the program, the prevention planning group that makes recommendations to the funding agency, and the political body that may decide the fate of the funding. Agency employees working on the intervention will also be interested in knowing if their work on Community PROMISE is making a difference for the people they are serving.

Equally important are the target population members, who will want to know that your intervention into their environment is effective and appropriate toward promoting their health and safety. Residents of the broader community, beyond the community of target population members, may also want to know that you are implementing an intervention that has the planned, beneficial outcomes.



There are three reasons to evaluate STD/HIV prevention projects such as Community PROMISE:

1. Accountability: Accountability may be to the funder, the staff, the clients, and the community
2. Program Improvement: Evaluation helps us to improve existing programs
3. Knowledge Development: Evaluation helps us to plan future programs

Overview of evaluation

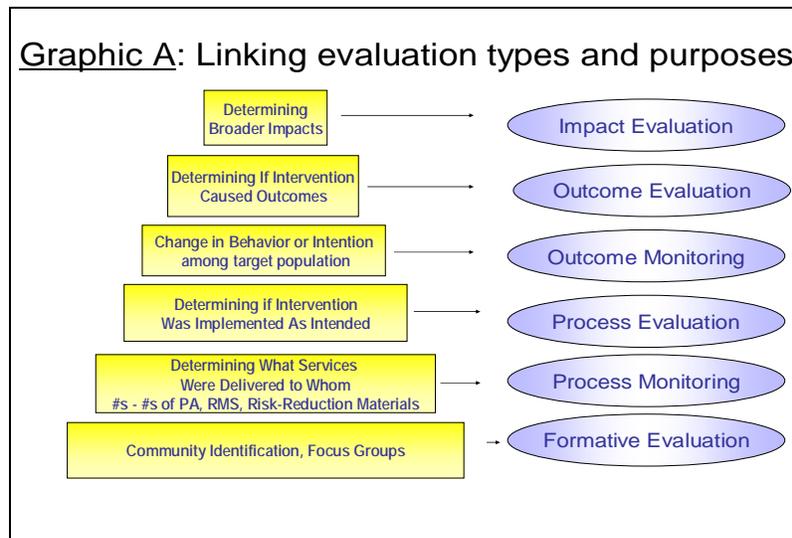
There are many schools of thought on evaluation types and techniques. For the purposes of this manual, six key types of evaluation will be discussed: Formative Evaluation, Process Monitoring, Process Evaluation, Outcome Monitoring, Outcome Evaluation and Impact Evaluation. These evaluation types are briefly described below and the link between each type of evaluation and its general purpose is illustrated in Graphic A on the following page.

1. Formative Evaluation collects data describing the needs of the population and the factors that put them at risk as well as factors that can help them reduce their risk and protect their health. Formative evaluation can answer questions such as: How should the intervention be designed or modified to address population needs? What can we learn from pre-testing our approach? Are the materials we are going to use appropriate?
2. Process Monitoring collects data describing the characteristics of the population served, the types of services provided and at what frequency, and the resources used to deliver those services. It assists with making changes and improvements during the implementation process, and can answer questions such as: What services were delivered? How and where were those services delivered? What population was served? What resources were used?
3. Process Evaluation collects more detailed data about how the intervention was delivered, differences between the intended population and the population served, and access to the intervention. It can answer questions such as: Was the intervention implemented as intended, with fidelity to the core elements? Did the intervention reach the intended audience? What barriers did clients experience in accessing the intervention?
4. Outcome Monitoring collects data about client outcomes before and after the intervention, such as knowledge, attitudes, skills, behaviors, or intentions for behavior change. It can answer the question: Did the expected outcomes occur? Outcome monitoring should be done only after process evaluation has shown that the intervention is being delivered as planned and that the intervention is mature.
5. Outcome Evaluation collects data about outcomes before and after the intervention for clients as well as with a similar group that did not participate in the intervention being evaluated. It can answer the question: Did the expected outcomes occur as a result of the intervention?

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6. Impact Evaluation collects similar data to outcome evaluation, in conjunction with data about HIV infection and other indicators at the jurisdictional, regional, and national levels, over a longer time frame. It can answer the question: What long-term effects do interventions have on HIV infection? Were the initial outcomes sustained over a specific time frame?



Source: ORC MACRO

Evaluating Community PROMISE

In the original research phase of Community PROMISE (ACDP described in Module 1), all evaluation methods listed above, including outcome and impact evaluation, were conducted. However, *it is not expected nor advised* for your agency to similarly conduct outcome and impact evaluation. For the purposes of implementing Community PROMISE in your agency and meeting the information needs of your stakeholders, you need only conduct: process monitoring, process evaluation, and possibly outcome monitoring. In Community PROMISE, formative evaluation is accomplished through the CID process (Module 2). Outcome evaluation and impact evaluation require a high level of technical expertise and resources. The original researchers have proved the positive and effective outcome and impact of Community PROMISE, so you don't need to.

To assist you in conducting process monitoring, evaluation, and outcome monitoring information and examples of methods, indicators and tools are provided in this module. See Table A. These resources are by no means comprehensive, and you should seek additional technical assistance from the Community PROMISE program and your own resources to plan and conduct evaluation activities.

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Table A: Sample evaluation methods, indicators and tools

Evaluation type	Methods	Sample indicators	Sample tools
Process Monitoring	-Tracking forms -Questionnaires -Interviews	-# of advocates recruited and trained -# of stories developed -# of materials published -# of materials distributed -To whom were materials distributed?	-Advocate Recruitment Form* -Quarterly Production Form* -Outreach Worksheets* <i>(*included in this module and in appendix)</i>
Process Evaluation	-Summary tracking forms -Questionnaires -Interviews	-Was the goal achieved for # of peer advocates recruited or role models stories developed? (summary of process monitoring in comparison to goals) -Did the role model stories developed contain the key elements? -Did the population receive the materials? -Were peer advocates trained appropriately?	-Summary forms of the periodic process monitoring forms, listed above. -Advocate debriefing questionnaire* -RMS Component Evaluation* <i>(*included in this module and in appendix)</i>
Outcome Monitoring	-Questionnaires -Interviews	-Did risk behaviors change in target population? -Was there progression in “Stages of Change” among target population? -Did attitudes or norms change?	

The first steps in conducting an evaluation are to develop an overall evaluation plan and to create a logic model of your intervention. You want to develop a plan for your evaluation effort to be sure that you have 1) all the data you need to do the evaluation, 2) the resources to complete the planned work, and 3) all the pieces linked together. You do not want to get to the end of Year 1

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and discover that you forgot to collect a piece of information that is vital to determining if you implemented the intervention with fidelity to the core elements. You also don't want to collect data that you will never need. You do not want to collect volumes of data and then have a year's worth of paper sitting waiting for someone to develop an entry program. Therefore, review the suggested forms presented here and adapt them for your own use. Add or subtract to the data items and tools as you need. Plan how you will collect the data, who will collect it, what will happen to it after collection, how will quality be reviewed, how will data be combined, and how will the analysis or evaluation of the results occur.

A logic model is a tool that can greatly assist you in developing an evaluation plan. There are several sources for information and training about logic models (www2.utsouthwestern.edu/preventiontoolbox is one example). A sample logic model can also be found in the Community PROMISE TA Manual. Logic models include the factors that your CID process has determined are influencing the specific behavior you are working to change, the activities of your intervention that you are conducting to alter those factors, and the expected short-term and intermediate outcomes you expect to see as a result of your intervention. It is these latter items that you will be exploring for your outcome monitoring. Your process monitoring and process evaluation will focus more on the inputs and outputs of the activities.

Process monitoring and evaluation

Process monitoring of Community PROMISE will identify if, when, how and how many program activities were implemented. Examples of process monitoring indicators include: the number of each level of CID interview completed, number of observations, number of focus groups, number of advisory board meetings or interviews, the number of peer advocates recruited and the number trained, the number of role model story interviews conducted and the number of role model stories written, published and distributed (See Table A).

Process evaluation of Community PROMISE tells you if the intervention was implemented as intended and planned. It can also Examples of process evaluation topics include whether the implementation process proceeded as planned (were the targeted # of peer advocates recruited, did the agency produce the goal # of role model stories, etc.) and whether the core elements were implemented correctly (did the role model stories contain the correct components; was a CID process conducted as fully as needed.) (See Table A).

Examples of process monitoring and evaluation indicators and sample instruments to collect corresponding information are included in this module and blank forms are also located in the appendix. These examples are by no means comprehensive and you should seek assistance from Community PROMISE TA providers and/or your own evaluation specialists in developing an evaluation plan and identifying appropriate tools (See Table A).

1. Peer Advocates recruited & trained.

The first step in keeping records about recruiting and training advocates is to track the number of attempts to interest a particular person in becoming an advocate. This will tell

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you the level of effort necessary to recruit new advocates and help with future staffing plans. There can be a simple log kept for each person you attempt to recruit – with the person who referred him/her or the place recruited from, the dates, the type of contact, and the result, including future plans to follow-up if necessary. Sample form A is an example.

Sample form A (Appendix G1):

Advocate Recruitment Report

Training Date: September 13, 1999 Number Attending: 8

Training Description: Training session held at the First Community Church. Included AIDS and program information, role-play, video, and quiz.

Incentive: Mug filled with candy

Name	I.D. #	Advocate Risk Group	Risk Group Served	Area/Network	# Materials Accepted
John	269	Current IDU	IDU	1 st , b/n Atlantic & Main	15-IDU stories
Sylvia	345	Former IDU	IDU	7 th & Rose	5-IDU stories 10-Partner of IDU stories

All the forms presented here can be used both for peer advocates and business advocates or persons who work in stores or businesses who agree to also pass out materials, role model stories, and discuss risk reduction with their customers.

A record of each training session should be kept to document: (a) the number of potential advocates invited to and attending the training, (b) the risk group(s) and geographic area or social network to be accessed by each advocate, (c) the number and types of materials given to each advocate, (e) a description of the training session, and (f) the incentives provided to attendees at the end of the training session. This information is valuable for tracking training activities, monitoring the performance of trainers and advocates, and making decisions about future recruiting efforts.

In order to ensure the accuracy of the records, relevant information should be recorded in written form prior to the end of the training session—avoid recording information in retrospect. Note that each advocate is given an identification number at the training session. On internal documents, advocates can be referred to by first name or first name and last initial. However, on reports and documents that circulate outside Community

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PROMISE, only the identification numbers should be used to reference the advocates. The identification number keeps the advocates' identities confidential. This is especially important if the advocate is currently or has formerly engaged in illegal behaviors, such as drug use or commercial sex work.

2. Role model stories developed

It is important to track the number of RMS interviews and the number and type and type of stories developed from interviews. This can be done with a simple tabular form that is updated periodically and totaled at the end of the program period, such as the sample Quarterly Production Report, sample form B. The content of the role-model stories should be examined to ensure they meet the guidelines for story production. As reviewed in *Module 3*, there are 8 key content components of role-model stories. They are: *characterization* of the role model, and of *membership* in the target population, the *risk behavior* engaged in by the role model, the *risk reduction goal*, movement between one *stage of change* to the next, the *influencing factors* for the role model to begin practicing risk-reduction behaviors, a *barrier to change* and the *method used to overcome* the barrier, and a *positive outcome* on the side of risk-reduction.

Sample form B (Appendix G2):

Quarterly Production Report

Months Covered: January– March

Year: 2003

Production Date	Story Title	Publication Number	Number Produced	Target Population	Prevention Behavior Modeled	Gender of Main Character	Ethnicity of Main Character	Initial Stage of Change
1/98	Respect yourself	1	500	Sex Worker	condom w/ main partner	F	Latina	Preparation
2/98	Time to make a choice	2	600	IDU	clean needles	M	African Amer.	Preparation
2/98	What's cool?	3	150	Youth	condom w/casual partner	M	African Amer.	Action
TOTALS	3 stories		1250	1: SW 1: IDU 1: Y	2: condom 1: needles	1: F 2: M	1: Lat 2: AA	2: Prep 1: Action

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Once a story has been developed, a different staff member should review the story to evaluate whether or not it contains the necessary components. The Role-Model Story Component Evaluation, sample form C, can be used to assess if the materials meet the criteria of a role-model story. The data from this evaluation also allow the agency to track the cumulative totals of the different components illustrated by the various stories.

Sample form C (Appendix E5, under role model stories materials):	
Role-Model Story Component Evaluation	
Story Title:	<u>Peaceful Easy Feeling</u>
Ethnicity of Main Character:	<u>White</u>
Gender of Main Character:	<u>Female</u>
	<i>Acceptable?</i>
1. Characterization: <u>name, children, and boyfriend shoot drugs</u>	<u>yes</u>
2. Target Population: <u>partner of IDU</u>	<u>yes</u>
3. Risk Behavior: <u>not using condoms with IDU partner</u>	<u>yes</u>
4. Goal Behavior: <u>condom with main partner</u>	<u>yes</u>
5. Stage of Change: <u>Contemplation to Preparation</u>	<u>yes</u>
6. Influencing Factor: <u>self-perception of risk</u>	<u>yes</u>
7. Barrier to Change & Method to Overcome Barrier: <u>he didn't want to use; she was persistent and said to try them</u>	<u>yes</u>
8. Positive Outcome: <u>use condoms, have fewer worries</u>	<u>yes</u>

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3. *Materials Published*

Similar to the log of role model story development, a log of role-model story publication should be kept. This log may be used to track the number of materials produced and the story content, including characteristics of the role model and the prevention behavior presented, and the stage of change. Information from this log should be summarized at least quarterly and reviewed to assess the mix of stories and the rate of story production. Tracking the mix of stories is useful in making sure that the stories depict a variety of situations and persons appropriate for the target population and that they have changed based on the continuing CID process as the community moves through the stages of change for each behavior as part of your process evaluation.

4. *Materials Distributed*

For both program management and process monitoring and evaluation purposes, a record of each contact made with each advocate, both peer advocates and business advocates, should be kept. The Advocate Contact Form, sample form D, starts with the first date of contact in the tracking period. A separate Advocate Contact Form should be used for each advocate. Information on the form should include the advocate's name and contact information, and information regarding materials distributed to the advocate. The results of any contact attempts should be recorded as well. In the notes, special successes and difficulties can be reported. Each outreach worker should carry the forms while he or she is in the field and should record information soon after any contact with an advocate. Contact is best made on a weekly basis or when the advocate needs new materials.

A periodic review of the Advocate Contact Form ensures that each advocate is seen regularly. It also allows any problems to be identified before the advocate drops out of Community PROMISE. In addition, the logs provide a means of updating information—such as hangout and address—on an ongoing basis. The interval for reviewing the Advocate Contact Form depends on the needs of the agency; forms can be collected for review and a new form begun for each advocate on a weekly, bimonthly, or monthly basis.



Sample form D (Appendix G3): Advocate Contact Form

Advocate First Name: Henry Nickname: Chino
 Last Name: Rodriguez Territory: B
 Address: 1216 E. 14th St. Phone: none
 Hangout/Location: Blue Liquor, Westchester Park Message Phone: sister - (562) 687-7665

Date	Publica. ID	No. Distrib.	Comment	Staff
3/14/99	12	8	Wanted more, gave him 15 new stories	Jeff
3/25/99	13	10	Liked this story	James
4/6/99	13	4	Been sick, hasn't passed out as many	Jeff

To track advocate activity and to evaluate that activity quarterly, you can use a tool similar to Sample form E. This form is organized by month and helps keep track of the total number of materials distributed over time to each advocate. It can be used to monitor the total distribution of materials as well as the performance of individual advocates. These numbers are useful for identifying advocates with especially low or high distribution of materials and for determining the need to recruit new advocates to expand overall distribution and fully cover known networks. Since the information in this report is not identified by advocate name, it is useful for quarterly reports on program performance that are required by some funding agencies. This is also the form that can be used for process evaluation to determine if the expected number of materials are being distributed and the expected number of people are being reached.

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Sample form E (Appendix G4):
Quarterly Advocate Activity Summary

Months Covered: October to December Year: 1999

Gifts: A = mug, B = cap, C = hygiene kit, D = _____, E = _____, F = _____, G = _____

Target Population	Advocate's ID #	Month: October			Month: November			Month: December		
		Story # <u>26</u>	Story # <u>14</u>	Gift	Story # <u>27</u>	Story # <u>28</u>	Gift	Story # <u>28</u>	Story # <u>15</u>	Gift
MSM	156	10		A	10	5		15		
MSM	133	5			7			10		
Youth	426		15	C					20	B

5. Population receives & reads materials

Once every two or three months, an outreach worker should interview each active advocate using the Advocate Debriefing Questionnaire, sample form F. The questionnaire assesses the nature of the advocate's program-related activities and his or her perceptions of Community PROMISE's impact. The interviews may be conducted during the outreach worker's usual activities in the field. (*Note: Outreach workers should receive some basic training in interviewing techniques before conducting the interviews using the Advocate Debriefing Questionnaire.*)

Examples of the types of information to be obtained from the advocates include:

- how, to whom, and when the advocate distributes materials
- the proportion of persons contacted who have not been previously exposed to Community PROMISE
- the reactions of those receiving the materials
- suggestions for improving Community PROMISE

The Advocate Contact Form that was described earlier can be used to document interviews in order to make sure that each advocate is interviewed at the appropriate time interval.

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**Sample Form F (Appendix G5):
Advocate Debriefing Questionnaire**

Date: 4/12/98 Interviewer: Tom Hanes
 Location of Interview: Alley behind Shady's
 Advocate First Name: Paul Nickname: Hiccup
 Last Name: Taylor

1. Whom do you pass materials out to? (*Check all that apply*)
 - (a) Gay men
 - (b) Commercial Sex Workers
 - (c) IDU
 - (d) Other (use direct words from advocate): _____
2. Are the number of stories we're giving you about right, not enough, or too many? (*Check one*)
 - (a) About right
 - (b) Not enough
 - (c) Too many
3. Whom do you mostly pass out materials to: people you know, people you don't know but recognize, or people you've never seen before? (*Check one*)
 - (a) People you know
 - (b) People you recognize

The responses to the Advocate Debriefing Questionnaire can be summarized for process evaluation purposes in a Quarterly Advocate Feedback Report, sample form G. The critical aspect of this report is that it should be maximally useful to the stakeholders. Thus, the information should be relatively brief and provided in a form that is easily understood (for example, using graphs and short summaries).

<Excerpt>

Sample Form G: Quarterly Advocate Feedback Report

During this quarter, 46 individual advocates were interviewed. Summaries of responses are presented below:

1. Whom do you pass materials to?

The majority of advocates interviewed (60%) distributed program materials to both IDUs and Commercial Sex Workers. Another 25% distributed materials to all three target populations (IDU, Female Sexual Partner of IDU, and Commercial Sex Worker). Very few of the advocates focused on a single population.
2. Are the number of stories we're giving you about right, not enough, or too many?

Most of the advocates interviewed felt that they were receiving the right amount of materials for distribution. About one-quarter of the respondents wanted more materials. Relatively few of the advocates wanted to be given fewer of each publication.

Outcome Monitoring

Outcome monitoring determines what outcomes or changes have occurred in the target population with which you have been working. The outcomes for which you monitor will be a function of the goals of Community PROMISE with your target population. These include: changes in risk behavior, such as sharing needles, having unprotected sex, etc.; movement in the stages of change for a specific behavior; and changes in the target population's attitudes or perceived norms. Additional questions can be developed to measure any of the factors that influence behavior that are addressed in your role model stories.

Outcome monitoring information is more difficult to measure than process monitoring and evaluation and it requires greater resources and expertise. Some guidance is provided below on outcome monitoring tools and methods. For additional information, you should consult the Community PROMISE TA Manual, TA Providers and other evaluation resources.

Methods to collect outcome monitoring information include questionnaires and surveys that are administered orally or in written form. The questions can be closed-ended or open-ended to collect a mix of quantitative and qualitative data. A sample questionnaire is provided in [Appendix H1](#).

Interviews with the target population are another means of outcome monitoring. Street-based interviews are particularly useful for reaching persons who may not be accessible through more traditional approaches, such as in clinic waiting rooms, through the mail, or over a telephone. Again, you want to choose a technique that gives you the optimum chance to obtain information that will reflect the entire target population. Every person within the target population should have an equal chance of being interviewed to ensure an unbiased result. [Appendix H2](#) contains detailed guidance on interviewing and [Appendix H3](#) provides a sample key observer interview.

You may find it useful to collaborate with another agency and each conduct some interviews with the other agency's target population. By having interviewers who are not involved in the intervention and the provision of risk reduction materials to that population, the answers you receive may be less influenced by the respondents' desire to please the interviewer.

In addition to comprehensive interviews discussed above, there are more simple means of monitoring outcomes. For example, to determine if there has been movement an individual's stage of change, you can employ a short series of staging questions, as discussed in Module 2 for your CID process. Let's say your target population practices anal sex without a condom, and one of your role model stories identifies the goal of moving from thinking about consistently carrying condoms (contemplation) to beginning to consistently carry condoms (preparation). To determine if there has been a behavior change toward your goal and a movement in stage, you could ask the target population members receiving the stories the following series of questions:

1. Have you started carrying condoms consistently with you?
2. Do you have one with you?

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3. Can I see it?

Remember, the goal is to move the target population only from one stage of change to the next.

Sample form H, Staging Instrument, located on the following page provides a more detailed tool for measuring stage of change. You can replace the sample risk reduction behavior with one that applies to your target population and adapt the questions accordingly. Please note that the questions in the Staging Instrument rely on the individuals' recollection and disclosure of information and therefore may not always be a 100% accurate measure.

Other outcome monitoring methods include determining if the target population is reading the stories. You can measure this by asking them to recount the stories. You could also ask them if the stories influenced them to consider changing behavior toward the goal identified in the story or if they have even already attempted the behavior change.

Again, if you choose to conduct outcome monitoring once the intervention implementation is underway and the program at a mature stage, we encourage you to refer to additional resources, such as the TA Manual, TA Providers and your own evaluation resources.

Summary

Evaluation of Community PROMISE is an important program management tool that can provide highly valuable data to improve the program in your agency and to meet the information needs of stakeholders. This module provided an overview of focused process monitoring and evaluation of the intervention, and highlighted the more challenging task of outcome monitoring.

Now that you are familiar with evaluation of Community PROMISE, the fourth and final core element, it's time to learn about management of the intervention in the next module.

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DETERMINING STAGE OF CHANGE

Note: To determine stage of change on a particular *goal behavior* (a protective behavior you are trying to encourage the target population to adopt), insert that behavior in the spaces indicated below when asking staging questions. Also, insert the *context* of the behavior in the sentence as well. The context is the situation in which the goal behavior occurs. For instance, the first question could be “how often would you say you use condoms when you have anal sex with your casual sex partners.” In this case, using condoms is the goal behavior; having anal sex with casual sex partners is the context in which the goal behavior occurs. Each goal behavior occurs in a specific context, and that context is critical—it makes the goal behavior different from the same *apparent* goal behavior in a different context. Main partners are different from casual partners; and anal sex is a different behavior from vaginal sex. If you simply ask “how often do you use condoms” your results won’t really tell you anything useful for your intervention. The context is critical in staging a goal behavior.

You need ask only two questions for each particular behavior you’re staging. The response to the first question will determine the form of the second question. Once you’ve asked the second question, you have the stage of change for that behavior.

To use these questions in an actual questionnaire, the behaviors and contexts you will ask about must be determined in advance and the questions should be typed in your questionnaire exactly as you want them asked, using this or a similar format.

1. *How often would you say you < goal behavior > when you < context >? Would you say you do this every time, almost always, sometimes, almost never, or never?*

Check one and go to specific second question indicated:

Always → 2. *How long have you been doing this?* _____
 (Write response)
 If six months or more: MAINTENANCE
 If less than six months: ACTION

Almost always → 2. *How likely is it that in the next 6 months you will start*
 Sometimes → *< goal behavior > every time you < context >? Would you say it is very likely, somewhat likely, somewhat unlikely, or very unlikely?*
 (Circle response and stage)
 If very or somewhat likely: PREPARATION (RFA)
 If very or somewhat unlikely: CONTEMPLATION

Almost never → 2. *How likely is it that in the next 6 months you will start*
 Never → *< goal behavior > every time you < context >? Would you say it is very likely, somewhat likely, somewhat unlikely, or very unlikely?*
 (Circle response and stage)
 If very or somewhat likely: CONTEMPLATION
 If very or somewhat unlikely: PRE-CONTEMPLATION

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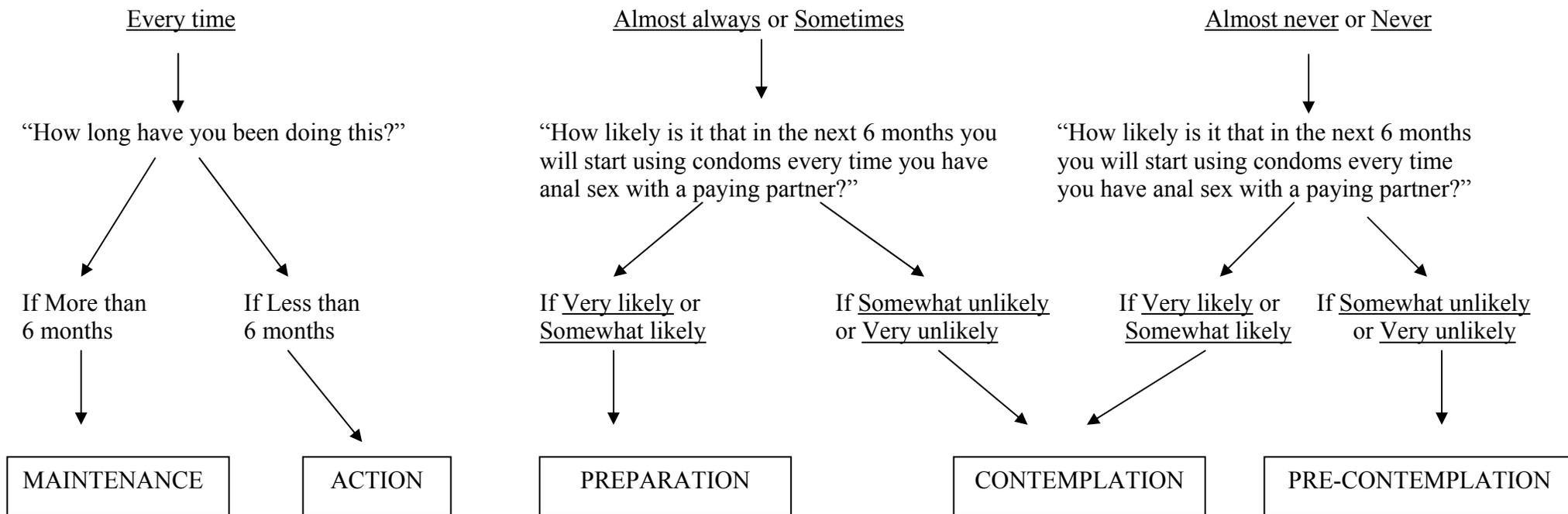
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Sample form H: Staging Instrument

Target Risk-Reduction Behavior: **USING CONDOMS FOR ANAL SEX WITH PAYING PARTNERS***
 (Circle each response given by person as he or she is being interviewed; circle final box indicated.)

“How often would you say you use condoms when you have anal sex with your paying partners?”



*This example uses “anal sex with paying partners” as an example. Substitute the goal behavior you are measuring, such as “vaginal sex with your main partner,” “oral sex with casual partners,” etc.



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MODULE 6: Management

Implementing Community PROMISE requires engaging in multiple, planned activities, as illustrated throughout the previous modules. The management of Community PROMISE requires an active approach and, perhaps, more management time than some other behavioral interventions. In this module, all the “pieces” are pulled together to show what steps are necessary to implement Community PROMISE during the different phases of the intervention.

Implementing Community PROMISE

If you have decided that Community PROMISES is right for your agency, you will need to engage in several activities in preparation for its implementation. A description of these pre-implementation activities follows:

1. *Market the intervention to the stakeholders.* The more support you have in implementing Community PROMISE, the better. It is important to approach your stakeholders in advance about the project. By stakeholders, we mean the decision-making board at your agency or organization, your staff and advocates, members of the population you will target, and perhaps your funding source. In speaking with stakeholders, you want to talk about: the basic elements of Community PROMISE, the appropriateness of the intervention for your agency and community, evidence of its effectiveness, and the resources necessary for the implementation. Having these discussions early improves the chance that your stakeholders will provide their commitment and help and will be sufficiently informed to speak out on your behalf.
2. *Network with other agencies and community organizations.* It is important to establish a network of community leaders and organizations when implementing Community PROMISE. Networking keeps you in touch with what others are doing in the targeted community, thereby reducing the likelihood of duplicating efforts. It also will familiarize other agencies with your programs and services and is a necessary step in eliciting their cooperation or support. Staff members of other agencies working with your target population are valuable resources for information and experience and should be included in your CID process.
3. *Form a community advisory board.* Although it is not a requirement for implementing Community PROMISE, forming a community advisory board will be helpful. Community involvement creates a sense of ownership and acceptance, and it results in a project that uniquely responds to the concerns of its population, and one that is more sustainable. Ideally, an advisory board consists of community leaders (people who are recognized as leaders by your target population or are gatekeepers), individuals who work with the target population (social workers, law enforcement, nurses, health educators, teachers), members of the target population, and others who can provide input into the planning and implementation of Community PROMISE. The advisory board may review materials and offer design and content ideas, find additional access points, and help with resources for events and for peer advocate incentives.



You will find excellent potential members for the advisory board through the CID process. If you do not form a formal advisory board, be sure to involve individuals from the target community in planning the proposed activities. Community involvement fosters commitment to the program. The advisory board can be a major part of the community mobilization effort and can be a source of key observers for your ongoing CID and evaluation efforts.

4. *Conduct CID.* Community PROMISE will be effective because it is tailored to the specific population whose behavior is being addressed. You will discover the behaviors that place that population at risk, the meaning of those behaviors to population members, and the context in which the risk behavior occurs. Since every sub-group of people is comprised of persons who are similar to each other in some ways and different in others, it is necessary to have a clear understanding of the general and specific characteristics of those who make up the target population. By “general,” we mean those characteristics they have in common (heroin use, sexual orientation, trading sex, etc.). By “specific” we mean those characteristics that separate them into different segments of that risk population (ethnicity, other drug use, gender, hanging out in different locations such as bars, parks, street corners, etc.).

Staff members may already be associated with the target population through social contact, ethnic ties, current or past behavioral association, sexual orientation, or a combination of these. Your agency may have already conducted focus groups or other types of assessment activities. All this information is important for the CID process and can be combined with the discovery process to allow for a much better understanding of the community.

5. *Decide on target population.* As mentioned earlier, when making a decision about what population to target for the intervention, be as specific as possible. Community PROMISE is not intended for the general population, nor is it intended to be used, for example, with all men who have sex with men in a city. It is more effective when it targets a group that has a similar, specific risk such as men who have sex with men with anonymous partners who frequent several specific gay bars. Members of the target population provide the content of the role-model stories, which keep the stories relevant and sensitive to the language and cultural nuances of the target population. Being specific and sensitive to the group is not possible with a highly diverse general population.



The role-model stories also describe techniques for overcoming barriers in practicing HIV preventive behaviors, therefore making the stories relevant to a specific population. Anyone who practices unsafe sex is at risk for HIV, of course, but in order to model changing that unsafe behavior, the role-model story must describe the risk behavior change in a context to which the target population can relate. This is possible only with a specific sub-population of individuals who practice similar HIV risk-related behaviors. In this way, risk-reduction stories can use the language and describe the cultural experiences of the target population with little likelihood of offending a part of the population not used to those behaviors or language. Without specifically targeting the message, Community PROMISE (or any other intervention) is not likely to be effective.

6. *Decide on the risk-reduction behavior you want to encourage.* The message for behavior change must be as specific as the target population. It is not enough to say, “Practice safer sex.” We must define the behaviors we would like to promote and the circumstances in which our population practices those behaviors. In the research behind Community PROMISE, the goal behaviors were for population members to use condoms during vaginal or anal intercourse with main and non-main sexual partners and/or to use clean needles for injecting drugs. Specifying the target risk-reduction behavior is important for the recruitment of an appropriate role model and the writing of the role model story.

Key implementation activities: Getting started

Staffing

To plan, implement, and evaluate Community PROMISE you need adequate staffing. Your resources and circumstances will dictate the size of the Community PROMISE program and staff required to implement it. For example, if the program is implemented in a large geographical area, such as in a rural area, one outreach worker can oversee approximately 10 to 15 peer advocates. However, if the target population occupies a smaller geographical area, an outreach worker can supervise 20 to 25 peer advocates. At the very least, implementing Community PROMISE will require two or three staff members for major tasks, some of which may be combined depending on how large the program is. For very large programs, six to 10 full- or part-time staff members may be required. Major paid positions and tasks are:

1. One management-level person responsible for planning, organizing, supervising, providing quality assurance, and conducting process evaluation and outcome monitoring for the program activities. This person should have experience with HIV prevention, implementing programs, and managing employees. They should also be capable of handling multiple program activities at the same time.
2. Staff members to interview role models, write role-model stories, and prepare publications for print. Each of these tasks can be assigned to different staff members on a part-time basis or be performed by one qualified and trained individual on a full or part-time basis.



- If you are preparing one role-model story to be distributed to one target population every three months, the total time required will be minimal—perhaps five to 10 hours per quarter. If, however, you are producing monthly publications for three different populations, much more time will be required.
3. Outreach workers responsible for conducting the CID process, accessing the target population, recruiting peer advocates and role models, and supervising peer advocates. Depending on the target population and the situations affecting the intervention, one full-time outreach worker can manage 10 to 25 peer advocates and perform related tasks. Outreach workers are essential to Community PROMISE and people with the right skills are critical to its success. The outreach staff should have experience with the target population, be able to engage others in conversations easily, and be willing to work outside regular office hours.
 4. A part-time staff assistant responsible for keeping records, typing interview transcripts (if done), maintaining correspondence and filing, duplicating, and providing project support.

Budgeting

After you have reviewed each of these modules and decided to implement Community PROMISE, you will need to begin to budget for the program's activities. At the outset, you need to budget for or have access to:

- project staff
- computer, printer, and software for word processing, desktop publishing, and data management and analysis
- basic office supplies such as paper, pens, pencils, toner, and paper clips
- telephones, fax machine, copier, and equipment maintenance
- digital camera (if you will be doing your own pictures for the publications), camera and scanner, or contract with photographer for role model story production; OR access to electronic clip art or an artist's services for drawings
- production and printing (see Module 3 for an outline of these costs)
- transportation for outreach workers
- incentives for peer advocates (hats, hygiene kits—discussed in Module 4)
- prevention materials to package with printed materials (if necessary, condoms and instructions, lubricant, needles in a needle exchange program, plastic bags)
- rent and utilities, etc for community storefront location if you want such a resource and can find and afford one

In your budgeting, remember that some core elements have a “good,” “better,” and “best” option for implementation. The decision about which option to use will depend upon the resources available to your agency. The “good” option is what minimally is needed for Community PROMISE to be effective. The next option, “better,” adds key characteristics that will improve



implementation. The “best” option depicts the ideal implementation. If your agency’s resources allow, try to implement the “best” of Community PROMISE.

Cost Considerations in Implementing Community PROMISE

The chart below lists the key personnel necessary to implement Community PROMISE, including the number and % of time for each position. In addition, the position responsibilities and required skills and knowledge are listed. This will assist you in estimating personnel needs and costs.

PERSONNEL: (Pay rates vary by Community , so have been omitted.)

Position	# @ x %	Responsibilities	Skills & Knowledge
Program Manager	1 @ 25–100% (depending on size of pgm.)	Seeing that pgm. integrity is maintained; supervise staff & debrief them daily; assure that supplies & publications are on hand when needed, that peers are trained and encouraged; monitor data collection; request T.A.; explain pgm. to stakeholders.	Supervisory skills; excellent knowledge of program elements such that can train & supervise staff, explain to stakeholders; knowledge of outreach and local community; competent in all skills needed (CID, role-model stories, peers, basic evaluation).
Outreach Workers	1–4 @ 100%	Make contacts in community; collect preliminary CID data; recruit & manage peer advocates; recruit and maybe interview role models. Each to supervise 10-25 peers.	Knowledge of community; comfort with target population; verbal communication skills; understanding of and commitment to project & its goals; taken CID & peer courses.
Role-Model Story person (may be part of another staff member’s job, if qualified)	1 @ 40–50%	In collab. with mgr., identify and inform outreach workers about type of role-models needed; interview role-models; write role-model stories; prepare them for publication (layout, paste-up).	Interviewing skills; story-writing skills consistent with theory; desktop publishing; has completed role-model story course, at minimum—preferably all courses.
Support Staff	1 @ 50%	Maintain program records, including data records (CID, process and outcome); order and follow-up on materials and publications; keep notes of debrief meetings & peer and staff trainings; duplicating.	Detail-oriented; good at record keeping & retrieval; can use data-base program of agency; understands concepts related to project; has completed overview course at minimum.

Other costs, beyond personnel, are listed below:

BASIC ASSUMPTIONS: One full-time outreach worker can effectively supervise from 10 to 25 peer advocates, depending on the distances from each other and from the office. Each peer advocate should be given from 10 to 20 packets of material each week or two to distribute to other members of the target population. Frequent (weekly) contact with peers keeps them working and provides management and training opportunities. At a minimum, one outreach worker X 10 peer advocates X 10 packets each to distribute X four weeks per month = 400



packets to deliver each month. Four outreach workers working 25 peers each at the same 10 packets a week X 4 weeks per month = 4,000 packets per month. These figures are based on a fully developed program. If you are just starting, halve the smaller figure, and build up from there. You should expect it will take a year before you will be operating a fully developed program.

Role-model story preparation for publication. If these are prepared in-house, using your own desktop publishing capabilities, the role-model story can be produced by your publication person, the time and costs of which are included above (for the role-model publications). If you must purchase outside services, the cost will increase. Even donated time may cost something in your time and materials.

Printing. Four-color printing may not be necessary. Your advisory board and focus groups held specifically to examine materials will guide your choice as to design, photographs or drawings, etc. Printing from your color or black-and-white printer may be sufficient. Assuming you use a small, local duplicating service at 10¢ per page side, for 20¢ each, you could print a four-page folded newsletter containing two role-model stories and other referral information for your population. Presuming you distribute 400 per month, your printing cost would be \$80 per month or \$960 for the first year.

Accompanying materials. Condoms may be purchased in bulk for less than 10¢ each. Your advisory board and focus groups held specifically to examine materials will provide you with information on how many to package with each publication (1–3, probably). Bleach kits, if you distribute them, can be purchased or you can assemble them yourself. Doing it yourself will only cost less than 50¢ each, and once you get going, you can get volunteers to assemble them once a month under staff supervision. Zipper-top bags for packaging all these cost a couple of cents each. Small one-time packages of lubricants are slightly more expensive than condoms, but should be distributed if your target population has told you that it is important. If you distribute 400 packages a month, your costs may be about \$200 per month (\$2,400 per year); multiply for additional quantities. Appendix S provides vendors of prevention materials.

Mileage. If you pay mileage to your outreach or other staff, calculate the costs of daily trips to the sites where peers and target population members will be found, since your outreach staff will be out in the field more than in the office.

Role-Model Incentives. Role-models can be paid for their time to be interviewed. This may cost as little as \$5 for an interview or as much as \$25, depending on the population and your region. Your advisory board can help with this decision. An extensive interview will provide data for up to three or four role-model stories, and less detailed interview may provide information for only one story. If you publish one or two stories a month, this is still only \$25 per month (\$300 per year). You can also provide non-monetary incentives, discussed below.

Peer-Advocate Incentives. You may find it useful to provide incentives for your peer advocates. Small gifts (ranging from candy to fast-food coupons to t-shirts) will cost from \$2 to \$10 each. Do not give a gift more often than once a month. Less often may be workable, depending on



what is indicated by your advisory board and your experience with peer advocates. Monthly gifts averaging \$3.50 per month for a dozen peers will cost \$42 per month (\$500 per year).

Peer-Advocate Parties/Events. Social events for peer advocates can take place once or twice a year, depending on your area. These may be barbecues in a park, indoor picnics in a local recreation center, or something similar, at which the peers may provide music, the staff may provide skits, and the program provides food, certificates, and small gifts of appreciation (which may be donated by local merchants). Peer advocates may invite their immediate families. The event could cost \$500 (perhaps less if community businesses contribute). Other ideas include bake sales or garage sales where items are donated and then sold by peer advocates. Those advocates who participate can then split the proceeds from the event as an incentive. This type of event teaches the advocates organizational skills and is very satisfying since the results are so tangible.

Community Storefront. You may choose to locate and rent a storefront, small apartment, or other facility in the target community which can serve as the base of operation for the outreach workers and peer advocates. This gives you a place to keep program materials, interview role models, and hold advisory board meetings as well as peer advocate trainings. Strongly consider this if your existing office is not in or near the target community. Costs may include rent, utilities, renovations, insurance, security systems, etc. You might find an existing organization that has space that is available during the times you need it.

Key Participant Survey Incentives and Key Observer Incentives. As part of the initial and ongoing CID process you will be interviewing members of the target population. Since these surveys (especially the key participant) are lengthy you may decide to offer them an incentive for their time. This could be a store gift certificate or fast food certificate. Again, your advisory board can assist in identifying appropriate incentives. The ongoing CID may also include some brief interviews with key observers. These interviews, while short, may be repeated over time with the same people so it may be advisable to provide them with periodic incentives.

General costs. As with any intervention you will have costs for overhead items: space, utilities, insurance, furniture, telephones and phone service, at least one computer and, perhaps, Internet access.

Total costs of the non-personnel intervention specific expenditures mentioned here would be a minimum of \$5,000 per year. This includes printing, accompanying materials to be packaged with the role-model story publications, and incentives and parties for the peer advocates. Almost half of these costs are for the accompanying prevention materials—condoms, bleach kits, etc.



Important note on review of intervention materials

Your agency's Community *PROMISE* program must be reviewed by a Program Review Panel (PRP) established by your health department and representing a cross-section of the local community. The PRP must have at least five members, one of whom is a health department employee.

Your local PRP must review all program materials (community identification tools, role model stories, etc.), as well as the program curriculum, to ensure that they are appropriate for the intended audience in terms of language used and cultural sensitivity.

Your agency is required to ensure that the content of materials to be used in your Community *PROMISE* program is consistent with local community standards of the target audience in terms of language appropriateness and cultural sensitivity.

Complete information concerning the local program review process and content requirements for HIV prevention programs is contained in Appendix M: CDC Content and Review Guidelines for HIV Programs.

Creating a timeline

After you have reviewed the steps described in this module, create a timeline for your work that will include initial program planning tasks, obtaining community support, conducting the CID, identifying role models, recruiting and training community advocates, developing a production schedule, and implementation plans. An example is provided below.



Example of Planning Schedule

Activity	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Recruit staff	X									
Recruit and hold meeting of community advisory board		X	X	X	X	X				
Conduct CID process		X	X	X	X	X				
Define target population and behavior				X	X					
Recruit and develop role-model stories						X	X			
Recruit and train community advocates							X	X		
Pretest and revise role-model stories								X	X	
Develop production schedule							X	X		
Distribute role-model stories										X

When you have finished reading the modules in this manual, we hope you will feel prepared to implement Community PROMISE. Additional reading and case study materials as well as technical support and training are available.



Finally, be flexible! Most sources of funding, such as block grants to health departments, are earmarked for specific risk behaviors and populations. While this ensures that certain priorities receive due attention, it can be a challenge to deal with the sometimes artificial boundaries and limits that you may encounter. As challenging as it may be, the rewards can be terrific.

A summary of tasks required to implement Community PROMISE

The following tables summarize the tasks required to implement Community PROMISE. The task items are useful in helping to plan your agency's efforts.

A. Planning and Preliminary Activities (i.e., Social mobilization, the CID process, recruitment and training of staff)

Task	Capacity and Knowledge Needed
Market intervention to stakeholders	Knowledge of intervention; marketing skills; ability to answer questions
Network with other agencies and community organizations	Knowledge of intervention; marketing skills; ability to answer questions; knowledge of community and agencies that impact your community
Form a community advisory board	Knowledge of intervention; marketing skills; ability to answer questions; ability to establish connections with community persons
Identify or establish a Program Review Panel to review intervention materials	Knowledge of Program Review Panels established by health department or local community; knowledge of CDC PRP guidelines (appendix M); knowledge of intervention
Prepare for the CID process: gather and refine/adapt the necessary materials: interviews, key participant interview, community observation protocol, focus group script and materials, informed consent, field safety guidelines	Questionnaire/interview development skills
Recruit, hire, and train interviewers (may be future implementation staff).	Detailed knowledge of interviewing skills and the various interview protocols to be used; training and supervisory skills; ability to relate to target population



Task	Capacity and Knowledge Needed
Survey internal staff	Knowledge of people in your own organization who interact professionally with target population; ability to establish trust; interviewing skills
Survey external sources of information	Knowledge of people who interact professionally with target population; ability to access them, create trust and elicit information; ability to explain your purpose; interviewing skills
Conduct gatekeeper interviews	Street knowledge; ability to interact with strangers, create trust and elicit information; ability to explain your purpose
Conduct key participant interviews	Street knowledge; ability to interact with strangers, create trust and elicit information; ability to explain your purpose
Conduct community observations	Street knowledge; ability to interact with strangers, create trust and elicit information; ability to explain your purpose; detail- oriented; observant
Conduct focus groups	Experienced at conducting focus groups (not therapy groups); group facilitation skills
Debrief staff using open-ended questions; assist staff in differentiating between inferences, assumptions, and observations. Assemble data and prepare comprehensive report about the target population	Skills in staff debriefing. Qualitative data-analysis and writing skills; group facilitation skills
Make final decision regarding target population	Knowledge of intervention and agency; understanding of agency's priorities and mission; knowledge of CID results to determine target population's need, stage of change and influencing factors
Decide on target behavior	Knowledge of intervention and agency; understanding of organization and funding agency's priorities and mission; knowledge of CID results to determine target population's need, stage of change and influencing factors
Recruit and hire outreach workers and other program staff	Knowledge of intervention and of outreach activities and type of personnel needed



Task	Capacity and Knowledge Needed
Train outreach and other staff. Training issues include safety, conducting outreach, documentation, and the intervention	Experienced in outreach, ability to engage target population; knowledgeable and committed to the intervention; knowledge of tasks required to implement Community PROMISE and forms to conduct evaluation; group facilitation skills
Select specific sites and means of accessing target population	Knowledge of sites frequented by target population; ability to access them; ability to establish trust with sites
Contact (surveys or focus groups) community advisory group and some members of the target population to identify preferred program name and materials (name for project, number and/or types of condoms, in packs, format of role model stories, use of photos versus drawings, etc.)	Street knowledge; ability to interact with strangers; ability to create trust and elicit information; ability to conduct focus groups and process results
Prepare and train staff on the necessary Community PROMISE forms and procedures for implementation in your agency and community	Form-development skills; knowledge of the intervention

Intervention Set-up (i.e., Recruit, screen and interview role models; write role model stories; pre-test and produce role model story publications)

Task	Capacity and Knowledge Needed
Recruit potential role model	Knowledge of intervention, target population, and type of behavior and stage of change needed; skills to explain the program and purposes of story
Screen potential role model	Knowledge of intervention, target population, and type of behavior and stage of change needed; skills to explain the program and purposes of story
Interview role model for story	Interviewing skills; familiarity with special interview format (transcriber) if interviews are taped



Task	Capacity and Knowledge Needed
Write role model story from transcript or interview notes and edit it after review for elements	Knowledge of theory; practiced at writing role model stories and using role model story worksheet; good understanding of purpose and intent of role model stories; writing skills
Decide on size of publication	Knowledge of target population preferences; knowledge of agency resources
Decide type of paper and colors for the publication	Knowledge of target population preferences; knowledge of agency resources
Decide on artwork: photographs (identify models and photographer) or drawings (identify artist)	Knowledge of local resources and target population preferences; ability to communicate what is needed from photographer or artist
Develop mock-ups of role model story publications	Graphic design skills
Locate printer or identify method of in-house publication of materials	Knowledge of local resources; ability to negotiate best price
Pre-test with the advisory board: the mock-up, the role model story itself, and the program name	Familiarity with form developed for purpose; ability to describe purpose and theory behind intervention; ability to manage the group process or individual meeting; group facilitation skills
Pre-test with members of the target population: the mock-up, the role model story itself, and the program name	Familiarity with form developed for purpose; street knowledge; access to target population; ability to manage a focus group process if one is done; group facilitation skills
Revise story as necessary	Same as writer



Task	Capacity and Knowledge Needed
Identify other information to be contained in publication (referrals, ads, coupons, credit for support, etc.)	Knowledge of community as well as needs and interests of target population
Prepare and publish approved version of publication.	Careful attention to detail; good proof-reading skills
Assemble first kits to be distributed (for example, role model publication, condoms, condom information)	Ability to direct and support clerical staff or peer advocates in assembly of materials

Establishing Outreach Component (Recruit and train peer advocates, map geographic distribution plan, establish advocate materials distribution schedule, peer advocate appreciate activity, conduct ongoing production of role model stories, develop material distribution packets for advocates)

Task	Capacity and Knowledge Needed
Recruit peer advocates by establishing community presence, identifying recruitment contacts or areas, initiating recruitment, and engaging in follow-up activities. Recruit to cover social networks. Invite potential advocates to Community PROMISE training	Street knowledge and comfort in the community; access to target population and ability to engage the target population; skills to explain the program and the peer advocates role in a way that makes it attractive to the potential advocate
Identify and pre-test peer advocate incentives	Comfort with target population; knowledgeable about peer advocates' needs and preferences
Conduct peer advocate training. Invite selected persons to become peer advocates and others to be community observers. Provide advocates with initial materials and assign outreach worker	Training skills; comfort with population; ability to thoroughly explain the intervention and the advocates' role



Task	Capacity and Knowledge Needed
Outline geographical area on a local map where materials distribution is to occur; place dot where each advocate works; recruit additional advocates to fill in gaps. Be aware of appropriate number of advocates to cover existing social networks	Knowledge of geographic area; familiarity with peer advocates and their social networks and areas of operation
Outreach workers establish weekly peer advocate visiting schedule. Provide peer advocates with new materials. Document materials distributed by peers	Friendliness, comfort with target population; knowledge of how to use forms; knowledge of Community PROMISE
Plan and implement periodic peer advocate appreciation activity (block party, special gifts, movie night, etc.)	Friendliness, comfort with target population; knowledgeable about peer advocates' needs and preferences

Ongoing Operations for Role Model Stories (Recruitment, interview, write, publish and disseminate)

Task	Capacity and Knowledge Needed
Recruit role models periodically	Knowledge of intervention, target population, and behavior and stage of change needed; verbal skills sufficient to explain the program, making it attractive to the potential advocates
Interview role model for stories	Interviewing skills; familiarity with special interview format (transcriber) if the interview was taped
Write role model story (1 or more) from transcript	Knowledge of theory; practiced at writing role model stories using worksheet; good understanding of purpose, intent of role model stories; writing skills
Publish the role model story	



Task	Capacity and Knowledge Needed
Pre-test all of the first five role model stories, then every fourth one, with at least 12 target population members	Familiarity with form developed for purpose; must be able to describe purpose, theory behind intervention; ability to engage target population; ability to ask open-ended questions
Revise role model stories as needed	Same as writer
Design and paste up each role model story publication	Graphic design skills
Reproduce each role model story publication in sufficient quantity	Knowledge of agency's resources and distribution needs
Package role model story with appropriate materials (condoms, condom instructions, plastic bags, etc.)	Ability to direct and supervise clerical staff or peer advocates in assembly of materials
Distribute materials to peer advocates, documenting numbers and dates when distributed	Knowledge of documentation requirements; ability to engage advocates and maintain their interest; ability to explain the intervention and provide on-going training to advocates as needed

Ongoing Operations for Peer Advocates (Recruitment, training, supervision in the field, incentive disbursement, other appreciation activities)

Task	Capacity and Knowledge Needed
Recruit peer advocates periodically	Street knowledge; access to target population; ability to engage target population; comfort in the community
Conduct peer advocate training. Invite additional persons to become peer advocates and others to be community observers. Provide advocates with initial materials and assign outreach workers	Training skills; comfort with population; ability to thoroughly explain the intervention and the advocates' role; group facilitation skills



Task	Capacity and Knowledge Needed
Visit peer advocates regularly in the field. Provide with supplementary materials, inquire about acceptance, field conditions, target population issues and preferences. Immediately following the interaction, document the content of the interaction and materials provided	Ability to maintain positive relationship with peer advocates and elicit their cooperation; knowledge of documentation forms
Provide incentives (hygiene kits, baseball caps, etc.): annually poll peer advocates regarding what small gifts they would like as incentives for volunteering. Give them a choice of items the program can afford	Friendliness, comfort with target population; knowledge of peer advocates' needs and preferences; creativity
Give peer advocates an appreciation party annually at a time convenient for them and you. Include food, certificates of appreciation, raffle, small door prizes or gifts, games, music, entertainment if possible	Friendliness, comfort with target population; knowledge of peer advocates' needs and preferences
Hold social gatherings, with cards and gifts for advocates	Friendliness, comfort with target population; knowledge of peer advocates' needs and preferences

Evaluation (Data collection; creation of database; manage, analyze and report data)

Task	Capacity and Knowledge Needed
Collect necessary evaluation forms	Knowledge of Community PROMISE evaluation forms, purpose, intent, and usage; instrument design experience; ability to motivate staff to complete forms; ability to communicate need for evaluation to staff
Generate database for data collected; manage database	Knowledge of data management techniques and software (Microsoft Access, Microsoft Excel, SPSS, SAS)



Task	Capacity and Knowledge Needed
Summarize data from evaluation forms	Ability to use basic commands for aggregating and reporting data
Analyze and report collected data	Knowledge of analysis techniques; knowledge about how organization and funding agency defines success

Summary

Effective management of staff, finances and other resources is essential for successful implementation of Community PROMISE and other interventions. This module provided an overview of managerial and administrative activities necessary to plan for and to implement Community PROMISE.

Now that you have learned about the core elements and implementation issues related to Community PROMISE, it is up to you to decide if the intervention is right for your agency and community. We encourage you to use the resources in this manual and those presented to you at the training, including opportunities for technical assistance provision.

Good luck!



Appendices

- A. Intervention research article: “Community-Level HIV Intervention in 5 Cities: Final Outcome Data From the CDC AIDS Community Demonstration Projects”**
- B. AIDS Community Demonstration Project information**
- C. Bibliography**
- D. CID tools**
 - D1. CID Planning worksheet**
 - D2. Systems Interview**
 - D3. Safety Guidelines for Field Staff**
 - D4. Key Participant Interview**
 - D5. Day of Focus Group Checklist**
 - D6. Preparation of Focus Group Discussion Outline**
 - D7. Focus Group Guide and Questions**
 - D8. Advisory Group Notes**
- E. Role Model Stories Materials**
 - E1. Consent to be Interviewed**
 - E2. Consent to be Photographed**
 - E3. Role Model Interview Guide**
 - E4. Role Model Story Content Worksheet**
 - E5. Interview Material Pre-Test**
- F. Peer Advocates Materials**
 - F1. Managing Peer Advocates**
- G. Process Monitoring and Evaluation Tools**
 - G1. Advocate Recruitment Report**
 - G2. Quarterly Production Report**

- G3. Advocate Contact Form**
- G4. Quarterly Advocate Activity Summary**
- G5. Advocate Debriefing Questionnaire**

H. Outcome Monitoring Tools

- H1. Questionnaire**
- H2. Interview Guide**
- H3. Key Observer Interview**

I. Prevention Materials

Important information from the Center for Disease Control and Prevention

- J. Center for Disease Control and Prevention's ABCs of Smart Behavior**
- K. Center for Disease Control and Prevention updates on Nonoxynol 9**
- L. Center for Disease Control and Prevention fact sheet on male latex condoms and sexually transmitted diseases**
- M. Center for Disease Control and Prevention guidance on content of AIDS-related written materials, pictorials, audiovisuals, questionnaires, survey instruments, and educational sessions**

Appendix A: Intervention research article: “Community-Level HIV Intervention in 5 Cities: Final Outcome Data From the CDC AIDS Community Demonstration Projects”

Appendix B: The AIDS Community Demonstration Projects

The Centers for Disease Control and Prevention AIDS Community Demonstration Project was a multi-site collaboration. The intervention was developed collaboratively by investigators at the individual sites, CDC staff, and a team of nationally recognized experts who served as consultants. The institutions and individuals who contributed to the design and implementation of the intervention trial are listed below by the site at which they worked. Affiliations are given for the period during which staff persons collaborated on this research project and do not necessarily represent their current affiliations. Along with the principal investigators are listed key staff members who worked on the study at one time or another.

Dallas, TX. Anne Freeman, MSPH, Dallas County Health Department (principal investigator). Key staff: Suzi Berman, Curtis Jackson, Martin Krepcho, PhD, Elvin Magee, MS, and Jo Ann Valentine, MSW.

Denver, CO. David Cohn, MD, and Cornelis Rietmeijer, MD, MSPH, Denver Health and Hospitals (principal investigators). Key staff: Tim Davis, RN, Steve Kane, MS, Catherine Martindale Fischer, RN, Janet Morgan, RN, Diane Ortega, Patrick Piper, and Keith Yamaguchi.

Long Beach, CA. Nancy H. Corby, PhD, and Fen Rhodes, PhD, California State University, Long Beach, and Long Beach Department of Health and Human Services (principal investigators). Key staff: Susan Enguidanos, MPH, Robert DeLuna, Margaret Jamner, PhD, Suzanne Padilla, MA, Richard Wolitski, PhD, and Jefferson Wood.

New York, NY. Susan Tross, PhD, National Development and Research Institute (principal investigator). Key staff: Abu Abdul-Qadar, PhD, Beatrice Krauss, PhD, Martha Sanchez, and Paul Simons.

Seattle, WA. Robert Wood, MD, and Gary Goldbaum, MD, MPH, Seattle-King County Department of Public Health (principal investigators). Key staff: Karen Hartfield, MPH, Thomas Perdue, John Wiesman, MPH, and Tianji Yu, MPH.

Scientists from the CDC were associated with the original research AIDS Community Demonstration Project throughout its life. Project officers were Kevin O'Reilly, PhD, (1989-1992), Donna Higgins, PhD, (1992-1994), and Wayne D. Johnson, MSPH (1994-1995). Other CDC staff who made important contributions to the study include Carolyn Beeker, PhD, Christine Galavotti, PhD, Carolyn Guenther-Grey, MA, Linda Kay, MPH, and Daniel Schnell, PhD.

Scientific consultants also made major contributions to the development, design, and evaluation of the AIDS Community Demonstration Projects. These individuals include Martin Fishbein, PhD, Alfred McAlister, PhD, LeaVonne Pulley, PhD, James Prochaska, PhD, John Sheridan, Cathleen Crain, MA, and Nathaniel Tashina, PhD.

Community HIV Prevention and Training Programs

The opportunity to test various methods of translating the original study into an intervention that would be useful to local agencies was provided by five agencies to which we wish to express our appreciation. The Los Angeles (CA) County Office of Programs and Policies and the Long Beach (CA) Department of Health and Human Services provided funding to continue the intervention with different populations following the conclusion of the research study. The State of California Office of AIDS enabled us to reach every corner of California with various versions of a training package. Family Health International (FHI) and the United States Agency for International Development (USAID) gave us the opportunity to implement both training and program in Ukraine and Indonesia, for which we are very grateful. We learned much from these efforts, and what we learned has helped make Community PROMISE a more effective tool.

Individuals whose efforts were especially appreciated in these prevention and training activities include Eduardo Archuleta, Michael Buitron, Donna Yankovich Cottrell, MA, Bobby DeLuna, Susan Enguidanos, Margaret Jamner, PhD, and Susan Padilla, MA. We also benefitted from the suggestions and contributions of Fen Rhodes, PhD, in enhancing the practical and effective implementation of the ACDP model for community-based organizations.

Appendix C: Bibliography

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Appendices D1-D8: CID tools

**Appendix D1:
Community Identification (CID) Worksheet**

The target population for this worksheet is: _____

The initial written materials to be reviewed about this target population will come from the following sources (journal names, government data or publications, statistical reports, etc.):

Enter the names or identities (job titles, location, etc.) of people you will initially recruit for each of the following types of CID data collection.

Internal Interviews: _____
Systems Interviews: _____
Interactor Interviews: _____
Gatekeeper Interviews: _____
Focus Groups: _____

In addition to areas suggested from the interviews above, field observations of this population will be conducted in the following areas:

Appendix D2: Community PROMISE Systems Interview (for use with staff, external agencies, interactors and gatekeepers)

1. Position or title (if sensible to ask): _____

2. Sex: MALE FEMALE (Circle one)

3. Age: _____

4. Ethnicity (self definition): _____

5. Language(s) spoken: _____

6. How long have you been in this position? (if sensible to ask) _____ years

7. We are interested in learning more about (*target population*) in this community. When you think about (*target population*) in your community do you divide them into different groups such as males/females or older/younger or users of different drugs, or anything else? What are those groups?

Now I am going to ask you questions only about the (*target population*) you mentioned.

8. How do you/have you had contact with (*target population*)?

9. Where can (*target population*) be found in this community? (specific areas)

10. What phrases or vocabulary do (*target population*) use that are unique?

11. What barriers, are there that, would make it hard to talk to (*target population*)?

12. What behaviors do (*target population*) have that put them at risk for HIV infection and STDs?

13. What do you think is motivating (*target population*) to continue practicing these high-risk behaviors (in spite of all the information that's out there?)

14. What do (*target population*) think about their own risks for HIV infection and STDs?

15. Who else would know about (*target population*) in this community?

Name	Address	Telephone #	Can we use your name?
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16. Who do (*target population*) listen to, who influences their opinions and behaviors?

Name	Address	Telephone #	Can we use your name?
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17. Do you know any (*target population*) we might talk to?

Name	Address	Telephone #	Can we use your name?
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18. If you had to try to convince (*target population*) to avoid high risk behavior, how would you approach the problem? What specific suggestions do you have (programs, techniques, etc.) for getting (*target population*) to reduce their risk of HIV?

19. What particular activities for (*target population*) would not work or should be avoided in developing HIV prevention programs?

THANK YOU VERY MUCH FOR YOUR ASSISTANCE

Appendix D3: Safety Guidelines for Field Staff

Safety guidelines apply to all staff at all times they are in the field, including at lunch or on a break.

Personal Appearance: Dress Down

1. Do not dress to impress. Wear neutral clothing that does not attract undue attention. Do not wear clothing that will be considered seductive or revealing. Be aware of gangs and their colors; do not wear red or blue clothing (other than jeans) or accessories in gang-identified areas.
2. Employees should not carry a purse or a large amount of money while in the field. Jewelry should be limited to small costume jewelry.
3. Have your project assessment on you before going into the field. The I.D. badge must be worn on a coat or a shirt where it is visible and can be easily produced. Identify yourself and tell people what you are doing and why.

Getting Along: Be Professional

4. Develop a friendly, professional relationship with clients you come into contact with, but do not interact with them socially, romantically, or financially.
5. Do not touch participants. Friendly gestures may be threatening on the street, and participants may react strongly to them.
6. Do not buy goods or accept gifts, food, or merchandise from target population members or others on the street—they may have been stolen. Do not give or lend money to participants—it suggests favoritism to observers.
7. Do not make assumptions, judgments, or generalizations about the target population members. Behave respectfully towards them and earn their trust and confidence. Avoid communication, through words or posture, which may convey arrogance or a judgmental attitude.
8. Do not play the role of therapist or counselor. Stay within your role of outreach worker or interviewer. Provide referrals to community services as appropriate.

9. Always interview respondents one at a time to protect their confidentiality, even if they say it is okay for someone else to listen.

Safety Policy: On-the-Job Rules

10. Field work may be conducted only during specific times of day approved in advance by your supervisor and should be conducted with another staff member in view or in sight of the project office unless the area and circumstances have been approved by a supervisor for a staff member to enter on his or her own. Field work at night may not be conducted without supervisor's permission.
11. When carrying incentives or cash, limit the amount to what you'll need during the day. Take care not to disclose the total amount of cash that you are carrying. Cash incentives should be kept in envelopes—one envelope per incentive—and only the number of cash or coupon incentives needed for half a day should be kept on your person. Return to the office or car to replenish your supply if needed.
12. Inform police officers of your presence and purpose for being in the area.
13. Your supervisor is required to know where you are when you are out of the office. Do not depart from your agreed-upon schedule. Telephone the office at the times agreed upon to check for messages from your supervisor and to inform others of your location. Be sure to notify your supervisor if you must leave the assigned area for any reason.

Avoiding Trouble: Be Alert

14. Be aware of your surroundings at all times. You can avoid trouble by carefully observing the area around you before you leave your car or enter a new area.
15. Stay in view of street traffic whenever possible. Do not enter shrubbery, alleys, buildings, or other areas where you are not visible, unless you are accompanied by a partner and the area is known to be safe.
16. If you are working with a partner, never leave your partner in the field or fail to meet at a previously arranged site.
17. Do not carry weapons.
18. Avoid getting in the middle of the sale of drugs or sex. If a drug or sex deal is conducted near you, leave the area quickly and quietly, without drawing attention to yourself. Never take, touch, or sample any person's drugs or merchandise on the street.
19. If you do not feel comfortable entering certain areas, or if you have reason to believe that your safety has been compromised, do not enter the area. Report to your supervisor immediately.
20. Make sure you know how to refer crime victims or someone who is in crisis to needed services (police, rape hotline, battered women's shelter, etc.).

21. You and your partner should establish a code word or action that means “leave immediately” so that you can warn each other of the need to move on.

If Trouble Occurs: Leave the Scene

22. If you are caught in a potentially dangerous position, stay calm and leave as soon as possible. In case of emergency, call 911.
23. Never yell or argue with anyone. If someone becomes angry or irritated at you, leave the area at once.
24. If someone is “under the influence” or otherwise behaving strangely or in a threatening manner, avoid him or her.

Appendix D4: Key Participant Interview

Basic Information

Age: _____ Location: _____

Ethnicity: _____ Date: _____

Gender: _____ Time of Day: _____

Interviewer: _____

Information Attainment

I want to ask you some questions about where you get information.

1. Where do you go, and/or what do you do to find out about what is happening in the community or your own neighborhood? Is there someplace or someone you seek to get information?
2. Do you ever read brochures or pamphlets? Would you read something like this? (*Show sample of role-model story publication.*)

Networks

I want to ask you some questions about yourself and the community.

3. How long have you lived around here? How much do you go outside of your own neighborhood where you live (*hang out*)? How do you get around? Do you have a car?
4. Where do you hang out? Whom do you usually hang out with?
5. Is your family here? Your friends? Whom do you live with? How long have you lived with these people? Do you have children? Do they live with you?
6. Whom do you talk to about personal problems or other things that bother you? Is this a friend, or someone in your family? (*Get relationship, not name.*)
7. How do you get money? (*Probe for multiple sources.*)

AIDS Information

Now I'd like to ask you some questions about AIDS.

8. How do you think people catch the AIDS virus?
9. Do you think it is likely you could catch AIDS? Why do you think you could or could not?
10. Are you doing anything to protect yourself from catching the AIDS virus? What? If nothing, why not?

Sex

Now I want to ask you some questions about sex.

11. When was the last time you had sex?
12. Where do you usually find your sexual partners?
13. The last time you had sex, did you use a condom? Why or why not? What kind of sex did you have? (for example, oral, anal, vaginal)
14. Have you had sex in the past month? When was the last time? (*If no sex in past month, skip to condoms section.*)
15. Was this person (were any of these people) someone you would say is your main or steady sex partner? (*If not main partner, who?*)
16. Is your main partner a man, a woman or transgender? (*If no main partner, were partners mostly men, women, or transgender?*)
17. In the last month, when you had sex, how often did you use a condom? Why did you use it (not use it)? What type of sex were you having?
18. What would you say is the reason you didn't use a condom every time?
19. During the next month, do you plan to use a condom when you have sex with your main partner? Every time? For what kind of sex? (oral, anal, vaginal)
20. In the last month, have you had sex with anyone to get drugs, money, or other things? (*If "no," skip to condoms section.*)
21. How often did you use a condom when you had sex in these situations? What kind of sex did you have? Did you use a condom for some kinds of sex and not others?
22. What would you say is the reason you did not (did) use a condom every time in these situations?
23. In the last month, did you have sex with somebody other than your main partner when it was not for drugs or money? Who? What kind of sex did you have? How often did you use a condom? For which kind(s) of sex?
24. What would you say is the reason you did not (did) use a condom every time?

Condoms

Now I want to ask you some questions about using condoms.

Condoms for Vaginal Sex (*If no vaginal sex, skip to anal sex questions.*)

25. Now tell me the kinds of things that would make it more likely that you would use a condom whenever you have vaginal sex. What about other people—what would make it easier for them? Is there anything else that would make it more likely that you or others would use a condom whenever you had vaginal sex?
26. What kinds of things keep you from using a condom? Is there anything else that makes it difficult for you or others to use condoms for vaginal sex?
27. What people do you think might want you to use a condom every time you had vaginal sex? Are there any other people who might like it if you used condoms all of the time for vaginal sex?
28. What people do you think might not like it if you used a condom every time you had vaginal sex? Are there any other people who might not want you to use condoms all of the time for vaginal sex?
29. Are there any people you might go to if you wanted advice or information about using condoms for vaginal sex? Who are these people?

Condoms for Anal Sex (If no anal sex, skip to alcohol and drugs section.)

30. Now tell me the kinds of things that would make it more likely that you would use a condom whenever you have anal sex. What about other people—what would make it easier for them? Is there anything else that would make it more likely that you or others would use a condom whenever you had anal sex?
31. What kinds of things keep you from using a condom? Is there anything else that makes it difficult for you or others to use condoms for anal sex?
32. What people do you think might want you to use a condom every time you had anal sex? Are there any other people who might like it if you used condoms all of the time for anal sex?
33. What people do you think might not like it if you used a condom every time you had anal sex? Are there any other people who might not want you to use condoms all of the time for anal sex?
34. Are there any people you might go to if you wanted advice or information about using condoms for anal sex? Who are these people?

Alcohol and Drugs

Now I'd like to ask you a couple of questions about alcohol and drugs.

35. When you have sex, do you sometimes use alcohol or drugs? Which drugs, etc.? How often?
36. How often do you drink alcohol or use drugs at other times? Which drugs, etc?

Injection Drugs

Now let's talk about shooting drugs.

37. Do you shoot drugs? Have you ever shot drugs? When was the last time? (If haven't used

drugs in the past six months, skip to Awareness of Services section.)

38. Does your main sex partner shoot drugs? Which? Does he/she try to hide it from you? Does he/she ever shoot with other people? Does he/she share needles? Does he/she use bleach? Have the two of you talked about AIDS?
39. In the last six months, if you shot after someone else or used someone else's outfit, how often did you clean the works with bleach before you used?
40. What would you say is the reason you didn't clean with bleach every time you shot after someone else or used someone else's outfit?
41. If you shoot in the next month, do you plan to clean your works with bleach every time you share?
42. What people do you think might want you to always use bleach to clean your works before sharing? Are there any other people who might want you to always clean your works with bleach when sharing?
43. What people do you think might not like it if you always used bleach to clean your works before sharing? Are there any other people who might not want you to always clean your works with bleach when sharing?
44. Are there any people you might go to if you wanted advice or information about always using bleach to clean your works?

Awareness of Services

Now I want to find out where you would get information about health for you and your family.

45. Where do you go for health care?
46. Where would you go if you wanted family planning services?
47. Where would you go if you had a question about HIV/AIDS? Why would you go there?
48. Where would you go if you wanted to be tested for HIV/AIDS?
49. Have you seen or heard anything about how to protect yourself from HIV/AIDS?
50. What did you see or hear?
51. Have you had any HIV/AIDS education before or been a part of a program that talked about HIV/AIDS? (*If "yes," find out what program— especially if ours.*)
52. Do you think you have ever been in a situation where you might have caught the AIDS virus? Do you believe you might be infected with the AIDS virus now?
53. Have you ever been tested for the AIDS virus? (*Skip next question if not tested.*)
54. Did you go back to get your test results? Would you share the results with us? What were

they?

55. Is there someone else that we should talk with about HIV/AIDS that can give us information to make our program better? If so, can we contact them? Can we mention your name?

Those were all of my questions. Thank you very much for your time. Your contribution will help us develop interventions that will have an impact.

Appendix D5: Day of Focus Group Checklist

1. Arrive early at the site.
2. Brief the staff on the anticipated duration of the focus group, procedures for signing people in and using registration and confidentiality forms, and how the pay-and-dismiss procedure will be handled.
3. Arrange the room (table and chairs) in the desired style.
4. Review and organize discussion aides, post-session handouts (referral information, HIV facts).
5. Review discussion outline.
6. If applicable, bring pre-counted cash in individual plain white envelopes for participants' fees.
7. Prepare sign-in sheet, release forms, and confidentiality forms and community identification process. who is responsible for having them completed.
8. Prepare refreshments.
9. At end of group, collect the audio- or video-tapes and label them for transcription or for future reference. Label tapes with information about city, date, and time of the focus group.

Appendix D6: Preparation of Discussion Outline

1. Cover the following preliminaries with participants:
 - self-introduction; do not use professional titles
 - explanation of project's purpose; do not be secretive
 - explanation of what a focus group is
 - ground rules for interaction (these are similar to those in other counseling groups)
 - participant introductions
2. Promote group formation and interaction by posing provocative opinion questions that encourage reflection.
3. Topics should go from broad to narrow. This provides a valuable context for participants and makes it easier to cover sensitive material.
4. Save the most sensitive items for the middle of the focus group, when trust and rapport have been established.
5. The outline should consist of questions you plan to pose to the group. Whether you use them all or not, it is wise to specify follow-up probing questions.
6. Assign time to each topic. As part of your preparation, reduce the number of topics until you feel you have adequate time to cover each one.
7. Be flexible. Topics may emerge in the discussion before they appear on your outline, and unanticipated topics may come up that need to be explored.
8. When appropriate and/or necessary, use any of the following techniques:
 - free association
 - paraphrasing
 - posing hypothetical or previous real-life situations
 - "if you had to choose" questions
 - playing the devil's advocate
 - asking group whether they agree or disagree with what others are saying
 - written or video materials
 - mini-surveys
 - getting group validation of generalizations you are drawing
9. Be sure to thank the group members for their time and participation, and remind them that what they have shared with the group today is confidential.

Appendix D7: Focus Group Guide and Questions

- **Introduce facilitators.**

- **Define purpose of focus group.**

We want to learn more about the lives of <Target Population> who use drugs and who also have sex, so we'll be talking today about sex, drugs, and HIV/AIDS.

- **Acknowledge diversity and commonality among participants.**

You may hang out in different parts of town or with different people, but you all have sex or use drugs in one form or another.

- **Explain the reason the session will be tape recorded.**

We are going to tape record our discussion today so that we won't have to take notes ourselves and can pay more attention to the conversation. Afterwards we'll have someone type up what was said on the recording; your names won't be included, just what you say. Once we get the recording typed up, we will erase the tape.

- **Establish rules of confidentiality.**

Please use your first names only, and, if you feel more comfortable, you don't have to use your real name. It's going to be up to all of you to keep what people have said here confidential after you leave.

- **Encourage participants to set limits.**

Share only what you're comfortable sharing; you don't have to discuss every topic, and you don't have to talk about yourself or your own situation unless you want to.

- **Identify location of bathrooms.**

If you need to use the bathroom, that's okay, but come back quickly because we need your input.

- **Allow participants to disagree.**

Feel free to say what you think; we want to hear all of your ideas, even if you don't agree with each other. It's okay to disagree; you just need to respect each others' opinions.

- **Introduce group participants.**

To start things off, why don't you tell us your first name, your age, and how long you've lived in this area. I'll go first.

- **Confirm understanding of group participants.**

Does anyone have any questions or concerns about what we are going to be doing today?

- **Turn on tape recorder and begin questions.**

1. Let's start off by talking about how <Target Population> are learning about AIDS here in <City Name>. Remember, you all have some things in common in that you all have sex and may use drugs. So could you start out by giving us an idea of where <Target

Population> in your situation are getting their information about how to protect themselves from coming in contact with HIV, the virus that causes AIDS.

- Whom do you think <Target Population> usually turn to for information about HIV and AIDS?

Is there anyone else who can think of where <Target Population> get their information from?

- Are there any places in <City Name> that you know of where people like yourselves usually get information about HIV and AIDS?

Tell us a little bit about these places and the kinds of people who get information there.

What about in the <Target Population> community? Would <Target Population> get information about preventing the spread of AIDS through connections with the community? What can you tell us about that?

- Do <Target Population> ever talk about getting information from outreach workers?

What kinds of things have you heard other people say about outreach workers?

What other kinds of things have you heard about outreach workers and AIDS prevention?

Tell us about people who aren't connecting with outreach workers.

How could outreach workers do a better job of reaching <Target Population> who are getting missed?

- It sounds like some sources are better than others for getting information about AIDS. Am I right about that?
- Where would most <Target Population> say they get the best information?

2. Tell us exactly what <Target Population> know about protecting themselves and preventing the spread of HIV. *[Facilitators: pay attention to (a) prioritization of responses and relevance to participants' risk behaviors; and (b) which prevention techniques are reported spontaneously, reported only in response to probing, and omitted.]*

- What else do <Target Population> know about preventing the spread of HIV?
- What about other ways to prevent the spread of HIV through sex (such as using condoms or latex barriers for oral sex, anal sex, vaginal sex; mutual masturbation; having fewer sex partners)?
- What about other ways to prevent the spread of HIV through using needles (such as not sharing needles; using needle exchange programs; not sharing cookers, cottons, rinse water; cleaning shared syringes with bleach)?

3. We've talked a lot about what <Target Population> actually know about preventing the spread of HIV. Could we talk for a while about the kinds of situations that <Target Population> get into where they don't use that information about how to stay safe from AIDS?

- What are some other situations where they would not use safer sex practices?

What kind of sex partners does that usually happen with?

- What are some other situations where they would not use safer injection practices?

What kind of drug partners does that usually happen with?

- Of the <Target Population> who are out there using drugs and having sex, which ones are the most likely not to play it safe?
- It sounds like taking risks (is often; isn't really; is only sometimes) related to drug use. Is that the case?
- What about <Target Population> who don't really know about HIV and AIDS? What can you tell us about <Target Population> who just don't know the full story about how HIV is spread?

Is there anything about staying safe from HIV that people are confused about?

4. Based on your own experience, and also what you know about the drug scene and the sex scene, what do you think would be the best kind of AIDS education program to have for people like yourselves?

- What would the program look like?
- Whom would the clients be?
- What about the staff? What kind of staff members do you think <Target Population> would trust the most to give them information about HIV and AIDS?

Would you prefer men, women, or transgender?

Does the staff person's sexual orientation matter? In what way?

What about former drug users or people who are infected with HIV?

- Are there other needs that people have that you'd like to include in the program?
 - Is there anything else you can think of that would help make a program really useful for people like yourselves?

Appendix D8: ADVISORY GROUP NOTES

Date: _____ Advisor: _____

Type of meeting: _____ Duration: _____

Support-statement:

Priorities for HIV Prevention:

Related health/social priorities:

Resources provided:

Ideas/suggestions:

Recommended contacts/contact information:

Volunteer for network?

Role model story?

Coordination/role definition:

Other comments:

Appendices E1-E5: Role Model Story Materials

Appendix E1: Consent to be Interviewed Form

This interview is part of a program being conducted by _____ (*Agency Name*).

The purpose of this interview is to gather information about people's experiences in trying to reduce their risk of STD/HIV. These experiences can be used to write stories to distribute to peers in order to help them reduce their risk also.

This interview is anonymous. We do not want to know your name or other identifying information. During this interview I will ask you personal questions about your sexual practices and drug use.

The interview will be tape-recorded, so please do not use your name or the names of other people you know while the recorder is turned on.

Only staff participating in this program will listen to the tape recording. In some cases, stories will be written based on the interview, and these stories may be printed—without identifying information—in STD/HIV prevention pamphlets or newspaper stories.

We would like for you to answer all the questions fully, but you may choose not to answer anything you are not comfortable with.

I have been informed about the nature and purpose of this interview. I agree to be interviewed and to participate in this program under the conditions that have been described to me.

Participant Signature

Date

Staff Signature

Date

Appendix E2: Consent to be Photographed

I agree to be photographed by _____ for HIV prevention
flyers and brochures. **(Agency Name)**

I understand that these pictures will be published without actual names in a way that will keep me from
being identified. These pictures may be published in educational flyers and stories for the prevention of
HIV/AIDS in the community of _____.
(City, State)

I have been informed about the nature and purpose of these photographs. I agree to be photographed
under the conditions described above.

Participant Signature

Date

Staff Signature

Date

Appendix E3: Intervention Material Pre-Test

- *Introduce yourself and project.*
- *Explain the purpose of our survey.*
- *Inform reviewer of incentive (if used)*
- *Hand him or her the role-model stories and ask the person to look at/read them.*
- *Record answers on lines provided.*

1. Comprehension and Attention to Message Content

(choose one story)

- What is the message, the main idea of this story?
- What do you think this story is trying to say?

2. Personal Relevance

- Do the stories relate to you and your friends?
- Would these stories make you think?

3. Believability

- Are the stories believable?
- From your experience, would you say these changes are real or not? Why/why not?
- Do you understand the language? Is it easy to read?
- Is this the way you talk?

4. Acceptability

- Is there anything offensive about the stories?
- What did you like best/least about the stories?
- What artwork or picture did you like best?
- How could the flyer be improved?

- What interests you about flyer? Would you look forward to next month's if it were included?

5. Production Value

- What catches your eye the most about the materials?
- What would you do with the materials? Where would you put them?

6. Access

- Where do you suggest we place these materials to reach your community?
- Would you pick this up from a counter, from a cashier at the liquor store?
- Would you pick it up from a rack outside the stores?
- Would you feel embarrassed if a clerk gave this to you and encouraged you to read it?

Appendix E4: Role-Model Interview Guide
ROLE MODEL STORY INTERVIEW GUIDE

I. SCREENING INFORMATION (from recruiter)

Interviewer name _____	Date _____
Interviewee name _____	Target pop: _____
Race/ethnicity _____	Gender _____ Age _____
Estimation of current sex-related risk-reduction behaviors (condom use, fewer sex partners, etc.)	
Behavior _____	Stage of Change _____
Behavior _____	Stage of Change _____
Estimation of current drug-related risk-reduction behaviors (cleaning needles, quit sharing, using new needles, etc.)	
Behavior _____	Stage of Change _____
Behavior _____	Stage of Change _____
HIV status: negative positive not tested	

II. INTRODUCTION AND BACKGROUND INFORMATION

- Introduce yourself **Hello. My name is _____ . I want to thank you for coming today.**

- Tell why doing this **I believe that _____ < staff member who conducted screening > has explained to you that we're interested in talking to people who are concerned about the risk of AIDS and who have done something towards protecting themselves or others. We want to know what people are doing so we can write up their stories for others to see, like this one here [show sample publication]. I appreciate your willingness to share what you have done because your story will help others reduce their own risk of AIDS.**

- Thank for participating

- Tape recording **As _____ explained to you earlier, I am going to tape-record our conversation today so I don't have to worry about taking notes. I hope that's okay with you. The tapes will be erased once transcripts are made, and everything will be kept in locked files all the time, and will be seen only by staff who will be working with them—the transcriber, writer, and program supervisor. In the story that is used, your name and identifying information will be changed to protect you.**

- Confidentiality

TURN ON TAPE RECORDER

- Consent form **Before we start, I need to get your permission to interview you and publish the story that is written from the information, again, keeping your name anonymous.** [Go over consent form. Obtain signature. Express appreciation.]
- Incentive **As you know, we will be giving you** [describe incentive] **at the end of the interview as a way of expressing our appreciation. You do not have to answer any specific questions to receive this—if any question makes you uncomfortable, let me know and we'll go on to another question.**
- Verify information **First, let me verify the information I have about you. You are currently . . . (And you are also . . .) Is that correct?** [Describe risk-reduction behavior(s) elicited during screening; confirm specific behavior(s) and reported stages of change.]
- You also said that you have (have not) been tested for HIV and [if tested] that you results were (negative, positive). Do I have that right?**
- Ask about background **Before we talk any more about what you have done or are planning to do to reduce your HIV risk, tell me a little about yourself, something about your background.**
- Length of time in local area
 - Relationship status (spouse, boyfriend, girlfriend)
 - Living situation
 - Employment, school, occupation
 - Where and with whom spend majority of time (hangouts, characteristics of associates)
 - Drug and alcohol use in general

Now let's go back to what you've done (are planning to do) about HIV. Tell me more about . . . [focus on one specific risk-reduction behavior, and lead into the questions below].

Ask the remaining questions in turn for EACH risk-reduction behavior (sexual and substance use) performed by the interviewee. Obtain complete information about one behavior before going on to the next. Note that some questions may not be appropriate for interviewees whose highest stage is Preparation. *It is important that all individuals who are interviewed have a current stage of change no lower than Preparation for at least one risk-reduction behavior.*

III. CONTEMPLATION AND PREPARATION

- **Try to remember, when was the first time you started thinking that maybe you should consider < doing the behavior >?**
 - **Was this because of AIDS?**
 - **What was it that made you especially concerned about the risk of AIDS in your case?**
 - **Was there any specific thing you can remember that happened back then that made you start thinking you should < do the behavior >?**
 - **Besides not getting infected with HIV (not transmitting the virus) were there other things that made < doing the behavior > seem like a good idea to you—any other advantages?**
 - **What were the main disadvantages that you saw to < doing the behavior >?**
- **When you first started thinking about < doing the behavior > how serious were you about doing it? What I mean is, how sure were you that you were really going to do it, maybe not right away but at least eventually?**
 - **When would you say you became really certain that you were going to start < doing the behavior >? How long after you first started thinking about it did you know for sure you were going to do it at some point in time?**
 - **Did something specific happen to make you certain? What changed that made you know for sure you were going to start < doing the behavior >, instead of just thinking about it?**

IV. ACTION [*Only ask if the person is in the Action stage on the behavior you are discussing. Otherwise, skip to section V.*]

- **Once you were really certain you were going to < do the behavior >, how long would you say it was before you actually started?**
 - **What made you decide to start then—how did that happen?**
 - **What were the things that kept you from starting earlier?**
 - **What was the situation the first time you tried < doing the behavior >? How did it work out that first time?**
 - **Were you < doing the behavior > from the start without any slip-ups, or were you doing it just some of the time?**
 - **Tell me some of the problems you ran into when you first started trying to < do the behavior >. How did you deal with these?**
 - **How much trouble has it been < doing the behavior > consistently, once you got going? Tell me about some of the difficulties you have experienced?**
 - **Have there been any times when you thought < doing the behavior > might not work out, but in the end you were able to do it? Tell me about that.**
 - **Tell me about any times when you were *not* able to < do the behavior >. How did you feel about that? What did you do to keep from becoming discouraged? Did you learn anything from those experiences that helped you later?**

V. RISK-REDUCTION EFFICACY AND SOCIAL SUPPORT

- **How effective do you think < doing the behavior > is in protecting against being exposed to (exposing someone else to) the AIDS virus (HIV)?**
 - **Is this what you have always thought?**
 - [If increased perception of effectiveness:] **What happened that made you more convinced? Was that before you had started < doing the behavior > or after?**
- **Do any of the people you know want you to < do the behavior >? Do any of them especially care about whether you do?**
 - **What about your friends? Your family?**
 - **What about your (spouse, boyfriend, girlfriend)?**
 - **Did any of these people have anything to do with your decision to start < doing the behavior >?**
 - **Who was that? Tell me about that situation.**

If there are additional goal behaviors to inquire about (listed on the screening section of this form), return to Section II, *Contemplation and Preparation*, and ask about the new behavior. You do not have to repeat the *Introduction and Background* section, since that will remain the same no matter what behavior you are asking about.

If the individual has not reached Action on those behaviors, skip the *Action* section (IV) and go right to Section V, *Risk Reduction Efficacy and Social Support*. When you have completed the interview on all relevant behaviors, continue below.

VI. CONCLUSION

- | | |
|--|---|
| <input type="checkbox"/> Questions? | Turn off tape recorder. |
| <input type="checkbox"/> Thanks | Thank the interviewee for his / her generosity to the community in participating, being so forthcoming. |
| <input type="checkbox"/> Incentive | Give incentive or tell how it will be given to him / her. |
| <input type="checkbox"/> Ask for others to interview | Ask if knows any others who might be willing to be interviewed, have helpful experiences. Get that person's or give your office contact information |
| <input type="checkbox"/> Give referral info. | Give relevant referral information (community resources, services).
Final thanks |
| Tell person the interview is over. Ask if any questions. | |

Appendix E5: Role-Model Story Content Worksheet

Story Title: _____

Ethnicity of Main Character: _____

Gender of Main Character: _____

Characterization:

Membership:

Risk Behavior:

Goal:

Influencing factor:

**Barrier to Change/
Methods to overcome:**

Positive Outcome:

Stage of Change Movement:



Appendix F: Managing Peer Advocates—Summary

Recruitment and Training

1. Definition and description of peer distributors and examples from various target populations
2. Roles and responsibilities of peer advocates
 - a. materials distribution
 - b. materials assembly
 - c. material evaluators (pre-testing)
 - d. key observers (interviews and focus groups)
3. Desired attributes of peer distributors and other peer advocates
4. Disqualifying characteristics
5. Soliciting target population members' participation
 - a. initial recruitment
 - b. orientation and evaluation of potential peer advocates
 - c. invitation to participate
 - d. field training for distribution; on-site training for assembly

Management of Materials Distributors

1. Relationships between peers and outreach workers, other staff members
 - a. expectations
 - b. rotating of staff assignments
 - c. avoiding favoritism
2. Incentives
 - a. selecting incentives
 - b. frequency of incentive distribution (variable reinforcement schedule once established as volunteer)
 - c. obtaining feedback on preferred incentives based on experience
3. Social reinforcers
 - a. praise and approval
 - b. cards and letters
 - c. awards and certificates
 - d. opportunities for public recognition
 - e. parties and socials



4. Managing difficult situations.
 - a. angry, violent, or otherwise difficult volunteer (alienates target population, other volunteers, or staff)
 - b. volunteer sells project materials
 - c. volunteer arrested or otherwise out of service for a period of time
 - d. volunteer steals from office or staff
 - e. volunteer throws away the materials, does not distribute them
 - f. volunteer distributes materials to wrong people
 - g. volunteer lies about distribution activities or provides false information related to community
 - h. discharging volunteers

5. Managing other peer tasks
 - a. materials assembly
 - b. material evaluators (pre-testing)
 - c. key observers (interviews and focus groups)



Appendices G1-G5: Evaluation tools



Appendix G1: Advocate Recruitment Report

Training date: _____ Number attending: _____

Training description: _____

Incentive: _____

Name	I.D. #	Gender	Ethnicity	Advocate Risk Group	Risk Group Served	Area	# Materials Accepted



Appendix G2 Quarterly Production Report

Months covered: _____

Production Date	Story Title	Publication Number	Number Produced	Target Population	Prevention Behavior Modeled	Gender of Main Character	Ethnicity of Main Character	Initial Stage of Change
TOTAL:								



Appendix G4

Quarterly Advocate Activity Summary

Months Covered: _____ Year: _____

Gifts: A = _____, B = _____, C = _____, D = _____, E = _____, F = _____, G = _____

Number Distributed										
Target Population	Advocate's I.D. #	Month: _____			Month: _____			Month: _____		
		Story # ____	Story # ____	Gift	Story # ____	Story # ____	Gift	Story # ____	Story # ____	Gift



Appendix G5

Advocate Debriefing Questionnaire

Date: _____ Interviewer: _____

Location of interview: _____

Advocate first name: _____ Nickname: _____

Last name: _____

1. Whom do you pass materials out to? (*Check all that apply and estimate percentage.*)

- a. gay men (____ %)
- b. injection drug user (____ %)
- c. commercial sex worker/sex industry worker (____ %)
- d. at-risk youth (____ %)
- e. other (use direct words from advocate): _____ (____ %)

2. Are the number of stories we're giving you about right, not enough, or too many? (*Check one.*)

- a. about right
- b. not enough
- c. too many

3. Whom do you mostly pass out materials to: people you know, people you don't know but recognize, or people you've never seen before? (*Check one.*)

- a. people you know
- b. people you don't know but recognize
- c. people you've never seen before

4. What are the race/ethnicity of the people you pass the materials out to? (*Check all that apply and estimate percentage.*)

- a. African American (____ %)
- b. Latino/Hispanic (____ %)
- c. Asian/Asian Pacific Islander (____ %)
- d. White (____ %)
- e. other (____ %)



5. What part of the day or night do you mostly pass out materials? Would you say morning, afternoon, or evening? (*Check one.*)

- a. morning b. afternoon c. evening

6. What part of the week do you mostly pass out materials? Would you say weekend or weekday? (*Check one.*)

- a. weekend b. weekday

7. How many flyers were you given to hand out last week?

number: _____

8. Out of all the people that you gave flyers to this week, about what percent had never seen <name of that publication> before?

percentage: _____ %

8. In the past week, how many people read the flyer at the time you first gave it to them? That is, that you saw read the flyer?

number: _____

10. In the past week, how many people did you see throw the flyer away without ever reading it?

number: _____

11. In the past week, how many people do you think used the <condoms, bleach> that you passed out with the flyers?

number: _____

12. Do you think people like the <brand of condoms, bleach> that are passed out with the flyers? (*Check one.*)

- a. yes
 b. no

13. Do you think they would prefer other brands?



- a. yes
- b. no

If yes:

13a. Which ones? _____

14. What comments do people make about the stories (good or bad)? _____

15. Do you have suggestions for how we could improve the stories? _____



Appendices H1-H3: Interview Resources



Appendix H1:
Community PROMISE Survey

ID: _____ Target population: _____

Date: _____ Location: _____

Interviewer: _____

Read aloud all parts shown in bold type. If respondent refuses to answer any question, write "REF" beside that question and continue with the interview.

INTRODUCTION

Hello, my name is _____, and I work with <Name of Agency>. We're talking to people in this area to learn how AIDS is affecting their lives and the lives of others in their community. We're not asking for names or addresses, so we're hoping people will feel comfortable giving us honest answers to important questions about sex, drugs, and other behaviors. Would you be willing to take a few minutes of your time to talk to me?

DEMOGRAPHICS

1. How old are you?
_____ Years (*If below minimum age specified by site, thank respondent and terminate interview.*)

2. Observed gender:
_____ a. male
_____ b. female
_____ c. transgender

3. How would you describe your racial/ethnic background?
_____ a. American Indian or Alaskan Native
_____ b. Asian/Pacific Islander
_____ c. Black
_____ d. Hispanic/Latino
_____ e. White (Anglo)
_____ f. other (please specify) _____

If under 18 years old:

4. How often do you spend the night at your parents' or legal guardian's home? Would you say:
_____ a. all the time (*End interview.*)



- b. most of the time
- c. some of the time
- d. never

ELIGIBILITY

Next I'd like to ask you some pretty personal questions about sex and drugs. Remember, we're not interested in who people are in this survey; we're just trying to learn more about what people do.

5. Have you had vaginal sex—straight sex—in the past 30 days?
- a. yes
 - b. no
6. Have you had anal sex—sex in the butt (or other local term)—(if male respondent add: “with either a woman or a man”) in the past 30 days?
- a. yes
 - b. no

If respondent reports not engaging in one or more of above sexual behaviors in the last 30 days then ask: “If I understood you right, you have not had (vaginal/anal) sex within the last month. Is that right?” (Record and circle any new response—do not erase old response.)

Now I'd like to ask you a couple of questions about your own drug use. Remember, some of these questions are pretty personal, but once we are finished here there is no way of connecting you to these answers.

7. Have you ever shot drugs?
- a. yes
 - b. no

If yes, ask:

7a. Have you shared works in the past 60 days?

- a. yes
- b. no

8. *Do not ask.* Interviewer assess eligibility for full interview and check below:
- a. eligible—sex in last 30 days-> (*Continue with survey.*)
 - b. eligible—needle sharing in last 60 days -> (*Continue with survey and ask additional needle sharing questions.*)



_____ c. not eligible (*End interview.*)

If eligible for full interview: That ends the first part of the interview. You've been very helpful. If you would be willing to answer some more questions, I can give you <incentive> for your time. The rest of the interview will take about 15 minutes. Remember, I won't be asking your name or address.

BEHAVIORAL SAMPLING

9. When you have vaginal or anal sex, how often do you use a condom? (*Read aloud slowly.*)

- _____ a. every time
- _____ b. almost every time
- _____ c. sometimes
- _____ d. almost never
- _____ e. never

If using a condom every or almost every time ask:

9a. How long have you been using a condom (every time/almost every time) you have

vaginal or anal sex?

- ___ a. 30 days or less
- ___ b. more than 30 days—less than 6 months
- ___ c. six months or more

10. The last time you had vaginal or anal sex, did you use a condom?

- _____ a. yes
- _____ b. no

11. In the next six months, how likely do you think it is that you will use a condom every time you have vaginal or anal sex? (*Read aloud slowly.*)

- _____ a. very sure I will
- _____ b. slightly sure I will
- _____ c. undecided—not sure if I will or won't
- _____ d. slightly sure I won't
- _____ e. very sure I won't



12. How sure are you that using a condom every time you have vaginal and/or anal sex will protect you from AIDS? (*Read aloud slowly.*)
- _____ a. very sure it will
 _____ b. slightly sure it will
 _____ c. undecided—not sure if it will or won't
 _____ d. slightly sure it won't
 _____ e. very sure it won't
13. How likely do you think it is that you could get AIDS by having vaginal or anal sex without using a condom? (*Read aloud slowly.*)
- _____ a. very likely
 _____ b. slightly likely
 _____ c. undecided—not sure
 _____ d. slightly unlikely
 _____ e. very unlikely

NEEDLE SHARING (*Only ask if person indicated he or she used needles.*)

Administer this section only to respondents who report sharing needles/works in the last 60 days.

Next I'll be asking questions about sharing and cleaning works (needles). In this next set of questions, when I say, "share," I mean either letting someone use your works or using works that belong to someone else. When I talk about "cleaning with bleach," I mean pulling bleach all the way into the syringe twice and then rinsing with clean water twice.

14. The last time you shared, did you clean with bleach before you used?
- _____ a. yes
 _____ b. no
15. When you share, how often do you clean your works with bleach before you use? (*Read aloud slowly.*)
- _____ a. every time
 _____ b. almost every time
 _____ c. sometimes
 _____ d. almost never
 _____ e. never

If cleaning with bleach every or almost every time, ask:



15a. How long have you been cleaning with bleach (every time/almost every time) you share?

- a. 30 days or less
- b. more than 30 days—60 days or less
- c. more than 60 days—less than 6 months
- d. six months or more

16. In the next six months, how likely do you think it is that you will start cleaning your works with bleach every time you share? (*Read aloud slowly.*)

- a. very sure I will
- b. slightly sure I will
- c. undecided—not sure if I will or won't
- d. slightly sure I won't
- e. very sure I won't

17. How likely do you think it is that from now on you will clean your works with bleach every time you share? (*Read aloud slowly.*)

- a. very sure I will
- b. slightly sure I will
- c. undecided—not sure if I will or won't
- d. slightly sure I won't
- e. very sure I won't

EXPOSURE TO COMMUNITY PROMISE

Now I have just a few more questions to ask. These won't take long at all, and then we're done.

18. Do you usually carry condoms with you?

- a. yes
- b. no

19. Do you have a condom with you now?

- a. yes
- b. no

If yes, ask:

19a. Just to give us an idea of what brands people are using, would you show me the condom you have with you?

Brand: _____



- _____ a. condom seen
- _____ b. condom not seen

20. Do you consider yourself to be straight, gay, or bisexual?

- _____ a. straight (heterosexual)
- _____ b. gay
- _____ c. bisexual
- _____ d. don't know

21. In the last three months, have you seen, read, or heard anything around here in the community about condoms or how to protect yourself from AIDS?

- _____ a. yes
- _____ b. no *(Probe: "So you haven't seen anything around here about AIDS, and nobody's given you a <pamphlet/newsletter/card> with condoms or bleach in it?")*
- _____ c. don't know *(Use probe above.)*

If yes, ask:

21a. What kinds of things did you see? Were they brochures, pamphlets, posters, or what?

- Item 1: _____ (Did you see anything else?)
- Item 2: _____ (Anything else?)
- Item 3: _____ (Anything else?)
- Item 4: _____ (Anything else?)

_____ **Item 1.** What can you tell me about <Item 1>? *(Probe for: title, content, where material was seen/received, and whether condoms or bleach were stuffed inside/attached. Write respondent's description below.)*

Did anyone talk with you about it?

- _____ a. yes
- _____ b. no *(Skip to Item 1; interviewer indicate.)*
- _____ c. don't know/not sure *(Skip to Item 1; interviewer indicate.)*

_____ Who talked with you? Was it a friend, someone in a clinic, someone on the street, or someone else?



Don't forget! (Do not ask; interviewer indicate.) Is Item 1 from Community PROMISE (interviewer indicate):

Interviewer indicate _____ a. yes
_____ b. no
_____ c. don't know

How many different times have you seen or read one of these <pamphlets/ brochures/cards/posters>?

_____ times

_____ **Item 2.** What can you tell me about <Item 2>? (Probe for: title, content, where material was seen/received, and whether condoms or bleach were stuffed inside/attached. Write respondent's description below.)

Did anyone talk with you about it?

_____ a. yes
_____ b. no (Skip to Item 2; interviewer indicate.)
_____ c. don't know/ not sure (Skip to Item 2; interviewer indicate.)

_____ Who talked with you? Was it a friend, someone in a clinic, someone on the street, or someone else?

Don't forget! (Do not ask; interviewer indicate.) Is Item 2 from Community PROMISE (interviewer indicate):

Interviewer indicate _____ a. yes
_____ b. no
_____ c. don't know

How many different times have you seen or read one of these <pamphlets/ brochures/cards/posters>?

_____ times

_____ **Item 3.** What can you tell me about <Item 3>? (Probe for: title, content, where material was seen/received, and whether condoms or bleach were stuffed inside/attached. Write respondent's description below.)



Did anyone talk with you about it?

- ___ a. yes
___ b. no (*Skip to Item 3; interviewer indicate.*)
___ c. don't know/not sure (*Skip to Item 3; interviewer indicate.*)

___ Who talked with you? Was it a friend, someone in a clinic, someone on the street, or someone else?

Don't (*Do not ask; interviewer indicate.*) Is Item 3 from Community PROMISE:
forget!

Interviewer ___ a. yes
indicate ___ b. no
___ c. don't know

How many different times have you seen or read one of these <pamphlets/
brochures/cards/posters>?

_____ times

___ **Item 4.** What can you tell me about <Item 4>? (*Probe for: title, content, where material was seen/received, and whether condoms or bleach were stuffed inside/attached.*)

Did anyone talk with you about it?

- ___ a. yes
___ b. no (*Skip to Item 4; interviewer indicate.*)
___ c. don't know/not sure (*Skip to Item 4; interviewer indicate.*)

___ Who talked with you? Was it a friend, someone in a clinic, someone on the street, or someone else?

Don't (*Do not ask; interviewer indicate.*) Is Item 4 from Community PROMISE:
forget!



Interviewer _____ a. yes
indicate _____ b. no
_____ c. don't know

How many different times have you seen or read one of these <pamphlets/ brochures/cards/posters>?

_____ times

22. In the last three months, has anyone else talked to you about AIDS, HIV, using condoms, or cleaning needles?

- _____ a. yes
- _____ b. no
- _____ c. don't know/not sure

If yes, ask:

22a. Was that person a friend or relative, someone in a clinic, someone on the street, or who? *(If respondent names only one or two persons, probe for additional individuals: "Anyone else?")*

- _____ a. _____
- _____ b. _____
- _____ c. _____

Individual(s) in question E9 associated with Community PROMISE *(interviewer indicate):*

- _____ a. yes
- _____ b. no
- _____ c. don't know

23. Have you ever been tested for HIV or the AIDS virus?

- _____ a. yes
- _____ b. no
- _____ c. don't know

If yes, ask:

23a. Would you be willing to share the results of your test with me? What were the results?

- ___ a. positive
- ___ b. negative
- ___ c. don't know



___ d. refuse to answer

24. Have you ever been interviewed with this survey before?

- _____ a. yes
- _____ b. no
- _____ c. don't know

If yes, ask:

24a. When was the last time? How long ago?

- ___ a. less than 1 month ago
- ___ b. 1 to 2 months ago
- ___ c. 3 to 5 months ago
- ___ d. 6 months ago or longer
- ___ e. don't know

25. Two more questions and we're done. Since we're interested in how AIDS is affecting communities, I'd like to ask you about your relationship to this community. By "community" I mean <geographical location of interview>. Which of the following would you say describes you best?

- _____ a. have been living, working, or hanging out in this community for a year or longer
- _____ b. have been living, working, or hanging out in this community for less than a year
- _____ c. am not really part of this community—just passing through

End Time: _____ a.m. p.m.

That's the end of the interview. I don't have any more questions for you. Do you have any you'd like to ask me?

Correct significant misconceptions about AIDS transmission/prevention and make referrals for counseling, testing, and other services as appropriate.
--

Thank you very much for your help with this survey.



Appendix H2: Interview Guide

Content of the Interview

There are three types of assessment that should be included in the interview:

- *Screening to ensure the individual is a member of the target population.* Determining whether an individual is a member of the target population should be done with few questions and a great deal of sensitivity (to increase the chances that the individual will complete the survey).
- *Outcome variables.* For those respondents who are members of the target population, information regarding the individual's degree of participation in risk-reducing and/or risky behaviors should be obtained. In addition, you can assess the interviewee's attitudes and intentions for condom use or safe needle practices. There are several outcome variables that can be measured:
 - a. frequency of a behavior (such as number of times engaged in vaginal or anal intercourse)
 - b. frequency of condom use with each behavior
 - c. condom carrying (for example, having a condom in their possession at time of survey)
 - d. intention to engage in behavior (such as the intention to use condoms)
 - e. attitudes about condoms
 - f. stage of change for behavior (such as the stage of change for condom use)
 - g. if applicable, needle sharing and needle cleaning behavior

Since both frequency and intention are necessary to determine the stage of change, including all three indicators is preferred.

Use this information to inform role-model story production

The use of information gained through interviews is also helpful in evaluating the community's stage of change. From these interviews you will be able to determine the stage of change for the group of target population members you interviewed. Knowing the stage of change will enable you to make your role-model stories relevant. Your stories will be relevant because the stories you produce will reflect the appropriate stage of change for the community you are trying to impact.

- *Exposure to intervention materials.* Exposure to the intervention should be measured



whether or not the individual is a member of the target population. This is in order to evaluate the degree to which Community PROMISE is being delivered to those who are not its intended target.

The manner in which the individual responds to the screening questions dictates whether he or she receives the full interview or the short interview. The full interview includes all of the questions and is intended for target population members. If during the screening the interviewer determines that the individual is not a target population member, the individual should receive the demographic and exposure-to-intervention questions, not the risk questions. Again, you give everyone the exposure-to-intervention questions in order to evaluate the degree to which Community PROMISE is being delivered to those who are not its intended target.

In the appendix of this module is an interview protocol. The questions are divided into several sections: basic demographics, establishing eligibility for the full interview (determine if interviewee is member of the target population), and questions regarding specific risk behaviors. Also included are questions about exposure to the intervention, condom carrying, and previous participation in the survey.

You may want to modify the interview that is included with this module. Prior to modifying the interview, several considerations should be taken into account:

- *Length.* Interviews should be kept as short as possible. Each question should be carefully assessed in terms of the contribution it makes toward evaluating Community PROMISE. Behaviors that are not directly relevant to Community PROMISE need not be asked. For example, it may be advisable to leave out questions concerning beliefs, attitudes, and knowledge of HIV.
- *Question tailoring.* The interview should be tailored to fit the target population. For example, if the target population is female sex workers, it would not be useful to include questions that are designed for men who have sex with men.
- *Assessing exposure to the intervention.* The enclosed interview asks respondents if they have seen or heard anything about AIDS or HIV prevention in the last three months. If they have, they are asked to describe what they have seen, and the interviewer will then categorize if Community PROMISE materials were seen. This method requires rigorous interviewer training and adds substantially to the length of the interview. One alternative to assessing intervention exposure is to ask respondents whether they have seen anything about AIDS or HIV prevention in their community, and then to follow up this question by asking if they have seen any materials from a list of programs (the list should include your program, any other major HIV prevention agencies in the community, and at least one fictional or bogus agency). The interviewer may show samples of materials to the respondent and ask whether he or she has seen them before. It is useful to include both real and



fictional examples of program materials to determine whether the respondent is able to discriminate between the two.

When asking whether a respondent has seen Community PROMISE materials, it is important to choose an appropriate time frame for the question. The time frame should be the amount of time that has elapsed since Community PROMISE was implemented or since the last time these questions were asked. For example, if the interviews are being conducted six months after implementation of Community PROMISE, exposure questions should ask if the respondent has seen program materials in the past six months. If a previous survey asking these questions took place three months ago, the exposure questions should use the three-month time frame.

Recruitment of Interviewers and Interview Respondents

By interviewing members of the target population, your goal is to assess the degree to which Community PROMISE materials have been distributed throughout the community. Consequently, the procedure for selecting interviewees should not be directly linked to Community PROMISE's delivery system. For example, if materials targeted for men who have sex with men are distributed at a bathhouse, interview participants should not be recruited from that same bathhouse. Recruiting from the same bathhouse would not reflect what is happening in the community.

It is also critical that interviewers select the respondents rather than having potential candidates self-select or line up to be interviewed. Persons who volunteer to be interviewed may in some way be different from those who do not volunteer. Those who volunteer may look more favorably on Community PROMISE; therefore, if a line forms as interviews are being done, the interviewer should move on to the next site.

In addition, individuals being interviewed should not immediately connect the interview with Community PROMISE. Maintaining independence between Community PROMISE and the evaluation is important in minimizing potential bias in the answers given by interview participants. For example, if respondents think Community PROMISE is good for the community or have friends in Community PROMISE (staff or advocates), they may respond to questions about their own behavior in a way they believe will make Community PROMISE look good. This bias is especially likely to happen if the respondents know the person conducting the interviews; therefore, interviewers should not be staff members who typically interact with the target population. Ideally, interviewers should be hired and trained specifically to conduct evaluation interviews and should not have prior association with the recipients of Community PROMISE.

If staff is limited and additional personnel are not available in your agency to permit



independent interviews, you may be able to collaborate with another agency. In collaborating, the outreach workers from each agency periodically conduct interviews with the collaborating agency's target population.

Interview Procedures

Some guidelines for conducting the interviews are as follows:

- A staff person should be responsible for identifying a number of distinct locations where members of the target population can be interviewed. It is recommended that multiple sites be identified.
- On each interviewing day, interviewers should be provided with a list of randomly selected sites to visit. The simplest way to accomplish this is to write each site name on a piece of paper and literally pick the sites “out of a hat” for each interviewer.
- A clear protocol must be established concerning the number of individuals to be interviewed at each location and the amount of time interviewers should spend at each location—for example, “each interviewer is to stay at a designated interview site for a minimum of 15 minutes and complete no more than three interviews with eligible respondents.” The purpose of establishing this protocol is to avoid interviewing too many people from one location and to increase the representation of the sample.
- Interviewers go out to each location. Depending on the level of personal risk associated with these areas, interviewers may need to work in teams of two.
- Interviewers approach individuals at the community site and screen them by asking a few pre-determined questions to ensure they are part of the target population. Interviewers consistently should approach every person at the site who appears to be within the specified age range or gender unless the person is participating in illegal activities at that moment or is working (such as a delivery person). Given the sensitivity of the interview questions, it is also critical that the interviewer identifies him- or herself immediately and includes the name of the agency he or she is working for.
- Members of the target population receive the full interview. Respondents who are not members of the target population complete the short interview.

To increase participation among reluctant individuals, it is useful for the interviewer to be able to offer a small incentive to potential respondents. Even a fast-food certificate worth one or two dollars may be sufficient to overcome reluctance in some respondents.



Finally, it is extremely important to preserve the anonymity of the respondents. Respondents to the interview should not be asked any identifying information, such as name or social security number. Allowing respondents to remain anonymous will increase the likelihood that they will answer questions honestly. Since the interviews are anonymous, it is possible that an individual will unintentionally be interviewed twice. To minimize duplicate interviews, respondents should be asked if they have been interviewed before. A more complex method of removing duplicate interviews from the data is also possible if the data are being analyzed using advanced statistical software. Duplicate interviews could be identified by identical demographic information, such as gender, birth date, ethnicity, and birth city. Only the first interview would be used and the duplicate interview would be deleted.



Appendix H3

Key Observer Interview

Name: _____ Date: _____

Place: _____ Interviewer: _____

Start time: _____ End time: _____

1. Changes in the neighborhood:

- a. During the last three months, have you noticed any major changes or trends among prostitutes, IDUs, or female sex partners of IDUs? Why?
- b. During the last three months, have you heard people in your neighborhood talking about using condoms or bleach?
 - c. During the last three months, have you seen people using their own outfits, using bleach, or carrying condoms?

2. Reasons for change:

- a. What do you think is causing people to <use condoms, carry condoms, carry bleach, use bleach, use their own outfits> more?

3. Educational materials:

- a. Have you seen the educational materials from our program?
- b. Have you seen people carrying our educational materials in the community? (*Ask specifically about flyers, bleach kits, condoms.*)
- c. Do you feel people in your neighborhood are aware of these materials?
- d. Do you think people know where to get the materials?
- e. Are people asking for the materials?

4. Advocates:

- a. Have you come into contact with any community advocates in your own neighborhood?
- b. Have you seen community advocates distributing materials?
- c. In the last two months, what have been people's responses to the materials?

5. Additional information:

- a. Since you know what we are passing out, have you seen any other AIDS materials around your neighborhood?
- b. Have you seen people from different programs talking to people in your neighborhood or passing out materials?



Appendix I

Obtaining Prevention Materials

When shopping for intervention material, be sure to indicate your non-profit status when calling for prices or placing orders. The cost difference between resale and non-profit can be significant. The following information is offered only as a suggestion as to where the needed material may be obtained. Shop around your area to find closer distributors or better deals.



Alcohol Pads/Cotton Balls

Can also be purchased easily through your local pharmacy or discount store.

Sterling Medical Products
8 Holland
Irvine, CA 92618
(800) 966-3342

www.walgreens.com
www.drugstore.com

Henry Schein
631-843-5500.
135 Duryea Road, Melville, NY 11747.
(800)472-4346
Small cotton pellets

Bleach/Water Bottles

General Bottle Supply Co.
1930 E. 51st St.
Los Angeles, CA 90058
(800) 782-0198

Alameda Commons Packaging
(510)651-0277
Bottle manufacturer
Bottles with Bleach Resistant Caps. Bottles do not have printed instructions on outside.
Cosmetic bottles

Safety Works
(800)723-3892 that's (800)SAFETY2
Buyers club
Bottles with Bleaching Instructions on outside.
Mamaroneck, NY

Syringes

Sterling Medical Products
8 Holland
Irvine, CA 92618
(800) 966-3342

North American Syringe Exchange
535 Dock St.
Tacoma, WA 98402
(253) 272-4857

Harrell Medical
11830 11830 SW Kerr Parkway, Suite 395
Lake Oswego, OR 97035
800-574-0976
www.harrellmedical.com

AllegroMedical.com
800-861-3211

Cookers

Safety Works
540 W. Boston Post Rd.
Mamaronek, NY 10543
(914) 698-3631

NASEN
North American Syringe Exchange Network
www.nasen.org
535 Dock St. #112
Tacoma, WA 98402
253-272-4857 fax 253-272-8415
Buyers club for existing exchanges
Syringes, Alcohol Wipes, Condoms(Ansell & Aladan), Cookers, Bio-Hazard "stick boxes," etc.. Pre-paid sales only.

Ziploc Bags

WesCo Supply Company
5520 E. Second St., Bldg. 1
Long Beach, CA 90803
(562) 596-9888

Consolidated Plastic
8181 Darrow Rd.
Twinsburg, Ohio 44087
(800) 362-1000

Associated Bag Co.
(800)926-6100
All kinds and sizes of bags

“Ziploc® Brand Containers are sold in the U.S. in grocery, drug, and discount stores. If you live in the U.S., you can also place an order through the SC Johnson Direct Mail Order service. Credit card orders call 1-800-848-2588. Or fax orders to: 1-920-751-5850.”

Condom Manufacturers and Distributors

Ansell Americas (Prime, Lifestyle)
Meridian Center 1
2 Industrial Way
Eatontown, NJ 07724-4299
(800) 327-8659, (908) 542-9500

Barnetts, International (Repackager)
610 Greenway Industrial Dr.
Charlotte, NC 28273
(704) 587-0390

Condomania- large selection of “novelty” items
351 Bleecker Street
Greenwich Village (1 block west of 7th Ave, 1 block up from Christopher Street).
212-691-9442
1.800.9CONDOM
condomania.com

Female Health Company –only buy in bulk (100), orders must be faxed
(Reality Female Condom)
875 North Michigan Ave., Ste. 3660
Chicago, IL 60611
(800) 635-0844, Fax: (312) 280-9360
www.femalehealth.com

Global Protection Corporation (Repackager)
12 Channel St.
Boston, MA 02210
(781) 933-0050, (617) 946-2800
800-5-PLAYSAFE
888-266-3665
Fax: (617) 946-3246
www.globalprotection.com

M&M Rubber Company, Inc.
2804 Cherry
Kansas City, MO 64108
(816) 931-5743, (800) 347-5743
Fax: (816) 931-5746

Mayer Laboratories (Kimono and Maxx)
646 Kennedy St., Bldg. C
Oakland, CA 94606
(510) 452-5555, (800) 426-6366
Fax: (510) 272-9021
www.mayerlabs.com
individuals can only place orders online, not over the phone

Paradise Marketing (reseller)
1204 Avenida Chelsea
Vista, California 92083
Tel: (800) 993-3664
Fax: (888) 810-3888
www.paradisemarketing.com

Total Access Group Inc. (ID Lube)
16842 Millikan Ave.
Irvine, CA 92606
(800) 320-3716
sells to non-profits

Condom Sense (<http://www.csense.com/>)
(888) 776-2906
2015 Polk St.
San Francisco, CA 94109
sells a wide variety of condoms and lubricants including the Avanti, Reality Female condom, brands like **LifeStyles, Trojan, Crown, Kimono & Maxx, Wet, Delube, AstroGlide**. Also has bulk non-profit pricing at cost + 10%.

Moi Safer Sex Products
(800) 438-7196 or (856) 464-9110
Email: Moi@snip.net
Extensive line of **LifeStyle, Trustex and Durex**, Reality female condom, Discretions condom envelopes. Also lubricants, and oral barriers. No minimums. Custom labeling and Safer Sex Kits.

Rainbow Rubber Company

(604)683-3423

Canadian Reseller

Oral Barriers: Latex barriers for oral-vaginal and oral-anal sex. Size, color, flavor/scent, and thickness vary between brands.

Latex Barriers for oral-vaginal or oral-anal sex.

Size, color, flavor/scent, and thickness vary between brands.

- **Glyde USA**
(206)283-7664
The only FDA approved latex barrier, Now called "**Sheers**" or as they are called in Australia, **LOLLYES** ("Lips On Lickable Latex Yes") Very thin individually packaged flavored latex rectangles.

Line One Laboratories

(800)222-9848 or (213)222-9848

Trustex condoms have flavored lubricant and are available in Vanilla, Strawberry, Chocolate, Banana, Grape, and Cola.)
Oral Barriers: **LIXX** (Vanilla or Strawberry)

Mercury Mail Order

(415) 621-1188

4084 18th St. San Francisco, CA 94114

Also sells "**Dammit's**" harnesses for latex dams.

Moi Safer Sex Products

(800) 438-7196 or (856) 464-9110

Email: Moi@snip.net.

Oral latex barriers (dental dams) available strawberry, vanilla, grape, banana, mint and plain. No minimums.

Rainbow Rubber Company

(604)683-3423

Canadian Reseller

Oral Barriers: Latex barriers for oral-vaginal and oral-anal sex. Size, color, flavor/scent, and thickness vary between brands.

SF Dental Supply

(415) 621-8406

1360 Mission Street San Francisco, CA 94103

Condom Keychains

Global Protection Corp. (Keepers)

12 Channel St.

Boston, MA 02210

(781) 933-0050, (617) 946-2800

Fax: (617) 946-3246

www.globalprotection.com

Dr. Marion A. Sanchez

(Condom Holding Key Chain)

24558 Ong Ct.

Hayward, CA 94545

(510) 786-1858, (800) 4 SAFE SEX

Rip N Roll 1-888-Rip n Roll,

www.RipnRoll.com

Rip n Roll Inc.

PO Box 224

Dunedin, FL 34697-0224

Phone - 727-734-7949

Fax - 727-734-4293

Condom Cards

Planned Parenthood of East Central IL

302 E. Stoughton

Champaign, IL 61820

(217) 359-3418

Condom Apparel

Rocket Wear

101 West 57th St., Ste. 15D

New York, NY 10019

(212) 977-9227

Condom Demonstration Models

Jim Jackson and Co.

33 Richdale Ave.

Cambridge, MA 02140

(617) 864-9063

Forbidden Fruit
Carries a variety of condom demonstration models in acrylic, latex, silicone, or realistic feeling materials, such as cyberskin. They range in price from \$13.50 up, but we offer a 20% discount to educators and can offer a larger discount for bulk orders. The models we carry range in size from 5" up and come in generic or realistic appearances. Please feel free to e-mail us or call us toll free at 1-800-315-2029 for further information.

Lubricant Manufacturers

B. Cumming Company, Inc. (Elbow Grease)
9990 Glen Oaks Blvd., Unit B
Sun Valley, CA 91352
(818) 504-2571
800-226-6464

BioFilm, Inc. (Astroglide)

(800)848-5900 or (800)325-5659
bulk orders
www.astroglide.com
Vista, CA

Davryan Laboratories, Inc. (Probe)
3812 SE Taylor St.
Portland, OR 97214
(800) 637-7623, Fax: (503) 235-8483
<http://www.davryan.com/>

Wet International (Wet and Comfort)
Valencia, CA
(800) 248-4811, (818) 901-1451
www.wetinternational.com

Johnson & Johnson Consumer Products
(KY Jelly)
199 Grandview Rd.
Skillman, NJ 08558-9418
(800) 526-3967

Mayer Laboratories (Aqua Lube)
646 Kennedy Street, Bldg. C
Oakland, CA 94606
(510) 437-8989, (800) 426-6366
Fax: (510) 536-9912
www.mayerlabs.com

Trimensa Pharmaceutical
(ForePlay/PrePair, Rubdown)
1050 Lawrence Dr.
Newbury Park, CA 91320
(800) 554-1313, (805) 499-2446
Fax: (805) 499-4366

Wallace-O'Farrell, Inc. (Slippery Stuff)
11302 164th St. East
Puyallup, WA 98374
(800) 759-7883
www.wallaceofarrell.com

Dynamic Concepts

(800)248-4811 or (818)901-1451
Manufacturer: **Wet** and **Comfort**

Global Protection Corporation

(800)5-PLAYSAFE or (888)266-3665
Distributor/Repackager Low minimums.
Custom packaging of **I-D** lube (in 3 or 10cc packets).

Moi Safer Sex Products

(800) 438-7196 or (856) 464-9110
Email: Moi@snip.net
Distributor: **Slippery Stuff** (unflavored, with or without N9) and **Rain** (in strawberry, vanilla, grape, chocolate, banana and cola flavors). Mix or match with no minimums.

Westridge Labs, Inc.

(800)646-2096
Manufacturer: **I-DLube**

Appendices J-M: Important information from the Center for Disease Control and Prevention

The ABCs of Smart Behavior

To avoid or reduce the risk for HIV

- **A** stands for abstinence.
- **B** stands for being faithful to a single sexual partner.
- **C** stands for using condoms consistently and correctly.

Appendix K: Center for Disease Control and Prevention updates on Nonoxynol 9

Nonoxynol-9 Spermicide Contraception Use—United States, 1999

MMWR, May 10, 2002 (Vol. 51, No. 18).

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.

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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,Z), 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 (Z). 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 (Z).

Spermicidal gel is used in conjunction with diaphragms (I); 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 (I).

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 (I). 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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For more information:
CDC's National Prevention Information Network
(800) 458-5231 or www.cdcnpin.org

CDC National STD/HIV Hotline
(800) 227-8922 or (800) 342-2437
En Español (800) 344-7432
www.cdc.gov/std

Fact Sheet for Public Health Personnel:

Male Latex Condoms and Sexually Transmitted Diseases

In June 2000, the National Institutes of Health (NIH), in collaboration with the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the United States Agency for International Development (USAID), convened a workshop to evaluate the published evidence establishing the effectiveness of latex male condoms in preventing STDs, including HIV. A summary report from that workshop was completed in July 2001 (<http://www.niaid.nih.gov/dmid/stds/condomreport.pdf>). This fact sheet is based on the NIH workshop report and additional studies that were not reviewed in that report or were published subsequent to the workshop (see "[Condom Effectiveness](#)" for additional references). Most epidemiologic studies comparing rates of STD transmission between condom users and non-users focus on penile-vaginal intercourse.

Recommendations concerning the male latex condom and the prevention of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are 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 of condom use and STD risk.

The surest way to avoid transmission of sexually transmitted diseases is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who has been tested and you know is uninfected.

For persons whose sexual behaviors place them at risk for STDs, correct and consistent use of the male latex condom can reduce the risk of STD transmission. However, no protective method is 100 percent effective, and condom use cannot guarantee absolute protection against any STD. Furthermore, condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV and other STDs. In order to achieve the protective effect of condoms, they must be used correctly and consistently. Incorrect use can lead to condom slippage or breakage, thus diminishing their protective effect. Inconsistent use, e.g., failure to use condoms with every act of

intercourse, can lead to **STD** transmission because transmission can occur with a single act of intercourse.

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.

Sexually Transmitted Diseases, Including HIV

Sexually transmitted diseases, including HIV

Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases (STDs), including discharge and genital ulcer diseases. While the effect of condoms in preventing human papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

There are two primary ways that STDs can be transmitted. Human immunodeficiency virus (HIV), as well as gonorrhea, chlamydia, and trichomoniasis – the discharge diseases – are transmitted when infected semen or vaginal fluids contact mucosal surfaces (e.g., the male urethra, the vagina or cervix). In contrast, genital ulcer diseases – genital herpes, syphilis, and chancroid – and human papillomavirus 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 basis for protection. Condoms can be expected to provide different levels of protection for various sexually transmitted diseases, depending on differences in how the diseases are transmitted. Because condoms block the discharge of semen or protect the male urethra against exposure to vaginal secretions, a greater level of protection is provided for the discharge diseases. A lesser degree of protection is provided for the genital ulcer diseases or HPV because these infections 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 rates of STDs between condom users and nonusers in real-life settings. Developing such measures of condom effectiveness is challenging. Because these studies involve private behaviors that investigators cannot observe directly, it is difficult to determine

accurately whether an individual is a condom user or whether condoms are used consistently and correctly. Likewise, it can be difficult to determine the level of exposure to STDs among study participants. These problems are often compounded in studies that employ a “retrospective” design, e.g., studies that measure behaviors and risks in the past.

As a result, observed measures of condom effectiveness may be inaccurate. Most epidemiologic studies of STDs, other than HIV, are characterized by these methodological limitations, and thus, the results across them vary widely--ranging from demonstrating no protection to demonstrating substantial protection associated with condom use. This inconclusiveness of epidemiologic data about condom effectiveness indicates that more research is needed--not that latex condoms do not work. For HIV infection, unlike other STDs, a number of carefully conducted studies, employing more rigorous methods and measures, have demonstrated that consistent condom use is a highly effective means of preventing HIV transmission.

Another type of epidemiologic study involves examination of STD rates in populations rather than individuals. Such studies have demonstrated that when condom use increases within population groups, rates of STDs decline in these groups. Other studies have examined the relationship between condom use and the complications of sexually transmitted infections. For example, condom use has been associated with a decreased risk of cervical cancer – an HPV associated disease.

The following includes specific information for HIV, discharge diseases, genital ulcer diseases and human papillomavirus, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV / AIDS

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.

AIDS is, by far, the most deadly sexually transmitted disease, 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. In fact, 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 STD pathogens.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as semen and vaginal fluids, 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 conclusively that the consistent use of latex condoms provides a high degree of protection.

Discharge Diseases, Including Gonorrhea, Chlamydia, and Trichomoniasis

Discharge diseases, other than HIV

Latex condoms, when used consistently and correctly, can reduce the risk of transmission of gonorrhea, chlamydia, and trichomoniasis.

Gonorrhea, chlamydia, and trichomoniasis are termed discharge diseases because they are sexually transmitted by genital secretions, such as semen or vaginal fluids. HIV is also transmitted by genital 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 discharge 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 chlamydia, gonorrhea and trichomoniasis. However, some other epidemiologic studies show little or no protection against these infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the discharge diseases. More research is needed to assess the degree of protection latex condoms provide for discharge diseases, other than HIV.

Genital Ulcer Diseases and Human Papillomavirus

Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male or female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Correct and consistent use of latex condoms can reduce the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. While the effect of condoms in preventing human papillomavirus infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

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/fluids. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are, or are not, covered (protected by the condom).

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 can protect against the transmission of syphilis and genital herpes. However, some other epidemiologic studies show little or no protection. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the genital ulcer diseases. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers in settings where chancroid is a leading cause of genital ulcers. More research is needed to assess the degree of protection latex condoms provide for the genital ulcer diseases.

While some epidemiologic studies have demonstrated lower rates of HPV infection among condom users, most have not. It is particularly difficult to study the relationship between condom use and HPV infection because HPV infection is often intermittently detectable and because it is difficult to assess the frequency of either existing or new

infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against HPV infection.

A number of studies, however, do show an association between condom use and a reduced risk of HPV-associated diseases, including genital warts, cervical dysplasia and cervical cancer. The reason for lower rates of cervical cancer among condom users observed in some studies is unknown. HPV infection is believed to be required, but not by itself sufficient, for cervical cancer to occur. Co-infections with other STDs may be a factor in increasing the likelihood that HPV infection will lead to cervical cancer. More research is needed to assess the degree of protection latex condoms provide for both HPV infection and HPV-associated disease, such as cervical cancer.

Department of Health and Human Services

For additional information on condom effectiveness, contact
CDC's National Prevention Information Network
(800) 458-5231 or www.cdcnpin.org

Appendix M: Center for Disease Control and Prevention Content and Review Guidelines for HIV Programs

Revised Interim HIV Content Guidelines for AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions for CDC Assistance Programs

I. Basic Principles

Controlling the spread of HIV infection and the occurrence of 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 protect themselves from acquiring the virus. These methods include abstinence from illegal use of IV drugs as well as 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 are often controversial. The principles contained in this document are intended to provide guidance for the development and use of HIV/AIDS-related educational materials developed or acquired in whole or in part using CDC HIV prevention funds, and to require the establishment of at least one Program Review Panel by state and local health departments, to consider the appropriateness of messages designed to communicate with various groups. State and local health departments may, if they deem it appropriate, establish multiple Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

A. Written materials (e.g., pamphlets, brochures, curricula, fliers), audiovisual materials (e.g., motion pictures and videotapes), pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) and marketing, advertising, Web site-based HIV/AIDS educational materials, questionnaires or survey instruments should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain practices that eliminate or reduce the risk of HIV transmission.

B. Written materials, audiovisual materials, pictorials, and marketing, advertising, Web site-based HIV/AIDS educational materials, questionnaires or survey instruments should be reviewed by a Program Review Panel established by a state or local health department, 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 educational 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. Program Review Panels must ensure that the title of materials developed and submitted for review reflects the content of the activity or program.

E. When HIV materials include a discussion of condoms, the materials must comply with Section 317P of the Public Health Service Act, 42 U.S.C. Section 247b-17, which states in pertinent part:

"educational materials . . . that are specifically designed to address STDs . . . shall contain medically accurate information regarding the effectiveness or lack of effectiveness of condoms in preventing the STD the materials are designed to address."

II. Program Review Panel

Each recipient will be required to identify at least one Program Review Panel, established by a state or local health department from the jurisdiction of the recipient. These Program Review Panels will review and approve all written materials, pictorials, audiovisuals, marketing, advertising, and Web site materials, questionnaires or survey instruments (except questionnaires or survey instruments previously reviewed by an Institutional Review Board--these questionnaires or survey instruments are limited to use in the designated research project). The 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.

Materials developed by the U.S. Department of Health and Human Services do not need to be reviewed by a panel. Members of a Program Review Panel should understand how HIV is and is not transmitted and understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.

A. The Program Review Panel will be guided by the CDC Basic Principles (see Section I above) 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 internal review panel or procedure of the recipient organization or local governmental jurisdiction.

B. Applicants for CDC assistance will be required to include in their applications the following:

1. Identification of at least one panel, established by a state or local health department, of no less than five persons who represent a reasonable cross-section of the jurisdiction in which the program is based. Since Program Review Panels review materials for many intended audiences, no single intended audience shall dominate the composition of the Program Review Panel, except as provided in subsection d below.

In addition:

a. Panels that 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 panel or as consultants to the panels.

b. Panels must ensure that the title of materials developed and submitted for review reflect the content of the activity or program.

c. The composition of Program Review Panels 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.

d. Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of a-c above. However, membership of the Program Review Panel may be drawn predominantly from such racial and ethnic populations.

2. A letter or memorandum to the applicant from the state or local health department, which includes:

a. Concurrence with this guidance and assurance that its provisions will be observed.

b. The identity of members of the Program Review Panel, including

their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

C. When a cooperative agreement/grant is awarded and periodically thereafter, the recipient will:

1. Present for the assessment of the appropriately identified Program Review Panel(s) established by a state or local health department, copies of written materials, pictorials, audiovisuals, and marketing, advertising, Web site HIV/AIDS educational materials, questionnaires, and surveys proposed to be used. The Program Review Panel shall pay particular attention to ensure that none of the above materials violate the provisions of Sections 2500 and 317P of the Public Health Service Act.

2. Provide for assessment by the appropriately identified Program Review Panel(s) established by a state or local health department, the text, scripts, or detailed descriptions for written materials, pictorials, audiovisuals, and marketing, advertising, and Web site materials that 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 chairperson of the appropriately identified Program Review Panel(s) established by a state or local health department, specifying the vote for approval or disapproval for each proposed item submitted to the panel.

4. Include a certification that accountable state or local health officials have independently reviewed written materials, pictorials, audiovisuals, and marketing, advertising, and Web site materials for compliance with Section 2500 and 317P of the Public Health Service Act and approved the use of such materials in their jurisdiction for directly and indirectly funded community-based organizations.

5. As required in the notice of grant award, provide to CDC in regular progress reports, signed statement(s) of the chairperson of the Program Review Panel(s) specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

D. CDC-funded organizations, which are national or regional (multi-state) in scope, or that plan to distribute materials as described above to other organizations on a national or regional basis, must identify a single Program Review Panel to fulfill this requirement. Those guidelines identified in Sections I.A. through I.D. and II.A. through II.C. outlined above also apply. In addition, such national/regional panels must include, as a member, an employee of a state or local health department.

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