

Healthy Relationships

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

Technical Assistance Guide

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SECTION 1: How to Use This Guide

The Technical Assistance Guide was developed as a resource for the provision of technical assistance (TA) to agencies that are implementing the **Healthy Relationships** intervention. The manual provides a review of key information regarding **Healthy Relationships**, such as the Core Elements, implementation activities, and addresses common questions that agencies may have regarding planning for, and implementing the intervention.

1.1 Intended Audience

This manual is intended to be a tool for TA providers who are helping agencies implement **Healthy Relationships** effectively, appropriately and with fidelity to the Core Elements. There are also many **Healthy Relationships** expert trainers and implementation specialists that can, as necessary, provide valuable guidance on the intervention. Further discussion on TA for **Healthy Relationships** including how to request and access TA, is contained in this “How to” section.

TA providers can use the manual to respond to specific questions posed by the implementing agency, or as a guide in providing a pro-active assessment of and response to overall TA needs.

While the manual is geared toward TA providers, it can also be a valuable resource for implementing agencies to refer to themselves, as a guide during the planning and implementing process. The content of this manual was developed from the experiences of eight agencies that tested the implementation packages, and questions raised during the trainings done with the Behavioral and Social Science Volunteers (BSSVs) and Capacity Building Organizations. Agencies may use this guide to supplement information provided in the Implementation Manual and training materials. However, this guide is most effective when combined with assistance by TA providers.

1.2 Content

This manual comprises eight sections. Section one introduces the manual. Section two lists the content of the **Healthy Relationships** package. Section three covers science based interventions and includes a section of commonly asked questions. Section four is a description of the intervention’s goals and objectives, core health education/risk reduction messages, Core Elements, Key Characteristics, stakeholder’s checklist and commonly asked questions. This section also describes the appropriate target population, risk factors, and a check list to help an agency in determining the appropriateness of the **Healthy Relationships** intervention for their setting and population. Section five covers planning the implementation of the intervention including information on staffing, training, a sample plan, a cost sheet, timeline, and commonly asked questions. Section six addresses maximizing cost effectiveness of the intervention. Section seven describes adapting **Healthy Relationships** and consists of questions concerning fidelity, adaptation/tailoring and examples from the field. The final section describes the evaluation process. This guide includes two appendices: a copy of the original research article which covers the background on the intervention, information on its theoretical premise, and the research results; and a stakeholder’s checklist which can be used during the planning of the implementation.

SECTION 2: Healthy Relationships Intervention Package

The contents of the intervention package consist of:

- Implementation Manual (3-D Ring Binder; Sectioned)
 - “Getting Started”
 - Pre-Implementation
 - Implementation (Facilitators’ Handbook – overview and five sessions)
 - Maintenance
 - Reference Materials
 - Video and Movie Clip Essence Tables
 - Session Implementation materials
 - Easel Chart Guides
 - Reference Article(s)
 - Personal Feedback Reports
- TA Guide
- **Healthy Relationships** marketing video
- Video/DVD educational videos (1 master copy for use)
 - HIV/ AIDS Infecting and Affecting our Communities*
 - When Men Talk About AIDS*
 - Safe in the City*
- Risk Continuum Banner and Cards
- Assessment/Evaluation materials
- **Healthy Relationships** Initial Assessment Survey (women, MSM, heterosexual men)
- Process monitoring and evaluation forms
- Outcome monitoring form
- Quality Assurance forms for managers
- Disk containing electronic version of forms and handouts (MS Word XP)
- Generic marketing information sheet

SECTION 3: Science-Based Interventions

3.1 Theoretical Concept

The **Healthy Relationships** intervention is based on Social Cognitive Theory. In a nutshell, the theory states that people learn by observing other people successfully practice a new behavior. Of course, behavior change is not simple, and many factors affect a person's ability to change. Social Cognitive Theory considers that behaviors, environment, attitudes, and beliefs influence and depend on each other. Therefore, in order for persons to successfully change their behavior, they need:

- Information—Such as awareness of risk and knowledge of techniques for coping with the environment
- Self-efficacy—Belief in their ability to control their own motivations, thoughts, emotions, and specific behaviors
- Outcome expectancies—Belief that good things will happen as a result of the new behavior
- Social skills within interpersonal relationships—Such as the ability to communicate effectively, to negotiate, and to resist pressures from others
- Self-regulating skills—Such as abilities to motivate, guide, and encourage oneself and to problem-solve
- Reinforcement value—“Rewards” produced by attempts at new a behavior, as opposed to “costs”

According to Social Cognitive Theory, these necessary things can be achieved by:

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

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

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

The goal of the Healthy Relationships intervention is to reduce sexual risk behavior among women and men living with HIV infection. Social Cognitive Theory predicts that enhancing self-efficacy for

managing life stress, including risk-producing situations, leads to effective coping responses. Coping with risky situations involves using behavioral skills and practicing risk reduction behaviors. Coping responses that are effective in reducing emotional distress also can be used to cope with risky sexual situations and with other interpersonal behaviors.

3.2 Commonly Asked Questions

Q. What are the concepts of the Social Cognitive Theory?

A. The concepts of this theory state that in order for persons to successfully change their behavior they need:

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

Q. With whom, when and where was the original intervention tested?

A. **Healthy Relationships** was conducted in 1997-98 with an intervention group (*Healthy Relationships* group participants) which was compared to a health maintenance intervention (control group) receiving standard care. The intervention was conducted with HIV positive heterosexual men and women and HIV positive men who have sex with men (MSM), most of whom were ethnic minorities. The intervention was conducted at the AIDS Survival Project, in Atlanta, Georgia.

Q. What were the results of the research project?

A. Results for this single-site project were published in the *American Journal of Preventive Medicine* (2001), vol. 21 (2): pages 84-92 in an article titled *Effectiveness of an Intervention to Reduce HIV Transmission Risks in HIV-Positive People*. Six months after taking part in **Healthy Relationships**, significant numbers of participants reported:

- Less unprotected sex with non-HIV positive partners
- Fewer sexual contacts overall
- Having refused to engage in unsafe sex

These results showed that the study group participants who were randomly assigned to the intervention reported greater self-efficacy for suggesting condom use with new sex partners and being able to satisfy sex partners and themselves by practicing safer sex, compared to persons in the control group receiving a health maintenance intervention. They also reported intentions to consider the pros and cons of HIV status disclosure to partners and to engage in safer sex with partners who did not know their HIV status. Measures were done at pre and post intervention. At 3-month and 6-month follow-up assessments, intervention group participants were significantly more likely to have followed through on their earlier intentions and to have considered the pros and cons of HIV status disclosure to sex partners. At the 6-month follow-up the intervention group participants were significantly more likely to have refused to engage in unsafe sex (which was not true at the 3-month follow-up). The intervention group participants also reported less unprotected intercourse, more protected intercourse, and fewer sexual contacts than the control participants at the 6-month follow-up. They also had less sexual intercourse and less unprotected intercourse with non-HIV-positive partners at both the 3 and 6-month follow-ups. Estimates of HIV transmission risk showed that the intervention resulted in lower transmission from males to both male and female partners. The intervention did not have different effects with persons of different sexual orientations; incarceration, drug use, or psychiatric histories; or current drug use. These results demonstrate that this intervention is broadly applicable, across subpopulations. The results also show that the effects are long-term (at least up to 6-months) and affect both reported behaviors and perceived self-efficacy.

Q. What are the Core Elements of **Healthy Relationships**?

A. Core Elements are components that are critical features of an intervention's intent and design, and are thought to be responsible for its effectiveness. Consequently, Core Elements are components that must be maintained without alteration to ensure the programs' effectiveness. **Healthy Relationships'** five Core Elements are as follows:

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

Q. What are the Key Characteristics of the **Healthy Relationships** intervention?

A. Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. **Healthy Relationships'** Key Characteristics are the following:

- Participants meet in small closed groups, similar in style to support groups.
 - Groups meet for at-least five 120 minute sessions.
 - Participants sit in a circle, face to face.
 - Groups contain members of the same gender and sexual orientation
 - At least one group facilitator is an experienced and skilled counselor and preferably is a mental health professional. This facilitator may or may not be HIV positive.
 - One facilitator is a peer counselor who is living with HIV.
 - One facilitator is male and the other female.
 - At least one facilitator matches the ethnicity of the majority of group participants.
 - Both facilitators have the personal characteristics and group skills of effective facilitators.
-

Q. What types of agencies have used **Healthy Relationships**?

A. Many different types of agencies have used **Healthy Relationships**. The agencies involved in testing the intervention package were community based organizations, clinics, substance abuse treatment centers and AIDS service organizations. These organizations implemented the intervention with various populations including heterosexual men and women, MSM, Injection Drugs Users and mono-lingual Spanish speaking populations.

SECTION 4: Intervention Description

4.1 Goals of Healthy Relationships

The goals of **Healthy Relationships** are for participants to examine their risks, develop skills to reduce their risks, and enable participants to make informed and safe decisions about disclosure skills and safe sex negotiation skills. These goals are achieved through fidelity to the Core Elements. The Personal Feedback Report, for example, assists participants in identifying behaviors they want to change, and promote the continuance of protective behaviors. During the sessions the participants see behaviors modeled, practice those skills and as a result of skill acquisitions, are able to make the necessary behavioral changes.

4.2 Core Health Education/Risk Reduction Messages

Participants attending the **Healthy Relationships** sessions will be exposed to the following risk reduction messages:

- You can reduce the stress of disclosing your HIV status to family, friends and sex partners
- You can build healthier and safer relationships
- Practicing these five coping skills will help you deal with the stress of living with HIV:
 - Awareness: ability to read and understand your surroundings and yourself
 - Triggers and Barriers: ability to recognize events and situations that can encourage or discourage you from doing something
 - Problem-solving: ability to think of possible plans to achieve the long-term and short-term results you want, including overcoming any problems or barriers
 - Decision-Making: ability to weigh the pros and cons of two options and to choose an option, such as to disclose or not disclose whichever will work
 - Pros are possible positive results from an option
 - Cons are possible negative results from an option
 - Action: ability to act on the option you chose and to communicate your decision to others

These risk reduction messages are taught in each of the sessions and will eventually be used by participants in making disclosure decisions and negotiating safer sex practices.

4.3 Core Elements of Healthy Relationships

Core Elements are intervention components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and, consequently, must be maintained without alteration to ensure program effectiveness.

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

To achieve fidelity to the intervention, these five elements must be maintained. **The Core Elements cannot be altered in any way.** When implemented properly these Core Elements have been shown to produce behavior change.

The video clips used in the intervention are the springboard for the discussions and role-plays which provide an opportunity for the participants to practice and personalize the skills taught in the intervention.

4.4 Intended Target Populations

Healthy Relationships was originally tested with the following populations: heterosexual men, women and MSMs. Those are the populations involved in the replication process as well, although some sites did include IDU populations (see planning section on what populations are appropriate for **Healthy Relationships**).

4.5 Risk Factors

The risk factors for appropriate participants are the following:

- Low social support
- Low perception of risk for self and others
- Low self-efficacy to practice and negotiate safer sex
- Low self-efficacy for appropriate disclosure
- Poor negotiation skills
- Poor communication skills
- Lack of condom use and the inability to use condoms correctly

4.6 Checklist of Appropriateness of Intervention

The purpose of this checklist is to stimulate thinking and engage key people in dialogue, so they might ask each other the right questions to determine if they wish to adopt **Healthy Relationships**. The checklist also provides questions agencies need to explore when thinking about adapting the intervention and any organizational changes required to implement the intervention. This checklist is not exhaustive.

- Does **Healthy Relationships** fulfill the mission of your agency?
- Does your agency have the resources necessary for the intervention?
- Would **Healthy Relationships** serve the needs of your population?
- Does **Healthy Relationships** address the factors that put individuals in your target population at risk?
- Will any of your agency's organizational practices change as a result of implementing **Healthy Relationships**?
- What type of organizational changes will need to occur?
- Will implementing **Healthy Relationships** change your agency's relationship with prevention and/or services agencies?
- Does your target population need an intervention which deals with disclosure decision-making skills and the negotiation of safer sex practices?
- How does **Healthy Relationships** fit into your current prevention services?
- How effective are your agency's current prevention services? What works and why?
- Will **Healthy Relationships** be more effective than current prevention services?
- What is your agency's philosophy of prevention? What are the values, attitudes, and beliefs of your staff about prevention? What is your staff's commitment to prevention services for individuals who are living with HIV/AIDS?
- What were your agency's prior prevention programs and how effective were those programs?
- Does your agency have access to HIV-positive populations? If so how many HIV-positive clients does your agency have access to?
- What is your agency's past experience with the HIV-positive community?
- What kind of reputation does your agency have in the HIV-positive community?
- Can your agency constructively impact the community of PLWHA?
- Does your agency have the resources necessary for the intervention?

4.7 Commonly Asked Questions

Q. What is **Healthy Relationships**?

A. **Healthy Relationships** is a five-session, small group intervention with men and women living with HIV/AIDS. It is based on Social Cognitive Theory and, as such, focuses on the development of skills, positive expectations and building self-efficacy about new behaviors through modeling behaviors and practicing new skills. Knowing that the lives of persons living with HIV/AIDS are stressful, the intervention focuses on building skills to reduce stress in three life areas: disclosure of HIV-status to family and friends, disclosure to sex or

needle sharing partners, and safer sexual behaviors. Although disclosure is addressed, this is not an intervention that promotes disclosure – the skills that are developed are decision-making and problem-solving skills that enable the participants to make informed and safe decisions about disclosure and sexual behaviors.

Healthy Relationships addresses participants' HIV-status, disclosure skills, and safe sex negotiation skills. Sessions involve both the practice of coping skills and motivational feedback. Participants see behaviors modeled for them, practice those skills, receive feedback and reevaluate their behaviors. **Healthy Relationships** uses feedback forms to help participants identify behaviors they want to change. In each of the three life areas, a series of exercises is repeated to create and develop the decision-making and problem-solving skills. The primary exercise is role-playing based on scenarios that are established by viewing short clips from popular movies. There are a variety of types of video and movie “clips” shown in the five sessions of **Healthy Relationships**: personal statements, HIV/AIDS information, condom demonstration, and, most importantly, segments from popular movies. The term “clip” is used, regardless of whether the clip is short or long or even an entire video. Facilitators use brief descriptions or “set-the-scenes” to introduce clips while tying them to the objectives of that session. The intervention is highly adaptable, based on the choice of movie clips, and is intended to create a positive, engaging, and creative atmosphere.

Q. What happens in a **Healthy Relationships** group session?

A. Groups consist of five to twelve people of common backgrounds. These small groups are closed to new members and are similar in style to support groups. Participants sit in a circle and share common experiences throughout a minimum of five 120-minute sessions. Two facilitators, one of whom may be a peer PLWHA, use Easel Chart Guides and video clips to lead participants through the **Healthy Relationships** content.

Healthy Relationships groups role-play and practice new skills in an effort to encourage participants to perform the newly acquired behavior and skill sets. **Healthy Relationships** leads participants to explore the pros and cons associated with behavior change in the context of disclosure and safer sex practices. Participants observe others, share experiences, practice new skills, and receive feedback from peers in the group. The group experience can have powerful effects on individual behavior, challenge perceptions that promote risk, and shift attitudes to support prevention.

Q. How are **Healthy Relationships** sessions different from support groups?

A. **Healthy Relationships** sessions are not on-going; there are five sessions in the series, although an agency can choose to add sessions at the end. The sessions are not meant to be counseling sessions; they are skills-building sessions. **Healthy Relationships** sessions have an agenda and objectives to accomplish for each session. **Healthy Relationships** can be done in an existing support groups or these sessions could be used to start a new support group. However, unlike many support groups, there is a formal enrollment process and a

distinct end to the group. The sessions are closed to new members once a series of sessions has begun. Also, there are two facilitators who facilitate the single-sex groups.

Q. Is **Healthy Relationships** a disclosure intervention?

A. The lives of persons living with HIV/AIDS are stressful; the intervention focuses on building skills to reduce stress in three life areas: disclosure of HIV-status to family and friends, disclosure to sex or needle sharing partners, and safer sexual behaviors. Although disclosure is addressed, this is not an intervention that promotes disclosure – the skills that are developed are decision-making and problem-solving skills that enable the participants to make informed and safe decisions about disclosure and sexual behaviors. **Healthy Relationships** addresses participants' HIV-status, disclosure skills, and safe sex negotiation skills.

Q. If a person living with HIV/AIDS wants to be a part of **Healthy Relationships**, does that mean s/he has to disclose his/her HIV status to their family, friends or sexual partners?

A. No. Although disclosure is addressed, this is not an intervention that promotes disclosure.

Q. What is an appropriate age of participants for **Healthy Relationships**?

A. The agencies that tested the **Healthy Relationships** intervention package had participants ranging from 13-65 years of age, with an average age of 40. One agency had a wide range of ages in their group (13-45); they discovered the range of participants' age was not ideal for group dynamics. The younger participants did not comprehend the concepts (especially the coping skills) and were not able to contribute to discussion of sexual activities and experiences. The facilitators had to spend extra out-of-session time with these younger participants explaining the concepts and making the material accessible. The subject matter of **Healthy Relationships** is geared towards mature audiences. The discussions and several of the exercises discuss sexual activities and behaviors, and the conversations can be very candid. Participants should be sexually active and old enough to discuss sex and sexual experiences in a mature and responsible manner.

Q. Why is there so much repetition in the curriculum?

A. It is crucial that implementing agencies understand that **Healthy Relationships** is built on repetition as a learning technique. It is through repetition that participants learn the coping skills and are able to successfully incorporate these skills into their daily practices and decisions.

SECTION 5: Planning the Implementation of the Intervention

This section of the TA Guide will prepare an implementing agency for delivering the **Healthy Relationships** intervention. It is during this pre-implementation period that your agency can make any necessary organizational changes; access needed resources, and develops marketing and evaluation plans. Before getting started, agencies must understand how, where and for whom a new intervention will be implemented, and mobilize the support necessary for smooth implementation.

5.1 Staffing

In order for **Healthy Relationships** to run smoothly you will need a program manager, at least one mental health professional or skilled counselor as a facilitator, and at least one peer facilitator.

Program Manager

The program manager is primarily responsible for the following tasks:

- Preparing the agency for the intervention
- Setting up training and technical assistance
- Managing the budget
- Determining the necessity of collaboration with other organizations
- Establishing the evaluation plan and overseeing the evaluation plan monitoring fidelity
- Quality assurance
- Securing the intervention needs
- Overseeing the intervention and intervention team
- Monitoring fidelity
- Hiring and managing the intervention team
- Conducting Debriefing Sessions

The program manager will assist with the following tasks:

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

Healthy Relationships requires two facilitators. At least one of the two should be an experienced and skilled counselor or preferably a mental health professional (MHP) with experience in group facilitation. The other should be a peer from the community (one of the Key Characteristics suggests that the peer facilitator be HIV-positive). One facilitator should be a male and the other female. A female facilitator assists in the role-plays in heterosexual men's group. Finally, at least one of the two facilitators should match the ethnicity of the majority of the participants.

Experiences in delivering the intervention have found that women feel more comfortable and safe discussing issues of sex and sexuality with women facilitators. If any of the women have been victims of domestic violence or any crimes against women, the presence of a female facilitator will help to create a safe and supportive environment.

The two facilitators must coordinate their responsibilities for each session and practice together in advance of the session. The two facilitators need to develop a method of signaling each other if one notes a participant in need of special attention. The MHP may have to handle participants experiencing suicidal or homicidal thoughts or being available after sessions to talk with participants if something is bothering them. The intervention (at any points or all the way through) could be emotionally moving or life changing for some participants. Both facilitators need to be aware and sensitive at all times.

The Healthy Relationships intervention includes discussions about personal behaviors such as sexual practices, major life events, and personal experiences of disclosing HIV serostatus or violence. Topics of discrimination and sexual coercion may arise as well. It is not unusual for some participants may feel uncomfortable talking about these topics. It is important for facilitators to be able to distinguish between normal discomfort and an adverse event. Adverse events include emergency and non-emergency situations. Examples of an adverse event occurring in the Healthy Relationships intervention include, but are not limited to:

- Report or display physical problems (such as hyperventilation).
- Reports or displays serious emotional distress.
- Reports or displays ongoing suicidal or homicidal thoughts or intentions to harm oneself or others.
- Participant is high or under the influence of a substance or alcohol resulting in problem behavior.

These events must be taken seriously and handled in a consistent manner based on agency written protocol. If an adverse event occurs, the group facilitators should follow the agency's protocol. Examples of steps to take include:

- Take the participant out of the session, if appropriate, or talk to the participant privately immediately following the session.
- Suggest that a call for an appropriate referral be placed.
- Send the participant for further assessment, if necessary.
- If the situation warrants an emergency response, call 911.

The Agencies implementing Healthy Relationships should develop a plan for addressing participants who may experience suicidal or homicidal ideation, violent outbursts, or other adverse events. This

plan will assist the facilitators in knowing where and how to refer participants for either additional assessment or treatment services. The following points can be included in the agency's plan. This list is not exhaustive, but it does cover the main areas to be addressed.

- Each agency should have written protocols for handling emergency and non-emergency situations that occur during or after HR sessions, handling suicidal or homicidal ideation and other duty to warn issues, identifying appropriate staff or a referral process for immediate assessment, etc.
- Each agency should provide training on these protocols to all staff involved in the Healthy Relationships intervention or services provided to clients participating in the intervention. This staff training should be documented for each staff person.
- Each agency should provide skills building training to help intervention staff differentiate between emergency situations and non-emergency situations that occur during or after a HR session. Related to the facilitators receiving skills building training, each agency's protocol should include mechanisms for referrals such as the Healthy Relationships Resource Packet or some other resource guide listing psychiatric or domestic violence services and a ways to follow-up on the referral made.
- Each agency should assess whether its existing written agency-wide protocols include the topics mentioned above and would, therefore, include the Healthy Relationships intervention and participants.
- In instances where the agency does not have a licensed/certified clinician in-house, each agency should consult with a licensed/certified clinician on specific cases. If the agency does have a licensed/certified clinician in-house, the agency should have this person provide supervision to the facilitators or seek clinical insight from a consulting clinician on an ongoing basis.

Where to Find Effective Facilitators

The following are some suggestions on how to find effective facilitators (skilled and peer facilitators)

- Observe support groups and other group leaders in action
- Ask your advisory board to make recommendations (for peer facilitators)
- Contact local AIDS service organizations (for peer facilitator)
- Network within your own organization for recommendations or with organizations who might know someone to recommend
- Ask your advisory board to make recommendations (for peer facilitators)
- Attend support meetings for people living with HIV/AIDS (for peer facilitators)

Characteristics and Skills of Facilitators

The facilitators will direct the intervention sessions guiding the participants through the content of **Healthy Relationships**. It is important to remember that the facilitators for **Healthy Relationships** will not operate in the role of counselors. The trained facilitators need to be clear

that **Healthy Relationships** is a behavioral intervention; the sessions are not counseling sessions, classes or public health forums. The following is a list of skills and characteristics to look for and the characteristics to avoid when selecting facilitators for Healthy Relationships. Many would also be applicable when choosing any group facilitator.

Skills and characteristics to look for:

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

Avoid the following characteristics:

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

Roles of Skilled Counselor/Mental Health Professional

The selection of a skilled counselor or MHP is an important part of **Healthy Relationships**. The MHP should have experience working with groups involving people living with HIV. The MHP for **Healthy Relationships** could be someone with a bachelor's level training in counseling/mental health work, a psychologist, a social worker, a Licensed Practicing Counselor or a Licensed Chemical Dependency Counselor. Hiring someone with an advanced degree is not necessary for **Healthy Relationships**. Hopefully, the wide range of suggested credentials will make finding a MHP easy and not create implementation barriers. Roles and responsibilities for a skilled counselor or MHP include:

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

Role of Peer-Facilitators

The selection of peer facilitators is also an important process. Like the MHP, the peer facilitators should have experience working with people who are living with HIV and with diverse populations. One of the Key Characteristics suggests the peer facilitator be HIV-positive. Your agency may want to consider selecting and training several peer facilitators if you are working with more than one population, to allow an appropriate cultural and gender mix of facilitators. Roles and responsibilities for the peer facilitator include:

- Prepare for sessions
 - Assist with tailoring and adapting
 - Promote communication
 - Facilitate discussion while following the session's curriculum
 - Practice and review materials
 - Build cohesion
- Along with the MHP:
- Create safe, welcoming and non-judgmental environment for participants
 - Affirm participant's past experiences while communicating an expectation for better future experiences
 - Balance the needs of the participants and the structure of the sessions
 - Create resource packets which provide information about other services offered to people living with HIV in their area
 - Probe for clarity
 - Deal with inappropriate behavior problems
 - Keep the momentum of the conversation going
 - Help handle emotional issues
 - Along with the MHP and group participants: set the group rules and enforce them
 - Along with MHP and the program manager: create a plan to deal with attendance issues and other logistical issues

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

5.2 Staff Training

Training on **Healthy Relationships** is available by registering the appropriate staff on the effective interventions website; the address is www.effectiveinterventions.org. Once agency staff has been registered, the Prevention Training Centers will conduct the training of facilitators for **Healthy Relationships**.

One important component of facilitator training is facilitation coordination and practice. The facilitation coordination and practice is a specially scheduled time where the two facilitators practice by holding practice **Healthy Relationships** sessions. One of the goals of the coordination and practice is to give the facilitators an opportunity to spend time learning the facilitator's handbook, the Easel Chart Guides and the intervention forms before the intervention begins. Facilitators will also want to practice segues between the clips, discussions and the role plays. In addition, the practice and coordination will give the facilitators a feel for the basic logistics of **Healthy Relationships**.

During facilitation coordination and practice, facilitators can also practice managing conflict and other difficult group dynamics. The practice sessions will increase each facilitator's comfort-level with the group process and promote flexibility in adjusting the agenda based on the needs of the participants. In addition, practice will help facilitators assess their facilitation skills. Program managers and relevant staff members may want to observe the mock sessions and provide facilitators with feedback. Some potential self-evaluation questions are:

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

Additionally, the practice will provide the facilitators with the opportunity to assess and evaluate their knowledge of the intervention content. Some sample evaluations questions are:

- Are the purpose of the session's goals and activities clearly understood?
- What will the participants learn at the end of the session?
- Are the learning objectives clear?

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

5.3 Commonly Asked Questions

Q. What resources (beyond those included in this package) are necessary to conduct the **Healthy Relationships** intervention?

A. In order to implement **Healthy Relationships** agencies will need to acquire the following list of supplies and electronic equipment before starting the group sessions:

- Blank video tapes or DVD disks
- Colored paper for Personal Feedback Reports and other handouts (we suggest using colors that correspond to the divider colors from the Implementation Manual: Session One-gold, Session Two-green, Session Three-blue, Session Four-orange, Session Five-purple)
- Name badges (for first names, or nicknames only)
- Food/snacks
- Male and female anatomical models for condom demonstration
- Condoms (male and female)
- Lubricant (“lube”)
- Push pins
- Latex dams
- Blank Personal Feedback Report Forms enlarged to poster size
- Resource Packets
- Enlarged Easel Chart Guides
- Movies clips chosen for your population (see question on page 44 on selecting clips)
- TV/VCR or DVD player with remote control
- Computer with printer (*optional, for ease of tailoring intervention materials/ non-tailored forms could be photocopied from the Intervention Manual*)
- Intervention tape or individual copies of clips
- Either video equipment to copy selected video clips onto an intervention tape or funds for a video contractor to create the tape for you (*optional*)

Q. How do I obtain “buy in” by others in my agency to implement **Healthy Relationships**?

A. Securing the “buy-in” is crucial because it assures the support of agency administration and allows for agency resources to be utilized for intervention implementation. Obtaining the “buy-in” is most effectively accomplished with an intervention *champion*, someone who strongly advocates for the intervention. The *champion* could be an individual or a group of people. Regardless of the number of *champions*, the central issue is convincing the agency that implementing **Healthy Relationships** will enhance the quality of prevention services, and that the agency is capable of implementing **Healthy Relationships**. A *champion* generally is someone who is a mid-to-upper level administrator who serves as a link between administration and staff. The *champion* needs to be adept at answering questions and mediating any changes in organizational structure and can serve as a negotiator of any necessary trade-offs or compromises. The *champion* becomes the intervention’s mouth-piece,

anticipating the reservations of staff, answering questions about the intervention needs and resources. The *champion* must have an excellent knowledge of the intervention including its costs, Core Elements, and Key Characteristics. In addition, the *champion* can use the marketing video available in the intervention package along with the information presented in this guide and the entire package, to further field any questions or concerns about **Healthy Relationships**.

Q. Who are my community stakeholders?

A. The stakeholders are those people on your Board of Directors/Executive Board or your staff, in your community, agency, or your funding source who have a stake in the successful implementation of an intervention. In Appendix B you will find a stakeholder's checklist which can be used to convince the stakeholders that **Healthy Relationships** is an intervention that your agency can and should implement because it meets the needs of the community your agency serves. The stakeholder's checklist contains useful ideas about marketing, recruiting and implementation steps.

Q. How does an advisory board help with implementing **Healthy Relationships** and how do I select one?

A. An advisory board serves as a community advisory panel. However, because of the members' unique insight into the target population, the advisory board can be helpful in tailoring **Healthy Relationships**. Assembling an advisory board is not a long or extensive process and the size of the board is not important. The advisory board is composed of people in the community who understand the various needs of the community and know the best ways to effectively communicate with the target population. Implementing agencies can use the advisory board to select appropriate and culturally relevant clips. The advisory board can also help your agency tailor the Easel Chart Guides, by helping make the language culturally appropriate. In addition, you can try out the intervention sessions with the advisory board, and their feedback can help your agency improve the quality of its delivery. Some other ways that the advisory board can assist your agency is by providing marketing, recruiting and retention ideas. The advisory board is a potentially valuable resource in making **Healthy Relationships** a culturally appropriate intervention.

Q. Why does **Healthy Relationships** have two facilitators?

A. **Healthy Relationships** requires two facilitators. At least one of the two should be an experienced and skilled counselor, preferably a mental health professional (MHP). The MHP should have experience working with groups of people living with HIV. The MHP for **Healthy Relationships** could be someone with a bachelor's level training in counseling/mental health work, a psychologist, a social worker, a Licensed Practicing Counselor or a Licensed Chemical Dependency Counselor. Hiring someone with an advanced degree is not necessary for **Healthy Relationships**. Hopefully, the wide range of suggested credentials will not create implementation barriers and will make finding a MHP easy. The purpose of having a MHP is to have someone with professional experience dealing

with some of possible psychological, social and emotional issues that may arise during the course of the intervention.

The other facilitator should be a peer from the community, and it is recommended the peer be a PLWHA (see Key Characteristics). Like the MHP, the peer facilitators should have experience working with PLWHA and with diverse populations. Agencies may want to consider selecting and training several peer facilitators if you are working with more than one population to allow an appropriate cultural and gender mix of facilitators.

It is important to remember that the facilitators for **Healthy Relationships** will not operate in the role of counselors. The trained facilitators need to be clear that **Healthy Relationships** is a behavioral intervention; the sessions are not counseling sessions. Some of the agencies that tested the **Healthy Relationships** intervention package found that facilitators who had been trained in 12-step facilitation had difficulty adjusting to the facilitation style and approach of **Healthy Relationships**.

Q. Why are male and female facilitators used to facilitate the sessions?

A. One facilitator should be a male and the other female. Experiences in delivering the intervention have found that women feel more comfortable and safe discussing issues of sex and sexuality with women facilitators. If any of the women have been victims of domestic violence or any crimes against women, the presence of a female facilitator will help to create a safe and supportive environment. In heterosexual men's group it assists the role-plays to have a female facilitator to be female character. Finally, at least one facilitator should match the ethnicity of the majority of the participants.

Q. How do you handle MHPs who are mandated reporters in their state or jurisdiction?

A. In Session One the MHP should introduce him/herself and, say "I am licensed by the state and, therefore, required to report (specify what) if it comes up. If it comes up, I will let you know privately that I will be reporting. However, since this is a skills-building intervention, not counseling I don't expect these issues to come up. Now, let's have my co-facilitator introduce him/herself."

Q. How can you tell if someone will be a good peer facilitator?

A. Not every member of the target population is appropriate as a peer facilitator. Peer facilitators should possess specific skills and abilities that include but are not limited to the following:

- Have an understanding group dynamics
- Be able to promote communication among participants
- Be able to practice and review materials for sessions
- The ability to deal with inappropriate behaviors

Each agency should develop criteria before starting the recruitment process.

Characteristics of a good peer facilitator include a non-judgmental attitude, a social network of peers who consider him/her a credible source, living or spending time with target population, ability to be reliably contacted, and lacking the need to reform the target population members or impose hidden agendas. It is recommended that implementing agencies consider the following items when assessing the appropriateness of a peer facilitator: the individual's time in recovery, his/her ability to role model, and personal coping skills, and reliability. Implementing agencies should also consider an applicant's ability to provide the time and energy that is required to be a peer facilitator to participate in the facilitation coordination and practice, and the debriefing sessions.

If the individual is not a PLWHA, the implementing agency should assess the individual's understanding of the dynamics of disclosure, their coping skills and their knowledge of HIV and the disease progression.

Q. Where do I find a mental health professional (MHP)?

A. There are many methods that can be explored when attempting to locate an MHP. First, if there are any local colleges or universities in your area you can approach the counseling or social work programs for students who may want to volunteer hours as a part of their school practicum or faculty who may want to volunteer their services. Second, you can look within your own agency for individuals with group facilitation experience. Also, you can check with other local AIDS service organizations (ASO), hospitals or mental health facilities in the area for staff who may want to volunteer time or will charge a reduced per hour or contract rate. Keep in mind the MHP for **Healthy Relationships** could be someone with a bachelor's level training in counseling/mental health work, a psychologist, a social worker, a Licensed Professional Counselor (LPC) or a Licensed Chemical Dependency Counselor (LCDC). It is not necessary to hire someone with an advanced degree. It is not a requirement to have a licensed mental health professional facilitate **Healthy Relationships**; however it is very important the skilled counselor or MHP have experience working with groups of people living with HIV.

Q. What happens if only one facilitator is able to be present?

A. Although it is recommended that **Healthy Relationships** groups utilize two facilitators it is not a requirement. If one of the facilitators feels that they are capable of facilitating the group alone, then it's okay. Just keep in mind that things can possibly get out of hand emotionally, so it's a good idea to have a back-up co-facilitator or a back-up staff person who can assist you if the need arises. It is not recommended that new facilitators be added to the group after the sessions have begun.

Q. If a facilitator or group participant is ill should the individual still attend the session?

A. **Healthy Relationships** is a group level intervention for PLWHA. Therefore, the participants have compromised immune systems, and if any participant is ill he/she should be excused from the session to protect the health of the other participants. If several participants are ill you may need to cancel the group until all participants are able to attend and participate. If one facilitator is ill the sessions can continue, if the other facilitator is comfortable running the group alone.

Q. If a potential facilitator does not have group facilitation experience, how can they get training?

A. There are several methods that individuals can use in order to gain an understanding of group facilitation as well as obtain some practice facilitating groups. Individuals can take courses at a local college or university on group dynamics and group facilitation. This will provide participants with a sound understanding of the concepts of group facilitation as well as provide an opportunity to practice concepts and skills learned.

Q. How can the implementing agency train staff members who weren't able to attend the **Healthy Relationships** training?

A. It is strongly recommended that individuals only receive training through one of two methods:

- Training by **official Healthy Relationship** staff who have been trained, or
- Training by individuals who have gone through the Training of Trainers Training (TOT) for **Healthy Relationships**.

Q. How can I request training for my agency?

A. To request or register for a training, visit the following website:
www.effectiveinterventions.org

Q. What type of site/room is most appropriate for **Healthy Relationships**?

A. **Healthy Relationships** is designed to be delivered in a private and secure location. The following are suggestions for site selection and room logistics:

- Central location along major transit routes so participants with limited or no access to transportation can easily and readily reach the location.
- Consider avoiding venues that advertise services provided to PLWHA due to the stigma associated with HIV/AIDS if that's important to your population.
- A site that is handicapped accessible.
- Flexible seating arrangement to accommodate a group of ten in a circle.

The agencies that tested the intervention package used a variety of venues to hold their sessions. The agencies reported that the following were good venues:

- Hotel conference rooms (at low occupancy times)
- On-site (using existing office space after hours or during lunch times when staff and/or clients are out of the office.)

Several agencies reported that the following problems made other venues less than ideal:

- interruptions (not a private space)
- small space or troublesome room configurations
- bad geographic locations
- noise levels

One agency used substance abuse treatment centers to deliver **Healthy Relationships** and reported that these centers worked well as venues.

Q. What are the steps for scheduling sessions for **Healthy Relationships**?

A. Some suggestions for scheduling sessions are:

- Identify as many potential venues as you can that can handle the group sessions.
 - Choose venues that have large private meeting rooms which can allow flexible seating accommodations and additional tables for food, are easily accessible via various transportation methods and are wheelchair/handicapped accessible. Also consider the length of time for which you can reserve the room in case the intervention runs longer than five weeks or five sessions.
 - Recruit your participants through a variety of methods. When recruiting participants, the implementing agency should keep in mind the days and times participants will be available as well as any additional needs the participants may have. It is also important to assess the participants' preference of male/female facilitators. During this process it is also important to take into account the availability of the identified **Healthy Relationships** facilitators.
 - Confirm a venue that can accommodate all your needs/requirements.
 - Schedule **Healthy Relationships** sessions on a day and time that is convenient for participants and facilitators.
-

Q. What if the session runs longer or shorter than the suggested two hours?

A. It is important that implementing agencies understand that the two hour length time recommendation is a Key Characteristic. Implementing agencies are not limited to two hours per sessions. In fact, the agencies that tested the intervention package reported that several sessions (specifically Sessions Two, Three and Five) took longer than two hours. These agencies tailored the session length to fit the needs of their communities in one of two ways: either breaking up the longer session into two parts or allowing a session to run longer than two hours.

These are some practical tips that can be done to manage the delivery of the intervention to fit in two hours.

- Use a room with a clock on the wall, or have the facilitator bring a large clock that can be placed where facilitators and participants can easily see it. This will help the facilitators keep track of time.
- Re-direct participants when they have strayed from the topic of conversation. **Healthy Relationships** may be the first time many participants have had the opportunity to discuss their sero-status with others PLWHA. The resulting discussions can take on a life of their own, taking the group away from the intervention focus. It is important to remember that **Healthy Relationships** is a protocol-driven intervention and there are objectives that must be covered during each session.
- Inform participants at the beginning of the intervention cycle that the sessions are packed with great and informative content, and that there may be times when the session length is extended or times when the sessions may be broken into two parts. Ask participants which one they would prefer.
- Use the facilitation coordination and practice to estimate the amount of time needed to introduce, explain and practice important concepts.
- Prioritize which concepts are the most important to the participants.

AS A LAST RESORT

- Tailor the number of role plays.
- Use one-line role plays: asking participants to simply state (in one line) “*what would they say or do differently*” encourages participants to be brief.
- Limit the Personal Feedback Report (PFR) discussion to 2-3 people.
- Use shorter educational videos or have verbal presentation of educational material.

Q. What kind of refreshments is it appropriate to offer during the session, and how do we get them?

A. It is important for implementing agencies to be very cautious and deliberate when planning for the needs of their participants. We recommend that agencies provide some type of refreshments for their participants. Some of the participants may be on a treatment regimen that requires food frequently. Also the time of the day the intervention is conducted will determine the type of snacks provided. It is important to avoid serving heavy meals because this may induce sleep and will interfere with the participants’ ability to concentrate on the intervention.

Also, implementing agencies should consider the diets of their participants with multiple health issues. For example, participants who are diabetic may not be able to eat sugary snacks or fruit with high fructose content.

If implementing agencies decide to provide a meal for their participants, it is recommended that the meal be served either before or after the session. Eating meals during the sessions interferes with full participation in the session.

Implementing agencies that cannot afford to offer refreshments may want to seek donations within their community. Local AIDS service organizations, food pantries/banks and community merchants are great places from which to solicit donations.

Q. What are Pre-Assessment Interviews or Participant Interviews?

A. Pre-assessment interviews are an opportunity for implementing agencies to speak individually with potential **Healthy Relationships** participants and assess their readiness to participate in the intervention. The conversations should be conducted by the facilitators in a private room where the potential participant can feel comfortable answering the questions in a welcoming, safe and supportive environment. During the interviews the facilitators ask the potential participants about their previous group experience and their ability to handle and resolve conflict. The pre-assessment interviews assist facilitators in assembling a group of participants whose personalities work well together. Additionally, during the pre-assessment interviews participants can complete the Initial Assessment Survey and have their questions about **Healthy Relationships** answered. See the following question for further information on the Initial Assessment Surveys.

A sample pre-assessment interview questionnaire is in Appendix III of the Implementation Manual. This tool can be adapted to fit your population.

Q. What forms are part of the implementation package and how are they used?

A. The required forms can be found in Appendices III and IV of the Implementation Manual. The following is an explanation of the forms in the package and how they are used in implementing **Healthy Relationships**.

Initial Assessment Survey (IAS): This survey is completed by the participants prior to the first session. (We recommend scheduling a time for each participant to fill out the survey individually in advance of Session One). The Initial Assessment Survey has five sections and can be adapted for specific populations. The first section asks participants to assess stressors in their daily life. The second section gauges the participant's ability to disclose HIV status to family and friends. The third section asks participants to assess their ability to disclose HIV status to sex/needle sharing partners and inquires about participant's ability to practice safe sex. The fourth section asks about history of sexually transmitted diseases. The final section is about needle sharing and drug using behavior. The facilitators may want to review each participant's assessment so they can be familiar with individual participant's responses. This will help oversee each participant's progress as the intervention proceeds. To ensure the privacy of the participants, create a list of the participants, assign each a code number, put the code number on their surveys, and keep the list of names and codes in a locked drawer. Which staff shall have access to the forms, the length of time the forms are to be maintained or at which point they should be destroyed, are based upon individual agency's policies and protocols.

Personal Feedback Reports (PFRs): PFR's are created based on each participant's responses on their Initial Assessment Survey. The forms need to be completed prior to the beginning

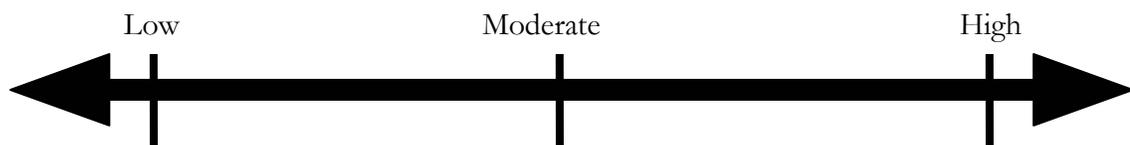
of the intervention; this can be done by anyone on the intervention team. Individual PFRs are handed back to participants in Sessions One, Three and Four. These are three different PFRs. The forms are used in several ways; first they remind participants how they responded to questions from the Initial Assessment Survey. Second, the forms can be used to help motivate participants to change by helping them 1) identify what they do compared to what they want to do, and two) reinforcing existing safer behaviors they want to maintain. During the sessions a blank PFR enlarged to poster size, specific to that session and identical to the ones handed back to the participants is used to review the questions and frame that session's discussion topics. The PFRs are colored coordinated according to session: the PFR for Session One is blue, the PFR for Session Three is yellow and the PFR for Session Four is green.

Clip Essence Tables: This table is designed to assist implementers in selecting effective video and movie clips to use in the intervention. The table contains helpful hints or tips about the selection of culturally appropriate clips, and how the clips are used in the intervention. Selection of culturally appropriate and/or competent clips tailors **Healthy Relationships** to your participants.

Easel Chart Guides: The guides were developed so the facilitators will not have to read from the facilitator's handbook during the sessions. The Easel Chart Guides are provided to visually reinforce the subjects under discussion and questions to consider. They can serve to remind the facilitators of the most important points to cover in a session. Many of the guides can be copied as is, but always consider their appropriateness for the participants and adapt them as needed. The Easel Chart Guides about video and movies clips will need to be adapted based on the clips selected for the group and the "set-the-scene" created for the clips.

Q. What is a Risk Continuum Banner and how is it used?

A. The Risk Continuum is a banner used in exercises in Sessions One, Three and Four. These exercises use a long banner with a double-ended arrow labeled from high to low (see Figure below). The line of the arrow may be covered with Velcro®, and the cards can have corresponding pieces of Velcro® on the back to allow them to be attached and detached easily from the banner. Alternatively tape, poster putty, or similar temporary adhesives can be used.



In each session where the Risk Continuum Banner is used, it is with a different set of cards. In Session One, the exercise deals with disclosure to family and friends, so the cards used in that session are labeled with familial relations and various types of friends. The exercise in Session Three deals with the disclosure to sexual partners so the cards are labeled with different type of sexual partners. In Session Four, the exercise is about risk of various sexual

behaviors, so the cards are labeled with different types of sexual activities. It is important to note that these exercises focus on risk because all the situations addressed, whether involving disclosure or risk reduction, are potentially risky to the participants. Participants attach the cards to various points along the continuum banner based on their personal evaluation of the risk involved. Facilitators can put a “No Risk” label above the left arrow if they want to.

Q. How are cards for the Risk Continuum Banner created?

A. How to create cards:

The Implementation Manual contains pages of cards for each version of the exercise. Each page of the cards is marked with a number in the upper right-hand corner. This number corresponds to the session in which they are used. The exercise about disclosure to family and friends is #1, disclosure to sexual partners is #2 and sexual behaviors is #3.

If you wish to adapt **Healthy Relationships** by creating your own cards, you can prepare the cards for use with the Risk Continuum Banner by cutting them out and laminating them four to a sheet, leaving space between them. Trim the cards so the space around them is fairly even (approximately ½ inch).

An electronic version of these cards is on a disk in the intervention package. With a computer and almost any word processing program, you can change the text on any of these cards or create your own cards.

Q. How is the Decision-Making Grid used?

A. The Decision-Making Grid is a visual image to allow individuals to weigh out options such as to disclose or not to disclose, based on what they see to be the pros and the cons of a particular option. Individuals should think of pros as possible positive results and cons as possible negative results from an option. The grid can help participants view an option from all sides. For an option to disclose, to tell would be taking an action that could change things, and not to tell would be leaving things as they are.

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

When using the grid:

- Ask participants to complete the grid based on what they see as pros and cons to tell or not to tell.
- Explain that sometimes the pros for telling and the cons of not telling can be the same, but often they are different.

Q. When do I use anatomical models to properly demonstrate the use of condoms?

A. The proper use of condoms (both male and female) is demonstrated in Session Five. In Session Five participants will discuss the pros and cons of condom use as well as demonstrate the proper use of condoms. Inform participants that they will view a condom demonstration video(s) because there is always something new to learn about condoms. It is important that implementing agencies are teaching skills that are in accordance with current CDC guidelines found at <http://www.cdc.gov/nchstp/od/latex.htm>. Also see Appendix E.

Q. How are role-plays conducted?

A. Role-plays to teach and practice coping skills are a Core Element and are essential to **Healthy Relationships**. The facilitators should set-up the role-play and explain that they provide an opportunity for the participants to act out how they would handle the situation they viewed on the clip. The facilitators will assign the roles and provide time limits for the role-play. The following are the steps to conduct the role-plays:

- After the clip has been viewed and discussed, ask for volunteers to act out a role-play based on the scene they just viewed.
- Ask the participants to demonstrate how they might have handled the situation and what they would do or say differently.
- Inform participants to use their own words and ideas; they do not have to repeat the dialogue from the clip.
- Have participants play the scene.
- Conduct one or two role-plays for each clip, using different volunteer participants each time if possible.

If time is an issue, facilitators can substitute one-liners (asking participants to simply state in one-line ***“what they would say or do differently”***) for the role-play. One-liners are also appropriate if the scene on the clip involved physical contact.

If none of the participants are willing to volunteer for the role-plays then the facilitators can do the role-play themselves; however, this should be done as seldom as possible. One of the purposes of having a male and female facilitator is to provide an opposite gender facilitator with whom the participants can role-play. This is especially important for the heterosexual men’s group.

Q. What are Resource Packets and how are they used?

A. Participants in **Healthy Relationships** may have questions and needs that cannot be addressed during the actual sessions. Because of this, each participant should receive a resource packet during the first session. Agencies need to create a packet to fit the services and other resources available in their community. The facilitators encourage participants to make use of these resources and remind them of the packet at the end of each session.

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

- Business card or other contact information for the facilitator(s) and the sponsoring agency
 - Information on the limits of confidentiality and relevant notification laws.
 - An introduction to the **Healthy Relationships** intervention and why it is being implemented by this agency
 - A list of “key contacts” for PLWHA
 - A variety of resource brochures specific to the community (e.g., information about where in the immediate area to find HIV/AIDS services, assistance with housing, food, medical treatments, prescriptions, etc.).
 - Up-to-date information on transmission of HIV, HIV drugs, HIV therapy/treatment
 - Printouts from websites of interest to your participants.
 - List of contributors for any donated gift certificates or coupons
 - Any other materials you believe might serve as a resource to your participants.
-

Q. Who is the intended audience for the marketing video?

A. The intended audience for the marketing video is anyone with a potential interest in the intervention:

- Agency staff
 - Board of Directors
 - Community stakeholders
 - Advisory board
-

Q. How should and where can **Healthy Relationships** be marketed?

A. Included in the package is a generic marketing information sheet that agencies can use to advertise **Healthy Relationships**. Your advisory board is another useful marketing tool because the members can advise implementing agencies where to distribute the marketing information sheet and identify other ways to generate interest. Agencies should concentrate their recruitment efforts where there are substantial numbers of PLWHA. Advertising can go beyond AIDS service organizations and support groups. Agencies can send fliers, press releases and public service announcements to local religious organizations and radio and TV stations, or place advertisements in local papers. They can also post information on the Internet. When marketing, we recommend that agencies provide general contact information but do not advertise the location of the intervention to protect the confidentiality of the participants.

Q. How should participants be recruited for **Healthy Relationships**?

A. Each agency should create a plan that details how participants will be recruited, recruitment venues and locations, recruitment/marketing tools and the number of participants to be recruited. Your advisory board can provide your agency with some ideas, including the best places to recruit and the best recruiting strategies for your populations. In the package there is a generic marketing information sheet that can be tailored (with the assistance of the advisory board) and used to recruit potential participants.

Q. What kind of screening tools can be used to screen potential participants?

A. The **Healthy Relationships** package include is a list of questions that can be by implementing agencies to determine the appropriateness of potential participants. The list can be found in Appendix IV.

Q. Is there a **Healthy Relationships** attendance policy?

A. Implementing agencies should have an attendance policy which clearly explains the agency's expectation that participants attend every session. The attendance policy should also address tardiness and the notification process for absences. Missing Session Two will make it difficult for participants to participate in the rest of the intervention, since all the basic skills are learned in that session. Participants who miss Session Two should be invited to participate in the next intervention cycle. Participants cannot miss more than two consecutive sessions. Each session builds on the previous session, so missing two consecutive sessions undermines the ability of participants to fully participate in the intervention.

Q. What is the minimum number of participants for an intervention cycle?

A. A minimum number of participants for **Healthy Relationships** group session is five. Having fewer than five means there would not be enough participants to adequately stimulate the discussions and to solicit the views of others. A maximum number of participants is twelve. Too many participants would prevent everyone from talking and participating in the session.

Q. Can a group have participants with different risk factors?

A. Yes, often times the risk factors of the participants in the group will be mixed. If the facilitators are aware of the different types of risk factors present in the group they should tailor the content so that all risk factors are addressed. However, multiple risk factors in one group would be a great reason to add another session to give the participants additional focused practice time and also to address other issues raised by the additional risk factors. More sessions can be added as long as the reasons for adding the additional sessions are

consistent with the Core Elements and the intent of the intervention. For example, with IDUs an additional session can be added that would discuss risk reduction for injecting behaviors. With MSMs an additional session on disclosure of sexual orientation could be added. However, we do not recommend mixing MSM and heterosexual men unless it is discussed with participants at the pre-assessment interview. If transgender persons are interested in participating but there are not enough to form their own group, have each individual choose which type of group they want to join.

Q. How is participant fatigue avoided?

A. One way to prevent participant fatigue is to have frequent breaks that will allow the participants to stretch, get some water or grab a snack, etc. Another method is to make the sessions very interactive and fun, allowing participants the opportunity participate/practice the content being delivered. Facilitators may also want to consider using humor appropriately, so participants can laugh and enjoy themselves and the intervention.

Q. What are some ways to keep the sessions fun?

A. Remember, making the sessions fun and avoiding participant fatigue are important. Session One promises that fun will occur during the cycle of sessions and, with that in mind, here are some suggestions:

- Look for ways to incorporate humor at the appropriate times during the sessions.
- The clips can also be a potential source of humor and fun; some of the essential ingredients call for a humorous clip. For example, clip 1-3 is intended to be fun and lighthearted.
- During the group discussions add humorous life experiences.
- Make the condom demonstration fun and exciting.
- Include humorous tidbits in the welcome back and check-in.
- Give applause, small incentives, or both to participants who take part in role plays or get an answer correct.

Remember the subject matter discussed in **Healthy Relationships** can be intense, so including humor can be a way to de-escalate the tense moments that can occur in the sessions.

Q. Can couples participate in the same group?

A. **Healthy Relationships** is not a couple's intervention. In the original research couples were not allowed to attend the same session. If both partners are living with HIV/AIDS one suggestion is to have them attend different groups to maintain each others' privacy and to not have the couple's personal issues become a focus during the sessions. If one partner is not living with HIV/AIDS, that partner cannot sit in on the sessions (see questions below about outside observers).

Q. Can the groups be co-ed?

A. It is recommended that the sessions be conducted as single-sex groups. The original research conducted the sessions as single-sex in order to promote and increase comfort-level for discussions around disclosure, sex and sexual practices. Also, for the heterosexual populations, single-sex groups reduced the opportunities for forming of relationships that could disrupt group dynamics during the cycle of sessions.

Q. How can I retain participants in the **Healthy Relationships** intervention?

A. Participants return if they enjoy the sessions and are learning something they value. However, keeping participants engaged in the learning process can be difficult. Facilitators should keep things moving, and make the content exciting, interesting, and fun. To aid the learning process we suggest having popcorn and other snacks available before or after the sessions. Providing the participants with frequent breaks is a way to keep their attention. Also, the appropriate use of humor, small prizes for participating in role plays or getting an answer correct and applause after role-plays are ways to keep participants engaged.

Q. Are non-**Healthy Relationships** participants allowed to attend sessions?

A. **Healthy Relationships** is a closed group, meaning that only participants and facilitators may attend. However, program managers may attend occasionally for quality assurance purposes. The program manager should be introduced, and participants told that the facilitators are being evaluated. Since Session Three is emotionally charged, no outside observers should be allowed. If a participant brings someone to the group, such as another adult, and does not get the permission of the facilitators or the other participants, then that individual should be excused from the room. If a participant brings a small child, then the facilitator(s) and the group should make the decision as to whether or not the child and/or the participant should be allowed to remain in the group. If you know that group members need assistance with child care, try to arrange for help in advance.

Q. How should you deal with inter-personal interactions within the **Healthy Relationships** groups?

A. Before the sessions actually begin, the facilitators and participants should establish group rules and set some boundaries for participants which govern their behavior during the sessions. Inappropriate touching of any kind and dating other participants are not permitted during the group sessions. Participants are strongly advised during the formation of the group rules that they should refrain from developing interpersonal relations of a sexual nature with other participants outside the sessions during their participation in **Healthy Relationships**. The mental health professional, whether the individual is from a social work or counseling background, has a professional code of ethics which govern his/her behavior with clients. The peer facilitator should sign a statement describing his/her expected duties and behavior with participants.

Q. How do I use the Clip Essence Tables?

A. The Clip Essence Tables, found in Appendix VI of the Implementation Manual, is a tool designed to assist implementing agencies in selecting appropriate video and movie clips to use in **Healthy Relationships**.

Explanation of table:

There are a variety of types of clips shown in **Healthy Relationships**: personal statements, HIV/AIDS information, condom demonstration, and, most importantly, clips from popular movies. We will use the term “video” to refer to clips from non-movie sources and “movie” to refer to clips from popular movies or TV shows. Choosing video and movie clips can be a difficult task, but the purpose of the Clip Essence Tables is to make that task easier for the **Healthy Relationships** intervention team. The Clip Essence Tables is designed to assist your agency in selecting effective video and movie clips to use for your target population. The table contains helpful notes about the selection of culturally appropriate clips and how the clips are used in the intervention. A tailored intervention video or movie clip is culturally appropriate or relevant for your target population. The table is divided into five columns. The first two columns contain the most important clip selection information. The remaining columns add supporting information, including descriptions of the clips used in the original research and sample descriptions of how to “set-the-scene.”

Column 1(Purpose) lists the reasons a clip is used at that point in the intervention and usually refers to the life area (disclosure to family and friends, disclosure to sexual partners, and healthier relationships) as well. For example, column 1 for Clip #3-1 says:

“to act as springboard for discussion around disclosure to sexual partners” and “to set up role-plays where participants can practice the skills learned in the previous session.”

Based on that information, an agency knows they need to choose a clip that will:

- stimulate discussion and role-plays, and
- relate to life area #2: disclosure to sex partners.

Column 2 (Essential Ingredients) lists those things that are essential in the clip chosen. In our example from Clip #3-1, the first essential is “be movie-quality.” That means the clip has to have high production values, which ties back to Core Element #5. It can be from a movie, a television show or other video source, as long as the quality is equal to that of a professional movie. The second essential is “be able to be tied back to the skills learned in the previous session.” Almost all of the clips used in **Healthy Relationships** are used for building coping skills. The skills learned in Session Two are discussed and practiced as related to the clips; therefore, the clips must contain elements that can illustrate disclosure, negotiation, or decision-making. The third element is “be suitable for discussion and stimulating role-plays around disclosure to sex partners.” This is to reinforce the purpose from the previous column and should already have been considered.

Column 3 (Options) contains suggestions on how to make the clip more effective in general or for a specific population. For Clip#3-1 these suggestions include:

- can show misunderstandings and stress in relationships when one or more partners are not honest about HIV-status or sexual orientation,

- can show how HIV-status is viewed,
- can show example of someone struggling with disclosure
- can show appropriate or inappropriate times to disclose.

In the original research study, one of the clips showed a young man who goes to his girlfriend's house when he was extremely angry and starts cursing and looking violent. For a group where the men are dealing with anger issues and are not offended by cursing, this could be an effective clip that would stimulate a lot of discussion. On the other hand, a women's group might find it offensive or frightening, decreasing its effectiveness. Therefore, the effects of these options on the audience for the clip (participants in a group) must be considered.

Column 4 (Original Video and Recommendations) includes a brief description of the original clip used for each of the three research groups: heterosexual men and women, and MSM. This is background information that may help in clip selection by providing a basis for comparison. If appropriate for their groups, an agency can use these original clips, the counter times and sources for which are listed in the detail pages at the end of the Appendix. This column also suggests an optimum length for the clip and, in some cases, makes basic recommendations related to the original clips.

Column 5 (Sample "Set-The-Scene") contains samples of brief ways to introduce the clips and describe which character is living with HIV, the emotions he or she is feeling, and the life area he or she is facing, before the clip is shown. These samples are numbered to relate them to the original clips listed in column 4. For example, "Set-The-Scene" #8 is for the original Clip #3-1 used with women's groups. It says:

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

The detail pages at the end of the Appendix, as mentioned in the paragraph about column 4, provide additional information about the clips used in the original research study. This table is divided by session and contains instructions on how to find the clips. It also identifies the ethnic and gender breakdown of the main characters in the clips and lists the target population with which they were used.

Q. Why do I need to make an intervention tape or DVD?

A. Putting together the intervention tape or DVD is central to the implementation of **Healthy Relationships**. The package contains educational clips and a Clip Essence Tables. This tool is provided to guide your agency in the compilation of your tailored intervention video or DVD. By using the Clip Essence Tables selecting appropriate clips will be not difficult. **Healthy Relationships** makes use of popular movie clips. Most of the videos or DVDs can be rented from local video rental stores or agencies may want to purchase the videos or DVDs or borrow them from employees or board members. The Clip Essence Tables also contains information on the movies used in the original research. If agencies do not want to choose clips more specific to their target population they can use the videos listed in the Clip

Essence Tables. The alternative to compiling clips on a single tape or DVD is to utilize multiple tapes or DVDs. Just cue the tapes or DVDs to the scene you want to show before the session begins. DVDs can be bookmarked; it is important to learn how your equipment bookmarks a clip. Read the instructions in order to familiarize yourself with the technology and its operations. If agencies want to make a DVD they should seek the technical expertise of a video production technician.

Q. How do I assemble or make an intervention tape(s) for **Healthy Relationships**?

A. The Clip Essence Tables is provided to guide your agency in the compilation of the tailored intervention video. The Clip Essence Tables is a tool designed to assist your agency in selecting effective video and movie clips to use for your target population. The following is a step by step guide for creating an intervention tape with two VCRs.

- Set-up two VCRs
- Label one VCR 1 and the other VCR 2
- Run a cable from the **“out to TV”** of VCR 1 to the TV
- Run the video/audio (red, yellow and white) cables from the **“line out”** of VCR 1 to the **“Video and Audio (L, R)”** ports on VCR 2
- Run the video/audio (red, yellow and white) cables from the **“line out”** of VCR 2 into the TV
- Cue the tape to the selected clip(s)
- Set the counter time and insert video recording **FROM** into VCR 1
- Insert blank video into VCR 2
- Press **play** on VCR 1 and press **record** on VCR 2 at the same time
- After clip(s) have been recorded onto the blank video tape, check to see that the new video is working properly

Agencies who would like to add a “black” space to their intervention tape can do so by using a camcorder or any type of handheld video camera to videotape a black background or the word “pause” or any other background the agency desires. Once the taping of the background is completed then the agency would record that background onto the intervention tape where the agency wants the “black” space to go.

Q. Where do I find clips to use in the intervention?

A. There are many places to locate videos or DVDs for clips:

- Library
- Advisory Board members
- Friends, families and co-workers
- Local AIDS Service Organizations
- Community Based Organizations
- Local video stores
- Online video sources

If purchasing videos or DVDs would be a barrier to implementation, then agencies should ask video stores or other merchants to loan agencies videos or DVDs. The Dallas implementation team made such an agreement with a local video store. The facilitators explained the purpose and goal of the program, and the store manager agreed to lend the videos. The list is organized from least expensive to most expensive means of acquiring the videos/clips.

Q. Why use movie clips and not produce clips to be used in the intervention?

A. Movie clips are used because they bring the element of reality to the guided-discussions. Making clips by having agency staff act out scripted scenes would not bring the same element of reality, and participants would not be able to divorce themselves from their knowledge of the staff member (actor) to concentrate on the coping skills. In addition, the cost to an agency, of making clips would be extreme and present a barrier for implementation.

Q. What are the advantages of using VHS and DVD and is it best to have clips on one tape or use separate tapes?

A. There are several advantages to using VHS over DVD. One advantage to using VHS is that you are able to have all the clips needed on one tape for ease of use. In addition, more people are familiar and comfortable VHS over DVD technology. Another advantage to using VHS is access-related; it may be easier to access a VHS over a DVD due to cost. Also duplicating a VHS is easier because it only requires two VCRs; however duplicating a DVD requires expensive software and a myriad of other technical knowledge.

The one advantage to using DVDs is the ability to scroll through the chapters and arrive at the desired clip faster. Some DVD players come with a specialized function which allows for the book marking of clips; it is important to note that ***not every machine has this special function.*** Book marking the clips is one way to access specific clips with speed and relative ease.

Q. How does an advisory board help with implementing **Healthy Relationships** and how do I select one?

A. An advisory board serves as a community advisory panel. However, because of the members' unique insight into the target population, the advisory board can be helpful in tailoring **Healthy Relationships**. Assembling an advisory board is not a long or extensive process and the size of the board is not important. The advisory board is composed of people in the community who understand the various needs of the community and know the best ways to effectively communicate with the target population. Implementing agencies can use the advisory board to select appropriate and culturally relevant clips. The advisory board can also help your agency tailor the Easel Chart Guides, by helping make the language culturally appropriate. In addition, you can try out the intervention sessions with the

advisory board, and their feedback can help your agency improve the quality of its delivery. Some other ways that the advisory board can assist your agency is by providing marketing, recruiting and retention ideas. The advisory board is a potentially valuable resource in making **Healthy Relationships** a culturally appropriate intervention.

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

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

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

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

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

Q. Are there legal and ethical issues tied to implementing the **Healthy Relationships** intervention?

A. One crucial step in preparing for the intervention is setting up the proper policies and procedures that will protect agencies, the **Healthy Relationships** intervention team and the participants. It is important to keep in mind that **Healthy Relationships** is an intervention that deals with disclosure of HIV status. Agencies implementing **Healthy Relationships** must know their state laws regarding disclosing HIV status to sexual partners. Each state has their set of laws regarding requirements to disclose HIV infection to sexual partners, and agencies are obligated to inform participants of the duty to warn spouses or sex/needle sharing partners according to their states laws. Agencies need to have a consent form which carefully and clearly explains in accessible language the agency's responsibilities and the participants' rights. The consent forms should contain at least the following components: what the reportable/duty to warn behaviors are in your state, explanation of what confidentiality means, information on what is inappropriate relationship/behavior between participants while the series of sessions is going on, and that all information will be kept under lock and key.

Agencies also need to inform participants about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors and elder abuse.

Q. What is a debriefing session and how is it conducted?

A. The purpose for the debriefing is to allow the **Healthy Relationships** facilitators a time to release emotions from the sessions and to gain support from their colleagues. **Healthy Relationships** deals with issues that may cause varied emotional responses for both the participants and the facilitators. Debriefing allows the facilitators a time to release those emotions in a supportive space. The program manager may want to lead the debriefing sessions for the facilitators. Their role is to guide the debriefing session, however the program manager **does not act as a counselor** during the debriefing. Debriefing is the outlet for the facilitators to express their feelings about the sessions through journaling or talking that any issues those arose during the sessions.

Create an environment where the facilitators can relax and voice their opinion without fear of scrutiny. Each individual will be given between 5-7 minutes to express both negative and positive feelings about the session. This time is used to allow time for each facilitator to decompress from the emotions experienced during the session.

The facilitators may experience the Stages of Grief: Denial, Anger, Bargaining, Depression and Acceptance and should be allowed to work through the stages during the debriefing sessions.

Guilt may be another emotion expressed by the facilitators. The facilitators may experience guilt when recognizing similar behavior patterns or risky behaviors of their own while listening to the group testimonials. The non-peer facilitators may experience guilt for not being infected with HIV. The feeling of guilt for peer facilitators could be a result of surviving, and not understanding why or how.

Questionnaires or questions can be used that are feeling, opinion, and behavior based so that the facilitators can express their emotions, thoughts and actions.

- How did you identify with the group members today?
- What made you uncomfortable during the session?
- What was the highlight of today's session?
- What was the low point of today's session?
- What would you like to see done differently with the group activities?
- Do you feel that your behavior may have indicated any discomfort with the group topic or an individual's statement at any time?

The debriefing topics should focus on the events of the job and not delve into personal issues (if possible).

- If personal issues are a problem and impede the group process, it might be suggested that the facilitators utilize their EAP (Employee Assistance Program) or seek private counseling.
- Journaling may be suggested to allow for the expression of personal issues and thoughts.
- Journaling also can be used to brainstorm ideas and to express issues about the group sessions.
- The program manager can have a special debriefing based on the need to confront certain blind spots that may be hindering the group's progress.
- The goal of the debriefing is for the facilitators to leave stress behind.
- Stretching and breathing techniques can be utilized at the end.

Completing session evaluations immediately after each session is important because it allows facilitators to capture their thoughts and feelings about the session. This is important if post session debriefing is delayed; completing the form can serve as a first step in debriefing.

Q. What are some ideas and helpful hints for self-care of both facilitators and participants?

A. Self care of the participants can be achieved in many ways. Utilizing the check-in method at the beginning of each session will enable you to see how individuals are doing and gain assurance that individuals are taking care of themselves. Encourage participants to talk with supportive family, friends and health care providers, to get enough rest, eat a balanced diet, and take their medications. Journaling provides an outlet to place emotions and thoughts on

paper. Providing an opportunity after each session for the sharing of emotions with other group members provides a sense of safety and security for participants. If a participant is in need of a mental health professional and does not have one, provide participant with a referral from the resource packet and at a later date follow-up to ensure the participant has accessed the needed mental health service.

Q. How do I respond to a question when I am unsure of the answer?

A. When you are unsure of an answer to a question inform the participant that you “do not know” the answer to the question, and reassure the participant that you will research an answer and get back with him/her at a later time, preferably by the next session.

Q. How are literacy concerns dealt with in the intervention?

A. **Healthy Relationships** is a low literacy intervention and the few times reading is required can be tailored to meet various literacy levels. The participant forms (Initial Assessment Survey, Continuum Cards and Personal Feedback Forms) can be read to participants. The Initial Assessment Survey can be completed with the assistance of the facilitators, for example, reading the questions and completing the survey for the participants. If the participant requires the PFRs to be read to them during the session, do so in a way that maintains the participant’s dignity and privacy.

Some practical suggestions:

- Make the language accessible by: avoiding big words, complicated syntax or complicated explanations. Use simple terms.
 - Have one facilitator be designated to spend time with participants who are having a difficult time reading or comprehending the forms, cards or Easel Chart Guides.
 - Consider having out-of-session meetings with individuals with literacy concerns to ensure their understanding of the materials and concepts being presented.
-

Q. How much preparation time is needed before each session?

A. We recommend that facilitators dedicate at least forty-five minutes to one hour to prepare before each group session. This time should be spent considering a number of things. First, review session objectives and practice delivering the content so that you can estimate the amount of time needed. Second, plan out the logistics of the session, for example, the location of the electronic equipment, Easel Chart Guides, banner and other intervention materials. Third, decide which facilitators will cover what material. Fourth, review the clips for that particular session. And finally, ensure that the electronic equipment is working properly and DVDs are bookmarked or videos are cued to their starting point.

Q. How do I deal with disruptive participants?

- A. There are several methods that can be utilized for dealing with disruptive participants:
- Call for a short break and address the issue with the disruptive participant.
 - One of the facilitators could excuse him/herself along with the participant and discuss the issue in another private setting.
 - Redirect/refocus the entire group without singling out any one individual.
 - Refer back to group's rules which should contain agreed upon appropriate behaviors of all participants.
 - Stop all action and direct all attention to the disruptive participant.
 - If action continues or repeats, the participant can be asked to leave the session as a result of their disruptive actions.

Violent outbursts should not be tolerated in sessions. If a violent outburst occurs, facilitators should remind participants of the group rules and what behaviors are appropriate during the course of a session. If the outburst disrupts the session, use a break to speak with the participant causing the outburst. If the situation cannot be dealt with during a break, asking the participant to not return from the break may be an option. If the participant can control their outburst and participate in the remainder of the session, speak with the participant privately after the session. It is important to not allow the outburst to negatively impact the session and dramatically alter the session's dynamics. Lastly, agencies should have referrals that can be given to the participants so they can access services where those situations can be fully explored. Remember, **Healthy Relationships** is not a therapy or process group so facilitators and agencies should have an established plan in place to deal with these situations when they occur. Agencies should have established protocols to deal with unexpected events such as violent outbursts, suicidal ideation and threats of physical violence. These are some examples of situations that should be covered in the adverse events policies. Turn to pages 19 and 20 for more details on adverse events policies.

Q. What are some of the pitfalls in the intervention and places where the MHP may need to be prepared to intervene?

A. Some things to watch for in each session are:

Session One

- Make session upbeat and positive.
- Make sure to end session on a positive, upbeat or humorous note.

Session Two

- There is little time in this session to discuss the copings skills so facilitators should have a plan in place to provide participants with the much needed time to discuss the coping skills.

Session Three

- The content begins discussions about sex and the level of sexual tension increases.

- Facilitators need to remind participants during this session that inappropriate touching of any kind and dating other participants is not permitted during the cycle of sessions. It is important to reaffirm boundaries for participants and facilitators.
- This is an emotional session and it is not appropriate for observers to attend.

Session Four

- Facilitators need to be thoroughly knowledgeable about risk behaviors and the inter-relationships of HIV and other STDs.
- Facilitators should have the most recent information about the inter-relationship between HIV and other STD infections and be prepared to answer difficult and challenging questions.
- The Risk Continuum Banner exercise is one place where there are right and wrong answers and the facilitators need to be prepared to correct mis-information

Session Five

- This is a session that has possible areas for mental health intervention. It is also a session in which “shaming” may occur. The facilitators need to be aware of these possibilities.
- Sex messages must not be negative. Participants should not be shamed or discriminated against because of issues that they communicate within the group. This may negate any positive impact the intervention may have had with participants.
- This session can contain clips that are explicit. Be sure that participants in the sessions know that they can remain sitting and do not have to touch one another.
- Facilitators should be aware that some participants may have a problematic behavior that could be stimulated by the content of the clips. Facilitators need to be prepared with appropriate assessment referrals if a participant reveals that a clip has triggered a sexual, emotional, or other behavior problem area and to urge the person to follow-up if they think it would be helpful for them.

SECTION 6: Maximizing Cost-Effectiveness

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

6.1 Cost Sheet

Categories for Provider Costs to Implement the Healthy Relationships Intervention

Categories		Pre-Implementation (start-up)		Implementation ¹ (intervention delivery)	
Personnel		# staff	% time or # hrs/wk (% FTE time spent on intervention)	# staff	% time or # hrs/wk (% FTE time spent on intervention)
Salaried:					
	Program Mgr.	1	50%	1	25%
	Admin. Asst.	1	20%	1	10%
	Facilitator, MHP ²	1	100%	1	25%
Hourly:					
	Facilitator, Peer ^{2,3}	1	10 hrs/wk	1	10 hrs/wk
Fringe benefits			25%		25%
Location(s)			(% time used for intervention)		(% time used for intervention)
Rent:	Office	\$	x % =	\$	x % =
	Small group meeting space	0		\$	x # sessions = (inc. pre-sessions)
	Utilities	\$	x % =	\$	x % =
	Telephone/fax	\$	x % =	\$	x % =
	Maintenance	\$	x % =	\$	x % =
	Insurance	\$	x % =	\$	x % =

Equipment		(% time used for intervention)		(% time used for intervention)		
Television	\$	x	% =	\$	x	% =
VCR Player with remote ⁴	\$	x	% =	\$	x	% =
Computer	\$	x	% =	\$	x	% =
Copier	\$	x	% =	\$	x	% =
Easel	\$	x	% =	\$	x	% =
Equipment maintenance	\$	x	% =	\$	x	% =
Internet service provider	\$	x	% =	\$	x	% =
Supplies						
Videos (other than in pkg./kit and by target population) ^{4, 5}	10 x # target pops. x	\$	/each =	0		
Postage & mailing	\$			\$		
Copying & printing	\$			\$		
Office supplies:						
Paper (white)	1 ream x	\$	/ream =	5 reams x	\$	/ream =
Paper (colored)	0			3 reams x	\$	/ream =
Certificate paper	0			1 pkg. x	\$	/pkg. =
Pens	1 dozen x	\$	/doz. =	3 dozen x	\$	/doz. =
Name badges	0			100 x	\$	/each =
Easel paper	0			2 pads x	\$	/pad =
Markers	0			1 pkg. x	\$	/pkg. =
Push pins	0			1 box x	\$	/box =
Masking tape	0			1 roll x	\$	/roll =
Pocket folders	0			10 x	\$	/each =
Blank video tapes (by target population) ⁴	2 x # target pops. x	\$	/each =	0		
Condoms:						
Male	0			2 dozen x	\$	/doz. =
Female ⁶	0			2 dozen x	\$	/doz. =
Lubricant ("lube")	0					
Anatomical models:						
Male	10 x	\$	/each =	0		
Female ⁶	10 x	\$	/each =	0		
Printed materials: ¹						
IAS	0			10 x	\$	/each =
Easel Chart	36 x # target					
Guides (by target population)	pops. x	\$	/each =	0		
PFR posters	3 x	\$	/each =	0		
PFR forms	0			30 x	\$	/each =
Information Sheets/flyers	5 gross x	\$	/grs. =			

Other materials: ¹			
Key chains	0		10 x \$ /each =
Prizes	0		8 x \$ /each =
Catering/refreshments			80 x \$ /pers. =
Recruitment (of staff/volunteers)			
Advertising	10 column inches x	\$ /inch =	10 column inches x \$ /inch =
Travel			
Miles to/from intervention site (if other than regular work place)	# miles x	¢/mile =	# miles x ¢/mile =

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

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

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

⁴ This budget lists a VCR player and video tapes. If DVDs are to be used, substitute DVD player and DVDs.

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

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

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

6.2 Timeline

A suggested timeline with specific tasks follows:

Timeline	Weeks 1&2	Weeks 3&4	Weeks 5&6	Week 7&8	Week 9&10	Week 11&12	Week 13&14	Week 15&16	Week 17&18	Week 19&20
Identify potential facilitators	X									
Arrange training for facilitators	X									
Identify members of the intervention team (Program Manager, admin staff)	X									
Identify potential venues	X									
Tailor marketing information sheet	X									
Secure buy-in	X									
Send facilitators to training		X								
Select facilitators and solidify HR Team		X								
Schedule facilitation coordination and practice		X								
Select venue		X								
Continue marketing		X								
Begin securing intervention resources		X								
Begin recruiting		X								
Tailor intervention materials			X							
Select and solidify all video clips			X							
Produce intervention tape			X							
Start facilitation coordination and practice			X							
Schedule sessions			X							
Develop evaluation plan			X							
Select participants				X						

Timeline	Weeks 1&2	Weeks 3&4	Weeks 5&6	Week 7&8	Week 9&10	Week 11&12	Week 13&14	Week 15&16	Week 17&18	Week 19&20
Schedule interviews and complete Initial Assessment				X						
Prepare intervention materials				X						
Assemble Resource Packets				X						
Confirm venue				X						
Arrange snacks / food				X						
Continue facilitation coordination and practice				X						
Schedule debriefing				X						
Create referral system				X						
Confirm participants				X						
Inform participants of session venue and time				X						
Obtain incentives				X						
Arrange room					X					
Conduct Session One					X					
Debrief Session One					X					
Practice Session Two					X					
Prepare Session Two materials					X					
Conduct Session Two					X					
Debrief Session Two					X					
Practice Session Three					X					
Prepare Session Three materials					X					
Conduct Session Three						X				
Debrief Session Three						X				
Practice Session Four						X				
Prepare Session Four materials						X				
Conduct Session Four							X			

Timeline	Weeks 1&2	Weeks 3&4	Weeks 5&6	Week 7&8	Week 9&10	Week 11&12	Week 13&14	Week 15&16	Week 17&18	Week 19&20
Debrief Session Four							X			
Practice Session Five							X			
Prepare Session Five materials							X			
Conduct Session Five								X		
Debrief Session Five								X		
Evaluate program effectiveness									X	

6.3 Sample Plan

A sample plan for **Healthy Relationships** implementation follows:

Implementation Steps

Planning and Preliminary Activities

Task	Capacity and Knowledge Needed	Notes
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 and hold meetings to obtain information on recruitment, venues, incentives, and marketing	Knowledge of intervention; marketing skills; ability to answer questions; ability to establish connections with community persons	
Recruit and hire mental health facilitator	Knowledge of intervention and advanced group facilitation skills. Knowledge of special needs of people living with HIV/AIDS	
Recruit and hire peer facilitator	Knowledge of group facilitation skills. Knowledge of special needs of people living with HIV/AIDS; suggested that the peer facilitator be a person living with HIV/AIDS	

Task	Capacity and Knowledge Needed	Notes
Identify possible venues for sessions	Knowledge of sites frequented by target population; ability to access them; ability to establish trust with people	
Develop marketing plan: tailor marketing information sheet, identify recruitment sites	Knowledge of target population, places to recruit participants, target populations members' preferences; ability to conceive a marketing plan	
Train mental health and peer facilitator. Training issues include background to intervention, group facilitation skills, adapting and tailoring and facilitating the five sessions	Knowledge of tasks and skills required to implement Healthy Relationships	
Begin to secure intervention resources	Knowledge of the intervention and required materials, knowledge of local and agency resources	
Schedule facilitation coordination and practice	Knowledge of the intervention materials and Implementation Manual	
Recruit potential participants	Knowledge of intervention, target population, and places/methods to recruit participants; skills to explain the program; ability to interact with strangers; ability to create trust and elicit information	

Task	Capacity and Knowledge Needed	Notes
Tailor intervention materials including the selection of video and movie clips and produce intervention tape, involving the community advisory board members	Knowledge of intervention, target population members' preferences, and potential popular movies and video clips; knowledge of technical methods to produce an intervention tape	
Develop an evaluation plan	Knowledge of the evaluation forms required by a funding agency and those desired by the implementing agency; knowledge of the purposes of the evaluation process	
Schedule interviews and complete Initial Assessment Surveys	Ability to communicate with potential participants; familiarity with the information to obtain during the initial interviews; knowledge of the content and purposes of the Initial Assessment Surveys	
Prepare Personal Feedback Reports	Knowledge of process of transferring information from the Initial Assessment Surveys to the Personal Feedback Forms; ability to keep personal information highly confidential	
Assemble resource packets and create referral system	Knowledge of target population needs; knowledge of agency resources; and knowledge of and familiarity with local resources, including personal contacts	
Continue facilitation coordination and practice	Knowledge intervention materials and Implementation Manual	
Obtain incentives and refreshments	Knowledge of local resources and target population preferences	

Implementation

Task	Capacity and Knowledge Needed	Notes
Set up, conduct, and debrief from each session	Knowledge of session content and materials needed, training on intervention facilitation, high level of facilitation skills, ability to lead a debriefing discussion	

Evaluation

Task	Capacity and Knowledge Needed	Notes
Collect necessary evaluation forms	Knowledge of Healthy Relationships 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)	
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	

6.4 Commonly Asked Questions

- Q. Are incentives a requirement for **Healthy Relationships**?
- A. In the original research, incentives were used to encourage intervention participants to arrive on time. The incentives were raffled off at the end of each session and only the participants who arrived on time were eligible to participate in the raffle. Incentives are not a core element or key characteristic of **Healthy Relationships** so agencies are not required to provide them. We recommend agencies consider using incentives for the same reasons they were used in the original research. We also encourage agencies to be creative with how incentives are used and delivered. If your agency doesn't have the financial capabilities to purchase incentives, you could consider soliciting from various merchants. Possible suggestions are fast food coupons, music or grocery store gift cards, movie rental cards, bus/trolley/subway tokens and movie passes. Another use of incentives is to keep participants engaged during sessions, such as food and small prizes for participating in role plays or getting an answer correct.
-

- Q. Do I need to find a video contractor to assist with **Healthy Relationships**?
- A. Obtaining a video contractor is not essential, however some agencies that tested the intervention package stated it was easier to have all the video clips on one tape. If you want to have all the intervention clips on one tape or DVD you can do it yourself or use a video contractor. To use a video contractor, first start out seeking the assistance of your local public access channel or your local community college or university to assist with your dubbing effort. You can also seek the assistance of members of the advisory board or coworkers that may have video dubbing experience.
- The alternative to using a contractor or dubbing the tapes on a single tape is to utilize multiple tapes. You can achieve this is by cueing the tapes to their appropriate place before the session begins, and this will enable the facilitator to have the materials available at the appropriate time.
-

SECTION 7: Adapting Healthy Relationships

Implementing agencies need to tailor **Healthy Relationships** so it adequately meets the needs of the community. The following is a list of aspects of the intervention that can be tailored:

- **Marketing information sheet:** A generic marketing information sheet is in the intervention package. This information sheet was included so implementing agencies can have a marketing tool to advertise the intervention and recruit participants. Implementing agencies can add their contact information to the back. If implementing agencies have an advisory board, this board can make suggestions about potential advertising venues, additions to the information sheet, marketing techniques and other ways to use the information sheet. If making additions, remember to keep the reading level around 7th grade.
- **Initial Assessment Survey:** The questions on the survey that are bolded or italicized are essential questions *which cannot be altered*. All the other questions can be tailored.
- **Continuum Cards:** Implementing agencies can tailor these cards by adding relationships and activities that are relevant to the participants.
- **Introductory Sessions:** Introductory sessions were not part of the original **Healthy Relationships**. Introductory sessions would not be necessary if **Healthy Relationships** is implemented with existing support groups. Many of the agencies that tested the intervention package used an introductory session to build cohesion for the participants who had not met before. These agencies planned their introductory session to take place the day before or the week before the first session. According to these agencies, the introductory sessions aided in rapport building and helped the participants and facilitators feel comfortable with each other.
- **Reunion Sessions:** The researcher who developed **Healthy Relationships** recommends implementing agencies host a reunion session several months after the completion of the intervention cycle. This session provides participants with the opportunity to share their experiences of practicing the skills learned during the intervention. This session can also serve as a booster, reviewing the skills and how they can be used in the everyday life.
- **Building Group Cohesion:** Building cohesion is essential to **Healthy Relationships** because participants may disclose personal experiences and they need to feel safe and supported as they do so. Building cohesion lays the foundation for building trust, and trust creates the safe and supportive environment necessary for **Healthy Relationships**. The agencies that tested the intervention used a variety of cohesion building activities. Some agencies used introductory sessions; others used meals served before or after the sessions. One agency conducted their sessions during a weekend retreat. The agency arranged tours of the weekend retreat location, group dinners at a local restaurant and a movie night. The participants who attended these activities reported feeling closer to the facilitators and other participants, and their feeling of closeness lessened the stress of disclosing personal information.
- **Food/Snacks:** Implementing agencies are encouraged to provide refreshments for their participants. This is not a core element but strongly recommended. See the Q

& A on refreshments on page 30 for ideas when planning refreshments for participants.

- **Time:** With practice, sessions can be finished in two hours. Many of the agencies that tested the intervention package extended the length of their sessions or broke certain sessions into two as a result of discussions running longer. For example, all of the agencies reported that Session Two took longer than two hours, so they either extended the time to three hours or they divided the session into two. Their decision was based on what the participants stated would work for their schedules. Any tailoring of time should fit the needs of the participants and the facilitators.
- **Session Frequency:** Like the session lengths/time the frequency of the sessions depends on the availability of the facilitators and the participants. The decision concerning the frequency of the sessions is something that should be made after the community assessment. The sessions in the original research were held twice a week for 2½ weeks. During the Dallas implementation, the sessions were held once a week. The agencies that tested the intervention package had a variety of session frequencies ranging from daily to over a weekend. When planning for the session frequency, there are several things to be considered:
 - Time for participants to think about what they have experienced
 - Ability to retain participants
 - Availability of both participants and facilitatorsParticipants need adequate time to practice and apply the concepts the intervention teaches. With that in mind, it is *not* recommended that an agency conduct all five sessions in one day. A 10-hour day is too long, too tiring, and will not aid participants in retention of the concepts.
- **Language:** Three of the agencies that tested the intervention package translated the participant handouts (Initial Assessment Survey, Continuum Cards and PFRs) into Spanish. These agencies stated that their preparation time doubled because of the time spent translating the session content and practicing delivering it in a way that was understandable for participants.
- **Easel Chart Guides:** The Easel Chart Guides that appear in Appendix II of the Implementation Manual should be tailored based on the clips selected. On the Easel Chart Guides related to the clips, there is a section called “set-the-scene.” This section contains a brief description of what is going on in the scene and ties the scene to one of the three life areas. Implementing agencies will need to write “set-the-scene” descriptions that will match the clips they have selected. Some of the agencies that tested the intervention package used different presentation methods. Some agencies used a dry erase board and another used a presentation software package like PowerPoint. The Easel Chart Guides are not mandatory: they are a means for the facilitators and participants to have a visual outline of the session and its activities. The guides are produced by printing enlarged copies of the guides at a copy center. After the enlarged copies have been made, staple the copies to a heavy duty cardboard backing. Laminating the guides can be done; however, if the guides change then the new copies will have to be laminated as well.
- **Homework:** There is no official homework in **Healthy Relationships**. Addition of homework violates the Core Elements of **Healthy Relationships**.

- **Visual Aids:** The use of visual aids can help in the comprehension and retention of concepts. We recommend that if visual aids are used that they be simple and universally understood. Visual aids can also help participants who have low literacy skills.
- **Location: Healthy Relationships** can be held anywhere there is a private room big enough for the participants, the electronic equipment and a refreshment table. The venue and room should be handicapped accessible. For some communities, venues that advertise services for PLWHA are not good places to hold **Healthy Relationships** sessions. Many of the participants have not disclosed their status and therefore would not attend sessions at a place that would compromise their privacy.
- **Video Clips:** The clips are the biggest area tailoring of **Healthy Relationships**. The clips are the springboards for discussion and role-play. These clips should reflect the participant population. Appendix VI of the Implementation Manual and page 35 of this guide contains advice on how to select population-appropriate clips.
- **Population: Healthy Relationships** was originally tested with three groups (heterosexual men, women and MSM populations). The agencies that tested the intervention package implemented **Healthy Relationships** with those populations and two agencies used this intervention with (actively using) IDUs. Conducting **Healthy Relationships** with IDUs was a challenge because of the participants' short attention span and other issues. Therefore we do not recommend implementing **Healthy Relationships** with IDUs.

7.1 Commonly Asked Questions

- Q. Can sessions be added to **Healthy Relationships** to cover additional topics?
- A. **Healthy Relationships** is a five session small-group level intervention. If implementing agencies want to add another meeting time to finish a sessions' content, such an addition is acceptable. If participants have identified something stressful and request more focused practice time (for example, disclosure of sexual orientation), such a session could be added at the end. The content of the additional session has to be consistent with the Core Elements and the intent of the intervention and include practice of the five coping skills. Adding an additional session because participants do not want the intervention to end is not an acceptable reason to add sessions.
-
- Q. Do you have to use videos for the intervention?
- A. Yes, the videos are used as a spring board for discussions and role-plays. The videos provide the participants an opportunity to see a video clip about individuals in stressful situations disclosing or discussing certain information and they allow the participants the opportunity to discuss what they have just seen. The participants discuss how the disclosure or discussion was done in the video clip and how they would have done it better or differently by re-enacting the scene in a role-play.
-

Q. Can implementing agencies use commercials as clips?

A. No, commercials are too short to show a minor portion of them and still comply with the Fair Use standards. In addition, the length of a commercial is so short that there would be no *pause point* in the clip to stop for discussion and have participants say what they would do differently.

Q. Can visual aids be used in **Healthy Relationships**?

A. Visual aids can assist with explaining a concept while also making it simple and easy to remember. There are several such aids in the implementation package. Feel free to create your own that are appropriate to your target population as long as you do not change the Core Elements of the intervention.

Q. How are population-appropriate clips selected? Can the original clips be obtained?

A. Implementing agencies should consider the ethnicity of a majority of the participants when selecting clips; the video clips should match a majority of the participants' ethnicity. First, consult the Clip Essence Tables found in Appendix VI of the Implementation Manual to obtain the purpose and the essential ingredients of the each video clip. Second, you can solicit assistance identifying appropriate clips from individuals within your agency, the advisory board and the stakeholders. After the videos have been obtained, you can watch the selected clips keeping in mind the purpose and the essential ingredients from the Clip Essence Tables. Also watch the counter times that are displayed on your electronic device so you can find the clips again. After you choose clips, you should watch the clips again, while keeping certain questions in mind:

- Is this clip too long?
- Is this clip too sexually explicit or sexually provocative?
- Is this movie used too often in the intervention?
- Are there any items in the clips that could present any barriers to use? (language, profanity, heavy accents, dialects and subtitles)
- Is the clip too old for individuals to identify with its intended message?

After you have selected the clips you think are most appropriate, we recommend that you solicit the opinions/advice of the advisory board, stakeholders and agency staff about the appropriateness of the clips for the identified purpose.

- Q. How do you write introductions to the clips used in the intervention?
- A. Clip selection must happen before writing introductions. Column 5 of the Clip Essence Tables, found in Appendix VI of the Implementation Manual, describes the introduction for the clips used in the original study. Use these as examples. Think about the clip you chose and the life area for the session in which the clip will be used. Write a brief introduction that describes which character is living with HIV, the emotions he or she is feeling, and the life areas he or she is facing. If the scene is about sex partners, add that the partner's HIV status is either negative or unknown and that there has been no disclosure prior to the scene by the person living with HIV/AIDS. It is also helpful to designate the type and length of relationship.
-

- Q. Were clinics used to test the **Healthy Relationships** intervention package?
- A. Yes, clinics (those providing primary medical care) that offered support groups for PLWHA participated in testing the clarity and usability of the package. Those clinics were able to provide participants, facilitators and the support needed to implement **Healthy Relationships**. These clinics reported great success in implementing the program.
-

- Q. Can **Healthy Relationships** be adapted for transgender populations?
- A. If transgender persons are interested in participating but there are not enough to form their own group, have them decide which type of group to join. In the original research only 1% of the participants were transgender, and they selected which groups they felt comfortable participating in. In all of the cases the participants selected the MSM groups. When conducting **Healthy Relationships** with transgender populations it is important to select culturally appropriate and/or competent clips. Some possible suggestions are documentaries. It is crucial for agencies implementing **Healthy Relationships** to have an advisory board to assist with the tailoring of the intervention to the target population. When demonstrating correct condom use, referring to anatomical models as “penile” and “vaginal” models, rather than as “male” and “female” models, is more sensitive to transgender persons’ physical states and sexual identities.
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SECTION 8: Evaluating Healthy Relationships

An implementing agency will conduct the following types of evaluation: 1) formative, 2) process monitoring, 3) process evaluation and 4) outcome monitoring. There are two key reasons to evaluate a program or intervention; accountability and improvement. Accountability could be to the community, staff, clients or funding source, but implementing agencies must consider their accountability to properly implement any program or intervention. Evaluation also helps improve the quality of the delivery of the intervention. Evaluation informs the agency what worked and what did not work, and this information is valuable in helping agencies fine tune their programs.

8.1 Formative Evaluation

Formative evaluation is the process of collecting data that describes the needs of the population and the factors that put them at risk. In **Healthy Relationships** the formative evaluation piece is the Initial Assessment Survey.

8.2 Process Monitoring

Process monitoring is the process of collecting data that describes the characteristics of the population served, the services provided, and the resources used to deliver those services. Process monitoring answers such questions as:

- How many sessions were delivered?
- How many people attended?
- What resources were used?
- What additional resources are needed?

8.3 Process Evaluation

Process evaluation is the process of collecting more detailed data about how the intervention was delivered, differences between the intended population and the population served, and access to the intervention. Process evaluation looks at whether the agency maintained fidelity to the Core Elements and what Key Characteristics the agency tailored and adapted. Process evaluation is a quality assurance piece that ensures agencies are delivering **Healthy Relationships** and not some variation of the intervention. Some sample questions include:

- Was each Core Element maintained?
- Were the sessions delivered as described in the Implementation Manual?
- Was the intended target population enrolled?
- Were the clips that were chosen for the target population appropriate?

8.4 Outcome Monitoring

Outcome monitoring is the process of collecting data about client outcomes *before* and *after* the intervention, such as knowledge, attitude, skills or behaviors. Outcome monitoring cannot be finished until agencies have done formative evaluation, process monitoring and process evaluation and the intervention is being delivered as planned. Outcome monitoring answers the questions:

- Did the expected outcome occur?
- Were there any changes in the participants' behaviors?

When agencies are ready to do outcome monitoring, the Initial Assessment Survey could be redesigned to be a post intervention survey to measure changes. See Appendix VIII for a sample.

For More Information

For more information please contact the Dallas STD/HIV Behavioral Training Center at 214-645-7353.

APPENDICES

Appendix A – The article with the original research

Appendix B – Stakeholder’s Checklist

- Assess the community to determine whether they will support the Core Elements of **Healthy Relationships**
- Identify your stakeholders
 - Your agency’s Board of Directors/Executive Board
 - Staff members from your agency who will have a role in the operation of the intervention
 - Administrators who will obtain financial support
 - Supervisors who will monitor the intervention
 - Staff who will interact with participants at any level
 - Local agencies from which you could recruit participants, facilitators, or both
 - Agencies offering support groups for PLWHAs
 - Health care providers and mental health professionals serving PLWHAs
 - Social service agencies reaching PLWHAs
 - Organizations of persons PWLHAs and organizations which may have PWLHAs as members
 - Organizations which could provide assistance or other resources
 - Merchants for incentives, loan of videos, refreshments
 - College video production classes, community cable organizations, corporate video production departments, videographers, etc. for help with video clip assembly
 - Agencies, merchants, printers, publishers, broadcasters, and others that can advertise the intervention
 - Agencies that can provide a venue for the intervention
 - Agencies that can provide child care
 - Agencies that can provide transportation
 - Advisory board to help tailor intervention (selecting video clips)
 - Other collaborating agencies to provide information for resource packets
 - Agencies with which your agency needs to maintain good community or professional relations
 - Local health department
 - Local medical and mental health associations
 - Your funding source(s)
 - Community Planning Group
 - Others

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

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

Appendix C – Advancing HIV Prevention

Healthy Relationships supports the initiative of the Centers for Disease Control and Prevention to reduce HIV transmission through one of the four priority strategies. Since the intervention is specifically designed to be conducted with persons living with HIV/AIDS and directly addresses prevention of transmission to others, it supports Strategy 3: prevent new infections by working with persons diagnosed with HIV. In addition, **Healthy Relationships** is an intervention found to be effective in reducing transmission from heterosexual men and also is effective in reducing risk behaviors in women living with HIV/AIDS.

Appendix D – 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 E – Condoms



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 Espanol (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**