



STARTER KIT

DRAFT

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ABOUT THE STARTER KIT

WHOM IS THE STARTER KIT FOR?

The Starter Kit was developed for agencies that need information to make a decision about implementing *Defend Yourself: d-up!*. Agency staff members who select and manage interventions within their agencies can use the kit when deciding whether to adopt *d-up!*.

WHAT IS THE STARTER KIT FOR?

This kit describes the organization infrastructure needed to make *d-up!* successful. It describes how to prepare for the intervention and how it is implemented to ensure that the intervention is a good match with the agency's mission and the needs of the populations served. This document contains information administrators need for developing a budget, selecting or hiring appropriate staff, and preparing for implementation. The information in this kit also can be used to answer questions from stakeholders, community members, and media.

***d-up!* OVERVIEW**

DESCRIPTION OF *d-up!*

d-up: Defend Yourself! is a community-level intervention that attempts to change social norms and perceptions of Black MSM regarding safer sex practices and improve their sense of self-worth as Black MSM. *d-up!* utilizes individuals, called opinion leaders, who are respected and trusted by their peers, to promote the benefits of consistent condom use and increase feelings of positive self-worth among their friends and acquaintances. *d-up!* is specifically designed for and targets Black MSM, incorporating culturally relevant messages, materials, and activities throughout the intervention.

Opinion leaders are members of a social network who are respected, credible, trustworthy, listened to, empathetic to friends, and self-confident. Because of these characteristics, they lead the opinions among those around them. Opinion leaders are the trendsetters among their friends. Opinion leaders may be members of the target population, or they may be persons with whom members of the target population have frequent and significant interaction, such as barbers, teammates, or fraternity brothers. Opinion leaders are identified during the community discovery (a type of formative evaluation to inform planning). Once identified and recruited by an agency implementing *d-up!*, opinion leaders participate in a four-session training. This training will prepare them to have risk reduction conversations with their friends and acquaintances (also known as their friendship group).

In addition to conducting conversations, opinion leaders identify new opinion leaders within their friendship groups. Over time, more opinion leaders have more conversations with more people in their friendship groups. As 15% of the members in each friendship group carry out conversations that endorse safer sex promote the self-worth of Black MSM, safer sex practices are ultimately accepted as the social norm in the social network.

SCIENCE BEHIND *d-up!*

HISTORY AND EVIDENCE

d-up! is an adaptation of Jeff Kelly's Popular Opinion Leader (POL) intervention. From 1991 to 1994, Kelly and his colleagues conducted and evaluated a randomized, community-level test of POL for predominately White men patronizing gay bars in eight small cities (Kelly et al., 1997). Before POL was implemented, bar patrons were surveyed to find out about their past sexual behaviors. Bar patrons in four of the cities received the POL intervention and those in the other four—serving as comparison cities—did not. After implementing POL for over a year, researchers asked the bar patrons to complete the same survey they filled out before the intervention. The results showed that bar patrons in cities that received POL reported a 50% increase in condom use and a 30% decrease in any unsafe sex. The increased numbers of free condoms taken from bars in the intervention cities confirmed these reports. Men from the comparison cities did not show any significant behavior change. Since the first study, POL has been implemented by HIV prevention organizations in the United States and other countries. It has been packaged as one of CDC's effective behavioral interventions and disseminated as part of DHAP's Diffusion of Effective Behavioral Interventions project.

POL is designed to identify, enlist, and train opinion leaders to encourage safer sex behaviors within their social network of friends and acquaintances. Opinion leaders are individuals who are viewed by members of their social network as being trustworthy and having integrity. After receiving training, opinion leaders endorse safer sex practices by having conversations with their friends and acquaintances. By doing so, they establish safer sex practices as a social norm within their social networks.

In response to the lack of evidence-based interventions for Black MSM, CDC's DHAP embarked on a project to adapt and modify POL for Black MSM (Jones, Gray, et al., 2008). In partnership with the North Carolina Department of Health and Human Services and with HIV prevention agencies funded by health departments, CDC modified the POL materials to reflect the cultural nuances of Black MSM and to address social and cultural factors that influence HIV risk behaviors. Focus groups and key informant interviews were conducted in three North Carolina cities. Participants were asked to identify issues and challenges faced by Black MSM, barriers to accessing prevention services, topics that prevention activities should address, and ideal ways of marketing intervention activities to Black MSM. Data were used to inform adaptations to POL, which included changing the design of the materials to reflect Black MSM culture; for opinion leader training, incorporating discussions of sociocultural factors that contribute to HIV risk; developing conversation practice scenarios that reflect Black MSM issues; and including condom demonstrations and practice. Focus group data also were used to create a logo that resonated in the Black MSM community in North Carolina, and the logo was

incorporated in conversation starters and intervention marketing materials. The adapted intervention—named *d-up: Defend Yourself!*—was piloted in three North Carolina cities.

Surveys conducted with the target population throughout the year found significant reductions in risky behaviors and an increase in consistent condom use. Significant reductions were observed for unprotected receptive anal intercourse (URAI) at 4 months (23.8%), 8 months (24.7%), and 12 months (44.1%). Reductions in unprotected insertive anal intercourse (UIAI) were found at 8 months (35.2%) and in any unprotected anal intercourse at 12 months (31.8%). Also, at 12 months, the average number of partners for URAI decreased by 40.5%, and the average number of episodes decreased by 53.0% for UIAI and by 56.8% for URAI. The number of Black MSM reporting always using condoms for insertive and receptive anal intercourse increased by 23.0% and 30.3%, respectively.

FRAMEWORK AND THEORY

Theories

The *d-up!* intervention is based on and supported by two theories:

- ▶ Preparation for bias
- ▶ Diffusion of innovation

Preparation for bias

Preparation for bias (also called race-related socialization) refers to strategies used to promote positive identification with one's own racial or ethnic group to prepare individuals to succeed in the face of racial bias. It is a class of protective and adaptive practices used by ethnic and racial minority parents to promote children's functioning in a world that is stratified by ethnicity and race. Preparation for bias involves positive identity development, negotiation of racial barriers, and an emphasis on culture, history, and heritage (Hughes, 2003).

d-up! opinion leader training raises awareness of how racism, homophobia poverty, incarceration, and community and family rejection contribute to risky sex behaviors. The training prepares opinion leaders to identify social and cultural issues that arise in conversations, and it teaches them how to craft messages to help moderate potential negative effects (Jones, Gray et al., 2008).

Diffusion of innovations

Diffusion of innovations (Rogers, 2003) suggests that if a practice or behavior is endorsed by key leaders in the community, that practice or behavior will be adopted by community members over time. For this to happen, community members must believe that there is some advantage to adopting the practice or the behavior, the practice or behavior can be

observed, it is easy to execute, there are communication channels through which the adoption is disseminated, it is compatible with existing community values, and it can be integrated into social norms.

d-up! opinion leaders are people who have influence and credibility within their social networks. They endorse safer sex practices and communicate the benefits, their support, and the ease of adopting safer sex practices. As this message is communicated within social networks, safer sex practices become the social norm.

Social Norms

d-up! attempts to modify social norms that support risky sexual behaviors. Social norms are unwritten rules (e.g., beliefs, customs, expectations) for a group of people (i.e., social network or friendship group) for specific behaviors. These norms shape and influence a person's attitudes, opinions, and behaviors. Therefore, members of a social network will modify their behaviors on the basis of their perception of whether their friends would approve or disapprove of a certain behavior. The existence of a social norm can be seen in the peer pressure that exists within a social network. For example, people often wear (individual behavior) a certain style of clothes because of the subtle, but significant, peer pressure about what clothes are appropriate and inappropriate (social norm). The norm is spread through both the wearing of and talking about clothes that takes place in their immediate social relationships.

Social Networks and Friendship Groups

d-up! uses opinion leaders to change the social norms within their own friendship groups to impact their wider social network. A social network is a group of people who share common characteristics and/or interests that are specific to that network. Members like each other and frequently socialize with one another. A social network is also a collection of people who share a culture of risk, such as engaging in unprotected sex or having sex while high. For example, a social network that an agency could target is young (18 to 24 years old) Black MSM who attend a particular university and who are engaging in HIV risk behaviors.

A social network is made up of linked friendship groups. Friendship groups are smaller groups of friends and acquaintances within a social network who know each other and share a unique characteristic and/or interest that distinguishes their group from other groups in the social network. The social network of Black MSM college students referenced above would be composed of various friendship groups of Black MSM with varying interests and characteristics, such as athletics, music, fraternities, student government, men who are "out," and men who conceal their same-gender relationships.

Behavior Change Logic Model

The purpose of a Behavior Change Logic Model is to teach the specific logic of change underlying an intervention. The main purpose of a Behavior Change Logic Model is to depict, in summary fashion, what change is intended to be accomplished. The emphasis on the Behavior Change Logic Model is the logic of or what behavior change is to be accomplished in contrast to the Implementation Summary which is to depict, in summary fashion, how the behavior change logic is intended to be or must be (central requirements implemented or put into practice).

A Behavior Change Logic Model conveys the logical inter-relationships between four major intervention concepts: the intervention: 1. risk group (risk factors defining the risk and group for intervention purposes, 2. social- cognitive determinants of behavior the intervention targets, 3. intervention activities to target the behavior, and 4. the intended immediate and intermediate outcomes of intervening with the intervention. (.

Knowledge and understanding of the Behavior Change Logic Model provides guidance for practice because it helps to specify the conceptual boundaries of the practice. For example, these logical relationships among: 1. the problem for intervention purposes with a specific intervention model, 2. the main determinants of behavioral risk used by the intervention, 3. the activities or operational examples of how the determinants of behavioral risk are to be addressed in practice, and 4. the outcomes that are intended to be accomplished by these activities can aid understanding to select, adapt, implement, monitor, and evaluate interventions. Moreover, without proven intervention components in hand from components testing the most realistic guidance that can be given on the “core” of the intervention or “fidelity” to the intervention is logical assessments of what “fits with” or “does not fit with” intervention logic (Behavior Change Logic Model) and required implementation of it (Implementation Summary). The Behavior change Logic Model also is a tool for design of an intervention because it serves as a summary outline of the intended intervention. In sum, the Behavior Change Logic Model is a conceptual framework that visual depicts the:

- intent of the intervention (what behavioral problem is to be change and what change is intended)
- actions expected to lead to behavior change
- anticipated outcomes
- relationships among intervention components

The Behavior Change Logic Model is useful in many ways to a variety of stakeholders.

Funding agencies can use the model to inform:

- decisions about which organizations and interventions to support
- their oversight of the intervention implementation and results

Agencies interested in conducting evidence-based interventions can use the model to:

- help determine whether the intervention is appropriate for the target populations they serve
- promote discussion of agency capacity to deliver the intervention

Implementing agency intervention staff can use the model to:

- enhance their understanding of the intervention and how it is supposed to work
- assess their progress in implementing the intervention

Program monitoring and evaluation staff can use the model to:

- provide a foundation for a monitoring and evaluation plan
- identify variables for data collection for process and outcome monitoring and process evaluation, including “fidelity”
- assess assumptions about how the intervention works

Implementing agency’s board of directors can use the model to:

- help determine whether the intervention is appropriate for populations served by the agency
- promote discussion of agency capacity to deliver the intervention
- enhance their understanding of the intervention and how it is supposed to work
- inform decisions about monitoring and evaluation

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

Statement of the Problem for Intervention

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.

Specific Behavior Change Logic

	Determinants To address risk behavior/factors	Activities To address behavioral determinants	Outcomes Expected changes as a result of activities targeting behavioral risk determinants	
Opinion Leader Training →	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.
<i>d-up!</i> Intervention →	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.

IMPLEMENTATION SUMMARY

An Implementation Summary is a conceptual framework which visually depicts and summarizes how a behavior change intervention is to be implemented or put into practice. Another way of saying this is that an Implementation Summary depicts in summary fashion the programmatic requirements necessary for and specific to implementation of an intervention (not agencies, “agency programs,” and “programs” in general).

An Implementation Summary relates the inputs (resources) that must be secured, developed, and put into use to carry out the implementation activities. The Implementation summary also describes the outputs (programmatic deliverables or products) that result when the implementation activities are conducted.

The Implementation Summary can be used by a variety of stakeholders.

Funding agencies can use the summary to inform:

- decisions about funding levels needed
- their oversight of the intervention implementation and results

Implementing agency intervention staff can use the summary to:

- assist with planning and implementation
- develop detailed budgets, plans, quality assurance protocols, and timelines

Program monitoring and evaluation staff can use the summary to:

- identify evidence of implementation (process monitoring)
- identify the expected outputs (quantitative or qualitative programmatic deliverables) of intervention activities

Implementing agency’s board of directors can use the summary to:

- help with decisions about intervention selection

IMPLEMENTATION SUMMARY OF THE INTERVENTION

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

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

BENEFITS OF IMPLEMENTING *d-up!*

The Community

Reach

As a community-level intervention, *d-up!* can reach many more people in a shorter amount of time, as compared with individual and small-group interventions.

Community empowerment

The community is seen as the answer, not the problem. The intervention gives Black MSM the opportunity to take an active role in the fight against HIV/AIDS by protecting themselves, their friends, and others from the virus. *d-up!* recognizes community strengths in both its design and reliance on community members to promote safer sex norms, ultimately resulting in fewer cases of HIV and other sexually transmitted infections. *d-up!* also can counter larger social issues that impact Black MSM, such as racism and homophobia, by promoting personal self-worth and addressing racial and sexual biases that Black MSM may encounter.

Network approach

d-up! employs a friend-influencing-friends approach, which is an effective and credible means of spreading information and attitudes. Messages are delivered in the everyday context of a social network and are tailored to be relevant and understandable to the persons receiving the messages. Because opinion leaders speak directly to their friends and acquaintances, conversations are sensitive to the unique characteristics of each friendship group. Through this approach, Black MSM who may be less likely to actively participate in HIV prevention interventions still can be reached and receive HIV prevention information.

Other issues

Although *d-up!* is primarily designed to rally Black MSM around the fight against HIV/AIDS, it may address other important issues, such as stigma, self-esteem, “coming out,” drug use, or the lack of social support systems. *d-up!* may help create a supportive environment in which Black MSM can talk about these issues and, ultimately, reduce risky sexual behavior.

The Agency

Cost-effective

d-up! requires few resources to reach large numbers of Black MSM who are potentially vulnerable to HIV infection.

Long term and low maintenance

Since opinion leaders recruit new opinion leaders (successive waves of opinion leaders), the intervention can continue over time with reduced effort from your staff members.

Recruiting and training new waves of opinion leaders lead to yet more conversations with more members of your target population. Once 15% of each friendship group is involved, your agency can extend *d-up!* to another social network and promote condom use in the wider Black MSM community. Some of your trained opinion leaders may become involved with your agency's other HIV prevention activities and interventions.

Community support

d-up! provides your agency with multiple opportunities to build positive relationships and support in your community. The intervention helps build your agency's image, increases awareness of your agency, and creates additional future outreach opportunities.

***d-up!* Opinion Leaders**

Helping others

d-up! opinion leaders have the opportunity to give back to the community and save their friends' lives. By participating in *d-up!*, opinion leaders assume a more active role in fighting HIV/AIDS in their community.

Personal growth

A person who serves as an opinion leader may improve his or her self-esteem and create positive, personal behavior change. Opinion leaders can feel good about themselves because they are helping others and seeing their skills and influence acknowledged by the program.

Low burden

Ultimately, the opinion leaders get to choose the amount of time they use for conducting the intervention. They also get to hold conversations in normal social contexts with their friends and acquaintances.

CORE ELEMENTS

Core elements are components of an intervention that are responsible for its effectiveness in changing risk behaviors. Core elements are identified by looking at constructs (specific concepts) of the theories that support the intervention and by reviewing research that applied those theories to the intervention. Because of the relationship of core elements to the effectiveness of the intervention, core elements must be maintained.

d-up! consists of 10 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 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 behavior 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 all opinion leaders have a chance to practice, 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.

KEY CHARACTERISTICS OF *d-up!*

Key characteristics are crucial activities and delivery methods for conducting an intervention. Key characteristics support the core elements. *d-up!* key characteristics include the following:

- ▶ Elicit the involvement, support, and cooperation of key gatekeepers in the community.
- ▶ Recruit opinion leaders by emphasizing their potential positive role as a HIV prevention resource to others.
- ▶ Train in groups.
 - Explain to opinion leaders that they were nominated on the basis of their respectability, credibility, and ability to influence others.
 - Explain the theory and philosophy of the intervention to opinion leaders.
 - Emphasize the role of opinion leaders in changing peer group norms through HIV/AIDS prevention messages delivered in conversations with friends and acquaintances.
 - Provide opinion leaders with correct HIV risk reduction information.
 - Provide opinion leaders with practical advice on how to implement HIV risk reduction behavior changes.
 - Model examples of effective peer risk reduction conversations, including how to spontaneously initiate risk reduction conversations.
 - Facilitate group problem-solving activities centered around how each opinion leader will have risk reduction conversations, allowing each person ample time to discuss issues particularly relevant to him or her.
 - Incorporate culturally-appropriate music, images, and activities to create a comfortable and familiar training environment.
- ▶ Organize reunions with all opinion leaders from each wave and key community gatekeepers to discuss the maintenance of *d-up!*.
- ▶ Monitor and evaluate intervention phases to identify if *d-up!* was implemented as planned and is achieving desired outcomes.

IS *d-up!* RIGHT FOR YOUR AGENCY?

Before deciding to adopt and implement *d-up!*, you should determine if *d-up!* is right for your agency and the Black MSM population served. This section will help you think through the structures, processes, and resources needed to successfully implement *d-up!* activities. The table below is a checklist of questions you need to consider before deciding if you should implement *d-up!*. The purpose of this checklist is to guide your decisions by stimulating thinking and dialogue.

Checklist of Intervention Appropriateness

Question	Yes	No
Are intervention goals appropriate for your agency?	<input type="checkbox"/>	<input type="checkbox"/>
Is your target population Black MSM?	<input type="checkbox"/>	<input type="checkbox"/>
Are intervention goals appropriate for your target population of Black MSM?	<input type="checkbox"/>	<input type="checkbox"/>
Are intervention objectives appropriate for your agency (i.e., SMART-specific, measurable, appropriate, realistic, and time based)?	<input type="checkbox"/>	<input type="checkbox"/>
Are intervention objectives appropriate for your target population (i.e., SMART)?	<input type="checkbox"/>	<input type="checkbox"/>
Are risk reduction messages appropriate for your agency's norms and values?	<input type="checkbox"/>	<input type="checkbox"/>
Are risk reduction messages appropriate for the target population of Black MSM's norms and values?	<input type="checkbox"/>	<input type="checkbox"/>
Are risk reduction messages appropriate for the (larger) community population's norms and values?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have the capacity to implement each core element?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have a governance (board of directors) commitment to implement each core element with fidelity?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have a management commitment to implement each core element with fidelity?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have a staff commitment to implement each core element with fidelity?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have sufficient resources to implement each core element with fidelity?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have the capacity to identify and recruit members of the target population of Black MSM for this intervention?	<input type="checkbox"/>	<input type="checkbox"/>
Is this intervention culturally appropriate for your target population of Black MSM?	<input type="checkbox"/>	<input type="checkbox"/>
Does this intervention address or have the capacity to address risk factors within your target population of Black MSM?	<input type="checkbox"/>	<input type="checkbox"/>

In addition to thinking through the above questions in detail, you can use the questions described below to determine if your agency has the capacity, or can build the capacity, to implement *d-up!*. After answering all of these questions, you should be able to determine if *d-up!* is the right intervention for your agency and community.

ARE THERE EXISTING HIV PREVENTION INTERVENTIONS FOR BLACK MSM IN YOUR AREA?

You should determine if *d-up!* would fill an unmet need and not duplicate or compete with other HIV prevention interventions. If HIV interventions for Black MSM, especially community-level interventions, are already available in your area, you may have difficulty recruiting enough participants. However, *d-up!* can complement and support other prevention interventions.

DO YOU HAVE ACCESS TO BLACK MSM?

d-up! was designed to reach a large number of Black MSM. To be effective, it needs to be implemented in locations that have at least 100 Black MSM, and 15% of them must be recruited as opinion leaders. Your agency must have a good reputation with members of this population, and you must be able to recruit and work with them. You also must have access to venues where Black MSM gather and socialize. Examples of potential social venues include fraternities, “ball houses,” clubs, bars, coffee shops, gay bookstores, gyms, and community centers.

IS THERE SUPPORT FOR *d-up!* IMPLEMENTATION?

Community Support

If there is a sizable Black MSM population in your area, you will want its members to have a vested interest in the intervention’s success. If there is no defined Black MSM population, you will need to assess interest and support for *d-up!* within the local Black¹ community. You will need to identify and enlist the support of stakeholders and leaders from your target population of Black MSM.

Agency Support

If you decide that you want to adopt *d-up!*, it is crucial to secure agency buy-in to ensure the support of agency administration and to allow agency resources to be used for intervention implementation. Obtaining buy-in is most effectively accomplished by identifying at least one agency administrator or staff person to champion the intervention, that is, to advocate for its integration into the agency’s existing services. A *champion* could be one person or a group of people and should be selected by an agency

¹ In order to be inclusive of individual members of the Black Diaspora who may not self-identify as African American, *d-up!* uses the terms “Black community” or “Black MSM.”

administrator. A *champion* is someone within the agency who is a mid- to upper-level administrator who generally serves as a link between administration and staff members. The *champion* needs to be adept at answering questions and mediating changes in agency structure; he or she can serve as a negotiator of any necessary trade-offs or compromises. The *champion* becomes the intervention's spokesperson, anticipating the reservations of staff members and answering questions about the intervention's needs and resources. The *champion* must have a thorough knowledge of the intervention, including its costs, core elements, and key characteristics; the *champion* can use information in the intervention package to field any questions or concerns about *d-up!*.

Regardless of the number of *champions*, the main issue is convincing the stakeholders that implementing *d-up!* will enhance the quality of your agency's services and that your agency will be capable of implementing *d-up!*. Stakeholders include your funding source(s), your agency's board of directors or executive board, and all agency staff members who will have a role in the operation of the intervention. The latter include administrators who will obtain funding, supervisors who will monitor the intervention, and staff members who will interact with opinion leaders at any level.

ABOUT ADAPTATION

Adapting *d-up!* involves customizing the delivery of the intervention and ensuring that training activities are appropriate for the opinion leaders and that messages are appropriate for the social network of Black MSM targeted by your agency without altering, deleting, or adding to the intervention's core elements. When adapting the intervention, remember to consider the needs of the target population that you identify through community discovery, the resources and capabilities of your agency, and the core elements of *s-up!*. Adaptation refers to the who, what, how, when, and where of *d-up!*, as it will be implemented at your agency.

An example of an adaptation is changing the frequency of *d-up!*'s opinion leader training sessions. In the original study, opinion leaders met once a week over 4 weeks. However, the sessions can be held twice a week over 2 weeks, as long as enough time is allowed between sessions for the opinion leaders to have risk reduction endorsement conversations. Attempting to do the entire training in 1 or 2 days is not recommended. Opinion leaders need time to practice the conversations, receive feedback on the issues they encountered, and complete the requested number of conversations. Marathon sessions do not provide that opportunity, and they may be unproductive.

Adaptations should not affect the core elements of the intervention. Instead, they should enhance the delivery of the intervention by your agency and allow your staff members to be creative and to develop ownership of the intervention.

Keep in mind that *d-up!* is an adaptation of Kelly's Popular Opinion Leader intervention and is designed specifically for Black men who have sex with men who are in social networks with other Black men who have sex with men. If your agency is considering using *d-up!* with a different population, we strongly urge you to make your own adaptation of Popular Opinion Leader rather than to adapt an adaptation.

GETTING STARTED

DEVELOP YOUR IMPLEMENTATION PLAN

The sample *d-up!* intervention flowchart on page 42 will help you develop your implementation plan. The flowchart lists the tasks for each phase of *d-up!*, the knowledge and capacity required for completing each task, responsible staff members, and timelines. The flowchart will help you complete your own *d-up!* flowchart template.

To develop your *d-up!* implementation plan, follow these steps:

1. Form a team to work on *d-up!* planning and implementation.
2. Review, in detail, the *d-up!* materials provided in the *d-up!* training.
3. Review, in detail, the implementation flowchart.
4. Hold a series of meetings to develop specific plans and timelines for creating objectives and completing each of the key tasks and activities of your *d-up!* intervention.
Note: For the most part, you should first determine your objectives before developing your intervention plan. However, some objectives will need to be modified once you have conducted your community discovery. For example, you will not know how many opinion leaders you will need to recruit until you know the size of your target social network.
5. Begin implementing *d-up!*. Document the progress and completion of tasks and activities in relation to the implementation plan and intervention objectives you developed.
6. Periodically hold team meetings and review the implementation progress. Adjust intervention plans and objectives as needed. Document revisions.
7. Review your implementation plan following Part I of the “Community Discovery” section, presented later in this manual.

DEVELOP YOUR EVALUATION PLAN

An evaluation plan is a written document that describes the overall approach that will be used to guide the monitoring and evaluation of an intervention. The plan describes what will be done, how it will be done, who will do it, and why it is being done. An evaluation plan may include the following information:

- ▶ A description or list of the information needed and how the information will be used (i.e., what you will measure)
- ▶ Data collection protocols for securing process and outcome data for objectives and program performance indicators (i.e., how and when you will measure)
- ▶ A description of how data will be managed and stored
- ▶ Procedures for analyzing, interpreting, reporting, presenting, and using findings for planning, program management, and program improvement
- ▶ Description of how funder input will be used (e.g., CDC's Prevention Program Branch's technical reviews and site visit reports)
- ▶ Descriptions of policies and protocols to secure data and ensure the confidentiality of client/participant information

Before developing an evaluation plan, identify and prioritize the information needs of various stakeholders (e.g., administrative and program staff, funding agency, partnering agencies or businesses, board of directors/advisory boards, consumers).

***d-up!* Cost Estimate Worksheet**

This cost estimate sheet will help you forecast *intervention-specific* costs of implementing *d-up!* in your agency/community. Note that some operating costs are not factored into this cost estimate (e.g., PEMS administration). Include costs that may be covered by donations, volunteers, or in-kind contributions, in case these costs do not get covered by other sources. The figures in the cost estimate worksheet are based on a target social network of 100 people, which means recruiting and training 15 persons as opinion leaders (OLs).

If your target social network is larger than 100 people, use the following formulas to calculate your staff time, and adjust the numbers in the implementation phase to match the number of OLs:

_____ (size of target social network) \times 0.15 (15% to train as OLs) = _____ (# of OLs)

Program coordinator: _____ (# of OLs) \times 4.6 hours per OL = _____ total hours

Facilitator: _____ (# of OLs) \times 4.7 hours per OL = _____ total hours

Administrative assistant: _____ (# of OLs) \times 0.4 hours per OL = _____ total hours

d-up! Cost Estimate Worksheet

Categories	Pre-Implementation (start-up)	Implementation (intervention delivery)
Personnel (hours spent on intervention, including travel time)		
	# of staff # of hours/15 OLs	# of staff # of hours/15 OLs
Program coordinator	1 × \$ /hr × 30 =	1 × \$ /hr × 39 =
Facilitator	2 × \$ /hr × 25 =	2 × \$ /hr × 46 =
Administrative assistant	1 × \$ /hr × 3 =	1 × \$ /hr × 3 =
Fringe benefits	% =	% =
Facilities (hours spent on intervention, including travel time)		
Rent—office	\$ × % =	\$ × % =
Rent—OL training space	\$ × % =	\$ × % =
Utilities	\$ × % =	\$ × % =
Maintenance	\$ × % =	\$ × % =
Insurance	\$ × % =	\$ × % =
Equipment (% of time used for intervention at depreciated value)		
Television	\$ × % =	\$ × % =
VCR/DVD player	\$ × % =	\$ × % =
Computer	\$ × % =	\$ × % =
Projector		\$ × % =
Projection screen		\$ × % =
Supplies		
Photocopying handouts	\$	\$
Paper	2 reams × \$ /ream =	5 reams × \$ /ream =
Pens	1 dozen × \$ /dozen =	1 dozen × \$ /dozen =
Easel paper		4 pads × \$ each =
Markers		1 dozen × \$ /dozen =
Masking tape		2 rolls × \$ /roll =
Condoms		1 gross × \$ /gross =
Conversation Starters		
Logo posters		50 × \$ /each =
Logo pins		3 dozen × \$ /dozen =
Logo key chains		3 dozen × \$ /dozen =
Logo dog tags		3 dozen × \$ /dozen =
Logo caps		2 dozen × \$ /dozen =
Logo T-shirts		2 dozen × \$ /dozen =
Other Expenses		
Catering/refreshments*	20 persons × \$ /each x meetings =	15 persons × \$ /each x meetings =
OL incentives		15 persons × \$ /each =
Venue owner/staff incentives	\$	\$
Staff travel expenses	round-trips × \$ /round-trip =	round-trips × \$ /round-trip =
Advertising to recruit staff	\$	
Consultancy: Logo development (OPTIONAL)	\$	
Subtotal per phase	\$	\$
Total for both phases		\$
Overhead (___ % of total)		\$
Grand total		\$

*For stakeholder and nomination meetings during the pre-implementation phase and for opinion leader trainings and reunions during the implementation phase.

***d-up!* INTERVENTION FLOWCHART**

The *d-up!* intervention flowchart is divided in steps. Table 1 presents the planning and preliminary steps, Table 2 provides the implementation steps, and Table 3 outlines the evaluation steps.

Table 1. 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	Intervention staff	Month 1	
Begin developing relevant community relationships	Knowledge of local HIV programs and gatekeepers from the Black MSM population	Program coordinator	Month 1	
Determine the size of a 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	Program coordinator	Month 1	
Recruit, hire, and train staff members	Knowledge of staff requirements and recruitment resources	Program coordinator	After you determine the network size	
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	Program coordinator	Month 2; after the first and second phases of community discovery	
Develop policy and procedures for your agency	Knowledge of local and national guidelines and laws, funder requirements, and <i>d-up!</i> activities	Program coordinator	Month 2	

Table 1. Planning and Preliminary Steps (continued)

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Develop a monitoring and evaluation plan	Knowledge of monitoring and evaluation and <i>d-up!</i> activities	Program coordinator	After you develop the implementation plan; after revisions to the implementation plan	
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	Program coordinator	Months 1–2; additional and ongoing support identified throughout <i>d-up!</i> phases	
Identify and collect information on possible Black MSM social networks	Knowledge of the Black MSM population; support from stakeholders; skills to conduct formative evaluation	Intervention staff	Months 2–3	
Identify potential venues	Knowledge of the Black MSM population and social venues	Intervention staff	Month 3	
Select the social network your intervention will target	Knowledge of specific social networks and their level of risk	Intervention staff	2 weeks after collecting and reviewing social network information	

Table 1. Planning and Preliminary Steps (continued)

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Select and access recruiting venues	Information on recruitment venues; support from venue owners	Program coordinator	2 weeks after selecting the target network and identifying venues	
Identify friendship groups in the target social network	Knowledge, skills, and staff to conduct formative evaluation; identification of target venue(s)	Intervention staff	3 months before the implementation phase	
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	Intervention staff	1 month before the implementation phase	
Develop a logo and conversation starters	Knowledge of target network's beliefs, norms, and attitudes; network members to review materials; ability to conduct focus groups	Program coordinator	1 month before the first opinion leader training	
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	Program coordinator	1 month before the implementation phase	

Table 1. Planning and Preliminary Steps (continued)

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Identify and secure training venues	Knowledge of number of opinion leader trainings you need to conduct, convenient times and locations, and funding	Program coordinator	1 month before the implementation phase	
Tailor opinion leader training as needed; refine and develop training materials	Data collected from community discovery, particularly on target network's knowledge, attitudes, and beliefs toward safer sex	Intervention staff	1 month before the first opinion leader training session	

Table 2. Implementation Steps

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Recruit opinion leaders	Knowledge of potential opinion leaders; recruitment skills	Intervention staff	1 month before the first opinion leader training session	
Conduct opinion leader trainings	Knowledge of opinion leader training; opinion leader training materials; trained facilitators; space, staff, and training materials	Facilitators	As needed until you have trained 15% of the members from each friendship group	
Monitor opinion leaders after they complete training and provide ongoing support	Opinion leader contact information; problem-solving skills	Facilitators	Ongoing	

Table 2. Implementation Steps (continued)

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Hold opinion leader reunions	Space to hold reunions	Facilitators	1 month after the completion of an opinion leader training	
Recruit successive waves of opinion leaders	Knowledge of potential opinion leaders, friendship groups, and number of opinion leaders needed; recruitment skills	Intervention staff	As needed until you have trained 15% of the members from each friendship group	
Revise messages, conversation starters, and logos as needed	Knowledge of target networks' current attitudes, beliefs, and behaviors; formative evaluation skills	Intervention staff	Every 6 months during the implementation phase	
Consider identifying other social networks to target 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 the number of Opinion leaders trained	Program coordinator	Before your last three opinion leader training waves	

Table 3. 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 monitoring and evaluation 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	Program coordinator	As you develop your monitoring and evaluation plan	
Conduct formative evaluation; collect data	Knowledge of formative evaluation methods; formative evaluation form(s)	Intervention staff	During community discovery	
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	Intervention staff	During pre-implementation, implementation, and maintenance phases	
Conduct quality assurance assessment of opinion leader trainings; collect data	Knowledge of quality assurance methods; facilitator fidelity/process form	Program coordinator	After every four opinion leader trainings	
If resources allow, conduct outcome monitoring of <i>d-up!</i> ; collect data	Knowledge of outcome monitoring methods; data collection forms	Intervention staff	At least 6 months after all opinion leaders have been trained	
Generate database for data collected; manage database	Knowledge of formative evaluation methods; formative evaluation forms	Intervention staff	During community discovery	

Table 3. Evaluation Steps (continued)

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Summarize data from evaluation forms	Knowledge of data management techniques and software (e.g., Microsoft Access, Microsoft Excel, SPSS, SAS)	Intervention staff	Ongoing	
Analyze collected data	Knowledge of analysis techniques	Intervention staff	Quarterly	
Review evaluation data and identify intervention areas and activities for improvement	Knowledge of intervention objectives and core elements	Intervention staff	Quarterly	
Report findings to stakeholders, staff, and funders	Skills to summarize and report data	Program coordinator	At least once every 6 months	

IMPLEMENTATION TIMELINE

The time it will take to implement *d-up!* will depend on the size of the social network you want to target. For example, if you target a network of 500 Black MSM, you will need to train 75 opinion leaders (15% of each friendship group within the total 500). You should assume that you will train 10 to 12 opinion leaders at a time during a 1-month period. At this rate, it will take about 7 or 8 months to train enough opinion leaders for *d-up!* to have an effect.

Table 4 summarizes the major activities for each *d-up!* phase. Use this as a guide to determine if you have the time to implement *d-up!*.

Table 4. Summary of *d-up!*'s Major Activities

Summary of <i>d-up!</i>'s Major Activities	
Pre-Implementation	Time Estimate
Identify a broad at-risk Black MSM population to target	1 month
Begin developing relevant community relationships	
Assess the applicability and feasibility of implementing <i>d-up!</i> in the community (begin community discovery)	
Determine the size of the social network you can target and how many opinion leaders you can train with available resources	
Train <i>d-up!</i> facilitators	1 month
<ul style="list-style-type: none"> • Begin developing <i>d-up!</i> implementation and monitoring plans <ul style="list-style-type: none"> ▪ Develop opinion leader recruitment plans and procedures ▪ Develop a training plan to train opinion leaders in groups ▪ Develop a retention plan and procedures ▪ Develop a support and maintenance plan 	1 month
Engage gatekeepers and key community members	1 month

Table 4. Summary of *d-up!*'s Major Activities (continued)

Summary of <i>d-up!</i>'s Major Activities	
Pre-Implementation	Time Estimate
<ul style="list-style-type: none"> • Complete community discovery <ul style="list-style-type: none"> ▪ Identify and estimate the size of the social network(s) that could be targeted ▪ Identify potential recruitment and target venues ▪ Define and select the social network to target and their venue(s) ▪ Get permission of venue owners/managers ▪ Identify friendship groups and their opinion leaders ▪ Develop and test project logos and conversation starters 	1–2 months
Finalize <i>d-up!</i> implementation and monitoring plans	2–4 weeks
Implementation	Time Estimate
Begin recruiting and screening opinion leaders	1 month
Begin ongoing training of groups of opinion leaders	1 month for every 10–12 opinion leaders
Maintenance	Time Estimate
Continue identification of opinion leaders (if applicable)	Occurs throughout implementation
Begin ongoing retention, follow-up, and support activities	
Provide reunion sessions	
Monitoring	Time Estimate
Monitor intervention objectives	Occurs throughout all intervention phases
Monitor opinion leader recruitment and training activities	
Assess adherence to core elements and key characteristics	
Assess changes in outcomes	2 months

STAKEHOLDER'S CHECKLIST

Your agency *champion* can use the stakeholder's checklist in table below to enlist support for implementing *d-up!*. The stakeholder's checklist contains those items the *champion* can use to convince the stakeholders that *d-up!* is an intervention that your agency can and should implement because it meets the needs of a community your agency serves.

Stakeholder's Checklist

Checklist Steps

- Step 1:** Assess the community to determine whether its members will support the core elements of d-up!.

- Step 2:** Identify your stakeholders to determine whether they will support the core elements of *d-up!*.

Stakeholders may include the following. Check the box next to the stakeholders that you plan to include:

- Board of directors or executive board
- Staff members who have a role in implementing *d-up!*
 - Administrators who will give support
 - Supervisors who may oversee the implementation of *d-up!*
 - Staff who interact with opinion leaders at any level
 - Other staff: _____
- Local agencies from which you could recruit community discovery participants, facilitators, or both:
 - Agencies offering support groups for Black MSM
 - Health care providers and mental health professionals serving Black MSM
 - Social service agencies reaching Black MSM
 - Organizations of Black MSM and organizations that may have members who are Black MSM
 - Other agencies: _____
- Organizations that could provide assistance or other resources:
 - Merchants for incentives or refreshments
 - Agencies, merchants, printers, publishers, and others that can advertise the intervention
 - Businesses that can provide a venue for the intervention
 - Agencies that can provide transportation
 - Advisors to help adapt the intervention
 - Others: _____
- Agencies with which your agency needs to maintain good community or professional relations:
 - Local health department
 - Local medical and mental health associations
 - Others

Checklist Steps

- Step 3:** Get stakeholders informed, supportive, and involved. Check the box next to the ones you plan to use:

There are several ways to involve stakeholders:

- Inform them about *d-up!*
 - Decide in advance what specific roles you want each stakeholder to play. Who you will ask to do each of the following:
 - Provide financial support
 - Identify other stakeholders
 - Participate in community discovery
 - Help adapt the intervention for your target population of Black MSM
 - Provide a venue in which opinion leaders can be recruited and in which opinion leaders can have safer sex conversations with friends and acquaintances
 - Assist with identifying opinion leaders for the intervention
 - Provide a room in which the sessions can be held
 - Supply refreshments for opinion leaders being trained
 - Donate small incentives for opinion leaders
 - Speak supportively about *d-up!* in conversations with associates
 - Send letters that tell stakeholders about *d-up!* and its importance; the fact that your agency is (or will be) implementing the intervention; the specific role(s) that you think they might play in the implementation of the intervention; and a point of contact for learning more about *d-up!*.
 - Call stakeholders in 2 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 *d-up!* promotional materials or the intervention package if the setting and time allow, and answer questions.
- Get support from the stakeholders.
 - Describe several specific roles they could play.
 - Emphasize the benefits of their involvement to themselves, their agency, the community, and Black MSM, and answer their questions.
 - Invite them to commit to supporting *d-up!* by taking on one or more roles. Keep track of their commitments.

Continued on next page

Checklist Steps

- Get them involved.
 - Soon after meeting, send each a thank-you letter that specifies the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later.
 - 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 and the value of their contributions, update them on the intervention's progress, and keep them engaged.

MARKETING TOOLS

You will need to market and promote *d-up!* to gatekeepers, stakeholders, and potential funders to gain their support. Please note *d-up!* does not use marketing to recruit opinion leaders, increase community awareness of the project, or link *d-up!* with agency services. When marketing *d-up!*, it will be important to provide your target audience with information included in this kit, including:

- ▶ Checklist of Intervention Appropriateness
- ▶ Cost Estimate Worksheet
- ▶ *d-up!* Overview
- ▶ Core Elements
- ▶ Implementation Summary
- ▶ Problem Statement (Appendix A)
- ▶ *d-up!* Fact Sheet (Appendix A)

STAFFING

Elements that should be included in the policies and procedures manual regarding staffing may include the following:

- ▶ Recruitment procedures
 - Who will recruit?
 - Where?
 - When?
 - What materials will be used?
- ▶ Hiring protocols
 - What is the interview process?
 - Who is responsible for hiring?
 - What is the process after hiring decisions have been made?
- ▶ Position descriptions
 - What are the job roles and responsibilities?
- ▶ Retention strategies

Staff recruitment and retention

Your agency's policies and procedures manual should include guidance on hiring staff. For the successful implementation of *d-up!* you will need the following personnel:

- ▶ One program coordinator
- ▶ Two facilitators
- ▶ One administrative assistant

Ideally, all staff members should have extensive experience working with Black MSM, and they should be members of this population. At the very least, one of your intervention facilitators should be a Black MSM. This can help increase the acceptability of *d-up!* among your target social network and ensure that the intervention is delivered in a culturally appropriate manner.

The program coordinator will be primarily responsible for overseeing and coordinating the implementation of *d-up!*. Your intervention facilitators will be responsible for conducting community discovery and identifying, recruiting, training, and monitoring *d-up!* opinion leaders. You should have two intervention facilitators running each opinion leader training session. The administrative assistant will provide project support and help coordinate intervention logistics, such as maintaining files, arranging catering, and placing advertisements. Depending on the size of your target social network and available resources, your program coordinator may need to take on some or all of the roles of a facilitator.

Roles and responsibilities

The table below further describes the specific requirements, roles, and responsibilities of each staff member.

Staff Roles and Responsibilities

Position Title	Roles and Responsibilities	Requirements
Program coordinator	<ol style="list-style-type: none"> 1. Manage and coordinate implementation of <i>d-up!</i> 2. Coordinate daily activities, such as assigning tasks, monitoring and ensuring progress of the project, and arranging staff meetings 3. Ensure data collection and management, monitoring and analysis 4. Hire staff 5. Supervise facilitators and arrange for facilitator training 6. Identify and secure session space 7. Identify the technical assistance needs of facilitators and project staff, and coordinate the provision of technical assistance 8. Monitor expenditures and budget 9. Plan and facilitate marketing activities 10. Promote the intervention in the community 11. Identify and work with community partners and gatekeepers 	<ol style="list-style-type: none"> 12. Comfort with sexuality (e.g., able to use sexual terminology, including colloquial terms; able to describe sexual behavior in concrete, specific terms, without being uncomfortable or embarrassed; nonjudgmental and open-minded about all of the possibilities of human sexuality) 13. Cultural sensitivity (e.g., respectful of others and of differences between people based on ethnicity/culture; empathetic; able to anticipate possible reactions of others to comments or terminology) 14. Persuasiveness (e.g., able to convey the importance of the intervention to staff, participants, and the community; able to motivate people) 15. Knowledge about HIV/AIDS (e.g., has accurate information; understands the impact of HIV among Black MSM) 16. Ability to inspire trust (respects confidentiality of group members; does not gossip; is honest) 17. Ability to understand confidentiality issues and the importance of maintaining confidentiality 18. Ability to supervise staff (e.g., understands all core elements and activities of the intervention; can monitor facilitators and deliver positive feedback to improve process; can monitor community discovery and opinion leader recruiting process; knows the importance of regular observation; is organized)

Position Title	Roles and Responsibilities	Requirements
Facilitator	19. Assist the program coordinator 20. Conduct community discovery (identify social networks, friendship groups, venues, and opinion leaders) 21. Work with venue owners 22. Promote the intervention in the community 23. Identify and work with community partners and gatekeepers 24. Recruit opinion leaders 25. Plan and conduct opinion leader trainings 26. Monitor opinion leaders 27. Coordinate and conduct reunions 28. Collect and compile monitoring data 29. Assist with marketing activities	30. Requirements 1–6 listed above 31. Knowledge of and experience with Black MSM (e.g., knows local issues and characteristics of Black MSM; understands Black MSM culture; is comfortable working with Black MSM and going to Black MSM venues; is respected by Black MSM) 32. Skills in guiding a group process (e.g., able to convey information clearly and simply; able to diplomatically guide group discussions; able to respond to comments or questions; able to elicit participation from all group members and attend to opinion leaders' feelings and behaviors) 33. Skills in guiding role-playing (e.g., able to choose and describe realistic and appropriate situations; able to direct and provide constructive feedback during participant role-plays) 34. Skills in guiding problem-solving (e.g., able to help participants identify goals; able to generate alternative strategies; able to provide encouragement after failure)
Administrative assistant	35. Enter data from assessments and record contact information 36. Record staff meeting minutes and organize lessons learned from notes 37. Secure appropriate materials (e.g., newsprint, paper, binders)	41. Cultural sensitivity (e.g., respectful of others and of differences between people based on ethnicity/culture; empathetic; able to anticipate possible reactions of others to comments or terminology) 42. Organization skills (e.g., able to keep track of intervention records and data; properly store and secure project supplies and equipment; track participant information; record and file project expenditures)

Position Title	Roles and Responsibilities	Requirements
Administrative assistant (continued)	38. Buy and arrange incentives (e.g., catering, gifts as decided) 39. Assist with securing training and reunion venues 40. Perform tasks related to publicity and retention (e.g., photocopying, arranging for printing the <i>d-up!</i> logo on promotional items)	43. Communication skills (e.g., able to take, compile, and summarize meeting notes; can use appropriate language when communicating with community partners and venue owners) 44. Experience with computers and word processing (e.g., can adequately use Microsoft Word, Internet Explorer, and e-mail)

Recruiting and retaining effective facilitators

Use the above table to help guide your search and establish criteria for your facilitators. A variety of approaches and resources can be used to find facilitators. The first place to look is within your own agency to see if you have staff members who are qualified and available to work on *d-up!*. For finding facilitators outside of your agency, try the following:

- ▶ Ask your advisory board for recommendations.
- ▶ Talk with staff members of other local HIV programs.
- ▶ Get recommendations from gatekeepers, key informants, and other leaders in the Black MSM population.
- ▶ Talk with previous intervention participants.
- ▶ Check the public health, social work, and education programs at local colleges.
- ▶ Look at advertisements in gay publications and on Web sites.

Once you have hired your facilitators, you will need to take the following steps to retain them during your intervention:

- ▶ Maintain good and ongoing communication.
- ▶ Involve facilitators in intervention planning and evaluation.
- ▶ Develop professional goals for each facilitator beyond *d-up!* and meet with him or her regularly.
- ▶ Provide training opportunities that address their professional goals.
- ▶ Communicate any intervention achievements and milestones.
- ▶ Have facilitators attend and present at HIV conferences.
- ▶ Make sure that they are not overworked and are comfortable with their given roles.

Training staff

All staff members, particularly program coordinators and facilitators, should receive training on *d-up!*. Use the following steps when training staff members who will be involved in implementing the intervention:

- ▶ Identify the training needs, such as group facilitation, of program coordinators, facilitators, and others who will be involved in the intervention implementation.
- ▶ At a minimum, ensure that facilitators are trained on how to facilitate *d-up!* opinion leader training sessions. (It is recommended that program coordinator and facilitators attend an official *d-up!* training. Training schedules for CDC-funded agencies are posted on www.effectiveinterventions.org.)

- ▶ Make sure that your implementation schedule accounts for the timing of available trainings.
- ▶ Monitor and communicate with staff members throughout the intervention's implementation to help identify any additional training or technical assistance needs.

COMMUNITY DISCOVERY

Part I

During the pre-implementation phase (and even when you are deciding if *d-up!* will work in your area), you will need to conduct some community discovery work. Community discovery (also known as formative evaluation) is a process where you attempt to learn more about your potential target population of Black MSM and community. Conducting community discovery as a part of the pre-implementation activities is *essential* in helping you define the specific way *d-up!* will be implemented in your area. Conducting such research will allow you to collect valuable data that you can use to identify and prioritize potential target populations of Black MSM. It also will help you gather information on who is at risk for HIV, who has the greatest need for the intervention, and whom you can afford to reach with your available funds. This information will inform your intervention planning process and the development of tailored *d-up!* materials and major implementation activities so they are appropriate for the Black MSM population you choose to target. The first part of your community discovery must be done early in the project to provide the basis for your plan to implement *d-up!*. After you develop your implementation plan, you can conduct additional discovery to collect valuable data that you can use to identify and prioritize potential social networks in the target population in your area.

Community discovery also will help you identify existing HIV prevention programs for Black MSM and potential resources, people, and interventions that can facilitate and support the implementation of *d-up!*. During the first part of your community discovery, you also may be able to identify key stakeholders or gatekeepers of your target population of Black MSM who can assist you with venue selection and the recruitment of opinion leaders. When conducting community discovery, you will need detailed information on the following:

- ▶ Targeted intervention population/social network and a significant community environment serving them (social venue)
- ▶ Friendship groups (units within social network)
- ▶ Respected and credible opinion leaders

Community discovery methods

You can use many methods to identify and assess your target population, social networks, friendship groups, opinion leaders, and behaviors. Certain methods work better for certain tasks. You may not be able to use all of the methods recommended or use them to their fullest extent; some methods can be very time consuming and use more resources to implement. You need to be practical and consider time and dollar limitations when conducting your community discovery. However, since the information you collect during this phase will be used to inform and guide your intervention activities, you do need to take some time to collect accurate information.

The community discovery methods and sources you can use include surveys; observations; gatekeeper/key informant interviews; focus groups; and existing needs and risk assessments. Basic data collection tools are included in appendices to this manual. The table below displays the key information areas and the possible methods you can use to collect the necessary information. A more detailed summary of the methods follows the table.

Possible Methods for Collecting Information

Information Area	Data Source/Method
Risk population	Review of existing agency and/or other epidemiological needs and behavioral risk data, reports, and assessments
Venue information	Onsite observations of venue Interviews with key informants, including venue owner, manager, and staff
Social networks and friendship groups	Survey Observations Key informant interviews
Opinion leaders	Survey Observations Key informant interviews Nominations
Logos/conversation starters	Focus groups Key informant interviews

Surveys. Ask gatekeepers and/or social network members to identify friendship groups and nominate the most respected and credible individuals within them. You can create a checklist for collecting information through interviews, or you can design and use a survey form that gatekeepers and members complete on their own. A checklist that you administer yourself is preferable, faster, and less expensive.

Observations. You may systematically observe and keep notes on the target population of Black MSM, including (1) its networks and friendship groups, (2) the number of social network members and friendship groups, (3) venues/locales where they gather, (4) key informants and gatekeepers, and (5) the most respected and credible individuals (opinion leaders) within the friendship groups. When conducting observations, staff members should only observe; that is, they should not interact too much with the people they are observing. At least two staff members should observe a venue or other social environment at the same time, so that they can more fully capture information and compare and discuss observation notes. You should conduct multiple observations of the same venue at various dates and times to make sure you observe all possible friendship groups.

Existing staff knowledge of the target population of Black MSM may be an important resource. Do not overlook the possibility that agency staff members already may have experience and relationships in the targeted community venues and can serve as observers at those venues.

You probably will need to conduct counts to estimate the size of your target population of Black MSM at venues. For example, if your plan is to target the patrons of a gym, you might ask the gym owner to estimate the number of patrons on the basis of door counts. You also could ask your own project staff to count patrons during certain time periods to estimate the numbers expected to be present at various times of the day. When counting, be sure that you do not count the same person twice in a venue, such as someone who steps outside to make a call and returns a few minutes later.

Key informant interviews. Persons who are actively involved in or serve the local Black MSM community, known as key informants or gatekeepers, can be interviewed to gain information on potential venues, friendship groups, and opinion leaders. Gatekeepers also can help guide your observations by indicating the contexts in which target population members can be accessed and observed. It may be efficient to hold a nomination meeting or meetings with key informants to identify opinion leaders. Ask gatekeepers and key informants not to tell people that they nominated them as opinion leaders. Not all nominees will fit the criteria, and you want to avoid creating expectations that will not be met.

Involve gatekeepers in your planning and implementation of *d-up!*. They can help with recruitment and provide other support for the intervention. They can help design and select a project logo and suggest conversation starters that would appeal to the target population. Gatekeepers also may be able to facilitate your intervention's acceptance and success in the community.

Focus groups. Conducting a focus group is a good way to gather detailed information on a specific, limited topic. Focus groups are most suitable for designing and testing intervention-related materials, like a logo or conversation starters. Focus groups also are good for interactive (between participants) data collection. Using focus groups to gather responses from each participant on several topics at once is not an effective way to use a focus group.

Existing data. You may be able to analyze data from existing needs and risk assessments. Your local Ryan White Planning Council and HIV Prevention Planning Group may be sources for these data. Often, these groups contract with private consulting firms and university-based researchers to conduct needs and risk assessments. Be creative in gaining access to these kinds of data. They will be most useful in determining your target population's risk behaviors and the social and cultural factors that influence them.

Program review panel

If CDC is funding all or part of your agency's implementation of *d-up!*, 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 Interventions. You must submit the intervention's sessions, content, information collection forms, opinion leader handouts, and any videos you plan to use for approval by a local program review panel (PRP). The PRP's assessment will be guided by the basic principles outlined for CDC funded agencies and found in 57 Federal Register 26742. If all of your funding for *d-up!* is coming from another source, check with that source for its policy on PRP approvals.

You should first find out what the local PRP's procedures are and work within them. Since *d-up!* contains a lot of material, the PRP may not want to review every page. Your PRP may want an abstract or executive summary of the intervention sessions to accompany the submission of all or part of the materials. If so, copy the section "How Does *d-up!* Work?" from this manual. Attaching this text to a copy of the intervention's research articles may be useful for PRP members who are interested in the scientific evidence supporting the intervention.

You should provide the PRP with a list of materials in the order in which they should be reviewed—starting with the marketing materials—so that the members of the PRP understand what *d-up!* is about and have a context for the other materials. Phased submission may be desirable, if allowed by your local PRP. Phased submission means requesting approval of the intervention concept and session content first and later requesting approval of the specific supporting materials, such as intervention logos, you plan to use. Do not use a phased approach if different PRP members may be reviewing the separate submissions.

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

Part II

Your agency can conduct the first part of the community discovery before the *d-up!* facilitators are trained. This initial community discovery work (Part I) provides a broad picture of the Black MSM in your area and identifies stakeholders and gatekeepers who can help you with the later, focused community discovery. Your facilitators will be prepared to discover and select social networks, social venues, friendship groups, and opinion leaders once they have received *d-up!* training.

Identify the target social networks

d-up! is designed to target Black MSM. However, you will need to narrow and more specifically describe your target population since *d-up!* will work best when it focuses on a specific Black MSM social network. Not all members of a broad population group, such as Black MSM, have the same behaviors, attitudes, and interests.

Your target social network for *d-up!* should be a group of people who can be identified in terms of their (1) close, personal relationships, (2) shared unwritten social rules driving their risk, and (3) a common venue that serves them in their everyday lives. You must simultaneously identify these three characteristics to define your intervention's target population. Your *d-up!* target social network must be one in which its members share everyday contexts, patterns of socializing, risk behaviors, opinions, beliefs, attitudes, and expectations for behavior. The target venue must be one where members of the target population gather as a stable and interactive social network, not one where the populations change or members do not interact socially, such as areas where people go to engage in anonymous sex. Since *d-up!* targets the socially shared risk-related norm among a network of connected friends and acquaintances (friendship groups), it is essential that you spend time identifying social networks. Later, you will do more research to learn about your target network's linked friendship groups.

Using community discovery methods, you will need to collect the following information on members of your potential target social networks:

- ▶ Their sexual risk behaviors
- ▶ Factors that influence these behaviors (e.g., knowledge, attitudes, perceptions, drug use)
- ▶ Demographic information (e.g., age, ethnicity)
- ▶ Their interests, activities, and venues where they hang out

You also will need to estimate the number of Black MSM in this social network.

Once you have this information, you will begin to identify a specific social network of Black MSM you can target.

Identify and access the target venues

To collect more information about potential target social networks, such as their size, you will need to identify and gain access to locations or venues where members of the network gather and socialize. After you select a network to target, you will need to return to their venues to identify friendship groups and opinion leaders. Later, you will use these venues as places to recruit opinion leaders. These venues also may serve as locations where opinion leaders carry out some of their risk reduction conversations.

A target venue for *d-up!* is a place where members of the target network socialize extensively. Potential venues are locations where members of your target population meet, gather as friends, develop friendship groups, and converse with each other on an ongoing basis. Remember that transient locations (e.g., bus stations, street corners, housing facilities, public sex venues) characterized by nonverbal interaction are not good venues. Virtual spaces, like Internet chat rooms or social Web sites, are NOT good venues because you cannot estimate the size of their social networks, determine the number of opinion leaders to recruit, or monitor outcomes.

Once you have identified the venues where potential target networks gather, you will need to gain access to them. You will need to identify and talk to the owner, manager, or leader of the venue or establishment, who then becomes one of your gatekeepers. General strategies for enlisting the support of gatekeepers are found under “Enlist Community Support” later in this section. The following specific strategies can be used for enlisting venue owners and managers:

- ▶ Whenever possible, arrange a face-to-face meeting with the venue owner and/or manager. Invite them to lunch, if possible. This will give you a chance to discuss the intervention in some detail and with little disruption.
- ▶ Describe the *d-up!* intervention you are planning to implement.
- ▶ Include the following benefits to the community and the venue as selling points:
 - The intervention will reduce risk and HIV infection within the local Black MSM community.
 - The intervention will generate community involvement and empowerment.
 - The intervention will create goodwill for the venue (patrons will see the venue making an investment in the community).
 - The intervention will create familiarity with the venue for return business.

- ▶ Be explicit regarding what you are asking of the venue owner, manager, and staff. Honesty and clear communication are very important to enlist the cooperation of owners and staff. Generally, you want to be able to do the following:
 - Conduct observations to identify social networks, friendship groups, and opinion leaders.
 - Enlist the aid of staff to identify and/or recruit opinion leaders.
 - Recruit opinion leaders.
 - Possibly display conversation starter logos on the property.
 - Possibly use the venue as a meeting and/or training space.

Using altruism and an opportunity to give back to the community as incentives work well when enlisting the aid of many owners. However, some owners are not part of the community and will respond better to other incentives. Previous implementation of interventions similar to *d-up!* found that conducting opinion leader training sessions during a venue's off hours actually increased its business. Opinion leaders who participated in the training stayed to socialize when the venue officially opened.

- ▶ Acknowledge issues that are often important to venue owners. Assure them of the following:
 - Your intervention will not disrupt business or cost them money.
 - The presence of *d-up!* does not imply that their venue is a site of high-risk behaviors.
 - They can decide to stop participating at any time during the intervention.

At the end of your meeting, be sure to give the owner your contact information in case he or she has any questions.

Select the target social network

Once you have identified several Black MSM social networks, you will need to select those that your agency will target. Your agency and *d-up!* staff members may be better prepared to serve one type of network than another. Staff members also may be more knowledgeable and comfortable with a particular network, and one network may be better suited to your agency.

You should consider the following questions when selecting your target social network:

- ▶ Which social networks' members are most at risk?
- ▶ Which social networks' members are not likely to have access to HIV prevention services?
- ▶ Which social networks would be most open to an intervention like *d-up!*?
- ▶ Which social networks could your agency readily reach?
- ▶ Which social networks gather at venues your agency can access?
- ▶ Which social networks could your agency target with its available resources?

To answer this last question, you will need to review the approximate sizes you determined for the potential target networks and calculate the number of opinion leaders needed for each network. Remember that you must train 15% of each friendship group in your target social network to be opinion leaders for *d-up!*. That number of opinion leaders will dictate the maximum network size you can manage and the number of people you can impact. Use the *d-up!* Cost Estimate Worksheet in Section 4, "Is *d-up!* Right for Your Agency?" to estimate the number of opinion leaders you can afford to support and the corresponding size of the social network you can afford to target. *d-up!* will not necessarily work well in a very small network (i.e., less than 100 members). Targeting a very large network may require more resources and time than you can spend, and if you are not able to train 15% of its members, *d-up!* will not succeed in changing behavior. As a rule, your target network should be somewhere between 100 and 1,000 Black MSM.

At least half of your trained opinion leaders should be Black MSM.

Once you have selected a target network, you can conduct further research to identify the venues, friendship groups, and opinion leaders within the network. Before or, at least, while you do this research, you should seek community support and buy-in to make the intervention successful.

Enlist community support

As previously mentioned, community support plays a critical role in this intervention. You will want to obtain the support of Black MSM gatekeepers and leaders, which may include venue owners, managers, and other key staff. Such people can help provide you with valuable information about networks, venues, behaviors, and risk factors related to Black MSM. They also can help promote your intervention and identify potential opinion leaders to participate in your *d-up!* intervention.

To identify gatekeepers and key leaders, you should create a list of organizations that provide relevant services to and have strong ties with the local Black MSM community and that would have a stake in the successful implementation of an intervention for Black MSM. Staff members and the leadership of these organizations may be good gatekeepers or, at least, can help you identify other gatekeepers. To identify possible gatekeepers, you also can conduct community observations at venues and events where Black MSM gather.

Once you have identified potential gatekeepers, meet with them to discuss implementation plans for *d-up!* and their possible roles. You and the gatekeepers must determine their level of involvement in the intervention promotion, planning, and implementation. For example, they may provide you with names of other gatekeepers one time, serve as an ongoing referral source, or serve on an intervention advisory board that meets once a month to provide support and guidance for *d-up!*.

Select and access target social venues

Recruiting venues. Once you select a recruiting venue and secure permission to access the venue, arrange with the owner/manager to have a few minutes with the staff members to describe the intervention. Venue staff members can be of immense help in recruiting opinion leaders, since they can do the following:

- ▶ Nominate opinion leaders.
- ▶ Interact in a friendly manner with agency recruitment staff, which can eliminate some of the distrust of outsiders.
- ▶ Tell patrons more about the intervention and explain how to enroll.
- ▶ Keep flyers, brochures, and posters available for patrons to look at and read.
- ▶ Occasionally act as contacts for patrons who are difficult to reach.

Training venues. At this point, you will need to identify a venue where you can conduct the opinion leader training. Characteristics of an appropriate training venue include the following:

- ▶ It has enough space to hold two trainings of two groups of opinion leaders, with 10 to 12 people in each. It has enough space to conduct the two trainings at the same time without one training group disturbing the other (i.e., two separate rooms).
- ▶ Opinion leaders will feel comfortable going to the venue. Sometimes, people may not be comfortable going to training at an HIV agency because they do not want to be associated with the disease. You may need to find a more neutral venue.
- ▶ Opinion leaders can easily travel to the venue. It should be in a convenient location that is accessible by public transportation.
- ▶ It is available during hours convenient to the opinion leaders (i.e., after 5 p.m.).
- ▶ It is affordable.

Identifying friendship groups within the targeted social network

Understanding social networks, friendship groups, and opinion leaders. As stated above, all members of a social network do not necessarily interact with all other members but, rather, belong to and socialize with smaller groups of friends and acquaintances, known as friendship groups. For example, say your targeted social network is Black MSM who go to a particular club. The Black MSM in this network share a common interest and are connected by the fact that they go to this club. However, although they go to this club, not every single club attendee hangs out with, talks to, or even knows every other attendee. Usually when people go to a club or bar, they go there to hang out and interact with their group of friends (i.e., a friendship group). Members of these groups share similar interests or simply have been hanging out with each other for some time. Members of friendship groups are closer to each other than they are with other club attendees. Also, each group will have its own well-liked and respected members who could serve as opinion leaders for *d-up!*.

Note: Just as each social network consists of smaller linked friendship groups, your target network is just one social network among many in the local Black MSM population. Not all Black MSM will go a certain club. You will need to target each social network separately in order to reach more Black MSM. But remember, *d-up!* works better when you just focus on one network at a time.

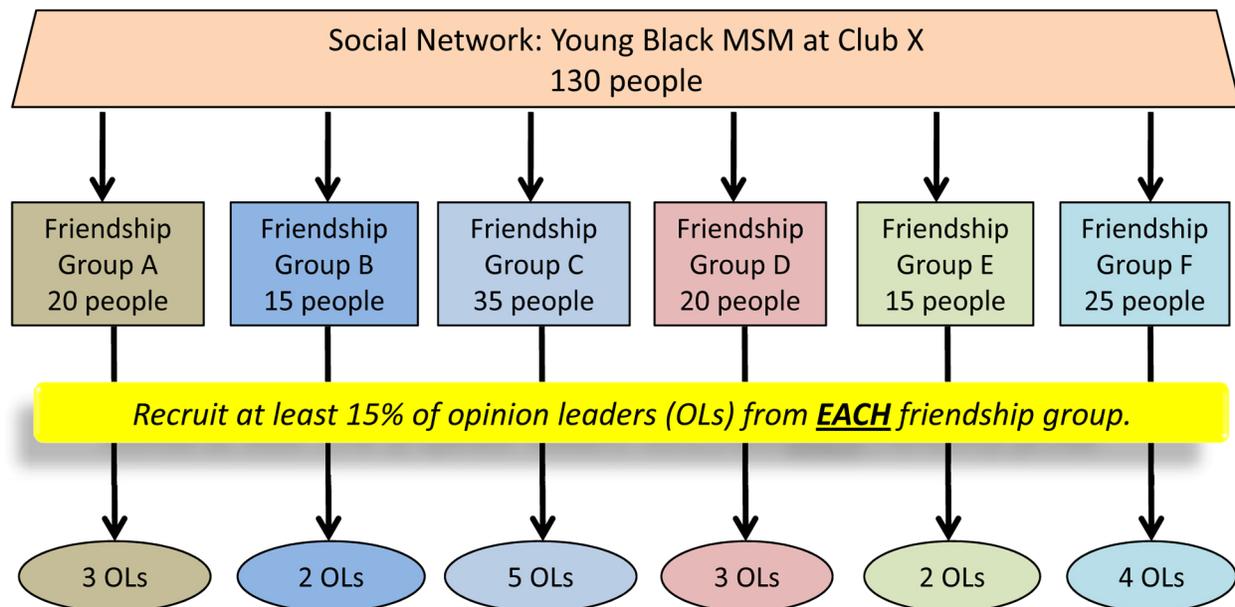
For *d-up!* to be effective, you need to identify, recruit, and train at least 15% of the members of **each** friendship group, and these members must be the groups' opinion leaders. As predicted by diffusion of innovation theory, *d-up!* is effective when opinion leaders have risk reduction conversations with their friends and acquaintances. Since the

opinion leader is someone whom the friendship group admires, respects, and trusts, the opinion leader is a trendsetter whom the rest of the group tends to follow. *d-up!* will not be effective if opinion leaders have conversations with any random stranger who really has no reason to listen to the opinion leader or care about what the opinion leader thinks. Also, just because someone is an opinion leader in the friendship group, it does not mean that he or she is an opinion leader of other friendship groups. A person who has influence and is well liked in one friendship group may not be influential and well liked within another friendship group. People in particular groups may actually detest someone who is very well liked within another friendship group. Therefore, opinion leaders are specific and relative to the friends around them.

It is important that you spend time identifying friendship groups (and their opinion leaders) to ensure that you ultimately recruit at least 15% of the members of each friendship group. It is not sufficient to recruit 15% of opinion leaders from the entire social network since you may not recruit any or enough opinion leaders from some friendship groups.

The figure below shows an example diagram of a social network, its friendship groups, and the number of opinion leaders who need to be recruited. The top box represents the target social network of 130 Black MSM. After conducting observations and further research, you identify six distinct friendship groups, consisting of anywhere from 15 to 35 members. The bottom row of circles shows the number (15%) of opinion leaders you will need to train from each friendship group.

d-up! Flowchart



It is also important to mention that many people are members of more than one friendship group and that some friendship groups overlap and interact with other groups. Likewise, an opinion leader can be a member of more than one friendship group. If you recruit a person who is an opinion leader of two distinct friendship groups, you will need to ask the opinion leader to choose or assign him or her to have risk reduction conversations with members from only one of the friendship groups.

Opinion leaders are those who lead opinions within their friendship group. This is not the same thing as being the most popular person overall. The most popular person may be the most fun to be around, but not necessarily credible with every friendship group member or within every friendship group in the social network.

How to identify friendship groups and opinion leaders. Once you have gained access to a venue frequented by your selected network, you will need to spend some time conducting research to identify friendship groups and opinion leaders. To recruit opinion leaders for *d-up!*, you need to take five basic steps:

- ▶ **Step 1.** Observe and identify possible friendship groups in the venue.
- ▶ **Step 2.** Evaluate each group to determine if it is a true friendship group.
- ▶ **Step 3.** After you have identified the friendship groups, identify one of the most influential persons in each of the groups.
- ▶ **Step 4.** Screen the person to determine if he or she is a leader or influential person in the friendship group.
- ▶ **Step 5.** After that person's position in the group has been verified, provide that person with information about the project and your contact information.

Steps 1 through 4 are done during the pre-implementation phase. Steps 4 and 5 are done in the implementation phase.

Step 1: Identify possible friendship groups. To collect information on friendship groups, you will conduct a series of observations at the venue. You should have two or three staff members conduct these observations. To identify all potential friendship groups, you should conduct several observations of the venue at various times and days during the week. Each friendship group will have a time when its members like to go to the venue. For example, some may like to go to a bar earlier in the evening, whereas others only show up at the end of the night. A particular theme night or weekly event may attract certain friendship groups.

Staff members should adhere to the following rules when conducting observations:

- ▶ Although it would be ideal to take notes when conducting observations, patrons may be put off by someone observing them. Staff members will need to be subtle about recording observations or simply write them down immediately after leaving the venue.
- ▶ To the greatest extent possible, staff interactions within the target venue should not disrupt the normal flow of activities.
- ▶ Staff members should blend in with the venue crowd. This will entail proper dress, conduct, and nonjudgmental behaviors and attitudes (both verbalized and nonverbalized).
- ▶ Staff members should limit the use of any substances that would alter their ability to make the necessary judgments and evaluations. They are at the venue to work.

Staff members should look for several criteria when observing groups of venue attendees. The following questions can be used to help determine whether the group is a friendship group:

- ▶ Do the members bond?
- ▶ Is this a stable group? Are you seeing the same collection of people hanging out at each observation?
- ▶ Do the members hang out together all night as a group?
- ▶ Do the members interact with each other?
- ▶ Do they talk to each other often?
- ▶ Are they usually doing the same kinds of activities?

If the answer to most of these questions is yes, then you have most likely identified a friendship group. To document the possible friendship groups you identified, collect the same kind of information you gathered when you were identifying potential target social networks. You need enough information to describe and differentiate one friendship group from another. Such information includes the following:

- ▶ **Characteristics.** Age, ethnicity, styles of clothing, educational level, and members of the target population
- ▶ **Behaviors.** What does the group typically like to do when they are at the venue? Are they usually dancing? Playing basketball? Sitting at a table?
- ▶ **Size.** How many people are members of this group?
- ▶ **Logistics.** When do members of this group usually hang out at the venue? What times and days of the week do they come to the venue?
- ▶ **Leaders.** Which people stand out the most in the group? Who seems to be more of a leader? Whom do group members seek out or defer to?
- ▶ **Uniqueness.** What makes this group different from other friendship groups? What is the common element that all members share that is unique to this group?

You can record this information in a community observation guide.

You also can collect information on friendship groups (and their opinion leaders) from venue staff members and owners. Since they spend a lot of time at the venue, they will have a good feel for the different friendship groups that come to their establishment.

Step 2: Evaluate the friendship groups. Once information on a possible friendship group has been collected and organized, *d-up!* staff members will need to discuss and decide if it truly is a distinct friendship group. Once everyone agrees that what you observed is indeed a distinct friendship group, move to the next step of identifying that group’s opinion leaders. If consensus cannot be reached, discuss other possible friendship groups that were observed. Continue until you are satisfied that you have identified all friendship groups that frequent the target venue. Since all venue attendees may not be Black MSM, review the descriptions in your community observation guide to verify which groups contain members of your target population.

Step 3: Identify possible opinion leaders. You can use several different approaches to identify opinion leaders, including observations and referrals. Remember that you will need to identify and recruit at least 15% of each friendship group to be opinion leaders. As you identify opinion leaders, you will need to track which friendship groups they represent.

Observations. While you conduct observations to identify friendship groups, you also can collect information on those groups’ possible opinion leaders. Identifying information on the opinion leaders can be collected in your community observation guide. Staff members should follow the same observation rules mentioned previously.

At least 50% of your opinion leaders should be Black MSM.

Opinion leaders are respected, credible, trustworthy, listened to, empathetic to friends, and self-confident. They are trusted and well-liked among their groups of friends. They can be either male or female, and not all opinion leaders will necessarily be Black MSM. Opinion leaders are the people who are greeted most often, who greet others the most, and who are sought out for advice by their friends. Some can be observed “holding court”—sitting in their favorite spot and being approached by a series of friends for one-on-one conversations. Staff should look for several criteria when identifying opinion leaders. The following questions can be used to help identify opinion leaders.

- ▶ Is this person the center of attention?
- ▶ Is this person a member of a friendship group?
- ▶ Does this person communicate—verbally or nonverbally—with others in the group?
- ▶ Do others appear to listen to this person?
- ▶ Does this person suggest new activities (e.g., getting a drink at the bar, changing locations in the bar, dancing to a particular song)?
- ▶ Do others in the group follow this person’s suggestions?
- ▶ Do others in the group get excited when they see this person?
- ▶ Does this person seem to talk to most people in the group?

If the answer to most of these questions is yes, then you have most likely identified an opinion leader.

Referrals. An easy way to identify opinion leaders is to simply ask members of the target social network whom they trust and would go to for advice.

Another method for identifying opinion leaders is to ask for nominations from people who are knowledgeable about your target network. These key informants may be venue staff, owners, community leaders, or others who are familiar with the Black MSM social network you are targeting. They can nominate people who they think are opinion leaders. You can meet with the informants individually or hold a group nomination meeting. Regardless of how you decide to collect the information, make sure you cover the following points:

- ▶ Explain that because they know the social network, they are in a position to identify the opinion leaders.
- ▶ Ask them to think carefully about the whole social network. Explain the characteristics of opinion leaders:
 - They are trusted and well liked among their groups of friends.
 - They can be either male or female. Not all opinion leaders will necessarily be Black MSM.
 - They are the people who are most often greeted, who greet others the most, and who are sought out for advice by their friends.
- ▶ Explain that a person is most likely an opinion leader if the following points describe him/her:
 - He/she is the center of attention.
 - He/she communicates—verbally or nonverbally—with others.
 - Others appear to listen to this person.
 - He/she suggests new activities (e.g., ordering something to eat, dancing to a particular song, starting a pickup game of basketball).
 - Others follow this person’s suggestions.
 - Others get excited when they see this person.
 - He/she seems to talk to most people he/she is with.
- ▶ Mention that no one is a leader everywhere in a social network. Therefore, ask for nominations for leaders from groups having different characteristics and behaviors (e.g., younger patrons, dancers, drinkers). You can use these traits to link nominees to the friendship groups that you identified.

- Keep your nominations confidential. Do not let a person know that he or she has been nominated as a potential leader. He/she may not make the final cut and may feel hurt for not being recruited.

You can ask key informants to suggest names of people to you during the meeting and collect information on the Nomination Meeting Activity Log. You also can ask them to observe and record their nominations on the Opinion Leader Nomination Form. You will need to follow up with the key informants to see if they have any questions and to collect the forms. The exact number of opinion leaders you ask them to nominate will depend on the size of your target network. If you have multiple people providing nominations, you can quickly identify potential opinion leaders when their names appear on multiple lists.

Some members of your target social network may not be identified as opinion leaders, yet they may have heard about *d-up!* and are committed to the effort to reduce the spread of HIV among Black MSM. Almost no one should be denied the opportunity to help their peers and himself/herself reduce his/her risk for HIV infection. If a person wants to be trained as an opinion leader, it is probably a good idea to go ahead and allow that person to train and serve as an opinion leader. If you believe this person will be disruptive during training or just would be a terrible opinion leader, you could find some other way for the person to be involved with your intervention, such as assisting with setting up an event or helping out at your agency.

Remember that you must be able to link a nominated opinion leader to a friendship group.

Step 4: Screen possible opinion leaders. Once nominations, referrals, and volunteers for possible opinion leaders have been received and organized, *d-up!* staff will need to find and observe the possible opinion leaders and apply the selection criteria. The staff will determine whether these persons are indeed members of the target social network and friendship groups. Remember to collect the information necessary to complete your community observation guide. The staff will review all of the identification forms, discuss the information, and determine which persons are truly opinion leaders and in which friendship groups they are an opinion leader. This information is critical for reaching the necessary 15% from each group and preventing over- or under recruitment from any group.

Advertising. You should not use advertising to recruit opinion leaders to prevent self selection of individuals who may not be appropriate to deliver the intervention (e.g., individuals who do not meet the criteria for an opinion leader)

Step 5: Recruit opinion leaders. Once consensus has been reached and everyone agrees on who is an opinion leader, you will have a collection of people to approach for recruitment during the implementation phase.

Designing logos and devices for starting conversations

When you implement *d-up!*, you will need to use a logo, symbol, and/or other conversation starters to help opinion leaders initiate risk reduction conversations with their friends and acquaintances. These conversation starters can be in the form of logos or slogans and can be placed on T-shirts, posters, buttons, dog tags, or other items. They should have an interesting design that raises the curiosity of friends to ask the opinion leader what it means. The primary purpose of the logo or conversation starter is to simply make it easier for opinion leaders to initiate risk reduction conversations.

The purpose of the logo is not to market the intervention or safer sex. Therefore, materials cannot have the *d-up!* logo and the agency's or other logos together. In *d-up!*, risk reduction is promoted actively and personally by opinion leaders, not passively and impersonally by pictures, advertisements, symbols, or stories.

You will need something to serve as a spark to the safer sex endorsement conversations. It will be up to you to determine if these images and items will work in your community or if you will need to create your own. Note that you do not necessarily have to call your intervention "*d-up!*"; you may want to choose another name to better suit your target population. You will need to conduct strong formative work to develop and test the conversation starters.

Steps to develop the logo or conversation starters. A good logo or conversation starter cannot be developed without input from the target social network. Although your staff may like a particular image, logo, or slogan, members of your target social network may not. Your logo or conversation starter should do the following:

1. Spark interest and generate questions
2. Have a positive (not negative) appeal
3. Be something your opinion leaders will be proud of and proud to display or wear
4. Be placed on items your opinion leaders will be glad to display or wear
5. Relate to the safer sex norm or indicate your primary risk reduction message
6. Only promote the *d-up!* intervention, not your agency

When you are choosing or developing a conversation starter, you must consider how much time, money, and resources you have for development. You do not need to enlist the services of a marketing firm or commercial artists. You can, with the help of local volunteers, develop a simple logo or conversation starter that will be effective in your target social network. Regardless of what you use, it is essential that you test it with members of your target network first.

Follow the steps below when developing your conversation starter:

1. Assemble a group of staff members and/or community volunteers to develop the conversation starter.
2. Educate the group about the specific focus of your *d-up!* intervention and the characteristics of your target social network, using your community discovery data.
3. Educate the group about the purpose of the conversation starter (i.e., to help spark the risk reduction conversations).
4. Develop ideas, items, and logo placements on items for testing.
5. Test the various ideas and items with members of your target network. A focus group is the best method for testing, but other community discovery methods also work. You need to see if the conversation starter is accepted by your target population and interesting enough to spark conversations. You also need to test the logo materials and conversation starter with your venue owner(s) to make sure they find them acceptable.
6. Refine the conversation starter on the basis of the tests results.
7. Test the refined conversation starter.
8. Refine and finalize the conversation starter.

Your opinion leaders will wear or display the conversation starter after you have delivered Session 3 of the opinion leader training. You also can place logos and other intervention materials in your target venues to help generate risk reduction conversations and to help you recruit additional opinion leaders.

In order to effectively market your intervention, you should not change your intervention logo once you have begun implementing *d-up!*. However, as you implement *d-up!*, you will find that you need to create new or other versions of your conversation starters to maintain interest. Also, if you decide to target new social networks after you have been implementing *d-up!* for a long time, you will need to create a new conversation starter for that network.

Remember that the logo and conversation starter are part of the materials that CDC-funded grantees submit to their program review panel.

REFERENCES

- Hughes, D. (2003). Correlates of African American and Latino parents' messages to children about ethnicity and race: A comparative study of racial socialization. *American Journal of Community Psychology, 31*(1/2), 15–33.
- Jones, K. T., Gray, P., Whiteside, Y. O., Wang, T., Bost, D., Dunbar, E., et al. (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.
- Kelly, J. A., Murphy, D. A., Sikkema, K. J., McAuliffe, R. L., Roffman, R. A., Solomon, L. J., et al. (1997). Randomised, controlled, community-level HIV-prevention intervention for sexual-risk behaviour among homosexual men in US cities. Community HIV Prevention Research Collaborative. *Lancet, 350*(9090), 1500–1505.
- Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: Free Press.



APPENDIX A

Additional Marketing Materials

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
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.

PROBLEM STATEMENT FOR INTERVENTION

Black men who have sex with men (MSM) face several kinds of discrimination, including homophobia, racism, and rejection by their families. This discrimination and rejection, which can include a loss of support from family and faith institutions, create different levels of stress, distress, and helplessness that impact these men’s sexual risk. The men in these networks are in need of skills to communicate about and support one another in safer practices. The social networks of Black MSM need greater emphasis on social norms that are supportive of safer practices.

<i>d-up! BEHAVIOR CHANGE LOGIC</i>			
Behavioral Determinants <i>Corresponds to risk or contextual factors</i>	Activities <i>To address behavioral determinants</i>	Outcomes <i>Expected changes as a result of activities targeting behavioral determinants</i>	
		Immediate	Intermediate
Social <u>norm</u> related to risk.	Influential, admired friends (opinion leaders), at 15% of each friendship group, clique, or “pocket” of the social network (or subculture) of Black MSM, endorse or promote the risk-related social norm to their Black MSM friends and acquaintances who most admire them.	The social network or subculture of Black MSM friends embraces the social norm related to the risk behavior.	Condom use behavior for sexual intercourse characterizes the social network of Black MSM.
Bias-based <u>attitudes</u> about race and sexuality.	Discuss experiences of bias, how these experiences relate to sexual risk, and skills for coping with racial and sexual bias.	<ul style="list-style-type: none"> • Increased skills for coping with bias • Decreased bias-based attitudes among the men in the social network. 	Increased behavioral skills for coping with bias that impacts sexual risk.

d-up! TRAINING OF THE OPINION LEADERS

Behavioral Determinants <i>Corresponds to risk or contextual factors</i>	Activities <i>To address behavioral determinants</i>	Outcomes <i>Expected changes as a result of activities targeting behavioral determinants</i>	
		Immediate	Intermediate
<u>Self-efficacy</u> , <u>attitudes</u> , <u>intention</u> , <u>knowledge</u> , and <u>norm</u> to communicate safer practices to friends.	<ul style="list-style-type: none"> • Brainstorm how experiences of bias impact safe sex practices. • Teach elements of effective communication. • Practice the communication. • Plan and make commitments to communicate about protecting one another and self. 	Increased self-efficacy, attitudes, intention, knowledge, and norm to communicate safer sex practices to Black MSM friends and acquaintances.	Increased communication about safety by the men in the targeted social network of Black MSM.



APPENDIX B

Additional Materials



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

Notice to Readers**CDC Statement on Study Results of Product Containing Nonoxynol-9**

During the XIII International AIDS Conference held in Durban, South Africa, July 9–14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (1). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted

Notices to Readers — Continued

diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, <http://www.cdc.gov/hiv>; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

1. van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9–14, 2000, Durban, South Africa.



MMWRTM

Morbidity and Mortality Weekly Report

Weekly

May 10, 2002 / Vol. 51 / No. 18

Nonoxynol-9 Spermicide Contraception Use — United States, 1999

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (1), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (2–4); one trial showed an increased risk (3). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (5,6), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title

X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%–18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%–5% of all women attending Title X clinics reported using N-9 contraceptives (other than condoms) as their primary method of contraception (Table 1). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9-lubricated (Table 2). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films

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Centers for Disease Control and Prevention

David W. Fleming, M.D.
Acting Director

Julie L. Gerberding, M.D.
Acting Deputy Director for Science and Public Health

Dixie E. Snider, Jr., M.D., M.P.H.
Associate Director for Science

Epidemiology Program Office

Stephen B. Thacker, M.D., M.Sc.
Director

Office of Scientific and Health Communications

John W. Ward, M.D.
Director
Editor, MMWR Series

David C. Johnson
Acting Managing Editor, MMWR (Weekly)

Jude C. Rutledge
Jeffrey D. Sokolow, M.A.
Writers/Editors, MMWR (Weekly)

Lynda G. Cupell
Malbea A. Heilman
Beverly J. Holland
Visual Information Specialists

Michele D. Renshaw
Erica R. Shaver
Information Technology Specialists

Division of Public Health Surveillance and Informatics

Notifiable Disease Morbidity and 122 Cities Mortality Data

Carol M. Knowles
Deborah A. Adams
Felicia J. Connor
Patsy A. Hall
Mechele A. Hester
Pearl C. Sharp

and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that N-9-containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

Reported by: *The Alan Guttmacher Institute, New York, New York. Office of Population Affairs, U.S. Dept of Health and Human Services, Bethesda, Maryland. A Duerr, MD, C Beck-Sague, MD, Div Reproductive Health, National Center Chronic Disease and Public Health Promotion; Div of HIV and AIDS Prevention, National Center HIV/AIDS, STDs, and TB Prevention; B Carlton-Tobill, EIS Officer, CDC.*

Editorial Note: The findings in this report indicate that in 1999, before the release of recent publications on N-9 and HIV/STDs (4,6,7), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9-lubricated; this is consistent with trends in condom purchases among the general public (8). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV infection and other STDs (7). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continue to be distributed provided the condoms have not passed their expiration date. The amount of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the studies in Africa and the use of N-9-lubricated condoms is preferable to using no condom at all. In the future, purchase of condoms lubricated with N-9 is not recommended because of their increased cost, shorter shelf life, association with urinary tract infections in young women, and lack of apparent benefit compared with other lubricated condoms (7).

Spermicidal gel is used in conjunction with diaphragms (1); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year (1).

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of

TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contraception, by Title X Family Planning Region — United States, 1999

Region*	No. of women served	Male condoms		N-9 products†	
		No.	(%)	No.	(%)
I	179,705	27,726	(15)	1,251	(1)
II	404,325	73,069	(18)	21,515	(5)
III	487,502	73,088	(15)	4,807	(1)
IV	1,011,126	93,011	(9)	29,630	(3)
V	522,312	61,756	(12)	2,489	(1)
VI	478,533	40,520	(8)	11,212	(2)
VII	238,971	15,949	(7)	1,386	(1)
VIII	133,735	15,131	(11)	4,885	(4)
IX	672,362	109,678	(17)	14,547	(2)
X	186,469	17,320	(9)	1,275	(2)
Total	4,315,040	527,248	(12)	92,997	(2)

* Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, Virgin Islands; Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee; Region V=Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin; Region VI=Arkansas, Louisiana, New Mexico, Oklahoma, Texas; Region VII=Iowa, Kansas, Missouri, Nebraska; Region VIII=Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming; Region IX=Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, Palau; Region X=Alaska, Idaho, Oregon, Washington.

† Primary method of contraception reported by these women was one of the following: spermicidal foam, cream, jelly (with and without diaphragm), film, or suppositories.

TABLE 2. Number of nonoxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/territories, 1999

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods					
		Condoms with N-9	Condoms without N-9	Gel	Vaginal			Jelly	Foam
					Film	Insert			
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841	2,400	
New York†	283,200	1,936,084	NA	0	73,788	NA	3,112	23,830	
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200	9,900	
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760	25,920	
Tennessee	111,223	2,865,160§	717,088	0	94,500	12,528	756	2,758	
Michigan	166,893	631,000	254,000	0	0	NA	1,000	1,200	
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200	0	
Oregon	57,099	151,900	276,000	345	25,764	2,074	272	3,007	

* Not available.

† 41 of 61 grantees responded.

§ Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.

49% of all pregnancies were unintended (9). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (1). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (2,7). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex

condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

References

1. Trussell J. Contraceptive efficacy. In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology: 17th Revised Edition*. New York, New York: Ardent Media, 1998.
2. Roddy R, Zekeng L, Ryan K, Tamoufe U, Weir S, Wong E. A controlled trial of nonoxynol-9-film to reduce male-to-female transmission of sexually transmitted diseases. *N Engl J Med* 1998;339:504–10.
3. Kreiss J, Ngugi E, Holmes K, et al. Efficacy of nonoxynol-9 contraceptive sponge use in preventing heterosexual acquisition of HIV in Nairobi prostitutes. *JAMA* 1992;268:477–82.
4. Van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9–14, 2000, Durban, South Africa.
5. Louw WC, Austin H, Alexander WJ, Stagno S, Cheeks J. A clinical trial of nonoxynol-9 for preventing gonococcal and chlamydial infections. *J Infect Dis* 1988;158:513–23.

6. Roddy RE, Zekeng L, Ryan KA, Tamoufe U, Tweedy KG. Effect of nonoxynol-9 gel on urogenital gonorrhea and chlamydial infection, a randomized control trial. *JAMA* 2002;287:1117-22.
 7. CDC. Sexually transmitted diseases treatment guidelines 2002. *MMWR* 2002;51(RR-6).
 8. Moran JS, Janes HR, Peterman TA, Stone KM. Increase in condom sales following AIDS education and publicity, United States. *Am J Public Health* 1990;80:607-8.
 9. Henshaw SK. Unintended pregnancy in the United States. *Fam Plann Perspect* 1998;30:24-9,46.
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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.



CONTENT OF AIDS-RELATED WRITTEN MATERIALS,
PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY



INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR
DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS

Interim Revisions June 1992

1. Basic Principles

Controlling the spread of HIV infection and AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can fully protect themselves from acquiring the virus. These methods include abstinence from the illegal use of IV drugs and from sexual intercourse except in a mutually monogamous relationship with an uninfected partner. For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages can be controversial. These principles are intended to provide guidance for the development and use of educational materials, and to require the establishment of Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

- a. Written materials (e.g., pamphlets, brochures, fliers), audio visual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.
2. Written materials, audiovisual materials, and pictorials should be reviewed by Program Review Panels consistent with the provisions of Section 2500 (b), (c), and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c), and (d), as follows:

"SEC. 2500. USE OF FUNDS.

(b) CONTENTS OF PROGRAMS. - All programs of education and information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such activities.

(c) LIMITATION. - None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.

(d) CONSTRUCTION. - Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to, or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene."

c. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

d. Messages provided to young people in schools and in other settings should be guided by the principles contained in "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (MMWR 1988;37 [suppl. no. S-2]).

2. Program Review Panel

- a. Each recipient will be required to establish or identify a Program Review Panel to review and approve all

written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization (s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or another CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:

- (1) Understand how HIV is and is not transmitted; and
 - (2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.
2. The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or procedure of the recipient organization or local governmental jurisdiction.
 3. Applicants for CDC assistance will be required to include in their applications the following:
 - (1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review panel, except as provided in subsection (d) below. In addition:
 - (a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either through representation on the panels or as consultants to the panels.
 - (b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a State or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.
 - (c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.
 - (d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.
 - (2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:
 - (a) Concurrence with this guidance and assurance that its provisions will be observed;
 - (b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.
 4. CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multi state), or statewide in scope, or that plan to distribute materials as described above to other organizations on a national, regional, or statewide basis, must establish a single Program Review Panel to fulfill this requirement. Such national/regional/State panels must include as a member an employee of a State or local health department, or an appropriate designated representative of such department, consistent with the provisions of Section 2.c.(1). Materials reviewed by such a single (national, regional, or state) Program Review Panel do not need to be reviewed locally unless such review is deemed appropriate by the local organization

planning to use or distribute the materials. Such national/regional/State organization must adopt a national/regional/statewide standard when applying Basic Principles 1.a. and 1.b.

5. When a cooperative agreement/grant is awarded, the recipient will:
 - (1) Convene the Program Review Panel and present for its assessment copies of written materials, pictorials, and audiovisuals proposed to be used;
 - (2) Provide for assessment by the Program Review Panel text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals which are under development;
 - (3) Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the Program Review Panel specifying the vote for approval or disapproval for each proposed item submitted to the panel; and
 - (4) Provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.