



# APPENDIX A

## *d-up!* Materials



# **APPENDIX A-1**

## ***d-up!* Research Article**



# Evaluation of an HIV Prevention Intervention Adapted for Black Men Who Have Sex With Men

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In the United States, high rates of HIV infection have been reported among Black men who have sex with men (MSM). From 2001 to 2004, rates of HIV infection remained higher among Black men than among men of other racial and ethnic populations, and 36% to 39% of new HIV diagnoses among MSM and MSM who inject drugs were among Black men.<sup>1</sup> Surveillance data from 5 cities showed that Black MSM had the highest HIV prevalence (46%) among MSM, and that two thirds of HIV-seropositive Black MSM were unaware of their infection.<sup>2</sup> In a 2000 study of young MSM, Black and multiethnic MSM were 9.1 times and Caribbean Black MSM were 10.2 times as likely to be infected with HIV as White men.<sup>3</sup> In another study of MSM aged 23 to 29 years in 6 cities, 30% of Black MSM were infected with HIV compared with 7% of White MSM.<sup>4</sup> A recent retrospective chart review in North Carolina found that 88% (49 of 56) of new HIV cases among men aged 18 to 30 years were among Black men and a majority reported MSM behavior.<sup>5</sup>

A recent literature review<sup>6</sup> suggests that Black MSM are at elevated risk because of high rates of STDs that facilitate acquisition and transmission of HIV,<sup>7</sup> less-frequent HIV testing,<sup>8</sup> and unrecognized HIV.<sup>2,3,8</sup> In another study, Black MSM who did not carry condoms and those who reported nonsupportive peer norms for condom use were more likely to engage in unprotected receptive anal intercourse.<sup>9</sup> Despite the high risk of HIV infection among Black MSM, a systematic review of published HIV prevention interventions for MSM identified only 1 specifically targeted to Black MSM.<sup>10</sup> In the absence of efficacious interventions for Black MSM, adapting and evaluating currently available evidence-based interventions designed for MSM<sup>12–19</sup> may be an effective strategy.<sup>20</sup>

**Objectives.** We assessed the efficacy of an HIV behavioral intervention adapted for Black men who have sex with men (MSM).

**Methods.** We conducted serial cross-sectional surveys, 1 baseline measurement followed by initiation of an intervention and 3 follow-up measurements, among Black MSM in 3 North Carolina cities over 1 year.

**Results.** We observed significant decreases in unprotected receptive anal intercourse at 4 months (by 23.8%, n=287) and 8 months (by 24.7%, n=299), and in unprotected insertive anal intercourse (by 35.2%), unprotected receptive anal intercourse (by 44.1%), and any unprotected anal intercourse (by 31.8%) at 12 months (n=268). Additionally, at 12 months, the mean number of partners for unprotected receptive anal intercourse decreased by 40.5%. The mean number of episodes decreased by 53.0% for unprotected insertive anal intercourse, and by 56.8% for unprotected receptive anal intercourse. The percentage of respondents reporting always using condoms for insertive and receptive anal intercourse increased by 23.0% and 30.3%, respectively.

**Conclusions.** Adapting previously proven interventions designed for other MSM can significantly reduce HIV risk behaviors of Black MSM. (*Am J Public Health.* 2008;98:1043–1050. doi:10.2105/AJPH.2007.120337)

One such intervention is the Popular Opinion Leader (POL) intervention,<sup>15,22,23</sup> a community-level intervention which seeks to increase safer-sex norms among members of a well-defined target population.<sup>15</sup> Based on the diffusion of innovation theory,<sup>21</sup> POL was designed for MSM and originally tested primarily among White MSM in 3 southern US cities.<sup>15</sup> Opinion leaders are recruited and trained to have risk reduction conversations with their friends to increase healthy sex norms. Critical components of the POL intervention have been previously published.<sup>24</sup> Early evaluations of POL showed decreases in unprotected anal intercourse of 15% to 29% from baseline levels.<sup>23</sup> A larger-scale, randomized trial of POL found a 37% decrease in unprotected anal intercourse in 4 intervention cities, whereas a slight increase occurred in the 4 control cities.<sup>22</sup>

Several adaptations of the POL intervention have been employed with various populations other than Black MSM, such as young Latino migrant MSM,<sup>25</sup> male sex workers,<sup>26</sup> and women.<sup>27</sup> It has been adapted for MSM in international settings such as London,

England<sup>28</sup>; Glasgow, Scotland<sup>29</sup>; and Russia and Bulgaria.<sup>30,31</sup> We measured the effectiveness of a POL intervention adapted specifically for young Black MSM aged 18 to 30 years in 3 North Carolina cities (Raleigh, Greensboro, and Charlotte).

## METHODS

We collected data from December 2004 through December 2005 while evaluating HIV-prevention activities. The evaluation was conducted in 3 North Carolina cities that had nightclubs in which the target population could be accessed, recruited, and trained for the intervention. The evaluation used methods similar to those used by Kelly et al.,<sup>23</sup> who evaluated the intervention based on pre- and posttest results in 3 cities with no control city.

## Intervention Development and Procedures

In September 2004, we conducted focus groups with the target population as well as key informant interviews with stakeholders

(such as bar and nightclub owners, community activists, and organizers of Black gay pride celebrations) in each city. Participants were asked to identify issues and challenges facing MSM, barriers to accessing prevention services, topics that prevention activities should address, and ideal ways of marketing intervention activities to Black MSM. Information gained through these interviews informed the adaptation of the intervention, social marketing materials, and assessments. Intervention sessions were adapted to include discussions about racism, homophobia, bisexuality, employment and poverty, and religion. Using role-play scenarios, opinion leaders learned how to deal with challenges facing Black MSM should these issues arise in their risk reduction conversations. We included a condom demonstration and created culturally relevant marketing materials, conversation starters, and a project logo.

Trained local prevention specialists used adapted ethnographic techniques to identify opinion leaders<sup>30</sup> at local nightclubs frequented by the target population. Once sufficient numbers were recruited, local prevention specialists conducted four 2-hour sessions. Sessions covered the following topics: local and state epidemiology of HIV/AIDS and STDs, facts and myths about HIV/AIDS, and characteristics of an effective risk reduction conversation. Intervention participants were also given opportunities to role-play potential conversations that they could have with their friends and acquaintances. To ensure that learning objectives were met, participants were given tests measuring their knowledge before and after the intervention sessions. To compensate them for their time, opinion leaders received \$100 in gift cards, marketing materials that contained the project logo, and safer-sex materials. All opinion leaders provided informed consent and signed confidentiality agreements. We sought to train 15% of the target population as opinion leaders because this is a core element of the intervention.<sup>15</sup> Finally, the lead investigator and a majority of the local project staff were similar to the target population, based on race, gender, age, and sexual identity.

### Outcome Monitoring Design

Based on available intervention literature,<sup>32,33</sup> sample sizes were calculated to

allow for an 8% decrease in unprotected anal intercourse. We determined that a single-group *t* test with a 0.05 2-sided significance level would have 85% power to detect the difference between the null hypothesis proportion and the alternative proportion when the sample size adjusted for the population size is 230.

Four equally spaced cross-sectional surveys were conducted during the 1-year study period. Respondents were recruited separately for each wave. As such, there was no effort to recruit the same individuals at subsequent waves. Each intervention city was approximately 60 miles apart, had at least 1 nightclub that catered to Black MSM, and had high rates of HIV infection among Black MSM. After the baseline assessment in each intervention city, we conducted interviews in the same venues in which we had recruited opinion leaders.

During 2 consecutive weekends for each assessment, trained interviewers recruited convenience samples of Black MSM in each city. Men were approached as they entered the nightclub. Interviewers explained the study and obtained informed consent. For initial screening, eligible respondents were (1) self-identifying Black or African American, (2) biologically male, (3) aged 18 to 30 years, and (4) living in or visiting the study areas since December 1, 2004. Because respondents may be uncomfortable disclosing specifics about their sexual behavior during an interview,<sup>34–36</sup> men were asked generally whether they had had sex with any male or female partners in the previous year. In self-administered assessments using handheld computers, men were later reassessed for their same-sex activities.

Men were ineligible if they appeared to be intoxicated or had already completed the assessment during the same wave. The assessment was programmed to include a brief tutorial and system checks to improve data reliability.<sup>37,38</sup> Of the men screened for eligibility ( $N=1481$ ), 80.4% ( $n=1190$ ) reported having had oral or anal intercourse with a man in the past year and were included in this analysis. On average, the self-assessment took 10.4 minutes ( $SD=3.2$  minutes) to complete. Those who completed the interview received a \$20 gift card as compensation for their time. HIV prevention information and condoms were made available.

### Independent Variables

Unless otherwise specified, men were asked about their behaviors in the 2 months prior to assessment. City of interview, age, education (high school or less, some college, and college or more), employment status, and sexual identity (gay or homosexual, straight or heterosexual, bisexual, do not identify or label myself, and other) were assessed. Men who did not identify as gay or homosexual were described as non-gay identified. The men were asked whether they had any sexual contact (oral, vaginal, or anal) with female partners in the previous 2 months as well as in their lifetime. Age of respondents was recoded into 4 categories: 18 to 20, 21 to 22, 23 to 25, and 26 to 30 years. Respondents were also asked whether they had been incarcerated during the 2 months prior to the interview.

Respondents were asked the number of times they had been tested for HIV over their lifetime. This variable was dichotomized as ever or never tested for HIV. Those who reported ever having been tested were further dichotomized into those tested in the past 3 months versus those tested more than 3 months ago or who were not sure of their testing date. Men who tested at least once were asked the status of their last HIV test. HIV-testing histories and results were categorized as positive, negative, or other (never tested, unknown, don't know, or refused). Respondents were also asked if they had been diagnosed with an STD in the past 2 months.

Exposure to the intervention was assessed by asking respondents how many times they had seen the project logo. This variable was dichotomized to indicate whether respondents had seen the logo or not. Additionally, respondents were asked if they had been trained as an opinion leader in the project.

### Outcome Variables

Respondents were asked the number of times they engaged in protected and unprotected anal intercourse with men and the number of male partners with whom they engaged in protected and unprotected anal intercourse. Separate questions were asked concerning insertive and receptive anal intercourse. A series of 3 dichotomous outcomes

were created to indicate whether the respondent had engaged in (1) unprotected insertive anal intercourse, (2) unprotected receptive anal intercourse, or (3) any unprotected anal intercourse with men, meaning either unprotected insertive anal intercourse or unprotected receptive anal intercourse.

The number of partners for unprotected anal intercourse was measured as 2 count variables: number of male partners for unprotected insertive anal intercourse and number of male partners for unprotected receptive anal intercourse. The number of episodes of unprotected anal intercourse with men was also available from the survey as 2 count variables: number of episodes of unprotected insertive anal intercourse with men and number of episodes of unprotected receptive anal intercourse with men.

Finally, the percentage of times that condoms were used during anal intercourse was calculated for respondents reporting insertive or receptive anal intercourse. Responses were recoded as always, sometimes, or never using condoms.

### Statistical Methods

Data from the serial cross-sectional surveys were analyzed in 2 ways. First, results of each follow-up wave were compared with results at baseline. Second, the linear trend across the entire study period was examined to estimate the average change per wave. Logistic regression was used for the 3 dichotomous outcomes: unprotected insertive anal intercourse, unprotected receptive anal intercourse, and unprotected anal intercourse. Generalized estimating equations with the negative binomial distribution and log link were applied to the 4 count outcomes: number of partners for unprotected sex (insertive and receptive) and number of episodes of unprotected sex (insertive and receptive). Proportional odds models were employed for the 3-level measure of percentage condom use. Changes relative to baseline are presented for statistically significant results. These were calculated between the baseline and follow-up.

Multivariable analyses were used to control for all variables associated either with wave (the independent variable) or with the dependent variable of interest.

## RESULTS

### Demographics

Approximately 300 men responded at each follow-up wave for a total of 1190 responses of men who reported oral or anal intercourse with a man in the past year (Table 1). Responses were approximately equal across each city with 31.4% from Greensboro, 34.2% from Raleigh, and 34.4% from Charlotte. The mean age of respondents was 23 years (SD=3.3 years). Two thirds had at least some college education, and 79% were employed.

Forty-three percent of the sample was non-gay identified, and 62% reported lifetime sexual intercourse with a female. However, only 17% reported recent sexual intercourse with a female. Over 5% of the sample reported incarceration in the past 2 months. Ninety percent of the sample reported ever testing for HIV with 35% having been tested in the 3 months prior to assessment. Of the entire sample, over 4% reported testing HIV positive and 15% had unknown results.

After the implementation of the intervention, 15% (131 of 881) of respondents also reported being trained as an opinion leader, and 61% (531 of 872) of respondents reported having seen the project logo. Also in waves 2 through 4, 25% to 27% of respondents reported completing a similar handheld survey approximately 4 months earlier when the previous assessment was being conducted.

### Decrease in Unprotected Anal Sex

At baseline, 29.3% of respondents reported unprotected insertive anal intercourse, 32.4% reported unprotected receptive anal intercourse, and 42.1% reported any unprotected anal intercourse (Table 2). In adjusted analyses, significant decreases were observed in unprotected insertive anal intercourse from wave 1 (baseline) to 4, in unprotected receptive anal intercourse from wave 1 to waves 2 and 4, and in any unprotected anal intercourse from wave 1 to waves 2 and 4. Unadjusted results for each type of unprotected sex were similar to the adjusted results. Additionally, a significant decrease was observed in unprotected receptive anal intercourse from wave 1 to 3. In terms of relative decrease, unprotected insertive anal intercourse decreased by 35.2% from wave 1 to 4 ([29.3%–19.0%]/29.3%).

From wave 1, unprotected receptive anal intercourse decreased by 23.8% at wave 2, by 24.7% at wave 3, and by 44.1% at wave 4. Unprotected anal intercourse decreased by 31.8% from wave 1 to 4. The adjusted and unadjusted linear trends per wave were significant for each of the 3 dichotomous outcomes.

At baseline, respondents reported a mean of 1.15 episodes of unprotected insertive anal intercourse and 1.25 episodes of unprotected receptive anal intercourse (Table 3). In adjusted analyses, significant decreases were observed for the number of episodes from wave 1 to 4 for both unprotected insertive anal intercourse and unprotected receptive anal intercourse. Unadjusted results were similar to adjusted results. In terms of relative decrease, the mean number of episodes decreased by 53.0% for unprotected insertive anal intercourse and by 56.8% for unprotected receptive anal intercourse. The unadjusted linear trend was significant for episodes of unprotected receptive anal intercourse only; adjusted analyses for linear trends per wave were significant for both.

### Decrease in Number of Unprotected Anal Sex Partners

At baseline, respondents reported a mean of 0.40 partners for unprotected insertive anal intercourse and 0.42 partners for unprotected receptive anal intercourse (Table 3). In adjusted analyses, a significant decrease was observed in the mean number of partners for unprotected receptive anal intercourse from wave 1 to 4. In terms of relative decrease, the mean number of partners for unprotected receptive anal intercourse decreased by 40.5%. Overall, the linear trend per wave was significant for partners for unprotected receptive anal intercourse. Although there was a decrease across time in partners for unprotected insertive anal intercourse, none of the changes were significant. Unadjusted results for each type of unprotected sex were similar to the adjusted results.

### Increases in Condom Use During Anal Sex

At baseline, 54.7% of the respondents always used condoms and 32.0% sometimes used condoms during insertive anal intercourse. During receptive anal intercourse,

**TABLE 1—Sample Characteristics, by Study Wave: Popular Opinion Leader Intervention Adapted for Black Men Who Have Sex With Men, North Carolina, December 2004 to December 2005**

	Wave 1 (Baseline)	Wave 2	Wave 3	Wave 4	Overall
Sample, no.	295	296	317	282	1190
City,*** no. (%)					
Raleigh	111 (37.6)	100 (33.8)	116 (36.6)	80 (28.4)	407 (34.2)
Greensboro	93 (31.5)	107 (36.2)	91 (28.7)	83 (29.4)	374 (31.4)
Charlotte	91 (30.9)	89 (30.1)	110 (34.7)	119 (42.2)	409 (34.4)
Age, y, mean (SD)	22.8 (3.14)	22.6 (3.32)	23.0 (3.49)	22.6 (3.29)	22.8 (3.32)
Age group, y, no. (%)					
≤20	78 (26.4)	97 (32.8)	84 (26.5)	92 (32.6)	351 (29.5)
21–22	79 (26.8)	66 (22.3)	77 (24.3)	64 (22.7)	286 (24.0)
23–25	84 (28.5)	76 (25.7)	77 (24.3)	73 (25.9)	310 (26.1)
>25	54 (18.3)	57 (19.3)	79 (24.9)	53 (18.8)	243 (20.4)
Education, No. (%)					
High school or less	91 (31.1)	105 (36.1)	109 (35.5)	88 (31.9)	393 (33.7)
Some college	122 (41.6)	115 (39.5)	126 (41.0)	124 (44.9)	487 (41.7)
College or more	80 (27.3)	71 (24.4)	72 (23.5)	64 (23.2)	287 (24.6)
Employed,** no. (%)	220 (75.1)	224 (75.7)	264 (84.1)	227 (80.5)	935 (78.9)
HIV testing, no. (%)					
Ever tested for HIV	265 (90.8)	260 (89.0)	281 (90.1)	242 (88.6)	1048 (89.7)
Tested within 3 months prior to survey	88 (29.8)	111 (37.5)	121 (38.2)	95 (33.7)	415 (34.9)
Tested more than 3 months prior to survey	155 (52.5)	130 (43.9)	140 (44.2)	123 (43.6)	548 (46.1)
HIV status, no. (%)					
Positive	14 (4.8)	14 (4.7)	17 (5.4)	8 (2.8)	53 (4.5)
Negative	242 (82.0)	236 (79.7)	260 (82.0)	223 (79.1)	961 (80.8)
Never tested/unknown/don't know/refused to answer	39 (13.2)	46 (15.5)	40 (12.6)	51 (18.1)	176 (14.8)
Diagnosed with STD, <sup>a</sup> no./total (%)	8/292 (2.7)	7/291 (2.4)	13/316 (4.1)	9/282 (3.2)	37/1181 (3.1)
Nongay identified, <sup>a</sup> no. (%)	139/293 (47.4)	130/295 (44.1)	118/313 (37.7)	121/281 (43.1)	508/1182 (43.0)
Sexual intercourse with a female, <sup>a</sup> no./total (%)					
Ever had it	179/294 (60.9)	176/296 (59.5)	201/316 (63.6)	178/282 (63.1)	734/1188 (61.8)
Had it in past 2 months	44/295 (14.9)	58/296 (19.6)	53/317 (16.7)	45/282 (16.0)	200/1190 (16.8)
Ever been in jail, <sup>a</sup> no./total (%)	22/293 (7.5)	15/293 (5.1)	15/311 (4.8)	12/276 (4.4)	64/1173 (5.5)
Popular opinion leader, <sup>a,†</sup> no./total (%)	11/292 (3.8)	38/292 (13.0)	54/310 (17.4)	39/279 (14.0)	142/1173 (12.1)
Seen logo, <sup>a,†</sup> no./total (%)	60/292 (20.6)	164/289 (56.8)	196/307 (63.8)	171/276 (62.0)	591/1164 (50.8)
Completed similar previous test, no. (%)	...	74 (25.3)	81 (25.6)	74 (26.3)	229 (25.7)

Note. STD = sexually transmitted disease.

<sup>a</sup>Change in sample numbers because of missing data.

\*\**P* < .05; \*\*\**P* < .01; †*P* < .001.

50.8% always used condoms and 36.1% sometimes used condoms (Table 4). In adjusted analyses, a significant increase was observed in the percentage of respondents reporting condom use during receptive anal intercourse from wave 1 to 4. Unadjusted results were similar to adjusted results except that the increase in condom use during insertive anal intercourse from wave 1 to 4 in the unadjusted analysis was significant. In

terms of relative increases, the percentage of respondents who reported always using condoms during insertive anal intercourse increased by 23.0% at wave 4 and by 30.3% during receptive anal intercourse at wave 4.

The adjusted linear trend per wave was significant for condom use during receptive anal intercourse, and the unadjusted results for condom use were significant for both insertive and receptive anal sex.

## DISCUSSION

These data demonstrate high levels of HIV risk among this sample; 42.1% reported unprotected anal intercourse in the 2 months prior to assessment. At the final assessment wave, there were significant decreases in the proportion reporting (1) unprotected anal intercourse, (2) the number of partners for unprotected receptive anal intercourse, and

**TABLE 2—Dichotomous Outcomes, Odds Ratios (ORs), and 95% Confidence Intervals (CIs) for Anal Intercourse With Male Partners, by Study Wave: Popular Opinion Leader Intervention Adapted for Black Men Who Have Sex With Men, North Carolina, December 2004 to December 2005**

	Reported Behavior, % (No.)	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
<b>Unprotected insertive anal intercourse with male partners<sup>a</sup></b>			
Sample, no.	1144	1144	1132
Wave			
1 (Ref)	29.3 (83/283)	1.00	1.00
2	25.9 (74/286)	0.84 (0.58, 1.22)	0.85 (0.60, 1.19)
3	26.7 (82/307)	0.88 (0.61, 1.26)	0.87 (0.62, 1.22)
4	19.0 (51/268)	0.56*** (0.38, 0.84)	0.58*** (0.40, 0.84)
Linear trend	...	0.86** (0.75, 0.97)	0.86*** (0.77, 0.96)
<b>Unprotected receptive anal intercourse with male partners<sup>b</sup></b>			
Sample, no.	1141	1141	1138
Wave			
1 (Ref)	32.4 (92/284)	1.00	1.00
2	24.7 (71/287)	0.69** (0.48, 0.99)	0.68** (0.46, 1.00)
3	24.4 (73/299)	0.67** (0.47, 0.97)	0.68* (0.46, 1.00)
4	18.1 (49/271)	0.46† (0.31, 0.69)	0.46† (0.30, 0.70)
Linear trend	...	0.79† (0.72, 0.88)	0.79† (0.70, 0.91)
<b>Any unprotected anal intercourse with male partners<sup>a</sup></b>			
Sample, no.	1141	1141	1130
Wave			
1 (Ref)	42.1 (119/283)	1.00	1.00
2	34.5 (99/287)	0.73 (0.52, 1.02)	0.73** (0.53, 1.00)
3	36.0 (109/303)	0.77 (0.56, 1.08)	0.77 (0.57, 1.06)
4	28.7 (77/268)	0.56*** (0.39, 0.79)	0.57† (0.41, 0.80)
Linear trend	...	0.85*** (0.76, 0.95)	0.85*** (0.77, 0.95)

<sup>a</sup>OR adjusted for city where survey took place, employment status, and ever been to jail.

<sup>b</sup>OR adjusted for city where survey took place, employment status, and HIV status (positive, negative, or unknown, don't know, refused, or never tested).

\**P* = .05; \*\**P* < .05; \*\*\**P* < .01; †*P* < .001.

(3) the mean number of partners for and episodes of unprotected sex. There also were significant increases in respondents reporting consistent condom use. The decrease in unprotected anal intercourse observed at 12 months (35.2% for unprotected insertive anal intercourse, 44.1% for unprotected receptive anal intercourse, and 31.8% for any unprotected anal intercourse) are comparable to findings from a previous evaluation of POL.<sup>22</sup> We believe our study is the first that suggests that adapting already-proven interventions developed for other MSM can reduce risk among Black MSM.

High levels of risk among this sample underscore the importance of designing and

testing interventions specifically for Black MSM. Twenty-five years since the first reported AIDS case, there has yet to be an intervention for Black MSM that has been rigorously evaluated, demonstrated to be effective, and reported in the literature. The Centers for Disease Control and Prevention (CDC) is currently funding prevention research activities for Black MSM. The studies include an evaluation of HIV-testing strategies for identifying at-risk Black MSM unaware of their HIV status, and efficacy trials of interventions to reduce the HIV risk of Black MSM. Because these study data are not yet available, it is important to simultaneously adapt interventions with proven efficacy,

particularly those designed for MSM and Blacks. To date, the CDC has identified 8 evidence-based interventions for MSM and 24 for Blacks.<sup>39–41</sup> None of the identified interventions were specifically designed for or tested among Black MSM.

Adapting these interventions will not be without challenges. For example, some adaptations of POL failed to produce significant effects compared with other evaluations.<sup>15,22,23,26–30</sup> Kelly cites several reasons for this discrepancy.<sup>24</sup> Flowers et al.<sup>29</sup> used health educators rather than opinion leaders to conduct risk-reduction conversations. Elford et al.<sup>28</sup> trained only a small cadre of peers (1.3%), far short of the 15% specified as a core element of POL (although POL has been shown to be efficacious with as little as 8% of the target population being trained as opinion leaders).<sup>22,24</sup> In our study, 11% of the target population was trained as opinion leaders, although 15% of respondents reported becoming opinion leaders after the implementation of the intervention. Therefore, maintaining fidelity to an intervention's core elements is important for successfully adapting interventions and was the case for our current adaptation.

A component of the intervention was to dispel myths about HIV/AIDS, including those that contribute to conspiracy beliefs. Such beliefs have been associated with inconsistent condom use among Black men.<sup>42</sup> Hutchinson et al. recommend that interventions for Black MSM be designed to address conspiracy beliefs and existing interventions be culturally adapted.<sup>43</sup>

As we did in our study, interventionists should assess community and agency needs and challenges,<sup>44,45</sup> and establish appropriate linkages between researchers, the target population, and community-based agencies<sup>46</sup> prior to designing, implementing, or evaluating prevention strategies. Demographic similarities between the target population, lead investigators, and project staff may have been important to this intervention's success.<sup>47</sup> Therefore, trained individuals who are similar to the target population on key characteristics (race, gender, age, and sexual identity) should be given lead roles in designing, implementing, and evaluating HIV prevention activities for Black MSM. Employing these strategies will help ensure that

**TABLE 3—Count Outcomes, Rate Ratios (RRs), and 95% Confidence Intervals (CIs) for Unprotected Anal Intercourse With Male Partners, by Study Wave, Number of Partners, and Number of Episodes: Popular Opinion Leader Intervention Adapted for Black Men Who Have Sex With Men, North Carolina, December 2004 to December 2005**

	Mean (95% CI)	Unadjusted RR (95% CI)	Adjusted RR (95% CI)
<b>Number of episodes of unprotected insertive anal intercourse with male partners<sup>a</sup></b>			
Sample, no.	1144	1144	1132
Wave			
1 (Ref)	1.15 (0.72, 1.57)	1.00	1.00
2	1.03 (0.66, 1.39)	0.90 (0.56, 1.44)	0.84 (0.52, 1.37)
3	1.48 (0.70, 2.26)	1.29 (0.81, 2.05)	1.19 (0.73, 1.93)
4	0.54 (0.35, 0.73)	0.47*** (0.29, 0.77)	0.45*** (0.27, 0.75)
Linear trend		0.87 (0.73, 1.03)	0.84** (0.70, 1.00)
<b>Number of episodes of unprotected receptive anal intercourse with male partners<sup>b</sup></b>			
Sample, no.	1141	1141	1138
Wave			
1 (Ref)	1.25 (0.83, 1.68)	1.00	1.00
2	0.98 (0.65, 1.30)	0.78 (0.49, 1.25)	0.73 (0.46, 1.18)
3	1.18 (0.66, 1.70)	0.94 (0.59, 1.50)	0.97 (0.60, 1.57)
4	0.54 (0.35, 0.72)	0.43† (0.26, 0.70)	0.42† (0.26, 0.70)
Linear trend		0.81*** (0.69, 0.95)	0.81*** (0.69, 0.96)
<b>Number of male partners for unprotected insertive anal intercourse<sup>a</sup></b>			
Sample, no.	1144	1144	1132
Wave			
1 (Ref)	0.40 (0.30, 0.50)	1.00	1.00
2	0.43 (0.31, 0.54)	1.07 (0.76, 1.50)	1.09 (0.78, 1.53)
3	0.36 (0.27, 0.45)	0.90 (0.64, 1.26)	0.85 (0.60, 1.20)
4	0.30 (0.20, 0.41)	0.76 (0.53, 1.09)	0.79 (0.55, 1.13)
Linear trend		0.91 (0.81, 1.02)	0.91 (0.81, 1.02)
<b>Number of male partners for unprotected receptive anal intercourse<sup>b</sup></b>			
Sample, no.	1141	1141	1138
Wave			
1 (Ref)	0.42 (0.32, 0.52)	1.00	1.00
2	0.39 (0.29, 0.48)	0.92 (0.66, 1.27)	0.89 (0.65, 1.23)
3	0.34 (0.26, 0.42)	0.81 (0.58, 1.12)	0.84 (0.60, 1.16)
4	0.25 (0.17, 0.33)	0.59*** (0.42, 0.85)	0.60*** (0.42, 0.86)
Linear trend		0.85*** (0.76, 0.95)	0.86*** (0.77, 0.96)

<sup>a</sup>RR adjusted for city where survey took place, employment, and ever been to jail.

<sup>b</sup>RR adjusted for city where survey took place, employment status, and HIV status (positive, negative, or unknown [don't know, refused, or never tested]).

\*\**P* < .05; \*\*\**P* < .01; †*P* < .001.

adapted interventions are culturally relevant, meet the needs of community-based organizations, maintain fidelity to the original intervention, and dispel myths about HIV/AIDS.

Increased attention must be given to Black MSM in prevention research to understand their decisionmaking for condom use. During our study, the percentage of respondents inconsistently using condoms decreased by

30.3% and 38.2% for insertive and receptive anal intercourse, respectively. Approximately 20% of Black MSM in this sample had unknown or positive HIV test results. Given high levels of undiagnosed HIV infection and high-risk social and sexual networks of Black MSM,<sup>48</sup> additional studies are warranted to understand why some, and especially those who rely on perceived sero-sorting

practices, continue to engage in risky sex. Thoroughly understanding this will inform the design, implementation, evaluation, and future adaptations of already proven interventions for Black MSM.

**Limitations**

This study had several limitations. First, the study did not include a control group. Therefore, it is impossible to know whether the observed changes would have occurred without the presence of the intervention. Second, it is possible that these results are not generalizable in locales in which HIV prevention information and resources are more abundant and MSM communities are more visible. Third, these results are based on convenience samples recruited at nightclubs, and MSM who attend nightclubs may be more likely to engage in high-risk behaviors.<sup>5</sup> Associations have been found between alcohol consumption, drug use (which may be likely in nightclubs), and unprotected anal intercourse.<sup>49,50</sup> It is possible that very-high-risk Black MSM may be overrepresented in this sample. Black MSM who do not go to nightclubs are likely to be underrepresented. Therefore, our findings are not generalizable to all Black MSM. Fourth, the study relied on self-reported behaviors. Some Black MSM may have felt uncomfortable disclosing risky behaviors, underreporting some behaviors and overreporting others. However, we attempted to limit this bias through the use of self-administered surveys on handheld computers. Research shows that respondents more readily report risky behaviors using computer technology rather than answering questions face to face.<sup>51,52</sup> Nonetheless, the presented results are promising and encouraging. Further investigations of adapted interventions, particularly those with rigorous evaluations, will bolster these findings.

**Conclusions**

We believe this study is the first to provide evidence suggesting that adapting proven interventions for Black MSM can potentially significantly reduce risky behavior for HIV transmission and acquisition. Our adapted intervention involved the community and addressed important communal and cultural concerns of the target population. It is critical that interventions are designed and tested specifically for Black MSM. However, while

**TABLE 4—Ordinal Outcomes, Odds Ratios (ORs), and 95% Confidence Intervals (CIs) for Condom Use for Anal Intercourse, by Study Wave: Popular Opinion Leader Intervention Adapted for Black Men Who Have Sex With Men, North Carolina, December 2004 to December 2005**

	Reported Condom Use			OR (95% CI)	
	Always, % (no.)	Sometimes, % (no.)	Never, % (no.)	Unadjusted	Adjusted
<b>Condom Use for Insertive Anal Sex<sup>a</sup></b>					
Sample, no.	713			713	703
Wave					
1 (Ref)	54.7 (99/181)	32.0 (58/181)	13.3 (24/181)	1.00	1.00
2	61.9 (117/189)	29.6 (56/189)	8.5 (16/189)	1.39 (0.93, 2.08)	1.34 (0.89, 2.02)
3	59.1 (114/193)	31.1 (60/193)	9.8 (19/193)	1.23 (0.82, 1.83)	1.21 (0.80, 1.81)
4	67.3 (101/150)	22.7 (34/150)	10.0 (15/150)	1.67** (1.08, 2.59)	1.51 (0.97, 2.36)
Linear trend				1.15** (1.01, 1.31)	1.12 (0.97, 1.29)
<b>Condom Use for Receptive Anal Sex<sup>b</sup></b>					
Sample, no.	665			665	663
Wave					
1 (Ref)	50.8 (93/183)	36.1 (66/183)	13.1 (24/183)	1.00	1.00
2	58.3 (98/168)	33.3 (56/168)	8.3 (14/168)	1.38 (0.92, 2.08)	1.45 (0.96, 2.19)
3	58.9 (103/175)	29.7 (52/175)	11.4 (20/175)	1.34 (0.90, 2.01)	1.34 (0.89, 2.02)
4	66.2 (92/139)	22.3 (31/139)	11.5 (16/139)	1.76** (1.13, 2.74)	1.82*** (1.17, 2.85)
Linear trend				1.18** (1.03, 1.36)	1.19** (1.03, 1.37)

<sup>a</sup>OR adjusted for city where survey took place, employment, ever been to jail, ever tested for HIV, and sex with a female partner in past 2 months.

<sup>b</sup>OR adjusted for city where survey took place, employment status, and HIV status (positive, negative, or unknown, [don't know, refused, or never tested]).

\*\* $P < .05$ ; \*\*\* $P < .01$ .

primary intervention research is being conducted, available efficacious interventions should be adapted to address cultural concerns and realities for Black MSM. Ultimately, these strategies will be conducive to increasing available prevention interventions and to reducing the HIV risk of Black MSM. ■

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### Contributors

K. T. Jones led the writing of this article and oversaw adaptation and field data-collection activities. P. Gray

and D. Bost supervised field data collection and monitored intervention activities. Y. O. Whiteside assisted in the adaptation of the intervention and led the implementation and facilitation of intervention activities at 1 project site. T. Wang and W. D. Johnson led statistical analyses activities and helped with writing the article and interpreting results. E. Dunbar and E. Foust assisted with monitoring the funded activities.

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### Human Participant Protection

This study was reviewed by the Centers for Disease Control and Prevention and local human subjects review boards and determined to be exempt from review by the North Carolina Department of Health and Human Services institutional review board.

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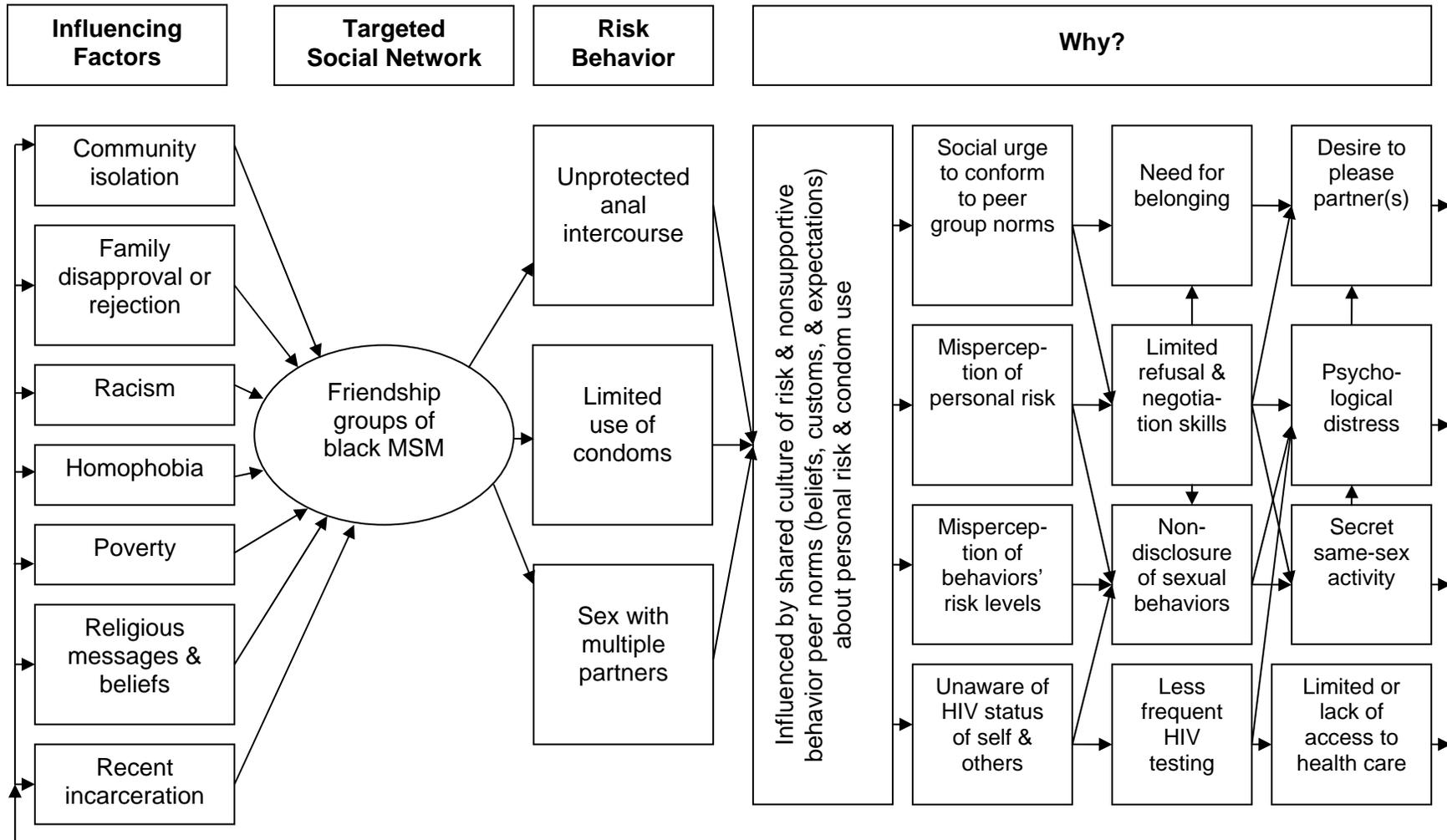
# *d-up!* BEHAVIOR CHANGE LOGIC MODEL AND BEHAVIORAL RISK ANALYSIS

## *d-up!* BEHAVIOR CHANGE LOGIC MODEL

<b>Statement of the Problem for Intervention</b>				
Social networks of black men who have sex with men share a culture of sexual risk taking, sustained by social norms that do not support safer sex practices. The nature and influence of the social norms come from sociocultural factors that lead to stress, social isolation, low self-efficacy, and an increased propensity for risk-taking behavior.				
<b>Specific Behavior Change Logic</b>				
	<b>Determinants</b> <i>To address risk behavior/factors</i>	<b>Activities</b> <i>To address behavioral determinants</i>	<b>Outcomes</b> <i>Expected changes as a result of activities targeting behavioral risk determinants</i>	
<b>Opinion Leader Training →</b>	Intention, self-efficacy, knowledge, and skill to deliver individually tailored and contextually appropriate safer sex messages to friends and acquaintances.	Opinion leaders are identified and recruited from all friendship groups within the targeted social network; they are trained through a four-session curriculum.	Opinion leaders develop the necessary motivation, self-efficacy, knowledge, and skill to carry out effective and appropriate risk reduction conversations within their social network.	Opinion leaders become long-term advocates and change agents to promote safer sex norms.
<b><i>d-up!</i> Intervention →</b>	Social norm(s) about safer sex and sexual risk in the targeted social network.	Trained opinion leaders engage members of their friendship groups in individually tailored and contextually appropriate risk reduction conversations about safer sex.	Friendship groups adopt safer sex attitudes and behaviors, thereby establishing safer sex norms within the targeted social network.	Safer sex norms are adopted and sustained by the targeted social network, thereby resulting in decreased rates of HIV transmission.

## *d-up!* BEHAVIORAL RISK ANALYSIS

(Based on behavioral risks of the identified social networks targeted for *d-up!* by the intervention developers)



## IMPLEMENTATION SUMMARY OF THE INTERVENTION

Inputs →	Activities →	Outputs
<ul style="list-style-type: none"> <li>• Agency capacity to conduct the intervention (e.g., time and resources).</li> <li>• Staff who are qualified, culturally competent, and interested in implementing the intervention.</li> <li>• Organizational policies and procedures.</li> <li>• Private space and equipment to conduct the intervention.</li> <li>• Materials to conduct the intervention.</li> <li>• Agency and staff who buy in to offer the intervention.</li> <li>• Baseline data/information about target population’s HIV risk behaviors and influencing factors.</li> <li>• Local/State public health officials’ support for implementation of the intervention.</li> <li>• Community support for implementation of the intervention.</li> </ul>	<p><b>Getting Started</b></p> <ul style="list-style-type: none"> <li>• Closely review the intervention and training materials and understand the theory and science behind <i>d-up!</i>.</li> <li>• Assess agency capacity to conduct the intervention and solicit technical assistance for areas of need.</li> <li>• Develop relevant community relationships.</li> <li>• Develop implementation plan, monitoring and evaluation plan, and agency policies and procedures.</li> <li>• Identify qualified, culturally competent, and interested staff to coordinate, facilitate, and recruit for the intervention.</li> <li>• Train and build skills of agency staff.</li> <li>• Identify logistics for implementation of the intervention (e.g., times, days, space).</li> <li>• Identify available networks of black men who have sex with men (MSM) and select which will be targeted.</li> <li>• Conduct a community discovery to learn about the targeted social network and venue, to map out friendship groups, and to refine intervention goals and objectives.</li> </ul>	<p><b>Getting Started</b></p> <ul style="list-style-type: none"> <li>• Implementation plan, tailored to target population, including measurable goals and process and outcome objectives.</li> <li>• Written participant recruitment procedures.</li> </ul> <p><b>Making It Happen</b></p> <ul style="list-style-type: none"> <li>• Materials are developed for the intervention, such as printed material, videos, and logo materials.</li> <li>• 15% of each friendship group is recruited to be an opinion leader.</li> <li>• At least 50% of recruited opinion leaders are black MSM.</li> <li>• The planned number of waves of opinion leader trainings is implemented</li> <li>• 80% of recruited opinion leaders complete training .</li> <li>• 8-10 opinion leaders per wave are trained to conduct risk reduction conversations.</li> <li>• Opinion leaders endorse safer sex practices and the norm of black MSM’s positive self-worth with friends and acquaintances.</li> </ul>

<b>Inputs →</b>	<b>Activities →</b>	<b>Outputs</b>
<ul style="list-style-type: none"> <li>• External technical assistance (as needed).</li> <li>• Access to black MSM and to venues frequented by them.</li> <li>• Access to social networks and opinion leaders required for implementation of the intervention.</li> </ul>	<p><b>Making It Happen</b></p> <ul style="list-style-type: none"> <li>• Begin to identify and recruit opinion leaders from each friendship group.</li> <li>• Develop/revise intervention materials, including logo materials and conversation starters, if needed.</li> <li>• Plan and schedule opinion leader trainings.</li> <li>• Recruit opinion leaders and conduct the training.</li> </ul> <p><b>Keeping It Going Strong</b> Monitor opinion leaders after they complete training and provide ongoing support.</p> <p><b>Making Sure You're Doing What You Said</b> Document implementation of training and risk reduction conversations.</p>	<p><b>Keeping it Going Strong</b></p> <ul style="list-style-type: none"> <li>• 15% of each friendship group consists of opinion leaders who initiate risk reduction conversations.</li> <li>• At least 14 conversations are held by opinion leaders with friends and acquaintances, at least 7 of which are with black MSM.</li> </ul> <p><b>Making Sure You're Doing What You Said</b></p> <ul style="list-style-type: none"> <li>• Evaluation data and summary reports with interpretation.</li> <li>• Documentation of regular program monitoring and program improvement in accordance with monitoring plan.</li> </ul>

# *d-up: DEFEND YOURSELF!*

## A Community-Level Intervention for Black MSM FACT SHEET

### Program Overview

*d-up: Defend Yourself!* is a community-level intervention for black men who have sex with men (MSM). *d-up!* is a cultural adaptation of the Popular Opinion Leader (POL) intervention and is designed to change social norms and perceptions of black MSM regarding condom use. *d-up!* finds and enlists opinion leaders whose advice is respected and trusted by their peers. These opinion leaders are trained to change risky sexual norms in their own social networks. Opinion leaders participate in a four-session training and endorse condom use in conversations with their friends and acquaintances.

### Target Population

*d-up!* specifically targets black MSM who are in social networks with other black MSM.

### Research Results

*d-up!* achieved the following results among targeted social networks of black MSM in three North Carolina cities:

- Rates of unprotected insertive anal sex decreased 35.2%.
- Rates of unprotected receptive anal sex decreased 44.1%.
- The number of black MSM reporting always using condoms for insertive anal sex increased 23.0%.
- The number of black MSM reporting always using condoms for receptive anal sex increased 30.3%.
- The average number of partners for unprotected receptive anal sex decreased by 40.5%.

### Program Materials

- Implementation manual
- Facilitator's guide for training opinion leaders
- *d-up!* CD-ROM with copies of slides, handouts, and additional intervention tools

### Core Elements

1. Direct *d-up!* to an **identified at-risk target population** in well-defined community venues where the population's size can be assessed.
2. Use **key informants and systematic observation** to identify the target population's

social networks and to identify the most respected, credible, trustworthy, listened to, empathetic to friends, and self-confident persons in each network.

3. Over the life of the program, **recruit and train** as opinion leaders 15% of the persons from each friendship group in the social network that is found in the intervention venue.
4. Raise opinion leaders' awareness of how negative **social and cultural factors** impact black MSM's sexual risk behavior in order to promote a norm of positive self-worth in their social networks and to address these biases in their conversations, as needed.
5. Teach opinion leaders **skills** for putting risk reduction endorsement messages into everyday conversations with friends and acquaintances.
6. Teach opinion leaders the elements of **effective behavior change messages** that target attitudes, norms, intentions, and self-efficacy related to risk. Train opinion leaders to personally endorse the benefits of safer sex in their conversations and to offer practical steps to achieve change.
7. Hold weekly sessions for small groups of opinion leaders to help them improve their skills and gain confidence in giving effective HIV prevention messages to others. **Instruct, model, role-play, and provide feedback** during these sessions. Make sure that all opinion leaders have a chance to practice and shape their communication skills and get comfortable putting messages into conversations.
8. Have opinion leaders set **goals** to hold risk reduction conversations with at-risk friends and acquaintances in their own social network between weekly sessions.
9. **Review, discuss, and reinforce** the outcomes of the opinion leaders' conversations at later training sessions.
10. Use logos, symbols, or other items as **"conversation starters"** between opinion leaders and others.

Please visit our website  
[www.effectiveinterventions.org](http://www.effectiveinterventions.org)  
to learn when trainings and new program materials become available.

\*\*\*\*\*

Kenneth T. Jones, MSW, Phyllis Gray, MPH, Y. Omar Whiteside, MEd, Terry Wang, MSPH, Debra Bost, BA, Erica Dunbar, MPH, Evelyn Foust, MPH, and Wayne D. Johnson, MSPH (2008). Evaluation of an HIV prevention intervention adapted for black men who have sex with men. *American Journal of Public Health*, 98(6), 1043–1050.



## **SAMPLE CONFIDENTIALITY AGREEMENT FOR *d-up!* STAFF MEMBERS**

To protect the confidentiality of people who participate in the *d-up!* intervention and to foster an atmosphere of respect for the opinion leaders, all persons involved in *d-up!* must agree to the following:

- ▶ Staff members should not discuss the identity of opinion leaders.
- ▶ Staff members should not discuss what was said by the opinion leaders with others who are not part of the *d-up!* staff.
- ▶ Staff members should not discuss opinion leaders outside the context of *d-up!*.
- ▶ Staff members should encourage opinion leaders to refrain from discussing or sharing the personal information of other opinion leaders.
- ▶ In a case where a staff member knows an opinion leader, the staff member should refrain from discussing that opinion leader with other staff members or sharing any additional information about the opinion leader.

Your signature below indicates that you understand and accept these conditions.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## *d-up!* INTERVENTION FLOWCHART TEMPLATE

Use the table below to develop your implementation plan. Be sure to list specific staff and dates in the appropriate columns.

### Planning and Preliminary Steps

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Identify a broad at-risk black MSM population to target	Knowledge of the black MSM population; support from stakeholders; skills to conduct formative evaluation			
Begin developing relevant community relationships	Knowledge of local HIV programs and gatekeepers from the black MSM population			
Determine the size of the network you can target and how many opinion leaders you can train with available resources	Resources, funding, and staff to target the specific network size			
Recruit, hire, and train staff members	Knowledge of staff requirements and recruitment resources			
Develop an implementation plan and program objectives that are consistent with the overall <i>d-up!</i> intervention; develop objectives that are SMART	Knowledge of SMART objectives, <i>d-up!</i> intervention activities, and core elements			
Develop policy and procedures for your agency	Knowledge of local and national guidelines and laws, funder requirements, and <i>d-up!</i> activities			
Develop a monitoring and evaluation plan	Knowledge of monitoring and evaluation and <i>d-up!</i> activities			
Identify, meet with, and enlist the support of gatekeepers and key informants	Knowledge of black MSM leaders and programs; ability to answer questions; ability to establish connections with community persons			

## Planning and Preliminary Steps (cont.)

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Identify and collect information on possible black MSM social networks	Knowledge of the black MSM population; support from stakeholders; skills to conduct formative evaluation			
Identify potential social venues	Knowledge of the black MSM population and social venues			
Select the social network your intervention will target	Knowledge of specific social networks and their level of risk			
Select and access social venues	Information on social venues; support from venue owners			
Identify friendship groups in the target social network	Knowledge, skills, and staff to conduct formative evaluation; identification of target venue(s)			
Identify and screen at least one opinion leader from each friendship group	Knowledge of friendship groups; knowledge, skills and staff to conduct formative evaluation; knowledge of opinion leader characteristics; information from key informants and stakeholders			
Develop conversation starters	Knowledge of target network's beliefs, norms, and attitudes; network members to review materials; ability to conduct focus groups			
Develop a plan and schedule for opinion leader trainings	Knowledge of number of opinion leader trainings you need to conduct, convenient times and locations, and availability of training venues			
Identify and secure training space	Knowledge of number of opinion leader trainings you need to conduct, convenient times and locations, and funding			

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Tailor opinion leader training as needed; refine and develop training materials	Data collected from community discovery, particularly on target networks' knowledge, attitudes, and beliefs toward safer sex			

### Implementation Steps

Step	Capacity and Knowledge Needed	Person(s) responsible	Timeline	Notes
Recruit opinion leaders	Knowledge of potential OLs; recruitment skills			
Conduct opinion leader trainings	Knowledge of OL training; OL training materials; trained facilitators; space, staff, and training materials			
Monitor opinion leaders after they complete training and provide ongoing support	OL contact information; problem solving skills			
Hold opinion leader reunions	Space to hold reunions			
Recruit successive waves of opinion leaders	Knowledge of potential OLs, friendship groups and number of OLs needed; recruitment skills			
Revise message and conversation starters as needed	Knowledge of target networks current attitudes, beliefs, and behaviors; formative evaluation skills			
Consider identifying other target networks to engage once 15% of the members of each friendship group have delivered the necessary number of risk reduction conversations	Data from initial research on potential target networks; knowledge of number of OLs trained			

## Evaluation Steps

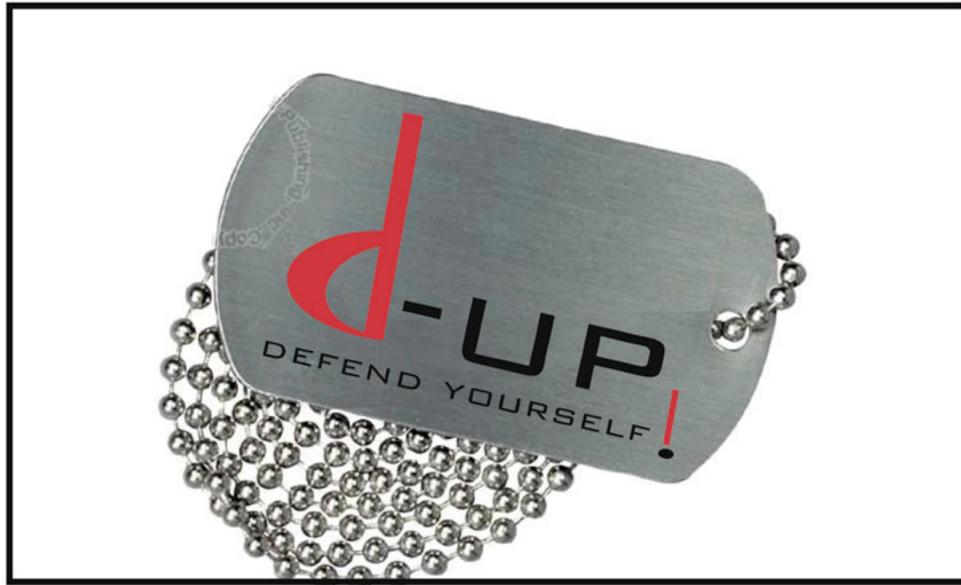
Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Determine which level of monitoring and evaluation you can conduct (formative evaluation, process monitoring, process evaluation, and outcome monitoring)	Knowledge of agency resources and time; knowledge of M&E concepts; Knowledge of the evaluation forms required by a funding agency and those desired by the implementing agency; knowledge of the purposes of the evaluation process			
Conduct formative evaluation; collect data	Knowledge of formative evaluation methods; formative evaluation forms			
Conduct process monitoring and evaluation; collect data	Knowledge of process monitoring and evaluation methods; process evaluation forms; knowledge of <i>d-up!</i> core elements			
Conduct quality assurance assessment of opinion leader trainings; collect data	Knowledge of quality assurance methods; Facilitator Fidelity/Process form			
If resources allow, conduct outcome monitoring of <i>d-up!</i> ; collect data	Knowledge of outcome monitoring methods; data collection forms			
Generate database for data collected; manage database	Knowledge of formative evaluation methods; formative evaluation forms			
Summarize data from evaluation forms	Knowledge of data management techniques and software (Microsoft Access, Microsoft Excel, SPSS, SAS)			
Analyze collected data	Knowledge of analysis techniques;			
Review evaluation data and identify intervention areas and activities for improvement	Knowledge of intervention objectives and core elements			
Report findings to stakeholders, staff, and funders	Skills to summarize and report data			

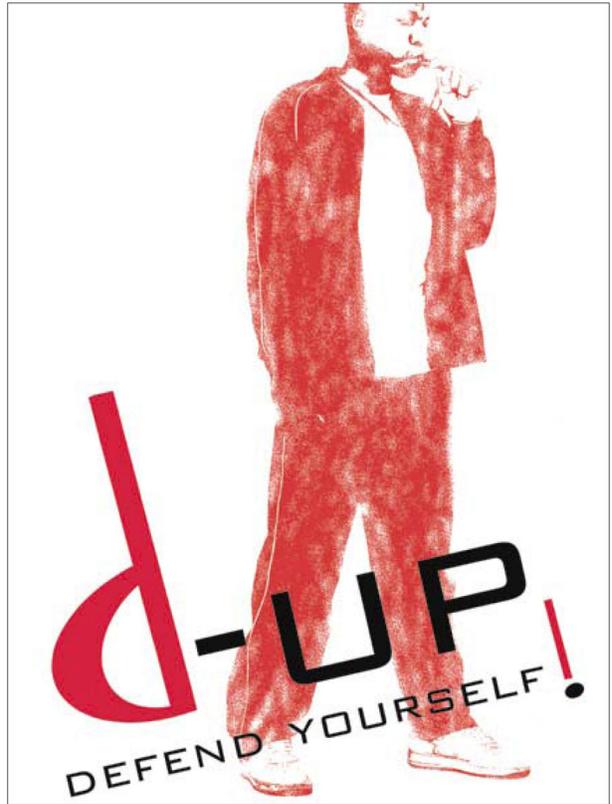
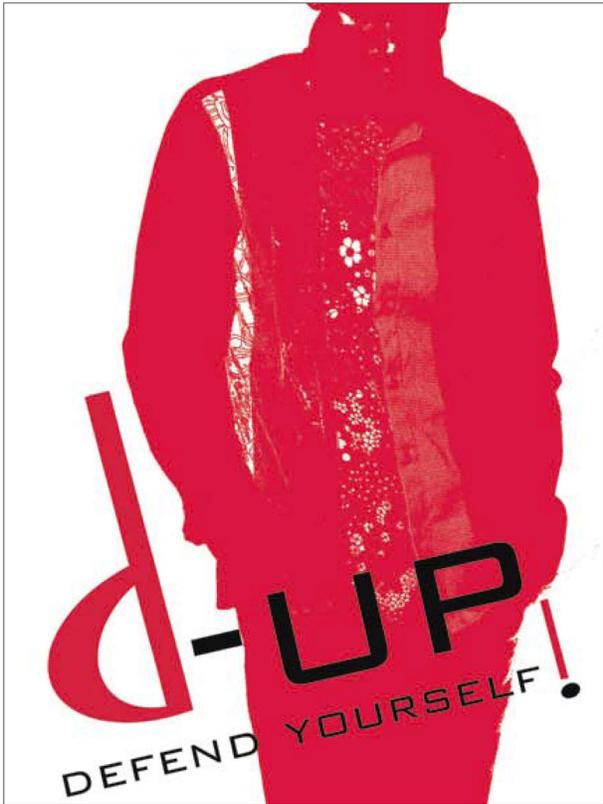
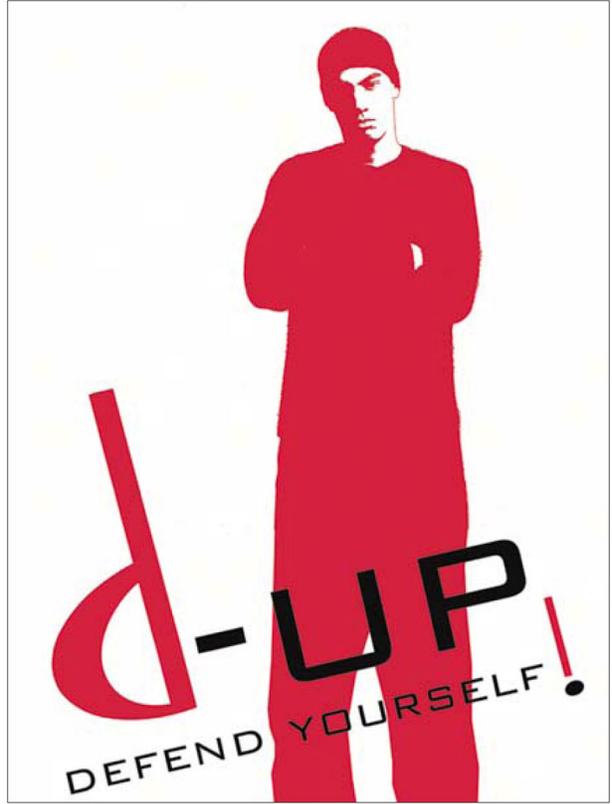
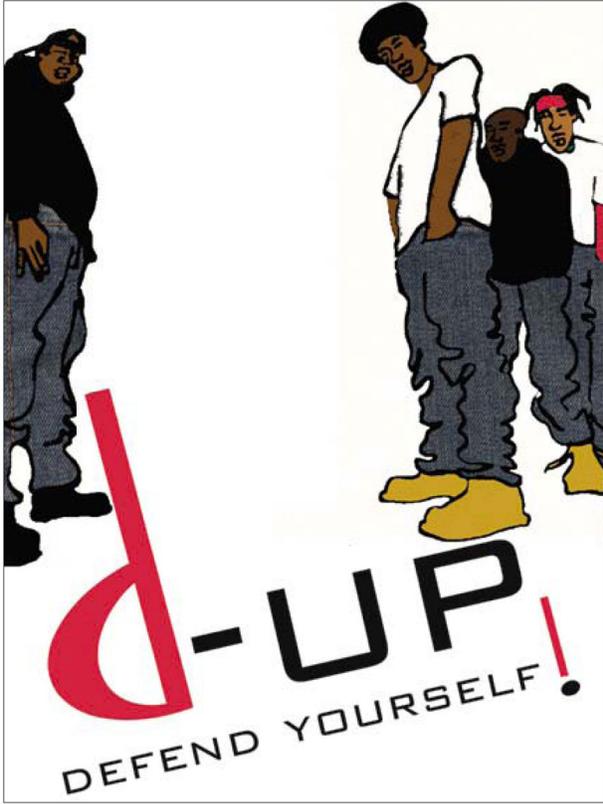
## SAMPLES OF CONVERSATION STARTERS AND *d-up!* LOGO

### North Carolina's Men's Health Initiative **Branding**



### North Carolina's Men's Health Initiative **Branding**





## SAMPLE LETTER

Dear Friend:

You have been identified as a person who is trusted, well liked, and respected among your group of friends. Because you have these qualities, you are in a unique position to save the lives of many people around you. That is why we are contacting you.

We are starting an AIDS prevention intervention called *d-up: Defend Yourself!*, which attempts to promote safer sex among black men who have sex with men (MSM). *d-up!* takes a unique approach by inviting key people like yourself—people who are popular and respected opinion leaders—to attend several informal AIDS educational sessions. These sessions will give you the latest information on HIV prevention and teach you how to talk about safer sex with your friends, placing you in a position to give advice to others and perhaps save some lives. Because you are already respected by your friends, they probably turn to you for advice, value your opinions, and may even model their behavior after yours.

We hope we've sparked some interest. Now, we would like to answer some questions we suspect you have.

**Who is doing this?** (Add information about your agency).

**What about the sessions?** We plan to have four training sessions. They will provide you with the most accurate information on the following topics: AIDS and practical ways to reduce risk; why AIDS is affecting black MSM; how to put risk reduction steps into practice; and how to explain the same information to your friends in a positive (rather than preachy) way. We invite you to attend all four sessions, which will last about 2 hours each. We are planning to hold the sessions at (Location and Times) for 4 weeks beginning (Date). We'll check back and see if that works for you.

**Who will be at the sessions?** We're inviting about (Number) people to the trainings. They will be people like you who have been identified as well liked and respected. You may know several people there, and they may be your own friends. The sessions will be led by two of our agency's staff members.

**(Location) is a small town, does this mean I will become “known” or associated with AIDS?** You won't be. Other people at the meetings will be folks you either know or who hang out in similar social circles as you. No one else will be told about the meeting, and only those involved with *d-up!* will attend. We have chosen a training venue that is not directly related to AIDS prevention.

**Is it going to be depressing?** AIDS has affected high numbers of black MSM and will continue to do so in the future. That's hardly good news. But the slant of *d-up!* is positive and not depressing. We're interested in learning about safer sex in fun, interesting, and positive ways.

**What if I already know a lot about AIDS?** Your knowledge will help make *d-up!* a success. The main objective of *d-up!* is to help you use your knowledge to become an expert resource for your friends and acquaintances who may not yet know enough.

**Will I get anything from attending?** Few people have the opportunity to learn and pass along information that can easily save other people's lives. You will have this opportunity, and if you take it, you will have made a positive impact in the fight against AIDS. We also think you will learn things of personal benefit, too. While we know that these are real reasons for people to attend, we are also able to offer (insert information about incentives).

**What's next?** We'd be happy to answer any questions you may have. We also would like to know, if you are interested, your contact information along with good times and days for you to attend the training sessions. If you have questions or want further information, you can call us at (phone number) and/or e-mail (e-mail address).

Thanks for your time. We hope to see you at the training!

Sincerely,

(NAME)

# OPINION LEADER CONTACT INFORMATION FORM

Name of opinion leader: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone (day): \_\_\_\_\_ Phone (evening): \_\_\_\_\_

May we leave a message? Yes \_\_\_\_\_ No \_\_\_\_\_

May we identify this intervention and leave a number? Yes \_\_\_\_\_ No \_\_\_\_\_

May we leave a meeting time? Yes \_\_\_\_\_ No \_\_\_\_\_

May we mail you information about *d-up!*? Yes \_\_\_\_\_ No \_\_\_\_\_

May we email you information about *d-up!*? Yes \_\_\_\_\_ No \_\_\_\_\_

Locations and times where we may find you:

Additional information:



## SAMPLE REMINDER LETTER

(Date)

Dear (Name):

Just writing to remind you of the time, date, and location of the first *d-up: Defend Yourself!* training session. The session will be held at (Location and Address), at (Time and Date). If you are unable to attend the meeting, please call or e-mail me.

I am looking forward to seeing you there! Thanks in advance for being part of *d-up!*. You will play a vital role in reducing HIV infections in (City).

Regards,

(Name)

(Phone Number)

(E-mail)

Directions to training venue:

