

Facilitator's Guide



A Small-Group Intervention for HIV/STD Prevention Among Black Gay Men



IMPORTANT INFORMATION FOR USERS

This HIV/STD prevention intervention is intended for use with persons who are at high risk for acquiring or transmitting HIV or sexually transmitted diseases (STDs), or both, and who are voluntarily participating in the intervention. The materials in this intervention package are not intended for general audiences.

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

Before you conduct this intervention in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved, the intervention package materials are to be used by trained facilitators who will implement the intervention.

ACKNOWLEDGMENTS

The Many Men, Many Voices (3MV) Facilitator's Guide was developed with funding from CDC. Dr. Hank Tomlinson of the Capacity Building Branch (CBB), Division of HIV/AIDS Prevention (DHAP), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), led the conceptualization, development, and distribution of this manual. Dr. David Whittier of the CBB also participated in its development. Significant contributions were made by Patricia Coury-Doniger of the Center for Health & Behavioral Training (CHBT); Gary English; and the staff at ICF Macro, an ICF International Company.

We thank Alvin Dawson and Ezekiel Goodwin for providing essential feedback and piloting the intervention materials. We also thank all of the men who participated in the pilot intervention. Finally, we wish to acknowledge the ICF Macro staff members who developed and produced this manual with the support of Dr. David Cotton, ICF Macro's HIV project director.

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PREPARING TO CONDUCT 3MV SESSIONS

FACILITATOR ROLES AND RESPONSIBILITIES

Many Men, Many Voices (3MV) is an intervention delivered by two culturally competent facilitators. It is recommended that at least one facilitator be a member of the target population and the other have experience with and be comfortable working with this population.

Facilitators are a critical part of this intervention and have various roles and responsibilities. The most important roles are to manage group processes and to conduct 3MV sessions with fidelity. The role of the 3MV facilitator is neither to teach nor preach, but rather to guide the participants through the intervention. The 3MV intervention is a process of increasing awareness, understanding, and self-discovery that can be described as the 3MV journey. While the 3MV intervention is designed to inform, educate, motivate, and encourage the personal growth of participants, it is not designed to be group therapy. Likewise, 3MV facilitators are not expected to act as therapists and should not consider themselves to be performing the role of a mental health professional.

The responsibilities of the 3MV facilitators include the following:

- ▶ Welcome participants
- ▶ Ensure all the session materials, handouts, prepared newsprints, and supplies are prepared before the start of each session
- ▶ Create a safe, engaging, and interactive environment in which participants are encouraged to participate and are supported in sharing personal information and experiences
- ▶ Establish and enforce the Ground Rules
- ▶ Deliver the intervention content with fidelity to the Facilitator's Guide
- ▶ Share personal knowledge and experiences as appropriate to enrich the intervention and to provide relevant examples and illustrations
- ▶ Build group cohesion and manage group process
- ▶ Respond appropriately to the emotional reactions and difficult behaviors of participants
- ▶ Ensure that all participants take part in the exercises and discussions

- ▶ Answer participants' questions accurately
- ▶ Manage time to ensure all intervention content is delivered
- ▶ Adhere to agency policies and procedures
- ▶ Balance the needs of the participants with the structure of the intervention
- ▶ Assist with adaptation, if needed

FACILITATOR'S NOTE

In 3MV, black refers to the racial/ethnic group of people who are of African descent living in the African diaspora (i.e., African Americans; Africans [e.g., Senegalese, Nigerian, Kenyan]; Afro-Caribbean/West Indian [e.g., Jamaican, Trinidadian, Haitian, Guyanese]; and black Latino or Hispanic [e.g., Dominican, Puerto Rican, Cuban]).

Training and Practice Sessions

3MV Training Series

All 3MV facilitators are required to attend a two-part training series sponsored by the Centers for Disease Control and Prevention (CDC). Facilitators must attend the 4-day Training of Facilitators (TOF), during which they are trained to deliver the intervention. The facilitators learn how to conduct the intervention by demonstrating each session's major exercises and receiving feedback from the trainers. More information on the 3MV TOF can be found at:

<http://www.effectiveinterventions.org>

Other Recommended Trainings

- ▶ **Group Facilitation Skills:** The 3MV series does not include training on group facilitation skills. Strong group facilitation skills are necessary to deliver the content, manage group dynamics, and build group cohesion. The content of 3MV is extremely personal and challenging and without strong facilitation skills, facilitators can lose control of the group dynamics and mismanage the content. A group facilitation course will teach facilitators how to manage the internal discomfort that can arise during the intervention and teach facilitators the proper method and timing for personal disclosure.
- ▶ **Bridging Theory and Practice:** Each 3MV exercise is designed to address factors that influence behavior change. Facilitators should have knowledge of these factors as they process each exercise. This course teaches the science of behavior change; behavioral determinants; and behavior change logic models.

- ▶ **STD Overview:** Many Men, Many Voices requires that facilitators have a strong knowledge of sexually transmitted diseases (STDs), including their signs and symptoms, modes of transmission, and treatment options.
- ▶ **HIV Overview:** This course teaches the basics of HIV transmission, including the STD-HIV interactions.

Course descriptions and a training calendar can be found on the National Network of STD/HIV Prevention Training Centers Web site:

<http://www.nnptc.org>

Practice Sessions

Facilitators should conduct practice sessions with agency staff or volunteers before conducting the sessions with participants. This practice session is a scheduled time when the facilitators hold a mock 3MV session to practice all the session's exercises, test the audio and/or visual equipment, and practice role-plays. Before the practice sessions, the facilitators should read each session, discuss the content with each other, get any questions about the content answered, and prepare all the materials. Conducting the practice sessions provides the facilitators with an opportunity to learn the material, review the prepared newsprints, and review the session handouts before delivering the session with participants. During the practice sessions, facilitators should also divide the responsibilities of delivering the content, using the equipment, and managing group dynamics. Often it is possible to have a coach (an experienced 3MV facilitator from another agency or a 3MV trainer) observe the practice sessions and give feedback to the facilitators.

Qualities of Effective 3MV Facilitators

The skills and methods of the facilitators in delivering the sessions are as equally important as the content of the curriculum. The enthusiasm that facilitators bring and the way they relate to the participants will be critical to the success of the program. Listed below are some qualities of effective 3MV facilitators.

As facilitators guide groups, they

- ▶ provide a supportive learning environment,
- ▶ acknowledge and respect diverse backgrounds,
- ▶ value what participants bring to the group,
- ▶ handle sensitive issues and conflicts,
- ▶ are nonjudgmental,
- ▶ know the influence of their own values and attitudes,

- ▶ respect confidentiality,
- ▶ are patient and authentic,
- ▶ model the attitudes and skills addressed in each session,
- ▶ follow session exercises as outlined in the manual and encourage participants to stay as close as possible to the topics and remain on task with session exercises,
- ▶ help the group move along so that exercises can be completed,
- ▶ make appropriate adjustment to exercises and time.

As skilled communicators, facilitators

- ▶ facilitate discussion,
- ▶ observe and listen,
- ▶ are approachable,
- ▶ speak clearly,
- ▶ use words that are easily understood by participants,
- ▶ maintain eye contact.

Facilitators display warmth as they

- ▶ help participants to feel welcome and accepted,
- ▶ establish positive relationships with participants,
- ▶ speak well of everyone,
- ▶ like and trust participants rather than fear them,
- ▶ build trust with participants,
- ▶ share and disclose personal information appropriately.

Well-organized facilitators

- ▶ prepare in advance,
- ▶ have objectives and goals clearly outlined for each session,

- ▶ have information well categorized so they can retrieve it in response to questions,
- ▶ acknowledge what they do not know (i.e., the facilitator is not always the expert),
- ▶ use time effectively,
- ▶ have working knowledge of multimedia equipment (e.g., LCD projector, laptop computer),
- ▶ follow up on identified needs.

Facilitators are

- ▶ enthusiastic about the content of the program,
- ▶ enthusiastic about people,
- ▶ enthusiastic about the process.

Facilitators have the ability to conduct role-plays that will

- ▶ model skills taught,
- ▶ allow participants to practice those skills.

GENERAL FACILITATION TIPS

Preparing for Each Session

The following is a checklist for the basic preparation activities that should be conducted before each session.

Facilitator's Checklist to Prepare for Each Session	
Review all of the Facilitator's Guide, handouts, and other session materials before delivering the intervention.	<input type="checkbox"/>
Review behavioral determinants to be addressed in the session.	<input type="checkbox"/>
Review all activities and materials and, if needed, practice facilitating activities within the session as well as transitioning between the assigned sections and exercises.	<input type="checkbox"/>
Meet with cofacilitator to assign roles and responsibilities.	<input type="checkbox"/>
Prepare all the newsprints.	<input type="checkbox"/>
Set up the easel in plain view.	<input type="checkbox"/>
Have extra markers and newsprints ready.	<input type="checkbox"/>
Photocopy all of the handouts.	<input type="checkbox"/>
Test all of the electronic equipment (including DVD remotes and remote presenters) and practice using the equipment.	<input type="checkbox"/>
Set the room up so participants can be comfortably seated and see the prepared newsprints and other audiovisual equipment.	<input type="checkbox"/>
Make the room culturally appropriate and appealing. Put pictures of black gay men, such as Langston Hughes, James Baldwin, E. Lynn Harris, John Amaechi, and Keith Boykin, around the room.	<input type="checkbox"/>
Call participants to encourage them to attend and remind them of the time and location of the session. Problem solve barriers to attending.	<input type="checkbox"/>

Using the 3MV Facilitator's Guide

Each session of the Facilitator's Guide is formatted as follows:

The session introduction pages contain the following information:

- ▶ Purpose of the Session—Explains the goal of each session
- ▶ Session Objectives—Lists the objectives of each session
- ▶ Facilitator Tips—General delivery and facilitation tips for delivering that session
- ▶ Session At-a-Glance—Lists the exercises' purposes, times, behavioral determinants, and materials needed
- ▶ Materials Checklist—Lists newsprints, session handouts, facilitator's materials, and other information that must be prepared in advance
- ▶ Session Materials—Contains the materials necessary to facilitate the session and also has supplemental reading on various topics to enhance the facilitators' knowledge

The session introduction is followed by the welcome and preview of the session. At the beginning of each exercise is a box that includes the exercise's purpose, estimated time, materials needed, and specific facilitation notes or important tips for the exercise. The specific procedures (instructions) to facilitate the exercise begin after the box. It is important for facilitators to follow the instructions as they are written. Each session has a session summary designed to check in with participants, answer any remaining questions, and preview the next session.

This manual also includes a Technical Assistance Guide that provides further information about 3MV and facilitating its sessions. It will be important to review the Technical Assistance Guide before you start implementing 3MV.

Understanding the Purpose of 3MV (Making the Connections)

The following tables describe the major themes of each session, the purpose of their exercises, how the exercises connect to each other, and the primary behavioral determinants addressed by the session. Facilitators should review these tables to understand the internal logic of 3MV and how the sessions build upon each other.

Session and Exercise Connections: Session 1

Primary Focus Areas:

- ▶ Dual identity
- ▶ Unique set of external and internal factors that influence risk behaviors of black gay men

Session	Exercises	Purposes and Connections
1.1	Welcome and Introductions	Welcome participants to the intervention and Session 1 and preview what will be covered in Session 1.
1.2	Why We Do the Things We Do	Participants learn about the external and internal factors that influence behavior and behavior change for all people and recognize that behavior change is challenging for everyone.
1.3	Dual Identity	Participants recognize the set of unique factors that influence black gay men, including the concept of dual identity and the social influences of racism and homophobia. Also, participants list the behaviors of black gay men that can lead to HIV/STD risk.
1.4	Making the Connection	Participants are led through a summary of Exercises 1.2 and 1.3 to recognize that out of all the factors that influence everyone's behaviors, there is a unique subset of those factors that particularly influences black gay men. Participants are further guided to recognize that the external factors of the social influence of homophobia and racism can be internalized and negatively affect the internal factors of attitudes, beliefs, self-standards, values, and identities of black gay men. As a result of homophobia and racism, many black gay men have experienced rejection from their families, communities, and the gay community. This leads to social isolation and a sense of dual identity where black gay men don't feel they fit into the black community or the gay community. They may not have a community in which they feel safe, accepted, and socially supported. Dual identity can negatively impact identity, self-standards, and values and lead to increased STD/HIV-related risk behaviors and to the disparities in HIV and other STDs rates among black gay men.
1.5	Session Summary	Participants provide feedback on the session, and facilitators preview Session 2.
Primary Behavioral Determinant		
Negative attitudes, beliefs, values, low self-standards, and an identity that stems from or relates to discrimination (e.g., racism and homophobia) and cultural and religious norms		

Session and Exercise Connections: Session 2

Primary Focus Areas:

- ▶ STDs
- ▶ STD-HIV interactions
- ▶ Factors that determine risk for transmission and prevention behaviors

Session	Exercises	Purposes and Connections
2.1	Session Preview	Welcome participants to Session 2, recap what was covered in the previous session, and provide an overview of what will be covered in Session 2.
2.2	Tops and Bottoms: Roles and Risks	Participants begin a discussion of the sexual relationship dynamics of Tops and Bottoms (which is more fully explored in Session 5) and how these sexual relationship roles relate to specific sexual behaviors and STD/HIV risks for black gay men.
2.3	What Do You know About STDs and HIV for Black Gay Men?	Participants learn more about the STD/HIV disparities for black gay men; common STDs; and health-promotion behaviors recommended for black gay men related to STD prevention. These behaviors become some of the options for prevention in Exercise 3.2.
2.4	How Do You Get an STD or HIV?	Participants learn that different kinds of sexual behaviors create different levels of risk for getting or transmitting HIV and STDs. Participants understand why the risk for getting HIV from oral sex is low but risk for getting some STDs from oral sex is high (i.e., syphilis). This exercise builds on information from Exercise 2.3.
2.5	Sex in the City	Participants recognize how having an STD increases the chances of getting HIV or passing HIV to a sexual partner and how this interaction affects STD/HIV rates in black communities and in black gay men.
2.6	Transmission Puzzle	Participants learn that one's chances of getting HIV or another STD depend on three main factors and how one's understanding of this "transmission puzzle" can lead to a variety of STD/HIV prevention options, which is the basis for Exercise 3.2.
2.7	Session Summary	Participants provide feedback on the session, and facilitators preview Session 3.
Primary Behavioral Determinant		
Lack of knowledge of STDs and the interrelations among STDs and HIV		

Session and Exercise Connections: Session 3

Primary Focus Areas:

- ▶ Developing a menu of STD/HIV prevention and harm reduction options
- ▶ Recognizing how partners can influence risk
- ▶ Identifying personal risk behaviors and health-promotion behaviors

Session	Exercises	Purposes and Connections
3.1	Session Preview	Welcome participants to Session 3, recap what was covered in the previous session, and provide an overview of what will be covered in Session 3.
3.2	Creating a Menu of Options for STD/HIV Prevention	Participants are guided to use information from Exercises 2.3 STD Overview and 2.6 Transmission Puzzle to create their own Menu of Options for STD/HIV Prevention (handout), including harm reduction options and health-promotion options. This menu (handout) is used in Exercise 4.3 Choosing to Act.
3.3	Take Your Own Inventory	Participants increase their perception of risk by recognizing that type of partner and one's relationship with that partner influence one's decision making about risk; what one is willing to do sexually; and therefore, one's chances of getting HIV or another STD.
3.4	My Personal STD/HIV Risk Behaviors	Participants increase their recognition of perception of personal risk in relation to their sexual, substance-using, and health-promotion behaviors and those of their partner(s). This list of personal risk behaviors is used in Exercise 4.3 Choosing to Act.
3.5	Session Summary	Participants provide feedback on the session, and facilitators preview Session 4.
Primary Behavioral Determinants		
<ul style="list-style-type: none"> • Lack of knowledge of risk reduction options and protective behaviors (e.g., reducing the number of sexual partners, getting tested for STDs) • Low perception of risk for acquiring STDs and HIV 		

Session and Exercise Connections: Session 4

Primary Focus Areas:

- ▶ Increasing readiness for change
- ▶ Reducing ambivalence
- ▶ Choosing a prevention or harm reduction option to try

Session	Activities	Purposes and Connections
4.1	Session Preview	Welcome participants to Session 4, recap what was covered in the previous session, and provide an overview what will be covered in Session 4.
4.2	Stage Yourself—How Ready Are YOU for Change?	Participants increase their understanding of the process of behavior change and that relapse is a normal part of behavior change. Participants assess their individual readiness to change. This concept of readiness is used in Exercise 4.4 Barriers and Facilitators of Selected Change.
4.3	Choosing to Act	Participants are guided in selecting a prevention or harm reduction option from Menu 1, which they created in Session 3. Each participant's choice is used as the focus for Exercises 4.3, 4.4, and 4.5.
4.4	Barriers and Facilitators of Selected Change	Participants identify their own perceived barriers and facilitators to the prevention or harm reduction option they selected in Exercise 4.3. Creates an environment where participants receive social support for behavior change from their peers.
4.5	Getting Ready for Action—Taking the First Step	Participants develop a plan for the behavior change option they chose in Exercise 4.3. Participants identify and agree to take a first step toward trying the prevention or harm reduction option they selected and practice it before the next session.
4.6	Session Summary	Participants provide feedback on the session, and facilitators preview Session 5.
Primary Behavioral Determinants		
<ul style="list-style-type: none"> • Lack of knowledge of the process and steps involved in purposeful behavior change • Lack of intentions to use condoms consistently during anal sex or adopt other prevention options • Low self-efficacy to engage in safer behaviors (e.g., consistent condom use with partners) 		

Session and Exercise Connections: Session 5

Primary Focus Areas:

- ▶ Sexual relationship dynamics of Tops, Bottoms, and Versatiles for black gay men
- ▶ Choosing a prevention options for partners to try

Session	Exercises	Purposes and Connections
5.1	Session Preview	Welcome participants to Session 5, recap what was covered in the previous session, and provide an overview what will be covered in Session 5.
5.2	The Man of My Dreams	Participants recognize what they want sexually and emotionally in romantic and sexual relationships. They define sexism and stereotyping, concepts that are applied in Exercise 5.4.
5.3	Who's Got the Power	Discussion continues from Session 2 with a focus on the power dynamics of Tops and Bottoms and how participants have experienced power in their previous sexual relationships. Participants recognize that while Tops are often seen as having more power in relationships (referred to as authoritative power), Bottoms also have power of a different kind (referred to as nurturing power).
5.4	Why We Choose the Ones We Choose	Participants recognize that the roles of Tops and Bottoms of black gay men were created from their perceptions of heterosexual couples. Then, participants are guided to recognize that assigning those roles to black gay men is a form of stereotyping and sexism as defined previously in Exercise 5.2. Participants learn that the social norms of how Tops and Bottoms are supposed to behave in a relationship may not match what they said they want in the ideal relationship(s) they described in Exercise 5.2. Participants recognize the need to reject the stereotypical roles of Tops and Bottoms and communicate verbally about power dynamics and their needs in their relationships. Finally, participants choose an option from the second Menu of Prevention Options (handout) involving communication and negotiation with a partner.
5.5	Session Summary	Participants provide feedback on the session, and facilitators preview Session 6.
Primary Behavioral Determinants		
<ul style="list-style-type: none"> • Low self-efficacy to communicate with sexual partners and to negotiate condom use with sexual partners • Lack of peer and social support for behavior change 		

Session and Exercise Connections: Session 6

Primary Focus Area:

- ▶ Building behavioral risk-reduction skills such as condom use, partner communication and negotiation, and problem solving

Session	Activities	Purposes and Connections
6.1	Session Preview	Welcome participants to Session 6, recap what was covered in the previous session, and provide an overview what will be covered in Session 6.
6.2	Play Your Own Scene	Participants practice partner negotiation and communication skills, practice problem solving, and receive social support for behavior change from their peers. They see a demonstration of proper condom use skills.
6.3	Falling Off the Wagon	Participants discuss relapse and develop skills to deal with relapse and problem solve.
6.4	Session Summary	Participants provide feedback on the session, and facilitators preview Session 7.
Primary Behavioral Determinants		
<ul style="list-style-type: none"> • Lack of HIV risk-reduction behavioral skills (e.g., technical skills related to condom use; self-management skills relating to addressing other issues in one's life that influence HIV risk behavior, etc.) • Low self-efficacy to communicate with sexual partners and to negotiate condom use with sexual partners • Lack of peer and social support for behavior change 		

Session and Exercise Connections: Session 7

Primary Focus Areas:

- ▶ Continuing the process after 3MV
- ▶ Seeking other services
- ▶ Continuing self-growth
- ▶ Building a community for black gay men for ongoing social support

Session	Activities	Purposes and Connections
7.1	Session Preview	Welcome participants to Session 7, recap what was covered in the previous session, and provide an overview what will be covered in Session 7.
7.2	What Else Do You Need?	Participants recognize and learn how to access services for ongoing prevention and related needs.
7.3	How Can I Build on This Experience?	Participants recognize the need for and the value of ongoing self-development and self-growth.
7.4	How Can WE Build a Community?	Participants identify ways to build a community in which black gay men can feel safe, accepted, and socially supported as opposed to the rejection, isolation, and dual identity discussed in Session 1.
7.5	The Survival Handbook for Black Gay Men	Participants receive a survival guide for black gay men that lists local resources for services and support.
7.6	Session Summary and Graduation	Participants celebrate completing 3MV.
Primary Behavioral Determinants		
<ul style="list-style-type: none"> • Lack of HIV risk-reduction behavioral skills (e.g., technical skills related to condom use; self-management skills relating to addressing other issues in one's life that influence HIV risk behavior, etc.) • Lack of peer and social support for behavior change 		

Managing Group Dynamics

Managing group dynamics and time are essential to the successful implementation of 3MV. The sessions are written with specific instructions that are designed to help facilitators manage time and deliver the content efficiently and effectively. Each session has discussion questions to guide and manage the group discussion. Many Men, Many Voices delves into personal information, including sexual and substance-using practices, and it is the responsibility of the facilitator to ensure that participants feel safe, accepted, and respected. Discussions should be free of judgment so participants will feel comfortable enough to share and get the most out of the intervention. Facilitators should also ensure that one or two participants do not dominate the group and that all participants can talk and share.

Setting and Enforcing Ground Rules

One of the first critical activities of Session 1 is to set Ground Rules to govern the behavior of the participants during the intervention. Asking participants to participate in listing and agreeing to Ground Rules can increase their buy-in and makes it easier for facilitators to enforce them. It is suggested that facilitators add respect and confidentiality as Ground Rules, if the participants do not list them.

Dealing With Challenging Participants

Attending a group facilitation course will help the facilitators to develop the skills they need to respond effectively to different personality types and behaviors that can be challenging to group dynamics. The facilitator will learn skills to deal with participants' difficult behaviors, such as dominating the group by responding to every question or withdrawing and not speaking at all. Facilitators will learn how to prompt some participants and how to encourage those who tend to dominate the discussions to give others a chance to participate. The following table provides information on dealing with different personality types and challenging behaviors.

Dealing With Challenging Participants

Participant Behavior: Complaining and Distracting	Effective Strategies to Deal With These Behaviors
<ul style="list-style-type: none"> • Complaining about a number of things • Rambling and taking the discussion off course • Presenting situations or issues that are outside of the topic of discussion 	<ul style="list-style-type: none"> • Listen even though it may be difficult • Acknowledge by paraphrasing the complaints • Don't agree with the complaints • Be prepared to interrupt and take control of the situation by redirecting the discussion • Use limiting responses that pin the complainer to specifics
Participant Behavior: Acting Indecisive	Effective Strategies to Deal With These Behaviors
<ul style="list-style-type: none"> • When decisions must be made, even simple ones, indecisive participants can delay the process • Indecisive participants may talk around an issue rather than stay on the topic of discussion 	<ul style="list-style-type: none"> • Bring issues out in the open and make it easy for them to be direct • Help them solve problems • Watch for signs that the pressure to make a decision may be overloading them • Give them lots of support after they finally make a decision
Participant Behavior: Being Super Agreeable	Effective Strategies to Deal With These Behaviors
<ul style="list-style-type: none"> • Participants who are super agreeable seem to agree with every point of view and don't contribute their own • Often, super-agreeable participants don't actually agree but are eager to please and reluctant to express their own views • Participants who act super agreeable tend to commit themselves to more than they can actually accomplish 	<ul style="list-style-type: none"> • Make honesty nonthreatening • Don't allow them to make unrealistic commitments they can't fulfill
Participant Behavior: Being Negative	Effective Strategies to Deal With These Behaviors
<ul style="list-style-type: none"> • Participants who object to everything • They tend to focus their attention and energies on the negative aspects of most things • They can always identify what's wrong with every situation and articulate why every strategy will be ineffective or simply can't be done 	<ul style="list-style-type: none"> • Avoid being overly distracted by their attitude • Ask other participants to present a different viewpoint • Don't agree with them—when necessary, make it okay to agree to disagree • Disagree while respecting their perspectives • Be patient • Ask them to propose a solution

Dealing With Challenging Participants (continued)

Participant Behavior: Acting Like the Expert	Effective Strategies to Deal With These Behaviors
<ul style="list-style-type: none"> Participant may act like they are an expert and know everything They may attempt to debate accuracy of materials presented 	<ul style="list-style-type: none"> Know your subject matter Listen to and acknowledge what they say Avoid being a counter-expert Use evidence presented by the research to support strategies presented
Participant Behavior: Being Silent or Unresponsive	Effective Strategies to Deal With These Behaviors
<ul style="list-style-type: none"> Participants who are acting silent and/or unresponsive may answer all questions with a yes or no They are the hardest to read of all participants 	<ul style="list-style-type: none"> Ask them open-ended questions Talk to them during the break; some people are not comfortable in a group process right away Pause for long periods; invite them to fill the void Discuss one-on-one after the session Don't place them in an uncomfortable situation
Participant Behavior: Acting Hostile or Aggressive	Effective Strategies to Deal With These Behaviors
<ul style="list-style-type: none"> Participants who are acting hostile or aggressive try to bully you and other participants They can be very critical of the content and the delivery They come across as angry and challenging 	<ul style="list-style-type: none"> Stand up for yourself without being threatening Give them time to run down Speak from your point of view Stay positive Reflect their feelings by saying, "You seem angry, is there something that we are talking about that is making you feel that way?"

Managing Time

While facilitators need to create a supportive environment during the sessions, they also need to keep the sessions structured according to this manual. Many Men, Many Voices is not a support group in which participants can take the discussion in any direction. Rather, it is a structured intervention with goals and exercises that are designed to address specific behavioral determinants to promote behavior change. If an exercise is not done according to the manual, the effect on behavior change may be weakened. In addition, managing time is a major facilitator responsibility. Each exercise has a suggested time limit. Facilitators have to adhere to the suggested times to keep from skipping an exercise, going over the allotted time, or both. Getting behind and skipping an exercise could leave a behavioral determinant unaddressed, which could negatively influence participant outcomes. Most sessions will last about 2 hours; however, Sessions 1, 2, and 7 are 3 hours and longer.

At the same time, it is imperative that facilitators balance the needs of the participants with the structure of the intervention sessions. This is done by managing the time for discussion. A discussion about attitudes, topics, and experiences is desirable as long as it is focused on the goals of the session. Some participant discussions can often get off track and focus on other concerns, issues, and experiences.

Facilitators have several strategies they can use to refocus a group discussion to cover all the materials for a session.

In Session 1:

- ▶ Establish appropriate expectations at the first session through use of the Ground Rules. Emphasize the importance of completing all activities in each session to optimize the participants' experience. Tell participants that the facilitators are responsible for enforcing the Ground Rules and will leave them posted on the wall during each session for this purpose.
- ▶ Explain both the importance of group discussion and the need to sometimes limit discussion to get through all the material.
- ▶ Explain the idea of a Parking Lot and how it will be used throughout the sessions. This explanation during the first session establishes an expectation that discussions sometimes may have to be stopped.

During the rest of the sessions:

- ▶ Assign the time management role to the facilitator who is not leading a particular exercise in a session. The facilitators can then take turns being the timekeeper.
- ▶ If the discussion goes on too long, refocus the group by telling participants that it is time to move on to the next topic. Start by acknowledging the positive aspects of the discussion (e.g., “This is a great discussion” or “Those are some great points”) and then inform participants that, to get through all the material, talks need to move forward (e.g., “We have some additional points to cover and we need to move on”).
- ▶ If the discussion gets off topic, use the Parking Lot. When limiting discussions, ask participants whether they want to put the topic or issue on the Parking Lot. At the end of the session, refer participants to the topics and issues listed on the Parking Lot and determine whether they want to continue the discussion of the topics or issues listed.
- ▶ If one person is continually dominating the discussion by interrupting others in the group, impose a rule of one comment per person. When this rule is in effect, no person can comment again until all members of the group have had the opportunity to comment.
- ▶ Gently remind participants of the need to move on so the session can end on time (this can be one of the Ground Rules).
- ▶ For any session that lasts longer than 2 hours, you should give participants a 10-minute break. It is best to give a break between exercises. Constantly assess participants' level of attention and energy to determine when you need to take a break.

Managing Role-Plays

Some 3MV exercises consist of conducting and managing role-plays with the participants. In Session 6, there is a series of vignettes for the participants to role-play. Role-plays are designed to help increase the participants' skills by practicing those skills while receiving social support (feedback) from their peers in the group. Facilitators need to clearly explain the purpose of the role-plays and then demonstrate how role-plays are done by role-playing the first vignette. In their demonstration, facilitators reduce the fear of going first, set the example of managing time by staying on topic, and avoid overacting. The topic or subject of the role-play and the skills to practice should be the focus, not on the acting. It is also recommended that role-plays have a short (2- to 3-minute) time limit.

Getting Participants to Attend the Sessions

To increase attendance for the first 3MV session, try to schedule the intervention within a short period after a participant has signed up. Also, the facilitators should call each participant between the time he signed up for the 3MV intervention and the first session to encourage his attendance and problem solve any barriers that may have developed. During the first session, the facilitators should emphasize the importance of attending all seven sessions and tell participants they will be calling them between sessions.

The sessions are cumulative and missing one will make it difficult for a participant to fully participate in the next. For participants who miss a session, facilitators should review the content of the missed session before they attend the next session. This can be done with a telephone call. For example, if a participant misses Session 1, he can attend Session 2 as long as a facilitator reviews the content and discussions of Session 1 with the participant before Session 2.

Facilitators can promote retention (i.e., keep attendance high) by calling participants between each session. The call is a check-in and a reminder of the upcoming session. In addition, during the call facilitators can answer any questions a participant did not feel like asking during the session; he can be encouraged to share something he was not comfortable sharing during the session. Finally, the calls can support the implementation of 3MV by fostering a sense of community, demonstrating that the facilitators care and are invested in the participants' successful completion of the intervention. Agencies implementing 3MV also need to have policies and procedures about attendance and adverse weather, with a way to notify participants if a session is cancelled and rescheduled.

Evaluating the Sessions and Debriefing

Monitoring and Evaluation

Facilitators of 3MV play an important role in monitoring and evaluating each session and the intervention overall. Facilitators are responsible for documenting their own activities and how well they maintained fidelity to the intervention. Included in this manual are fidelity checklists (each checklist can be found in the Session Materials section) that can be used to ensure each session has been delivered with fidelity. Program managers can also help to monitor the sessions and facilitators' activities. It is recommended that program managers use the fidelity checklists to ensure that facilitators deliver the session with fidelity and document any changes and the reason for those changes on the forms.

Facilitators are also responsible for collecting information on participants' knowledge, attitudes, and behavior (KAB) by distributing and collecting the 3MV KAB Surveys. Participants need to complete a survey before Session 1 starts and again at the end of Session 7. The KAB Survey is included in the Session 1 and Session 7 materials located behind the Session Materials tab.

Participants will need to complete the Participant Satisfaction Questionnaire at the end of Session 7.

Debriefing

Another tool that can be used to monitor the sessions and the effectiveness of the facilitators is postsession debriefing. Through this process, facilitators can share their thoughts about what happened in the session, their delivery of the content, and their reactions to the session. It is recommended that the program manager conduct the debriefing sessions with the facilitators soon after each session, while the session is fresh in their minds. Program managers should wait no longer than 3 days to conduct the debriefing session. Debriefing is also a time for the facilitators to decompress and share the emotions and thoughts that would be inappropriate to share during the session. If the program manager is unable to participate in a debriefing, the two facilitators should still have an informal debriefing.

A debriefing form to be completed by the facilitators is located in this manual's M&E Tools section. The first section of the form has general questions about the session. The second section has more specific questions about the session's exercises and how those exercises were delivered. The third section has questions about any adverse events that may have occurred during the session. In the last section, facilitators can share any additional comments about the session. The facilitators should complete the debriefing form at the beginning of the debriefing session and then discuss their reactions to the session. This time is important for the facilitators to think about the session and how their delivery could be improved, as well as talk through any issues that arose for them during the session. It is recommended that debriefing sessions last no longer than 1 hour.

SESSION 1: BLACK MEN WHO HAVE SEX WITH MEN (MSM) AND DUAL IDENTITY

PURPOSE

The overall goal of Session 1 is to increase participants' understanding of how a unique combination of internal and external factors can affect the HIV-related behaviors of black gay men and contribute to disproportionately high rates of HIV and other STDs.

SESSION OBJECTIVES

Facilitators will help participants to:

- ▶ Learn that behavior does not occur in a vacuum, but rather is influenced by a combination of personal factors, the norms of one's family and social networks, and the influence of social attitudes and norms
- ▶ Discuss the unique combination of factors (racism and homophobia) that influences the behavior of black gay men, including the dual identity of being a black man and a gay man; explore norms for black gay men and the lack of an identified community for black gay men
- ▶ Explore how the reactions of family, religious communities, and society in general to black gay men can lead to lack of disclosure of sexual identity, isolation, fear, and internalized racism and homophobia
- ▶ Gain awareness of how internalized racism and homophobia can lead to negative emotions, self-standards, and values and to the development of a negative self-concept
- ▶ Understand how all these factors can lead to high-risk sexual and substance-using behaviors of black gay men and contribute to disparities in STD/HIV infections

FACILITATOR TIPS

- ▶ During this session, it is important that you create a warm, friendly, and relaxed environment for participants. Smile and greet participants as they arrive, have some soft music playing in the background, and introduce yourself. Your pleasant and upbeat attitude will help to make the participants feel comfortable. Before the session begins, introduce the participants to each other as they arrive. Knowing the

names of other participants will help to break the ice and get participants acquainted with one another.

- ▶ To be prepared to discuss the influencing factors of behavior change and the concept of dual identity of black gay men, read the supplemental materials located behind the Session Materials tab.
- ▶ Session 1 may take a little longer than 2.5 hours because participants need to complete any agency paperwork and the KAB survey at the beginning of the session.
- ▶ Exercises 1.2, 1.3, and 1.4 use prepared newsprints that build on each other. In Exercise 1.2, the wall cards THINGS ON THE INSIDE and THINGS ON THE OUTSIDE should be posted on wall 1 (see below). In Exercise 1.3, the BLACK MEN, GAY MEN, and BLACK GAY MEN newsprints should be posted on wall 2 and the RISK BEHAVIORS OF BLACK MSM newsprint should be posted on wall 3. During Exercise 1.4, you will make references to the content of the previous exercises.

Exercise 1.2—Post on Wall 1

THINGS ON THE INSIDE	THINGS ON THE OUTSIDE
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Exercise 1.3—Post on Wall 2

BLACK MEN	GAY MEN	BLACK GAY MEN
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Exercise 1.3—Post on Wall 3

RISK BEHAVIORS OF BLACK MSM

Session 1 At-a-Glance

Session	Activities	Time (minutes)	Purposes	Materials
1.1	Welcome and Introductions	35	Welcome participants to the intervention and Session 1 and preview what will be covered in Session 1.	<ul style="list-style-type: none"> • Sign-in sheet • Name tags • Pens or pencils • Prepared newsprint: 3MV GROUND RULES • Prepared newsprint: PARKING LOT • Handout: KAB Survey • Sticky notes for PARKING LOT
1.2	<i>“Why We Do the Things We Do”</i> Factors That Influence Behavior Change	30	Participants learn about the external and internal factors that influence behavior and behavior change for all people and participants recognize that behavior change is challenging for everyone.	<ul style="list-style-type: none"> • Prepared newsprint: EXAMPLES OF BEHAVIOR CHANGE • Prepared wall cards: THINGS ON THE INSIDE and THINGS ON THE OUTSIDE • Prepared Influencing Factors of Behavior Change wall cards • Handout: What Have You Tried to Change?
1.3	Dual Identity	45	Participants recognize the set of unique factors that influences black gay men, including the concept of dual identity and the social influences of racism and homophobia. Also, participants list the behaviors of black gay men that can lead to HIV/STD risk.	<ul style="list-style-type: none"> • Prepared newsprint: BLACK MEN • Prepared newsprint: GAY MEN • Prepared newsprint: BLACK GAY MEN • Prepared newsprint: RISK BEHAVIORS OF BLACK MSM

Session 1 At-a-Glance (continued)

Session	Activities	Time (minutes)	Purposes	Materials
1.4	Making the Connection	20	Participants are led through a summary of Exercises 1.2 and 1.3 to recognize that out of all the factors that influence everyone's behaviors, there is a unique subset of those factors which particularly influence black gay men.	<ul style="list-style-type: none"> • Prepared wall cards: THINGS ON THE INSIDE and THINGS ON THE OUTSIDE • Prepared Influencing Factors of Behavior Change wall cards • Prepared newsprint: BLACK MEN • Prepared newsprint: GAY MEN • Prepared newsprint: BLACK GAY MAN • Prepared newsprint: RISK BEHAVIORS OF BLACK MSM
1.5	Session Summary	10	Participants provide feedback on the session and facilitators preview Session 2.	<ul style="list-style-type: none"> • Prepared newsprint: PARKING LOT
Session 1 Primary Behavioral Determinant				
Negative attitudes, beliefs, values, low self-standards, and an identity that stems from or relates to discrimination (e.g., racism and homophobia) and cultural and religious norms				

Session 1: Black Men Who Have Sex With Men (MSM) and Dual Identity

Materials Checklist

Prepared Newsprints:

- GROUND RULES
- PARKING LOT
- EXAMPLES OF BEHAVIOR CHANGE
- WALL CARDS:
 - THINGS ON THE INSIDE
 - THINGS ON THE OUTSIDE
 - SOCIAL NORMS—FAMILY/CULTURAL/RELIGIOUS/PEER
 - KNOWLEDGE
 - ATTITUDES AND BELIEFS
 - PERCEPTIONS OF RISK
 - OTHER PERCEPTIONS
 - INTENTIONS
 - SELF-EFFICACY
 - EMOTIONS
 - VALUES, SELF STANDARDS/IDENTITY
 - SKILLS
 - SEXUAL RELATIONSHIP DYNAMICS
 - SOCIAL INFLUENCE—RACISM
 - SOCIAL INFLUENCE—HOMOPHOBIA
 - POLICIES
 - SOCIAL SUPPORT
 - LAWS, REGULATIONS
 - ENVIRONMENTAL FACTORS/BARRIERS

- BLACK MEN
- GAY MEN
- BLACK GAY MEN
- RISK BEHAVIORS OF BLACK MSM

Session Handouts:

- KAB SURVEY
- WHAT HAVE YOU TRIED TO CHANGE?

Facilitator Materials:

- SUPPLEMENTAL MATERIALS ON DUAL IDENTITY
- SUPPLEMENTAL MATERIALS ON INFLUENCING FACTORS OF BEHAVIOR CHANGE
- 3MV FACILITATOR'S GUIDE
- SIGN-IN SHEET
- NAME TAGS
- PENS OR PENCILS
- STICKY NOTES FOR PARKING LOT
- MARKERS
- NEWSPRINT
- TAPE

Advanced Preparations:

- Prepare the newsprints and wall cards
- Photocopy participants' handouts
- Review supplemental materials under the Session Materials tab

Exercise 1.1 Welcome and Introductions

Purpose: Welcome participants to the intervention and Session 1 and preview what will be covered in Session 1.

Time: 35 minutes

Materials:

- Sticky notes for PARKING LOT
- Prepared newsprint: PARKING LOT
- Prepared newsprint: GROUND RULES
- Handout: KAB Survey
- Pens/pencils
- Sign-in sheet
- Name tags

Notes on Exercise 1.1

Facilitator should be prepared to answer questions about Many Men, Many Voices (3MV). Participants may have questions about the intervention topics and session length. It is important to take the time to answer participants' questions and set an interactive and open environment. See the Implementation Manual for information on the background of 3MV and how the intervention works.

Procedures

1. Welcome the participants to the first session of 3MV

- ▶ Introduce yourself and your cofacilitator to the group.
- ▶ Tell participants that more formal introductions will follow soon.

2. Introduce 3MV to the participants, using the talking points below

- ▶ 3MV was developed by and for black gay men.
- ▶ 3MV was developed by Gary English, a black gay man, who was the Founding Director of Men of Color Health Awareness (MOCHA) and the Executive Director of People of Color in Crisis (POCC), and Patricia Coury-Doniger, the Director of the Center for Health & Behavioral Training (CHBT) in 1998. As a result of their partnership, 3MV was developed as an HIV/STD prevention behavioral intervention that would be culturally appropriate address and the unique HIV prevention needs of black gay men.
- ▶ This is not an educational program; you will not hear lectures about what you should and shouldn't do. Instead, we talk about our knowledge, beliefs, and experiences as black gay men living in a world with high rates of HIV and other STDs.
- ▶ We will listen to each other's ideas about how we can improve our lives, our romantic relationships, and enhance our sexual health.
- ▶ Session 1 is going to last about 2.5 hours. During that time, we will have interesting discussions and some fun.

3. Introductions

- ▶ Introduce yourself, including details about your background and your role with the agency.
 - Include information about your HIV prevention experience, experience working with communities of color, experience working with black gay men, and a fun fact.
- ▶ Ask participants to introduce themselves and provide the following:
 - Name
 - Age
 - Fun fact

FACILITATOR'S NOTE ON THE TERM BLACK GAY MEN

In 3MV, when the term black gay men is used, it includes the following:

- Gay-identified black men
- Non-gay-identified black men who have sex with men
- Same-gender-loving men
- Queer-identified black men
- Bisexual black men

4. Provide information about logistics

- ▶ Review any agency paperwork that needs to be completed, including the sign-in sheets.
- ▶ Remind participants to sign in before the session is over.
- ▶ Tell participants the locations of the restrooms, kitchen (break room), and telephones, as well as any other information they need to know about your space.
- ▶ If providing any food or refreshments, discuss when and how they will be provided.

5. Set the Ground Rules

- ▶ To keep this a safe, relaxed, and comfortable environment for everyone, we need to set some Ground Rules.
- ▶ Ground Rules are what we, as a group, decide is okay and not okay to do while we are in the 3MV sessions.
- ▶ What Ground Rules would you like in place during our time together?
- ▶ Record ground rules on the prepared newsprint: GROUND RULES.

6. Distribute the KAB Survey

- ▶ This survey is a way to evaluate how well 3MV works as an STD/HIV prevention approach for black gay men.
- ▶ Please answer the questions honestly. Your name does not need to go on the survey and all information will be strictly confidential.
- ▶ Collect the surveys and answer any questions.

FACILITATOR'S NOTE ON GROUND RULES

Add the following Ground Rules if they are not mentioned:

- Confidentiality
- Respect
- Have fun

Remind participants that one of the roles of the facilitators is to help everyone stick to the Ground Rules.

7. Review the Parking Lot

- ▶ The Parking Lot is a tool to help keep the discussions focused and the sessions on time.
- ▶ It is a place to park issues or questions that cannot be fully addressed during the sessions.
- ▶ We would use the Parking Lot if you had a question and we did not have the time to answer the question, or the question will be answered during another session. You could also use the Parking Lot to park a question you did not want to ask in front of the group.
- ▶ All questions on the Parking Lot will be answered at the end of the session or at the beginning of the next session.
- ▶ You can write your questions or concerns on the sticky notes around the room and then post them on the Parking Lot.
- ▶ Answer any questions.

Exercise 1.2 “Why We Do the Things We Do” Factors That Influence Behavior Change

Purpose: Participants learn about the external and internal factors that influence behavior and behavior change for all people and recognize that behavior change is challenging for everyone.

Objective: To help participants identify, recognize, and understand that all people experience challenges when changing behaviors. Participants will also identify, recognize, and understand the personal, social, and cultural factors that influence behavior change for everyone.

Time: 45 minutes

Materials:

- Prepared newsprint: EXAMPLES OF BEHAVIOR CHANGE
- Prepared wall cards:
 - THINGS ON THE OUTSIDE
 - THINGS ON THE INSIDE
- Prepared Influencing Factors of Behavior Change wall cards:
 - SOCIAL NORMS—FAMILY/CULTURAL/RELIGIOUS/PEER
 - KNOWLEDGE
 - ATTITUDES AND BELIEFS
 - PERCEPTION OF RISK
 - OTHER PERCEPTIONS
 - INTENTIONS
 - SELF-EFFICACY
 - EMOTIONS
 - VALUES, SELF STANDARDS/IDENTITY
 - SKILLS
 - SEXUAL RELATIONSHIP DYNAMICS
 - POLICIES
 - SOCIAL SUPPORT
 - LAWS, REGULATIONS
 - ENVIRONMENTAL FACTORS/BARRIERS
 - SOCIAL INFLUENCE—RACISM
 - SOCIAL INFLUENCE—HOMOPHOBIA
- Handout: What Have You Tried to Change?

Notes on Exercise 1.2

This exercise is designed to get participants thinking about behaviors and the process of behavior change. This is the first opportunity for participants to share personal information and it is important that you review and reinforce the Ground Rules.

Read the supplemental materials, Influencing Factors of Behavior Change, under the Session Materials tab before conducting this exercise.

Procedures

1. Introduce this exercise

- ▶ In this exercise, we are going to discuss behaviors and the things (factors) that influence behavior change for everyone.
- ▶ Some people think that behavior change is simple; if you know that doing something is bad for you, then you will automatically stop doing it.
- ▶ However, behavior change is not that simple. There are many factors that influence whether or not a person can change his behavior.
- ▶ Behavior change can be difficult and usually happens in stages with many stops and starts, and that is normal and okay.

2. Discuss behavior and behavior change

- ▶ Define a behavior as things, patterns, activities, or actions we do. Provide the following examples of behaviors:
 - Smoking.
 - Overeating.
 - Exercising.
 - Speeding.
- ▶ Ensure participants understand the difference between behaviors (the things we do) and attitudes (the way we feel).
- ▶ Remind participants that behavior change is a difficult process for everyone.
- ▶ One example of behavior change is going from an inactive lifestyle to getting regular exercise. Can anyone provide other examples of behavior change?
- ▶ Record participants' responses on the prepared newsprint: **EXAMPLES OF BEHAVIOR CHANGE**. Some potential responses could be:
 - Saving money.
 - Quitting smoking.
 - Eating healthy food.
 - Dieting to lose weight.
 - Reading instead of watching television.

3. Instruct participants to pair up with a partner and sit next to him for the following activity

4. Distribute What Have You Tried to Change? handout

- ▶ This handout will help you to identify one behavior you have tried to change, what helped you change, and what your barriers to change were.
- ▶ Ask each pair to share with each other one behavior (a thing, pattern, or activity a person does) that each has tried to change and what things made it easier (what helped me) and what made it harder (what were my barriers).
- ▶ Remind participants it could be any behavior. For this exercise, the behavior should be something other than sexual behaviors. The behavior could be dieting or smoking. As one person in each pair shares, his partner should write on the handout the behavior and what made it easier and harder to change. Give each pair 10 minutes to complete the handout.

5. Discuss What Have You Tried to Change? handout

- ▶ Ask pairs to share with the large group what they wrote on the handout. As pairs share, ask them:
 - What behavior did your partner try to change in the past?
 - If the participant does not list a behavior, ask the participant to think about a behavior like smoking, watching less television, a lack of exercise, or saving money that they would like to change.
 - What are the things that made it difficult for him to change?
 - What are the things that helped him to change?
- ▶ As each participant names something that made it easy or difficult for him to change, ask whether it was something on the inside (internal factor) or on the outside (external factor).
 - THINGS ON THE INSIDE are personal factors, such as the things we know, think, or believe.
 - THINGS ON THE OUTSIDE are social factors, such as the attitudes of families, friends, communities, or society.
- ▶ Place the Influencing Factors of Behavior Change wall card (e.g., INTENTIONS, SELF-EFFICACY, PERCEPTIONS) that corresponds to the participant's example under the appropriate wall sign (THINGS ON THE INSIDE or THINGS ON THE OUTSIDE).
 - For example, if the participant said having friends made it easy to change his behavior, place the SOCIAL SUPPORT wall card under THINGS ON THE OUTSIDE.

- If the participant said he did not believe that his behavior was unhealthy, place the PERCEPTIONS wall card under THINGS ON THE INSIDE.
 - If a participant names a factor that is already on the wall, point out which wall card corresponds to it.
- ▶ Once all participants have shared one factor, put up the remaining wall cards that were not mentioned. Be sure to explain what each wall card means as you put it up.

FACILITATOR'S NOTE ON INFLUENCING FACTORS OF BEHAVIOR CHANGE WALL CARDS

The Session Materials include a supplemental material sheet called Influencing Factors of Behavior Change that defines these factors. It is important to review and know this information before conducting this exercise.

6. Lead a discussion on the influence of internal and external factors on behaviors using the following probes

- ▶ We just discussed some of the things that make behavior change easy and difficult for everyone.
- ▶ You can see that there are many factors that influence behavior and changing a behavior is complicated and challenging for everyone.
 - Some of those factors are THINGS ON THE INSIDE such as what we know, think, believe, and know how to do (skills).
 - Some of the factors are THINGS ON THE OUTSIDE such as the influence of our partners, family, church, and attitudes of our communities and society.
- ▶ Why do you think it is important to know about how THINGS ON THE INSIDE and THINGS ON THE OUTSIDE influence our behavior?
- ▶ Answer any questions.

7. Summarize the discussion, using the following talking points

- ▶ In order for anyone to change their behaviors, they have to be aware of the factors that help or prevent them from changing.
- ▶ We need to address these factors to successfully change our behaviors.
- ▶ We will spend more time later discussing all the things (factors) that are known to influence behavior change later.

FACILITATOR'S NOTE ON INTERNAL AND EXTERNAL FACTORS

Make sure participants know that everyone's behaviors are influenced by internal (THINGS ON THE INSIDE) and external (THINGS ON THE OUTSIDE) factors. This becomes the background for the next exercise, in which the participants recognize the unique factors that influence the risk behaviors of black gay men.

Exercise 1.3 Dual Identity

Purpose: Participants recognize the set of unique factors that influence black gay men, including the concept of dual identity and the social influences of racism and homophobia. Also, participants list the behaviors of black gay men that can lead to HIV/STD risk.

Objective: To help participants recognize how being black, gay, and male can influence their behaviors and risk behaviors.

Time: 50 minutes

Materials:

- Prepared newsprint: BLACK MEN
- Prepared newsprint: GAY MEN
- Prepared newsprint: BLACK GAY MEN
- Prepared newsprint: RISK BEHAVIORS OF BLACK MSM

Notes on Exercise 1.3

This exercise is designed for participants to say whatever comes to mind when prompted by the following phrases: BLACK MEN, GAY MEN, and BLACK GAY MEN. What they say may be what they think or what they have heard others say. Participants should be encouraged to be honest and not politically correct. Do not censor the participants; record what they say, as they say it. It is important to reinforce the Ground Rules here to maintain the positive group dynamics.

It is essential for the group to really get into this exercise and develop a list of the top 10 to 12 things stated. Some participants may be shy and you may need to get the list started using a few probes and examples.

Read the supplemental materials on dual identity behind the Session Materials tab before conducting this exercise.

You will also need four prepared newsprints for this exercise. See the Facilitator Tips (page 23) on where to post prepared newsprints around the room.

Procedures

1. Introduce the exercise

- ▶ We are going to do an exercise where we ask you to say the first thing that comes into your mind when you hear the terms BLACK MEN, GAY MEN, and BLACK GAY MEN.
- ▶ Don't worry about being politically correct or censoring yourself. We want you to speak your mind.
- ▶ You can say what you think or what other people may think about each group of men.
- ▶ Once we get about 10 to 12 words on the list, we will move to the next newspaper.

2. Ask participants what comes into their minds when they think of BLACK MEN

- ▶ Think about black men—not specifically black gay men because that comes next—but black men in general.
- ▶ Ask, “What have you heard others say?”
- ▶ Record responses on the prepared newspaper: BLACK MEN. Some potential responses include:
 - Sexy
 - Strong
 - Funny
 - Big dicks
 - Proud
 - Passionate
 - Underappreciated
 - Loving
 - Intelligent
 - Complex
 - Racism
 - Spiritual
 - King
 - Athletes
 - President
 - Singers
 - Artist

3. Ask participants what comes into their minds when they think of GAY MEN

- ▶ Think about gay men—not specifically black gay men because that comes next—but gay men in general.
- ▶ Record responses on the prepared newsprint: GAY MEN. Some potential responses include:
 - Sexually free
 - Cliquish
 - Educated
 - High maintenance
 - Liberated
 - Homophobia
 - Mostly white
 - Got money, wealthy
 - Leaders
 - Intelligent
 - Hypersexual
 - Sissy
 - Sincere
 - Trend setters
 - Fashionable
 - Effeminate
 - White
 - Artsy
 - Uninhibited

4. Ask participants what comes into their minds when they think of BLACK GAY MEN

- ▶ Record responses on the prepared newsprint: BLACK GAY MEN. Some potential responses include:
 - Tops
 - Bottoms
 - God-fearing
 - No guts
 - Seeking acceptance
 - Guarded
 - Persecuted
 - Hopeful
 - Abomination
 - Broken
 - Fighters
 - Misunderstood
 - Sexy
 - Resented
 - Fashionable
 - No real black, gay community
 - DL (down low)
 - Sissy
 - Father
 - Loving
 - Authors
 - Preachers
 - Rejected by black church
 - Racism and homophobia
 - Beat up—not safe in our own black community
 - Not accepted
 - Black women think “what a waste”
 - Choir directors
 - Rejected by gay community
 - Resented
 - Girl
 - Stunt queens
 - Club hoppers

5. Discuss the brainstorm with participants

- ▶ Let's look at our lists.
- ▶ What are your reactions to what was listed for:
 - BLACK MEN?
 - GAY MEN?
 - BLACK GAY MEN?
- ▶ What differences and similarities do you see between the three brainstorms?
- ▶ Which list do you see as more positive? Why?
- ▶ Which list do you see as more negative? Why?

6. Ask participants to list behaviors of black gay men that may negatively impact their health

- ▶ These are any behaviors that could negatively impact the health of black gay men.
- ▶ Record responses on the prepared newsprint: RISK BEHAVIORS OF BLACK MSM. Examples of risk behaviors include:
 - Sharing needles
 - Going to sex parties
 - Cruising on the Internet
 - Cruising in parks
 - Drinking
 - Having sex for drugs
 - Having multiple partners
 - Picking up trade
 - Unprotected anal sex
 - Unprotected vaginal sex
 - Substance use
- ▶ Thank participants for responses and tell them we will revisit them soon.

Exercise 1.4 Making the Connection

Purpose: Participants are led through a summary of Exercises 1.2 and 1.3 to recognize that out of all the factors that influence everyone's behaviors, there is a unique subset of those factors that particularly influences black gay men.

Objective: To help participants recognize how their unique combination of influencing factors, including dual identity, experiences of rejection related to racism and homophobia, and lack of an established black gay community, can be internalized and negatively affect one's self-standards, values, and identity and can lead to increased sexual and substance-using risk behaviors.

Time: 15 minutes

Notes on Exercise 1.4

You will refer to the prepared newsprints and wall cards from Exercises 1.2 and 1.3 during this exercise.

Procedures

1. Review the previous exercises

- ▶ So far, we have discussed the factors that influence behavior and behavior change for everyone (THINGS ON THE INSIDE and THINGS ON THE OUTSIDE) and identified what makes behavior change easy or difficult.
- ▶ We also discussed the popular views of black gay men and listed their risk behaviors.
- ▶ We're now going to talk about how these factors affect us as black gay men.

2. Discuss how THINGS ON THE OUTSIDE can affect black gay men

- ▶ Refer participants to the THINGS ON THE OUTSIDE wall cards.
- ▶ What effects do the THINGS ON THE OUTSIDE have on us as black gay men? Allow time to discuss the impact of THINGS ON THE OUTSIDE on black gay men.
- ▶ Have any of these factors affected you personally? How?
 - If necessary, ask participants how any of the following factors have affected them:
 - Being rejected by family or community.
 - Racism.
 - Homophobia.
 - The black church.

3. Segue into a discussion on how THINGS ON THE OUTSIDE affect THINGS ON THE INSIDE

- ▶ Do the THINGS ON THE OUTSIDE (racism, homophobia, rejection by the church, rejection by the black community, and rejection by the gay community) get into our head?
 - What happens if they do?
- ▶ How do THINGS ON THE OUTSIDE affect THINGS ON THE INSIDE?
- ▶ How do THINGS ON THE INSIDE affect us?

4. Segue into a discussion on how THINGS ON THE OUTSIDE and THINGS ON THE INSIDE affect risk behaviors of black gay men

- ▶ Refer participants to the RISK BEHAVIORS OF BLACK MSM.
- ▶ How do the factors (e.g., racism; homophobia; low self-esteem; being alone, being scared) relate to the behaviors you listed?
 - If necessary, provide the following example to start the discussion.
 - Someone who has low self-esteem may not care about his health and may not be concerned about behaviors that put him at risk. In fact, such behaviors as unprotected sex or drug use may make him, temporarily, feel better about himself.
- ▶ Do any of factors listed affect your own risk behaviors? If so, how?
- ▶ Discuss the impact of the risk behaviors on the lives of black gay men.

5. Segue into a discussion on the connection between risk behaviors and HIV and STD rates for black gay men

- ▶ What do you know about the rates of HIV and STD for black gay men?
 - If not mentioned, point out that HIV and STDs rates for black gay men are higher (i.e., disproportionate) than other groups of people (e.g., white gay men, black women, Latinos, etc.).
- ▶ Discuss the connection between the risk behaviors and the rates of HIV and STDs for black gay men.
 - What is contributing to the high HIV and STD rates for black gay men?
 - If not mentioned, point out that risk behaviors (which are affected by external and internal factors), in part, are driving and maintaining these high rates.
 - Because black gay men have higher rates of HIV and STDs, we are at higher risk for getting HIV or an STD when we do these behaviors.

FACILITATOR'S NOTE ON EXERCISE 1.4

It is very important that the participants understand that everyone's behaviors are influenced by internal and external factors. There are some factors that are unique to the lives of black gay men, such as the negative influences of racism, homophobia, stereotyping, negative messages from the black church, and rejection from one's family and community; these can be internalized and negatively affect self-standards, values, and identity. These factors then can lead to risky behaviors (e.g., unprotected sex, substance-using behaviors) for black gay men, which can ultimately lead to higher HIV and STD rates. While they may not be able to immediately change external factors, they can change and deal with how they internalize those factors and let them drive their behaviors.

6. Summarize the connection between black gay men's external and internal factors, risk behaviors, and HIV/STD rates

- ▶ We have learned how things on the outside can be internalized, and that these factors can influence our behaviors.
- ▶ We learned the connection between internal and external factors; risk behaviors; and HIV and STD disparities among black gay men.
- ▶ The good news is now that we know some of the things that are responsible for influencing behavior, we can change our thoughts, attitudes, and beliefs about ourselves as black gay men, change our behaviors, and keep ourselves healthy.
- ▶ Ask for and answer any questions about the exercise.

Exercise 1.5 Session Summary

Purpose: Participants provide feedback on the session, and facilitators preview Session 2.

Time: 10 minutes

Materials:

- Prepared newsprint: PARKING LOT

Procedures

1. Check in with participants

- ▶ Do you have any questions about Session 1?
- ▶ Does anyone want share any feelings or thoughts about anything covered in Session 1?

2. Review the Parking Lot

- ▶ Answer any questions on the Parking Lot.
 - Tell participants that any questions not answered will be answered in the next session.

3. Review the Ties That Bind

- ▶ We have all worked together and have come up with some important thoughts and points.
- ▶ We have learned that many factors influence behavior for everyone.
- ▶ We have also learned there are some of these factors that are especially important for black gay men (refer to impact of dual identity, homophobia, and racism on self-standards, values, and identity).
- ▶ We have learned how some of those factors can lead to risky behaviors.
- ▶ During our next session we will discuss the roles and risks for Tops, Bottoms, and Versatiles. We will also discuss how the risk behaviors and factors we identified in this session are connected to our sexual health.
- ▶ We will also discuss STD and HIV infections and get some important facts.
- ▶ Just a reminder. Session 2 will take place (____) and will begin promptly at (____).
- ▶ (Facilitators) are here if you have any questions.

FACILITATOR'S NOTE

Each 3MV session will close with the Ties That Bind. They are used to wrap up what was discussed and to preview the next session.

SUPPLEMENTAL MATERIALS

DUAL IDENTITY

Dual identity is a concept that describes the “twoness” of identity and how that twoness influences black gay men. Dual identity means being a black man and a gay man and having to manage both identities; that is, fit into the black community and fit into the gay community. The need for a dual identity often results from the lack of a visible black gay community with which one can identify.

Dual identity results in black gay men having to manage two separate identities—being a black man and being a gay man. In the black community, black men are supposed to be strong, masculine, and heterosexual. They are fathers and providers; black men marry black women and take care of black families. The image of black maleness is devoid of romantic and sexual contact with other men. Black men also have to deal with the pressure, stress, and bias that result because of their race. In the black community, many black gay men encounter homophobia and disapproval from their churches, family, and friends, which may be internalized and result in negative feelings about oneself (internalized homophobia).

In the gay community, there is a contrasted image. The image of gayness is white and feminine, the exact opposite of the image of black maleness. Black gay men may encounter racial discrimination and disapproval in the gay community because of their race, which may be internalized and result in negative feelings about oneself (internalized racism).

Many black gay men have to manage this dual identity and at the same time, try to create an identity that supports their blackness, maleness, and gayness. Many black gay men find it challenging to find and assert their place in the larger black community and in the gay community. Many black gay men find it more fulfilling to create safe spaces where they can relax and be themselves with other black gay men. In this environment, a single identity of being a black gay man can be experienced and other black gay men provide social acceptance and support for this identity. The safe space is sacred because it can affirm the individual; in that space, it is okay and desirable to be a black gay man.

In *Many Men, Many Voices (3MV)*, dual identity is discussed in Session 1. Participants discuss how the struggle of trying to maintain a dual identity can result in internalized racism and homophobia and lead to risky behaviors such as engaging in unprotected sex or using substances to deal with the pressure and stress. The 3MV sessions model a safe space for black gay men in which they can feel free to experience their own identity.

Sources:

Peterson, J. L., & Jones, K. T. (2009). HIV prevention for black men who have sex with men in the United States. *American Journal of Public Health, 99*(6), 976–980.

Hart, T., Peterson, J. L., & the Community Intervention Trial for Youth Study Team. (2004). Predictors of risky sexual behavior among young African American men who have sex with men. *American Journal of Public Health, 94*(7), 1122–1124.

DEFINITIONS—INFLUENCING FACTORS OF BEHAVIOR CHANGE

THINGS ON THE INSIDE—INTERNAL FACTORS

- ▶ **Knowledge**—What we know about the behavior and the health problem.
- ▶ **Attitudes and Beliefs**—What we think and believe about the behavior and the health problem and how that may affect use of risk reduction.
- ▶ **Perceptions of Risk.**
 - **Perceived risk/susceptibility**—Belief that we are personally at risk and vulnerable to the health problem.
 - **Perceived severity**—Belief that getting an STD or HIV is a serious threat to our health.
- ▶ **Other Perceptions**
 - **Perceived barriers**—Obstacles that get in the way of the behavior change (for a given person).
 - **Perceived benefits**—Positive results of making the behavior change (for a given person).
- ▶ **Intentions**—Willingness to try to change the behavior.
- ▶ **Self-Efficacy**—Feeling confident that we have the capacity to change the behavior, that we can do the new behavior.
- ▶ **Emotions**—How we feel such as happy, sad, scared, anxious, guilty, or ashamed (negative emotions can trigger risk behaviors).
- ▶ **Values, Self-Standards/Identity**—These are interrelated concepts of self. Values define how we see ourselves as individuals—what we believe in, what we think is okay and not okay for us to do. Identity refers to the concept of how a person defines who he is and where he fits in society. Self-standards refer to how the behavior fits in with how we see ourselves.
- ▶ **Skills**—The actual ability we need to do the new behavior.

THINGS ON THE OUTSIDE—EXTERNAL FACTORS

- ▶ **Sexual Relationship Dynamics**—Issues of power, control, and decision making within one’s sexual relationship(s).
- ▶ **Social Norms (Family/Cultural/Religious/Peer)**—What we have learned from our families, culture, religion, or our social network about the behavior, whether it is right or wrong or whether it is okay or not okay to do.
- ▶ **Social Support**—Positive reinforcement of the behavior change efforts from partners, family, and peers. Encouragement to make the change from people in one’s social network.
- ▶ **Policies, Procedures of Agencies/Providers**—The rules in places that we need to help us with the change, whether the rules help or create barriers.
- ▶ **Laws, Regulations**—The laws or regulations that govern whether the behavior is legal or illegal and whether they support the positive behavior change or create barriers.
- ▶ **Environmental Factors/Barriers**—Things in your neighborhood or community that make the change easier or harder, whether we have access to the necessary prevention materials to support the behavior change, whether we have access to health care preventive services.
- ▶ **Social Influence: Racism**—Perceived and experienced negative societal attitudes, beliefs, and actions based on race that affect a person’s behaviors, attitudes, and beliefs.
- ▶ **Social Influence: Homophobia**—Perceived and experienced negative societal attitudes, beliefs, and actions based on sexual orientation that affect a person’s behaviors, attitudes, and beliefs.

WHAT HAVE YOU TRIED TO CHANGE?

This handout will help you identify what helps you to change your behavior and what makes it hard to change your behavior.

Behavior Change Handout		
What behavior have I tried to change in the past?	What helped me to change?	What made it hard for me to change?
<i>Getting more exercise</i>	<i>Friends encouraged me and I wanted to lose weight</i>	<i>Making time in my schedule</i>

SESSION 2: STD/HIV PREVENTION FOR BLACK MSM—THE ROLES AND RISKS FOR TOPS AND BOTTOMS

PURPOSE

The purpose of Session 2 is to provide basic information about transmission, symptoms, testing, and treatment of STDs and HIV and how STDs increase the chance of HIV infection for black men who have sex with men. Another purpose is to introduce the concept of Tops and Bottoms and discuss how sexual position affects the chance of getting an STD and HIV. The session provides the participants with the information they need to build their menu of prevention and harm reduction options in Session 3.

SESSION OBJECTIVES

Facilitators will help participants to:

- ▶ Recognize how the assigned roles and positions of Tops and Bottoms influence risk for acquiring STDs and HIV for black MSM
- ▶ Increase knowledge of STDs and HIV
- ▶ Understand how having an STD increases the chances of getting or transmitting HIV through sex
- ▶ Understand the three factors that determine risk of getting STDs and/or HIV and can be used for prevention options
- ▶ Learn why the epidemic of STDs and HIV is increasing for black MSM—the epidemiology
- ▶ Understand how black MSM can be at high risk for HIV even with low-risk behaviors

FACILITATOR TIPS

- ▶ This session has two PowerPoint slide presentations. Make arrangements to have a laptop and an LCD projector on hand. Practice using the equipment, and be sure to load the PowerPoint presentation on the laptop.
- ▶ You will present some information on rates of HIV and STDs for black gay men (or just black males if data are not available) in your community, as well as local resources for HIV/STD testing and treatment. You will need to get this information and update materials before the session. For national-level information on black MSM HIV rates and risk, go to:
<http://www.cdc.gov/hiv/aboutDHAP.htm>
- ▶ Practice facilitating all the exercises, particularly Exercise 2.5 (Sex in the City) at least once with agency staff or other volunteers. It will be important to see how each scene is performed before delivering the session.
- ▶ This session provides a lot of facts and information on STDs. Be sure to review STD 101 for Facilitators found in the Session Materials section. It will help you to get a thorough understanding of all the STDs, including their signs, modes of transmission, and treatment options.
- ▶ You can invite a nurse or other clinician or a health educator to present the HIV/STD information covered in Exercises 2.3 and 2.6.
- ▶ Participants may feel discouraged by the rates of HIV and STDs among black gay men and how almost any behavior can put them at risk for an STD. Emphasize that while these things may be true and are important to consider when deciding to have sex, they do not mean that participants cannot have a fulfilling and enjoyable sexual experience safely.

FACILITATOR'S NOTE

This session will take more than 3 hours, so you may want to provide some food and drinks to your participants.

Facilitator's Guide

Session 2 At-a-Glance

Session	Activities	Time (minutes)	Purposes	Materials
2.1	Session Preview	10 to 15	Welcome participants to Session 2, recap what was covered in the previous session, and provide an overview of what will be covered in Session 2.	<ul style="list-style-type: none"> • Sign-in sheet • Sticky notes for PARKING LOT • Name tags • Pens or pencils • Prepared newsprint: GROUND RULES • Prepared newsprint: PARKING LOT
2.2	Tops and Bottoms: Roles and Risks	20	Participants begin a discussion of the sexual relationship dynamics of Tops and Bottoms (which is more fully explored in Session 5) and how these sexual relationship roles relate to specific sexual behaviors and STD/HIV risks for black gay men.	<ul style="list-style-type: none"> • Prepared newsprint: TOPS: ROLES AND BEHAVIORS • Prepared newsprint: BOTTOMS: ROLES AND BEHAVIORS • Prepared newsprint: VERSATILES: ROLES AND BEHAVIORS • Prepared newsprint: STDs • Markers
2.3	What Do You Know About STDs and HIV for Black Gay Men?	60	Participants learn more about the STD/HIV disparities for black gay men, common STDs, and health-promotion behaviors recommended for black gay men related to STD prevention. These become some of the options for prevention in Exercise 3.2.	<ul style="list-style-type: none"> • Prepared newsprint: STDs • LCD projector • Laptop • STD 101 slides • STD 101 brochure

Session 2 At-a-Glance (continued)

Session	Activities	Time (minutes)	Purposes	Materials
2.4	How Do You Get an STD or HIV?	25	Participants learn that different kinds of sexual behaviors create different levels of risk for getting or transmitting HIV and STDs. Participants understand why the risk of getting HIV from oral sex is low but risk of getting some STDs from oral sex is high (i.e., syphilis). This exercise builds on information from Exercise 2.3.	<ul style="list-style-type: none"> • Newsprint • Markers • Masking tape • Risk behavior wall cards
2.5	Sex in the City: An Inside View	40	Participants recognize how having an STD increases the chances of getting HIV or passing HIV to a sexual partner and how this interaction affects STD/HIV rates in black communities and in black gay men.	<ul style="list-style-type: none"> • Poster board—in 5 colors • Hole puncher • Elastic cord or clothespins • 1 to 4 index cards with “HIV” written on the front • Markers
2.6	Transmission Puzzle	40	Participants learn that one’s chances of getting HIV or another STD depend on three main factors and how one’s understanding of this “transmission puzzle” can lead to a variety of STD/HIV prevention options, which is the basis for Exercise 3.2.	<ul style="list-style-type: none"> • Transmission Puzzle slides • Laptop • LCD projector
2.7	Session Summary	10	Participants provide feedback on the session, and facilitators preview Session 3.	<ul style="list-style-type: none"> • Prepared newsprint: PARKING LOT

Session 2 Primary Behavioral Determinant

Lack of knowledge of STDs and the interrelations among STDs and HIV

Session 2: STD/HIV Prevention for Black MSM—The Roles and Risks for Tops and Bottoms

Materials Checklist

Prepared Newsprints:

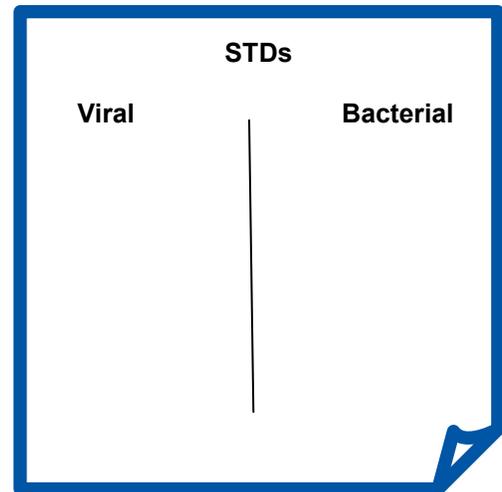
- PARKING LOT
- GROUND RULES
- TOPS: ROLES AND BEHAVIORS
- BOTTOMS: ROLES AND BEHAVIORS
- VERSATILES: ROLES AND BEHAVIORS
- STDs (SEE EXAMPLE)

Session Handout:

- STD 101

Facilitator Materials:

- STD OVERVIEW FOR FACILITATORS
- RISK BEHAVIOR WALL CARDS
- STD 101 POWERPOINT SLIDES
- TRANSMISSION PUZZLE SLIDES
- NAME TAGS
- PENS/PENCILS
- MARKERS
- INDEX CARDS
- LAPTOP
- LCD PROJECTOR
- HOLE PUNCHER
- ELASTIC CORD OR CLOTHESPINS
- STICKY NOTES FOR PARKING LOT



Advanced Preparations:

- Update STD 101 brochure with information on local HIV/STD testing and treatment services. Make enough copies for participants.
- Get local and national STD and HIV rates among black gay men. Visit the following CDC Web site to get the latest information on HIV, STDs, and black MSM:
<http://www.cdc.gov/hiv/aboutDHAP.htm>
- Prepare the materials for Sex in the City.
- Prepare newsprints.

Exercise 2.1 Session Preview

Purpose: To welcome participants to Session 2, recap what was covered in Session 1, and provide an overview of what will be covered in Session 2.

Time: 15 minutes

Materials:

- Sticky notes for PARKING LOT
- Prepared newsprint: PARKING LOT
- Prepared newsprint: GROUND RULES
- Pens/pencils
- Sign-in sheet
- Name tags

Notes on Exercise 2.1

At the beginning of Session 2 (and all future sessions), you will need to address any questions from the Parking Lot that you have not answered.

Procedures

1. Welcome participants to Session 2

- ▶ Welcome any new participants and have them briefly introduce themselves.

2. Ask participants to review key points from Session 1; if not mentioned, be sure to cover the following points

- ▶ We learned how things on the outside (external factors) and things on the inside (internal factors) influence our behavior and our ability to change.
- ▶ Black gay men experience a unique combination of some of those factors.
 - Things on the outside include attitudes of society toward black gay men, rejection by your community, rejection by the white gay community, homophobia in communities of color and church, and racism.
 - Things on the inside (internal factors) include identity, self-standards, values, attitudes, skills, and confidence.
- ▶ We talked about how external factors, such as racism and homophobia, can get inside our heads and influence how we see and feel about ourselves.
- ▶ We also recognized that all these factors contribute to risk behaviors and high STD and HIV rates for black gay men.

3. Review and answer any questions on the Parking Lot

4. Preview Session 2

- ▶ In this session, we will begin to talk about Tops and Bottoms and how these roles can affect STD/HIV risk.
- ▶ We will learn a lot of information about HIV and other STDs, how STDs are related to HIV infection, and what determines your chance of getting HIV/STD each time you have sex.
- ▶ You will use this information to build a list of things you can do to reduce your chances of infection and protect yourself.
- ▶ This session will last about 3 hours.

5. Review the Ground Rules and ask the participants if they have any questions

Exercise 2.2 Tops and Bottoms: Roles and Risks

Purpose: Participants begin a discussion of the sexual relationship dynamics of Tops and Bottoms (which is more fully explored in Session 5) and how these sexual relationship roles relate to specific sexual behaviors and STD/HIV risks for black gay men.

Objective: Participants will identify and discuss the actions, relationship roles, and STD/HIV risk for Tops and Bottoms.

Time: 20 minutes

Materials:

- Prepared newsprint: TOPS: ROLES AND BEHAVIORS
- Prepared newsprint: BOTTOMS: ROLES AND BEHAVIORS
- Prepared newsprint: VERSATILES: ROLES AND BEHAVIORS
- Prepared newsprint: STDs
- Markers

Notes on Exercise 2.2

This exercise is designed so participants can reflect on the roles, behaviors, and risks for Tops and Bottoms. The discussion and talking points about Tops and Bottoms focus on commonly held beliefs and perceptions. Not all Tops and Bottoms assume these roles. It is recommended that you have one facilitator record responses while the other facilitator asks questions.

Procedures

1. Ask participants about the roles and behaviors of Tops

- ▶ Use the following questions as probes:
 - What are Tops?
 - What does it mean to be a Top (i.e., what is his expected role)?
 - Besides being the insertive partners, what do Tops do during sex?
 - How do Tops behave in a relationship?
- ▶ Record the responses on the prepared newsprint: TOPS: ROLES AND BEHAVIORS. Be sure that the following points are covered:
 - Tops are expected to assume the role of the man in the relationship.
 - Tops are the ones who insert their penis in their partner's anus.
 - Tops are seen as the ones who are in charge or in control of what happens.

2. Ask participants about the roles and behaviors of Bottoms

- ▶ Using the following questions as probes:
 - What are Bottoms?
 - What does it mean to be a Bottom (i.e., what is his expected role)?
 - Besides being the receptive partners, what do Bottoms do during sex?
 - How do Bottoms behave in a relationship?
- ▶ Record their responses on the prepared newsprint: BOTTOMS: ROLES AND BEHAVIORS. Be sure that the following points are covered:
 - Bottoms are expected to assume the role of the woman in the relationship.
 - Bottoms are the receptive partners who receive their partner's penis in their anus.
 - Bottoms are perceived to be more submissive in a relationship.

3. Ask participants about the roles and behaviors of Versatiles

- ▶ Using the following questions as probes:
 - What are Versatiles?
 - What does it mean to be a Versatile (i.e., what is his expected role)?
 - How do Versatiles behave in a relationship?
- ▶ Record their responses on the prepared newsprint: **BOTTOMS: ROLES AND BEHAVIORS**. Be sure that the following points are covered:
 - Versatiles are partners who enjoy either the insertive or receptive role.
 - Versatiles do not necessarily have a defined relationship role.

4. Describe how sexual position can affect the risk for getting HIV and STDs

- ▶ Being a Top or a Bottom is one factor that can determine your risk for getting HIV or an STD during sex.
- ▶ During one episode of unprotected sex, you are more likely to get HIV if you are a Bottom because you can come in contact with the partner's semen (cum). However, there are other factors that place Tops at risk for HIV and we'll discuss those later.
- ▶ This not the same for STDs, where Tops also have a good chance of getting an STD during unprotected sex.
- ▶ We will learn more later in the session about what factors increase our risk for getting HIV/STDs.

FACILITATOR'S NOTE

When discussing Tops, Bottoms, and Versatiles, be sure to note that sexual position is not the only factor that affects a person's HIV risk.

5. Ask for and answer any questions participants have about Tops, Bottoms, and Versatiles

- ▶ We will talk more about how to change the power dynamics of Tops and Bottoms to make it a more level playing field in Session 5.

Exercise 2.3 What Do You Know About STDs and HIV for Black Gay Men?

Purpose: Participants learn more about the STD/HIV disparities for black gay men, common STDs, and health-promotion behaviors recommended for black gay men related to STD prevention. These become some of the options for prevention in Exercise 3.2.

Objective: Participants will learn about common STDs, including modes of transmission; the differences between viral and bacterial STDs; treatment (for viral) and cure (for bacterial); and, vaccines to prevent getting STDs. They will also learn that HIV is an STD.

Time: 60 minutes

Materials:

- Prepared newsprint: STDs
- LCD projector
- Laptop
- STD 101 slides
- Handout: STD 101 brochure (with updated information on local screening and treatment facilities)

Notes on Exercise 2.3

This exercise covers a lot of information on STDs. It is important that you review and understand the supplemental reading material: STD 101.

You will also need to set up and practice using the LCD projector and laptop because you will give the STD 101 PowerPoint slide presentation.

Finally, you will also discuss national and possibly local STD/HIV rates for black gay men. Ensure that you have the latest information on these rates. You should at least have the following information:

- Percentage of black gay men who have HIV (national).
- Percentage of black gay men (or just black males) who have HIV (local). If your State does not have data on black gay men, just present rates for black males.
- Percentage of black gay men (or just black males) who have certain STDs that are present at high rates in your community. You may have more than one STD that occurs at high rates in your area.

Information on national rates can be found at:

<http://www.cdc.gov/hiv/topics/surveillance/index.htm>

Contact your local health department to get information on HIV and STD rates.

It is recommended that you update your STD 101 brochure with information on local screening and treatment facilities.

Procedures

1. Introduce the exercise using the following points

- ▶ These days, people know more about HIV than about other STDs, even though the other STDs are more common and can cause serious illness and death.
- ▶ In this exercise, we are going to learn more about STDs, including HIV. Specifically, we will learn
 - the differences between viral and bacterial STDs,
 - how STDs are spread and treated,
 - what kinds of STD testing you need to ensure you don't have an STD.

2. Ask participants what the main difference is between viral and bacterial STDs

- ▶ If not mentioned, point out that the main difference is that bacterial STDs can be cured with antibiotics, which don't work on viruses.
- ▶ Some viral STDs can be managed with medications but not cured. Some viral STDs are lifelong infections and never go away.
 - There are vaccines to prevent some viral STDs.
- ▶ The good news is that both bacterial and viral STDs are totally preventable! We are going to learn more about STDs and STD testing and use the information to develop our menu of prevention options.

3. Create list of STDs with the participants

- ▶ Ask the group to name the most common STDs and specify whether they are viral (cannot be cured) or bacterial (can be cured).
- ▶ Record their responses on prepared newsprint: STDs. Be sure to put the STD under the appropriate column (VIRAL or BACTERIAL).
- ▶ If not mentioned, be sure to ask the participants where HIV and Hepatitis C belong on the list.

BACTERIAL	VIRAL
Gonorrhea—"the Clap" Chlamydia Syphilis Trichomoniasis Chancroid	HIV Herpes Simplex Virus (HSV) Hepatitis A Hepatitis B Hepatitis C Human Papilloma Virus (HPV)—wart virus

4. Discuss list of STDs using the following talking points

- ▶ Some STDs are spread through direct contact of mucous membranes (e.g., herpes). Mucous membranes are pink parts of tissue inside your mouth, penis, and rectum. We will find out more about pink parts in the next exercise.
- ▶ Some are transmitted through discharge from the penis (semen), rectum, or vagina (e.g., gonorrhea).
- ▶ Some are transmitted by sharing needles and through semen (cum) or vaginal fluids (e.g., HIV; Hepatitis B and C).

5. Discuss what kinds of behaviors put people at risk for getting STDs

- ▶ Sexual behaviors—having unprotected sex (anal, vaginal, or oral); kissing or licking body parts that are currently infected with warts, sores, or lesions; rubbing together infected pink parts (penis, anus, or lips) may put you at risk for some STDs.
- ▶ Injection drug use behaviors—using and sharing dirty (i.e., infected) needles and works.
- ▶ Using drugs and drinking can also lead to poor judgment and may make you less likely to use condoms, to ask your partner to use condoms, or to clean your needles and/or works.

6. Describe the different types of STD tests

- ▶ Swabs from mouth, rectum, and penis—gonorrhea and chlamydia and HIV rapid tests.
- ▶ Urine tests—gonorrhea and chlamydia.
- ▶ Blood drawn into tubes—syphilis; Hepatitis A, B, and C; herpes; and HIV.
- ▶ Examination of mouth, skin, penis, or rectum—genital warts, lice, scabies, and other STDs.

FACILITATOR'S NOTE

There are talking points to cover for each slide. You do not have to read them word for word. It is best if you use your own words when delivering these points. It is important that you spend time reviewing these before giving the presentation.

7. Present the STD slide presentation, using the following talking points for each slide

▶ Slide 1.

- This presentation is an overview of the most common sexually transmitted infections/diseases (STIs and STDs) that affect black gay men. In the United States, there are approximately 56,000 new cases of HIV every year compared with 18 million new cases of STIs.
- The bad news is that black gay men are more likely to have these infections than other men—which is one of the reasons that rates of HIV are so high for black gay men.
- The good news is that most can be cured and there are vaccines to prevent getting others!
- The purpose of this presentation is to give black gay men the knowledge of STIs that they need to empower them to advocate for their sexual health and reduce their chances of getting HIV.
- When it comes to STIs—the mantra is: GET TESTED, GET TREATED, GET CURED, GET THE VACCINES!

▶ Slide 2.

- The STDs we will discuss include three caused by bacteria: gonorrhea, chlamydia, and syphilis, and four caused by viruses: HIV, herpes, human papilloma virus (better known as HPV), and hepatitis.
- Remember that all the bacterial STDs are curable with one-time antibiotic treatments.
- The viral STDs—hepatitis and HPV—can be cleared by the body alone over time. In addition, vaccines can totally prevent these infections.
- Herpes cannot be cured but remains inactive in the body most of the time.
- HIV cannot be cured but there are very effective treatments.

▶ Slide 3.

- Gonorrhea (GC) is one of the most well-known STDs.
- How many of you have heard of GC?
- GC disproportionately affects black men in the United States.
- What percentages of cases of GC in men in the United States do you think occur in black men? Answer: Almost 80%.
- Is it curable? Answer: Yes, the good news is that GC is easily cured with one antibiotic pill.

- ▶ Slide 4.
 - Gonorrhea is caused by a bacteria and is curable!
 - It is passed by contact of pink parts with semen, vaginal fluids, and rectal fluids, and a mother can pass it to a newborn during delivery.
 - Black gay men can get GC in their throat, in their pee hole (penis), and in the rectum depending on the kind of sex they have.
 - There are usually no symptoms of GC in the throat or rectum—you can have it and not know it.

- ▶ Slide 5.
 - If the penis is infected, there may be symptoms of burning and discharge from the urethra.
 - Does a black gay men with GC always have symptoms? Answer: Hardly ever if the GC is in the throat or rectum and about 70% of the time if the GC is in the urethra.

- ▶ Slide 6.
 - If men don't get treated early, there can be complications; GC can travel from the urethra to the testicles and sometimes into the bloodstream.
 - GC infection in the testicles is known as epididymitis. There is a lot of swelling and pain and it can cause men to be sterile.
 - GC infection in the blood is known as disseminated gonococcal infection (DGI). This is rare but serious and needs immediate medical care.
 - The good news is that these complications can be totally prevented by being screened and getting early treatment.

- ▶ Slide 7.
 - There are two tests for GC; one is based on collecting a urine specimen and the other is done by collecting swabs.
 - Please know that all gay men should have a separate test at each place where there might be GC—penis, throat, and rectum.
 - The urine test only detects GC in the penis and is not recommended for black gay men.
 - If a black gay man only has GC urine testing, what percentage of GC would be missed? Answer: About half.
 - Why? Answer: Because black gay men commonly have GC in the throat and rectum and don't know it.

- Advocate for your sexual health—tell your doctor you need your throat and rectum tested for GC!

▶ Slide 8.

- Chlamydia is a bacterial STD that is now more common than GC but less well known.
- How many of you have ever heard of chlamydia (CT)?
- What percentages of cases of CT in men in the United States do you think occur in black men? Answer: Almost 65%.
- Is it curable? Answer—Yes, the good news is that CT is easily cured with one antibiotic pill.

▶ Slide 9.

- CT is caused by a bacteria and is curable!
- Just like GC, chlamydia is passed by contact of pink parts with semen, vaginal fluids, and rectal fluids, and a mother can pass it to a newborn during delivery.
- Black gay men can get CT in their throat, in their pee hole (penis), and in the rectum depending on the kind of sex they have.
- There are usually no symptoms of CT in the throat or rectum. If CT is in the penis, there can be burning and a little discharge but often there are no symptoms of CT in the penis either—you can have it and not know it.
- What percentage of men with CT of the penis have no symptoms? Answer: About 40%.

▶ Slide 10.

- If men don't get treated early, there can be complications; just like GC, CT can travel from the urethra to the testicles. In women, CT can travel up to the uterus and tubes and cause pelvic inflammatory disease (PID).
- CT infection in the testicles is known as epididymitis, which has a lot of swelling and pain. CT is the most common cause of sterility in men.
- PID is the most common cause of sterility in women in the United States.
- The good news is that these complications can be totally prevented by being screened and getting early treatment.

▶ Slide 11.

- There are two tests for CT; one is based on collecting a urine specimen and the other is done by collecting swabs.
- Please know that all gay men should have a separate test at each place where there might be CT—penis, throat, and rectum.
- The urine test only detects CT in the penis and is not recommended for black gay men.
- If a black gay man only has CT urine testing of the penis, what percentage of CT would be missed? Answer: About half—50%.
- Why? Answer: Because black gay men commonly have CT in the throat and rectum and don't know it.
- Advocate for your sexual health—tell your doctor you need your throat and rectum tested for GC!

▶ Slide 12.

- Syphilis has now become common in gay men.
- How many of you have heard of syphilis?
- Syphilis disproportionately affects black men in the United States.
- What percentage of cases of syphilis in men in the United States do you think occur in black men? Answer: Almost 43% (in 2008).
- Is it curable? Answer—Yes, the good news is that syphilis is easily cured with one or more antibiotic shots.
- What percentage of black gay men who get syphilis already have HIV? Answer: About half—50%.
- Why? Answer: In recent years, many gay men with HIV are living longer and healthier and having sex for longer periods of time after infection. Some are sero-sorting relative to HIV, but also have other STIs. Also, many don't know that unlike HIV, syphilis is easily passed through oral sex only.

▶ Slide 13.

- Years ago, syphilis was called bad blood because it is a blood infection, just like HIV. It can take up to 3 months after infection to show any symptoms, but the first symptoms often appear in 2 to 3 weeks.
- Syphilis is passed by direct contact of pink parts to pink parts—it doesn't depend on semen, vaginal fluids, or rectal fluids to be exchanged.
- The good news is that it is totally curable!

▶ Slide 14.

- Syphilis goes through stages; some stages have symptoms and some stages have no symptoms. In the first stage, a sore can appear on the penis, rectum, or in the mouth.
- This sore is painless and heals by itself in about 7 to 10 days with no treatment, so many times it goes unnoticed or is thought to be due to something else.
- After the sore goes away, a rash appears on the body and may spread to the hands and feet. There can also be white patches in the mouth and wartlike bumps on the penis or anus.
- What percentage of men with syphilis have no symptoms? Answer: About half–50%.

▶ Slide 15.

- This slide shows a syphilis sore on a male, but as typical of these slides, it shows a very extreme case. Often the sore is much smaller and if it appears on the anus, it may not be noticed at all. The sore will heal completely in 7 to 10 days with no treatment at all.

▶ Slide 16.

- This slide shows a syphilis sore on the outside of the lower lip; again, this was passed through oral sex.

▶ Slide 17.

- After the sore goes away, the syphilis germs travel into the bloodstream and cause other symptoms including rash, which may be accompanied by a slight fever or swollen glands.
- The rash can last 2 to 6 weeks and then go away without treatment.
- During this time, millions of syphilis germs are present in the mouth, penis, and rectum, so the infection can be passed by any kind of sex.

▶ Slide 18.

- This shows the syphilis rash. It is not painful but may begin to itch after a few weeks. On black skin, the rash looks like darker brown spots.

- ▶ Slide 19.
 - Unlike many other kinds of rashes, the syphilis rash can be seen on the face. This slide is extreme, though; often there may be just a few spots on the face.
- ▶ Slide 20.
 - Also, unlike other rashes, the spots can spread to the palms of the hands and even to the soles of the feet. Remember, this rash will clear up after about 3 to 6 weeks with no treatment.
- ▶ Slide 21.
 - If left untreated, syphilis can cause serious damage to the bones, joints, and nervous system and can even cause death. Before antibiotics were discovered in the 1940s, syphilis was often a fatal infection, just like HIV used to be.
 - The good news is that these complications can be totally prevented by being screened and getting early treatment.
- ▶ Slide 22.
 - Syphilis is easily diagnosed with a simple blood test.
 - Be an advocate for your sexual health—tell your doctor you want a syphilis screening test.
 - Remember the mantra: GET TESTED, GET TREATED, GET CURED!
- ▶ Slide 23.
 - Herpes simplex virus is also known as HSV, or just herpes.
 - Herpes is a viral STI and is passed by direct contact between pink parts during sex.
 - Herpes cannot be cured but can be managed with medications.
- ▶ Slide 24.
 - There are two common types of herpes.
 - Oral herpes (called a cold sore or fever blister). Chancre sores that can appear inside the mouth are not herpes.
 - Genital herpes. This type causes sores to appear on the penis or around the anus.
 - There are two types of herpes virus: herpes 1 and herpes 2.

- Herpes 1 is usually passed in childhood and causes the common cold sore.
 - Herpes 2 is usually passed through anal sex in black gay men. However, either type can be passed to either site during sex.
 - How can cold sores on the mouth cause genital herpes? Answer: The virus can be passed to the genitals of a sexual partner through oral sex.
- ▶ Slide 25.
- Usually about 7 to 10 days after infection occurs, sores can develop on the penis, anus, or mouth. These are small blisters that are filled with clear fluid, like water blisters. The first time a person gets the sores, they also may have fever, body aches, and headache. Then, the sores will heal completely in about 2 weeks with no treatment. However, the virus doesn't go away but becomes inactive in the nerves under the skin.
- ▶ Slide 26.
- Here you can see some herpes sores. In this case, the water blisters have broken open and then scabbed over.
- ▶ Slide 27.
- Sometimes, you can get herpes on the skin if there is a break in the skin that then comes in contact with another person's pink parts during sex.
- ▶ Slide 28.
- Just like for all STIs, some people get herpes and have no symptoms or very few sores that they don't notice.
 - Herpes can be spread to a sexual partner even when there are no visible sores—which is called asymptomatic shedding.
- ▶ Slide 29.
- Herpes can be detected by a swab test, if there are sores, and by a blood test, if there are no sores.
 - The good news is that there are three different antiviral medicines that can make the sores go away faster when there are outbreaks.
 - The medicines can also cut down on the amount of asymptomatic shedding, if taken every day.
 - There is still a chance of passing herpes to a sexual partner if you are taking the medicines every day, but it is a very small chance.

- ▶ Slide 30.
 - Human papilloma virus (HPV) is better known as genital warts. This is currently one of the most common STIs. HPV is a virus and is not curable with medicines.

- ▶ Slide 31.
 - HPV is passed by direct contact of pink parts to pink parts during sex. A woman can pass HPV to a newborn during vaginal delivery.
 - Most people with HPV do not have symptoms, so the incubation time is not clear.
 - The good news is that most of the time, a person's own immune system will inactivate the virus and the person will no longer be able to pass it to a sexual partner. This usually takes about 6 months.

- ▶ Slide 32.
 - There are many different types of HPV that infect the genitals. Many of these types are very benign and cause some small warts on the penis or rectum that can go away over time.
 - Many people, though, who get HPV never get any warts.
 - The warts can look like small bumps with a rough surface (like the surface of a cauliflower). They usually do not hurt and can be present for years.

- ▶ Slide 33.
 - Here are some pictures of warts on the penis. Sometimes, they can just be a few small bumps. Many men don't notice the bumps at all.

- ▶ Slide 34.
 - The warts can be removed with a variety of different methods.
 - Removing the warts doesn't get rid of the virus because it is in the skin around the warts.
 - Eventually, though, a person's own immune system will make the virus inactive—usually in about 6 months.
 - The good news is that there is now a very effective vaccine to prevent HPV and it is now recommended for males.
 - Be an advocate for your sexual health—ask your doctor about getting the HPV vaccine!

- ▶ Slide 35.
 - Some types of HPV can lead to cancer of the penis and rectum in a small number of men. Some doctors are doing anal Pap smears to detect HPV in gay men. Treatment of abnormal Pap smears in gay men, however, is not clear at this time.
 - In women, some types of HPV cause cervical cancer.
 - The good news is that these complications are preventable if you get the vaccine!

- ▶ Slide 36.
 - Hepatitis A, B, and C are related viruses.

- ▶ Slide 37.
 - All types of hepatitis infect the liver.
 - Hepatitis A is most commonly spread by food workers who go to the bathroom, wipe themselves, don't wash their hands, and then handle food.
 - For gay men, Hepatitis A can also be spread by rimming or by touching a person's rectum (who has Hepatitis A) and then putting your fingers in your own mouth.
 - Hepatitis B and C, though, are spread like HIV, from semen, vaginal fluids, or rectal fluids to the pink parts and then to the bloodstream. They are also spread by needle sharing.

- ▶ Slide 38.
 - With Hepatitis A, the immune system will clear the virus after a few weeks.
 - With Hepatitis B and C, the immune system will usually clear the virus after a few weeks.
 - However, for some people, the immune system doesn't clear the infection and they become chronic carriers.

- ▶ Slide 39.
 - If a person becomes a chronic carrier of Hepatitis B or C, they are more likely to develop liver disease, liver cancer, and liver failure over time. They can also pass their infection to a sexual partner.

- ▶ Slide 40.
 - The good news is that there are some new treatments that can cure the carriers of their chronic infection.
 - The better news is that Hepatitis A and B are totally preventable with safe and very effective vaccines.
 - All black gay men are recommended to receive these vaccines.
 - Be an advocate for your sexual health—tell your doctor you want the hepatitis vaccines!

- ▶ Slide 41.
 - How do the high rates of STDs contribute to the high rates of HIV for black gay men? Answer: STDs make it easier to get HIV and easier to pass HIV to a sexual partner.
 - How can the high rates of STDs for black gay men be reduced? Answer: Be an advocate for your sexual health and that of your partners. Talk to your partners about the mantra: BE TESTED, BE TREATED, BE CURED, BE VACCINATED!

8. Distribute the updated STD 101 brochure to participants

- ▶ The pamphlet contains information on what was covered in the exercise.
- ▶ It also has information on where you can go to get tested and treated for STDs and HIV and the types of tests you should get.

FACILITATOR'S NOTE

Consider asking a provider from a local STD clinic to come and offer STD testing one evening after the session. The provider must be able to do rectal and throat testing.

9. Facilitate a discussion on STD/HIV disparities in black communities in the United States

- ▶ Use the following questions as probes:
 - Which STDs are highly present in our local community of black gay men?
 - What have you heard about HIV rates in among black gay men, both locally and nationwide? Is the number of men with HIV increasing?
 - Recalling what we previously discussed in Session 1, why are we at an increased risk for HIV?

- ▶ Be sure to mention the following information during your discussion on HIV:
 - Percentage of black gay men with HIV in the United States: _____
 - Percentage of black gay men (or just black males if data are not available) with HIV in your community: _____
 - Percentage of black gay men (or just black males) with an STD that is highly prevalent in your community:
 - STD 1: ____%
 - STD 2: ____%
 - STD 3: ____%
 - A recent CDC report¹ stated that among the 8,153 MSM interviewed and tested in 21 cities, black MSM had the highest prevalence rate of HIV (28%). In addition, 59% of black MSM with HIV were not aware of their status.

10. Summarize the exercise, covering the following points

- ▶ Remember that some STDs can be cured with medicine (bacterial) and some STDs can't be cured and may be with you forever (viral).
- ▶ The good news is that STDs and HIV are preventable, and we will talk about options for prevention in the next session.
- ▶ The sooner you get tested and treated for STDs, the better chance you have of either curing or treating it before it gets worse. Also, you will lower your chances of spreading the STD to others.
- ▶ Because there is no cure for viral STDs, including HIV, it is also important to reduce or stop behaviors that may put you at risk for getting a virus, such as having sex without a condom or using dirty needles and works.
- ▶ If more black gay men get tested and treated for STDs and reduce their risk behaviors, the better chance we have of lowering the high rates of HIV and STDs in our community.

¹ Centers for Disease Control and Prevention. (2010). Prevalence and awareness of HIV infection among men who have sex with men—21 cities, United States, 2008. *Morbidity and Mortality Weekly Report*, 59(37), 1201–1207.

Exercise 2.4 How Do You Get an STD or HIV?

Purpose: Participants learn that different kinds of sexual behaviors create different levels of risk for getting or transmitting HIV and STDs. Participants understand why the risk of getting HIV from oral sex is low but the risk of getting some STDs from oral sex is high (i.e., syphilis). This exercise builds on information from Exercise 2.3.

Objective: Participants will learn about which sexual behaviors put them most at risk for getting HIV or an STD.

Time: 25 minutes

Materials:

- Sexual behavior wall cards
- Blank newsprint
- Markers
- Masking tape

Notes on Exercise 2.4

During this exercise, you will have participants name sexual behaviors that put one at risk for acquiring HIV and STDs. Encourage participants to use whatever terms they usually use to describe these behaviors. Be sure that participants clarify what a term means so that everyone understands it. Whenever a behavior is named, ask participants about other terms they use to describe that behavior.

For this exercise, participants will place sexual behavior wall cards in order of lowest to highest level of risk for getting HIV. After they complete the ranking, you will note that some behaviors, such as deep kissing and oral sex, pose a lower risk for getting HIV but pose a higher risk for certain other STDs.

If the group contains more than 12 participants, break them into small groups of 4 to 6 participants. Give the groups 10 minutes to come up with a list of sexual behaviors. Have each group then take a turn naming a sexual behavior and record the responses on the newsprint.

Procedures

1. Facilitate a discussion on what kinds of sex put people at risk for getting HIV

- ▶ Ask participants to brainstorm and call out the different kinds of sex black gay men have.
- ▶ Encourage them to use their own terms for describing the sexual behavior and/or ask them to clarify what that term means.
- ▶ Record responses on newsprint. Be sure that the following are listed in their own language:
 - Mutual masturbation
 - Deep kissing
 - Getting sucked with a condom
 - Sucking with a condom
 - Fucking with a condom
 - Getting fucked with a condom
 - Getting sucked without a condom
 - Sucking without a condom
 - Fucking without a condom
 - Getting fucked without a condom

FACILITATOR'S NOTE

Other behaviors participants might mention include fingering, fisting, or rimming (oral to anal contact). These are relatively low-risk behaviors when it comes to HIV transmission. Rimming may have the same HIV/STD risk as sucking without a condom.

2. Ask participants to rank the behaviors from lowest to highest risk for getting HIV

- ▶ Hand out the sexual behavior wall cards, giving one to each participant.
- ▶ Point out that these cards list behaviors that can put one at risk for getting HIV.
 - Tell participants that everything on their list can be summarized into these wall cards.
 - We will use the cards so that everyone is clear about what specific kind of sex we are discussing.

- ▶ Tell participants to tape their card on the wall, in order of risk for getting HIV.
 - Lower-risk cards should be taped toward the top while higher-risk cards should be taped toward the bottom.
 - NOTE: The list above ranks the behaviors from lowest to highest risk.
- ▶ Give them 5 minutes to complete the exercise. Encourage them to talk and work with each other to make sure the behaviors are in the correct order.
- ▶ Once all the cards are up, review the cards, going from the low risk (top) to the high risk (bottom) behaviors.
- ▶ If 1 card is out of order, say something like “I think there is something that is less risky than this. Who can tell me what behavior should go before this one?”
- ▶ When reviewing the cards, ask why that behavior is a low or high risk for getting HIV.
- ▶ Continue the process until all the cards are reviewed.

3. Review the ranked list with participants

- ▶ Note that some behaviors, such as deep kissing and oral sex, pose a lower risk for getting HIV but pose a higher risk for other STDs (e.g., herpes).
- ▶ Point out that different types of sex have different levels of risk for getting an STD or HIV. Having types of sex that are lower risk means we can still enjoy sex and lower our chances of getting an STD or HIV.
- ▶ Ask for and clarify any questions they have about the list.

Exercise 2.5 Sex in the City: An Inside View

Purpose: Participants recognize how having an STD increases the chances of getting HIV or passing HIV to a sexual partner and how this interaction affects STD/HIV rates in black communities and in black gay men.

Objective: Participants will increase their knowledge of how STDs and HIV spread inside our bodies and how our bodies fight them. Participants will also increase their understanding of the connection between STDs and HIV and how treating an STD can lower their risk for getting and spreading HIV.

Time: 40 minutes

Materials:

- Poster board—in 5 colors
- Hole puncher
- Elastic cord or clothespins
- 1 to 4 index cards with HIV written on the front
- Markers

Notes on Exercise 2.5

This exercise requires open floor space for participants to act out their roles. You may need to clear out some floor space or move to a more open room, if space is limited.

You will need to prepare the cards listed in the table below before you conduct Session 2. Cut each poster board into pieces that measure 8 by 11 inches. Punch two holes into the top two corners of each piece and insert elastic cord so the card can be worn around a person's neck (an alternative is attach one or two clothespins so that the card can be clipped to a person's shirt). Write the name of the part being portrayed in large print. The cards indicate a mucous membrane (pink part), a type of white blood cell, or a type of organism (germ). The role, minimum and suggested number of players, and color for each type of card are included in the following table.

Sex in the City Cards

Color	Role	Minimum Number	Suggested Number
Pink	Mucous Membrane Lining Cells (i.e., pink parts) Write "Vagina, Rectum, Mouth, Urethra" on front.	3	8
Green	Scout Immune Cells Write "Scout Immune Cells" on front.	1	4
Orange	T4 White Blood Cells Write "WBC T4" on front.	1	3
Blue	STD Germs Write "STD" on front.	1	4
Yellow	HIV Germs Write "HIV" on front.	1	4

FACILITATOR'S NOTE

Because the number of participants you have will vary, add or subtract the number of persons assigned to be cells or germs. It is important that each participant gets a role and takes part. If you do not have enough participants, you can use empty chairs for the pink parts.

Procedures

1. Introduce and set up the exercise

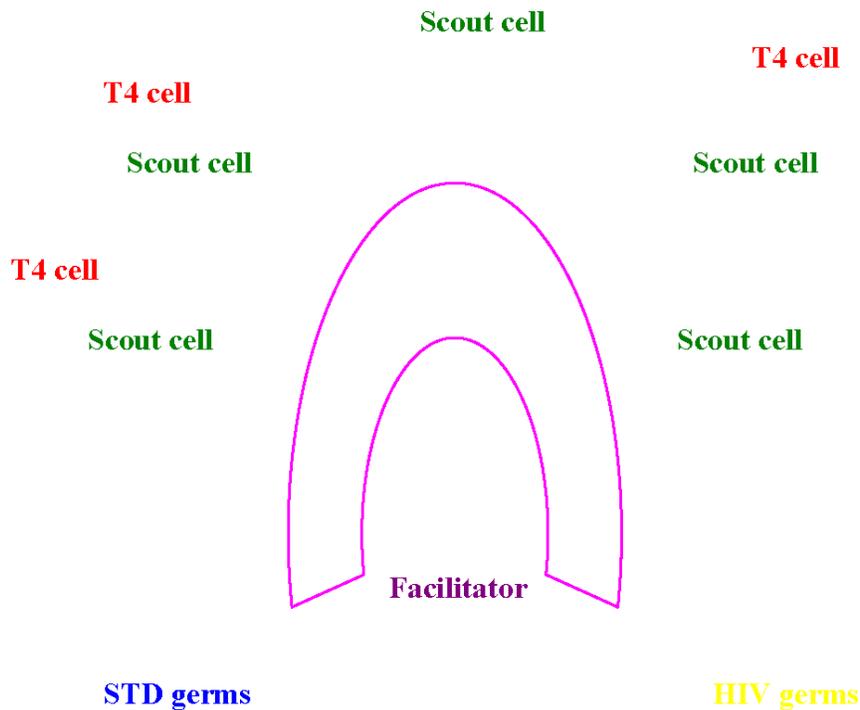
- ▶ We are now going to participate in a theater exercise we like to call Sex in the City: An Inside View.
- ▶ All of you will get to play a role in this exercise, and you will experience what really happens during sex when HIV is transmitted and how STDs make it easier for HIV to infect your body.
 - Distribute to each participant a colored card and tell him to wear the card around his neck. Participants assigned to play HIV should also receive an HIV index card.

FACILITATOR'S NOTE

Sex in the City is a scripted, educational theater exercise. It is important that you follow the script as closely as possible when facilitating the scenes.

2. Arrange the participants in the following manner (see the diagram below for details)

- ▶ Instruct the pink parts to form an inverted “U” shape in the middle of the space. You can arrange chairs to form a U if you don't have enough participants.
- ▶ Place the scout cells around the outside of the U.
- ▶ Place the T4 cells around the outside of the U, but further out.
- ▶ You stand at the open part of the U.
- ▶ Ask the STD and HIV germs to stand by you at the open part of the U: STD germs on one side and HIV germs on the other.



3. Introduce the players using the following script

- ▶ “I will be the narrator and director for all the scenes. I have the only speaking part. The PINK PARTS are nonmoving, but the rest are moving parts.”
- ▶ “Before we begin, let me introduce you to the players.”
- ▶ “First, we have a BODY CAVITY, formed by the pink parts, into the shape of a U. A body cavity is lined with pink parts, which are really squamous and columnar epithelial cells that line the surface of the vagina, rectum, urethra, or mouth. Its lining is the same in all sites. These cells overlap and form a barrier and provide some protection against getting STDs and HIV.”
- ▶ “All pink parts now join hands. Choose the body cavity you would like to portray.”
- ▶ “Next, meet the SUBMUCOSA. This is the layer just underneath the lining of the body cavity. Here you will find some WHITE BLOOD CELLS (WBC), who are soldiers in the battle that takes place when germs enter any body cavity.”
- ▶ “The people with green cards are the SCOUT IMMUNE CELLS, affectionately known as SCOUT CELLS. Scout immune cells include macrophage cells and dendritic cells. The scout cell’s job is to rush to the pink parts if any germs or irritants get into the body cavity. The scout cell then tries to destroy the germ.”
- ▶ “The people with the red cards are the T4 LYMPHOCYTE CELLS. When a germ gets into the body cavity, the T4 cells signal other cells in the bloodstream to start making antibodies to fight off the infection.”
- ▶ “A strange coincidence is that both scout cells and T4s have a specific receptor on the outside called a CD4 RECEPTOR.”
- ▶ “Scout cells and T4s, please raise one arm and open your hand. Keep your arm raised. This is the CD4 receptor.”
- ▶ “Now, meet the HIV GERM. HIV is a scary germ, but really is sort of wimpy in that it can’t live on its own. It has to get inside a cell and live there. If HIV doesn’t infect a cell and get inside it after 24 hours (often only 6 to 8 hours), it will die.”
- ▶ “The HIV germ has a protein on the outside called an ATTACHMENT PROTEIN. HIV germs, please raise one arm and make a fist.”
- ▶ “In order for HIV to infect a cell, the attachment protein has to find a cell with a specific receptor. It just so happens that the one and only receptor that fits HIV is the CD4 receptor.”

- ▶ “These, of course, are on the scout cells and the T4 cells, represented by their raised, open hands. If this connection is not made, then infection can’t happen.”
- ▶ “Lastly, meet the STD GERMS. These can be bacterial ones like gonorrhea and chlamydia, or viral ones like herpes. They all have the same effect in connection with HIV. Unlike HIV, STD germs directly infect pink parts.”
- ▶ “STD germs, do a dog-paddle motion with your hands and paddle against the joined hands of the pink parts.”
- ▶ “Pink parts, drop your arms to show that you have been infected and the layer of protection is disrupted.”
- ▶ “STD germs, now leave the body cavity, and pink parts, rejoin hands.”

SCENE 1 MAJOR POINTS

Scene 1 features normal resistance; pink parts intact; no target white blood cells for HIV attachment and infection.

4. Conduct Scene 1 using the following script

- ▶ “Now for our first scene! Here is a healthy body cavity. See how the cells are joined and form a barrier. (Gesture to pink parts holding hands.) The scout cells and T4 cells are under the surface, but not on the lining of the pink parts.”
- ▶ “Sex happens. It could be oral sex, vaginal sex, or rectal sex, it doesn’t matter. The body fluid (either semen or cervical/vaginal secretions) gets into the body cavity. The body fluid has HIV germs in it.”
- ▶ “HIV germs, please go into the body cavity with your arms raised with fists.”
- ▶ “The HIV germs are desperately looking for a CD4 receptor to live. But, they can’t find one. The pink parts don’t have CD4 receptors and HIV can’t infect them. They also can’t reach the scout cells or the T4 cells because the lining is intact.”
- ▶ “Scout cells, please wave your raised arms with open hands. The HIV germs are dying.....dying.....dying.....dead.”
- ▶ “HIV germs, please run out of the body cavity.”
- ▶ “The HIV germs are now just part of the wet spot on the sheet. CUT!”

FACILITATOR'S NOTE

For a fun twist, have the other facilitator pretend to be an "Under the Covers Reporter" and go up to different participants and ask the questions.

5. Ask the following questions about the first scene to assess participants' understanding

- ▶ What just happened here?
- ▶ What provides the first line of defense against HIV?
 - Pink parts.
- ▶ Can HIV infect the pink parts directly?
 - No.
- ▶ What does HIV need to cause an infection?
 - A scout cell.
- ▶ Where are the scout (white blood) cells?
 - Not in the pink parts.
- ▶ True or false? If there are no white blood cells on the pink parts, the chance of getting HIV is low.
 - True.
- ▶ Ask for and answer any questions participants have about the scene.

SCENE 2 MAJOR POINTS

Scene 2 features HIV-negative person getting an STD; increase of scout cells in the body cavity; person is more vulnerable to HIV due to increased white blood cells on pink parts.

6. Conduct Scene 2 using the following script

- ▶ "We will now act out our second scene. Here is the same healthy body cavity. See how the cells are joined and form a barrier? (Gesture to the pink parts, who should still be holding hands.) Again, the scout cells and T4 cells are under the surface, but not on the lining of the pink parts."
- ▶ "Sex happens. This time, STD germs are in the semen or cervical/vaginal secretions. Unlike HIV, some STD germs do directly attack the pink parts and infect those cells."

- ▶ “STD germs, please go into the body cavity and start paddling the joined hands of the pink parts.”
- ▶ “Pink parts, please drop your hands after being struck to show that you have been infected and the barrier is broken.”
- ▶ “This wakes up the scout cells, which rush into the cavity to fight off the STD germs. Scout cells, please go inside the body cavity.”
- ▶ “Now, let’s say the person who owns this body cavity actually goes for care and gets treatment for the STD infection. The STD germs die.”
- ▶ “STD germs, please run out of the body cavity.”
- ▶ “Even though the STD is cured, some of the scout cells still hang out in the body cavity because they’re not really sure what is happening. Maybe the STD germs are coming back? CUT!”
- ▶ “STDs aren’t the only things that cause scout cells to come out into the body cavity. Things that cause inflammation, such as douches, products, and sex, can have the same effect.”

7. Ask the following questions about the second scene to assess participants’ understanding

- ▶ What just happened here?
- ▶ Can STDs directly infect the pink parts?
 - Yes. Unlike HIV, STDs can directly infect the pink parts.
- ▶ What happens when an STD infects the pink parts?
 - Scout (white blood) cells rush into the body cavity and cover the pink parts.
- ▶ True or false? Your white blood cells go away immediately after an STD is treated.
 - False. Even after the STDs are cured, some white blood cells remain for a time.
- ▶ Which germ directly infects white blood cells?
 - HIV.
- ▶ Ask for and answer any questions participants have about the scene.

SCENE 3 MAJOR POINTS

Scene 3 features continuation from previous where person has white blood cells in the body cavity; HIV infection occurs on pink parts and is then carried into the bloodstream.

8. Conduct Scene 3 using the following script

- ▶ “We are now on to our third scene. This scene builds on our last scene where the person had an STD infection. Sex happens again. This time, there are HIV germs in the semen or cervical/vaginal secretions.”
- ▶ “HIV germs, please enter the body cavity with your raised fists. This time, the HIV germs find their lifeline, the CD4 receptors, on the scout cells. Remember, these scout cells are hanging out because of the previous STD infection.”
- ▶ “Scout cells, please grab the fist of the HIV germ with your raised open hand. The scout cells are now infected. They go back to the submucosa and they take the HIV germs with them.”
- ▶ “Attached scout cells and HIV germs, please move to the submucosa ...our pink parts. There, they find the T4 cells and give some HIV to them.”
- ▶ “HIV germs, give the T4 cells your index card with HIV written on it.”
- ▶ “The T4 cells run to the bloodstream to alert other immune cells to begin making antibodies, but HIV finds more T4 cells to attach to in the bloodstream and this is how the bloodstream becomes infected.”
- ▶ “T4 cells, take the HIV card and run to the bloodstream. Meanwhile, infected scout cells remain in the submucosa. CUT!”
- ▶ “This scene shows us how having a prior STD infection made it easier for HIV to link to a receptor since the scout cells were present in the submucosa. Remember that in our first scene, HIV was not able to enter the body since it could not latch on to a CD4 receptor
- ▶ “Also remember other things can cause irritation of the pink parts and increase the number of white blood cells there.”

9. Ask the following questions about the third scene to assess participants' understanding

- ▶ What just happened here?
- ▶ Why were there scout (white) blood cells on the pink parts?
 - Because of the previous STD infection.

- ▶ Did HIV have to find a break in the pink parts or a sore in order to cause infection?
 - No.
- ▶ How did HIV infection actually happen?
 - HIV attaches to the white blood cells.
- ▶ True or false? HIV only infects white blood cells.
 - True.
- ▶ What things can increase the number of white blood cells on your pink parts?
 - STDs. Things that can irritate the pink parts, such as having sex or douching.
- ▶ Why does having an STD increase your chances of getting infected with HIV?
 - Because having an STD increases the amount of white blood cells on the pink parts, which HIV needs to get into the body.
- ▶ Ask for and answer any questions participants have about the scene.

SCENE 4 MAJOR POINTS

Scene 4 features HIV-infected person who gets an STD; having an STD increases the chances that HIV and the STD will be passed to a sexual partner; getting the STD treated lowers the chance of HIV and STD transmission.

10. Conduct Scene 4 using the following script

- ▶ “We are now in our final scene. This is now the body cavity of a person who is living with HIV/AIDS. The HIV is in the bloodstream in the T4 cells and also still in the scout cells under the surface of the pink parts. The pink parts are healthy, with just a little HIV being shed.”
- ▶ “Pink parts, please join hands again and one HIV germ should stay in the cavity. The rest of the HIV germs, please stay joined to the scout cells in the submucosa.”
- ▶ “Sex happens AGAIN. This time, an STD is in the semen or cervical/vaginal fluids.”
- ▶ “STD germs, please run into the body cavity. The STD germs again attack the pink parts and destroy some of the lining.”
- ▶ “Pink parts, please drop your joined hands.”

- ▶ “The scout cells again come out to fight off the STD infection, but they bring the HIV germs with them.” (If they have not done so, tell the scout cells and their attached HIV germ to come into the cavity.)
- ▶ “So more HIV is being shed, making it more likely to be passed to other sex partners.”
- ▶ “Now, let’s say that this person living with HIV/AIDS actually got STD testing and treatment. The STD germs will die.”
- ▶ “STD germs, please run out of the body cavity.”
- ▶ “The scout cells eventually go back to the submucosa and the amount of HIV germs in the body cavity goes down again.”
- ▶ “Scout cells, please take the HIV germs and go back to the submucosa. One HIV germ should stay in the body cavity. CUT!”
- ▶ “So, by getting STD treatment, the person living with HIV/AIDS can reduce his chances of passing HIV to a sexual partner because there will be less HIV germ in the body cavity.”

11. Ask the following questions about the fourth scene to assess participants’ understanding

- ▶ What just happened here?
- ▶ True or false? Once a person has HIV, his white blood cells in the submucosa (pink parts) are infected with HIV.
 - True.
- ▶ If you are already infected with HIV, how does having an STD increase the chances that you will pass HIV on to your partner?
 - When a person gets an STD, his scout cells come to fight it off, but they bring HIV to the pink parts along with them. Therefore, the person with HIV now has STDs and a lot of HIV in his pink parts.
- ▶ Ask for and answer any questions participants have about the scene.

12. Process and summarize the exercise, discussing what participants learned about the interaction of HIV and STDs

- ▶ We say the STD-HIV connection is a double-edged sword because:
 - If you don't have HIV—and get an STD—you are more likely to also get HIV.
 - If you have HIV—and get an STD—you are more likely to pass HIV to a sexual partner.
- ▶ For communities with high rates of STD and HIV disparities, such as the black community, it means that folks are more likely to get and give both STDs and HIV.
- ▶ The good news is that many STDs are treatable. Treatment will get rid of the bacterial STD and reduce the chances of HIV transmission. Let's remember this when we talk about our menu of prevention options in the next session.

Exercise 2.6 Transmission Puzzle

Purpose: Participants learn that one's chance of getting HIV or another STD depends on three main factors and how one's understanding of this "transmission puzzle" can lead to a variety of STD/HIV prevention options, which is the basis for Exercise 3.2.

Objective: Participants will increase their knowledge of the factors that increase one's chances of getting HIV and other STDs.

Time: 40 minutes

Materials:

- Transmission Puzzle slides
- Laptop
- LCD projector

Notes on Exercise 2.6

Thoroughly review the slides and talking points before conducting this session. You should not read directly from the slides, and you will need to face your participants when you talk. The point of this exercise is to show how dose, exposure, and resistance affect risk of transmission of HIV and other STDs and how this information can be used to build a menu of prevention options in Session 3.

Procedures

1. Introduce the exercise using the following talking points

- ▶ Remember that in Session 2, we talked about how Bottoms can be at increased risk of getting HIV through unprotected anal sex but that sexual position is only one of the factors that determine risk for getting an STD or HIV.
- ▶ There are three factors that act together to determine one's chance of getting HIV or other STDs, or any other infection for that matter.
 - These are called dose, exposure, and resistance.
- ▶ While these factors are part of a scientific formula used by infectious diseases experts, we will make it more user friendly and call it the Transmission Puzzle.
- ▶ In this exercise, you will learn more about these three factors and begin to see how to use this information to build your own menu of prevention options.
- ▶ Let's go through a slide presentation and learn about how these three factors determine whether you get HIV or another STD through sex.

2. Present the Transmission Puzzle slides, using the following talking points for each slide

- ▶ Slide 1.
 - These slides will provide an overview of the factors that determine your chances of getting HIV and other STDs and how having an STD makes it easier to get HIV.
 - Later we will use this information to build a menu of options to reduce your chances of getting HIV and other STDs.
- ▶ Slide 2.
 - Everybody always wants to know—What are my chances of getting HIV?
 - What are my chances of getting syphilis? If I do this ...and he does that ... what are my chances of getting infected?
 - Also, people have heard a lot of things about risk.
 - "I heard Tops can't get HIV."
 - "I had sex for about a week with someone who I found out later has HIV and we didn't use condoms, I must be resistant to getting HIV."
 - "I heard oral sex is very low risk."
 - "I heard that the chance of getting HIV from sex is 1 in a 1,000."

- The truth is none of those things are true. It is not that simple.
 - There is no single thing that determines your chances of getting HIV or another STD.
 - Rather, it is interplay between the three factors described by the Transmission Puzzle.
- The Transmission Puzzle will show you how your chances of getting infected depend on how these three factors play out with each other at any given time.

▶ Slide 3.

- This is the Transmission Puzzle. It shows the three factors that affect your chances of getting infected. To make it easier to learn the puzzle, we are going to focus only on risk for getting HIV infection.
 - **Factor 1—Dose.** Dose refers to how much germ you are exposed to through sex. How much germs depends on several things, which we will discuss in a few minutes.
 - **Factor 2—Exposure.** Exposure refers to how long you are in contact with the germ, how many times you are in contact through sex, and what the likelihood is that your sexual partner is infected,
 - **Factor 3—Resistance.** In the case of HIV and other STDs, this means resistance of your mucous membranes that are exposed to germs during sex. We call these your pink parts—the tissue of your mouth, penis, and rectum.
 - You will see that for each of these factors, there are circumstances that can increase or decrease risk.

▶ Slide 4.

- Here you see how the factors as they play out with each other.
 - Risk = Dose times Exposure over Resistance
- That means Dose and Exposure can increase your chances of getting infected and Resistance can decrease your chances.
- We will talk about each of these factors separately.

▶ Slide 5.

- As we previously explained, dose refers to how much HIV germs you are exposed to during sex.
- Most people think that if you have sex with someone with HIV, you will automatically get HIV.
- But in reality, you have to be exposed to a certain amount of HIV germs during sex to get infected.
- The higher the number of germs (dose) present, the greater the chance that you will get infected.

▶ Slide 6.

- So, what does dose depend on?
 - Which fluid you are exposed to during sex.
 - Which stage of HIV infection the person you are having sex with is in.
 - Whether or not the person with HIV you are having sex with has an STD.

▶ Slide 7.

- This slide shows how dose depends on the stage of HIV infection.
- There are three main stages of HIV infection.
 - The acute HIV infection, which occurs in the first 2 to 3 months of infection.
 - The asymptomatic phase, which lasts on average 10 years.
 - The AIDS stage, during which the person develops illnesses.
- The line graph shows that the amount of virus the person with HIV is shedding—how much germ—varies with each stage.
- Following the line, you can see that a person with HIV has a high amount of HIV germ in his blood/semen in the first few months of his HIV infection.
- Some experts think that up to one-half of all new HIV infections occur when one person is in the first 3 months of his infection.
- Unfortunately, this is also the time known as the window period, when many people test negative on their HIV antibody test (if they bother getting a test at all).

- This period is called acute HIV infection and is one of the reasons that unprotected sex with a new partner in the first 3 months you know him is especially risky.
 - He could be in the window period.
 - He could have a large amount of HIV but test HIV-negative.
 - Sometimes men use condoms in the beginning of a new relationship but when they have been together in a month or so, they get tested and stop using condoms. Sometimes they don't get tested and stop using condoms.
 - Either way, why is this a risky approach?
 - Answer: Because one partner could have a lot of HIV and a test would not detect it.
 - Following the line, you can also see that the amount of HIV then lowers and then goes up again in his blood/semen when he begins to develop AIDS.
 - According to the line, when are other times that the dose (amount of HIV germ) goes up?
 - Answer: When the person has an STD.
 - When a person with HIV has an STD, does the amount of germ (viral load) in the blood go up during the STD infection?
 - Answer: Usually not. Only the amount of HIV germ in the semen goes up.
 - So, why do most men with HIV think they can't pass HIV to a sexual partner if their blood viral load is undetectable?
- ▶ Slide 8.
- The previous slide showed that how much germ—dose—also depends on whether or not the person with HIV has another STD.
 - Most people don't know that for a person who has HIV, getting another STD makes the amount of HIV in that person's semen or rectal fluids very high, even though that person is taking their HIV medications and the blood viral load is low or undetectable.
 - Remember from the Sex in the City exercise, if you have HIV and get an STD, the white blood cells that come into the penis or rectum to fight off the STD are carrying HIV germ. So, all of a sudden the person's semen or rectal fluids have a high STD dose and a high HIV dose.
 - So, what percentage of men with an STD have no symptoms and don't know it?
 - Answer: About two-thirds have no symptoms.

▶ Slide 9.

- Now let's talk in detail about the second factor—exposure.
- The exposure to an infection depends on:
 - How long you are in contact with the germ.
 - In the case of HIV, how long are you in contact with infected semen or rectal fluids?
 - How many times you are in contact with infected fluids.
 - What are the chances that your partner has HIV or another STD?
 - This depends on what your partner does and also on the level of infection in your sexual network of friends/lovers.

▶ Slide 10.

- Exposure depends on the type of sex you have.
- The type of sex determines how long the germ is in contact with your pink parts (mouth, rectum, penis); the longer the germs are in contact, the greater the chance of infection.
- In general, whoever ends up with the semen in the rectum has the greatest duration of contact with the germ.
- However, this does not mean that Tops are not at risk as this is only one of the three factors. Tops do get STDs and HIV. We will talk more about this in a few minutes.

▶ Slide 11.

- This slide shows that HIV germs can live in semen up to 24 hours after sex and STD germs can live in semen up to 3 days! So, you can see that your chances of getting HIV and other STDs can last a lot longer than the sex act.
- Depending on the kind of sex you have, you can be exposed to HIV for up to 1 day and to STDs for up to 3 days for an episode of sex that lasted 20 minutes.

▶ Slide 12.

- So, let's look at how the duration of exposure depends on the type of sex you have.
- For every episode of unprotected rectal sex with an infected partner, the Bottom is exposed to HIV for up to 1 day and to STDs for up to 3 days!

- Heterosexual women are likewise exposed for days after each episode of unprotected vaginal sex.
- Tops and heterosexual men are only in contact with the germ during the time they are having sex—minutes.
- This also explains why oral sex is a lower risk for HIV—the semen does not stay in the throat, so the duration of exposure is actually just during the time one is having oral sex—just minutes.

▶ Slide 13.

- Exposure also depends on how many times you come in contact with HIV through sex.
- So, you see, Tops are at less risk for HIV given one episode of unprotected anal sex, but the more times they have unprotected sex, the more they increase their chances of getting HIV.

▶ Slide 14.

- Exposure also depends on the chances that a partner has HIV. Remember that most people with HIV have no symptoms.
- So, if your partner has had risky behaviors, including unprotected sex with multiple partners, drug use, and never being screened for STDs and HIV, you can bet that he has a higher chance of having HIV or other STDs.
- But if your friends/partners in your sexual network have high rates of HIV and other STDs, your chance of exposure is increased, even if you have low-risk sexual behaviors.
 - In general, are the rates of HIV and other STDs in black MSM high or low?
 - What does that mean for your chances of choosing a partner who has HIV or other STDs?
- In this slide, which partner is more likely to be infected, Partner A or Partner B?

▶ Slide 15.

- Some people think that monogamy is low risk—that is, you only have one sexual partner.
- However, if that person has HIV, you are exposed to HIV every time you have unprotected sex with that one person.

▶ Slide 16.

- If, however, you and your partner decided to be mutually monogamous—you and he only have sex with each other—this can be very safe as long as you both have been tested for HIV and STDs and are out of the window period in the first 3 months of your relationship.
- Another option is for you both to be tested in the beginning and then repeat the testing in 3 months, using condoms in between tests.
- The point is that monogamy is very, very safe if you can be sure that you and your partner are disease free. If either of you has sex with other people and/or never gets tested, then you could still be at risk.

▶ Slide 17.

- As we talked about before, resistance to getting HIV and other STDs depends on the health of your pink parts—the tissue of your penis, rectum, and mouth.
- We are not talking here about your overall health and resistance.
 - You can eat right, go to the gym and work out, take vitamins, and still have unhealthy pink parts.
 - We are talking about the health of the tissue inside your mouth, penis, and rectum.

▶ Slide 18.

- Here is a slide showing pink parts of the male and female.
- No matter which body cavity, the tissue is all the same.
- In men, the pink parts are the tissue in the mouth, rectum, inside the penis, and under the foreskin in men who are not circumcised.
- Remember from the Sex in the City exercise, HIV germs cannot directly infect pink parts. However, STD germs can.

▶ Slide 19.

- So, if HIV does not infect pink parts, exactly how does HIV cause infection through sex?
 - It used to be thought that HIV had to find a way into the bloodstream for infection to occur.
 - It was thought that there needed to be a sore or break in the skin or some kind of bleeding for HIV to enter the body.
 - This is not true.

- As you saw in the Sex in the City exercise, HIV infects white blood cells (the ones that fight off infection), not red blood cells.
- So, as long as there are white blood cells on the surface of the pink parts, HIV infection can occur. Then, the infected white blood cells carry the HIV virus into the bloodstream.

▶ Slide 20.

- This slide shows how HIV gets into the body.
 - The HIV finds and attaches to the white blood cells on the surface of the pink parts of the rectum, penis, and mouth.
 - The HIV is then carried to the bloodstream by the infected white blood cells.
- The more white blood cells on the pink parts, the more likely a person is to get HIV from sex.
- So, what causes a lot of white blood cells to be on the pink parts?
 - Anything that causes infections and inflammation (irritation or swelling) can increase the number of white blood cells.
 - For black gay men, this is mostly STDs! Remember, we said that STDs infect the pink parts.
- What can cause inflammation besides STDs?
 - Anything that irritates the pink parts.
 - Rectal douching, especially if scented products are used.
 - Fisting and rough sex can cause swelling of the rectum and anus.
 - If you are sick with a sore throat, the number of white blood cells in your throat increases.

▶ Slide 21.

- So, if the pink parts are healthy with no STDs, no sores, and no inflammation, there is greater resistance to getting HIV even with exposure.
- And visa versa.

- ▶ Slide 22.
 - Let's see how these three factors play out with each other to determine the chance that HIV or other STDs will be passed through sex.
 - For the sake of example, let's say that all three factors are average, so your risk of transmission is average.

- ▶ Slide 23.
 - Now let's say you don't have HIV.
 - Your partner just got HIV and neither of you know he has it yet. He is in the window period and tests negative on the HIV antibody test.
 - Remembering what we discussed earlier about dose, does he have a high or low amount of HIV virus? So, are his chances of passing it to a partner high or low?
 - Answer: He has a lot of HIV germ, so risk is also high.
 - You can see the amount of germ—dose—is up. So, even though the other factors stay the same, your risk goes up!

- ▶ Slide 24.
 - Now let's say again, you don't have HIV.
 - This time you are a Bottom and have unprotected rectal sex with someone with HIV.
 - Does your risk of getting HIV go up? Why?
 - Answer: Yes, because the longer you are exposed to HIV, the higher your risk for getting infected. Because there is semen with HIV inside you, you are exposed to HIV for a longer time.

- ▶ Slide 25.
 - Now let's say you don't have HIV but get an STD, such as chlamydia in your rectum, and don't know it.
 - What happens to the pink parts in your rectum? What happens to the number of white blood cells in your rectum?
 - Answer: The number of white blood cells increase so that you have thousands of them on your rectum's pink parts. This means your resistance goes down.
 - So if you get an STD, the health of your pink parts goes down and your risk of getting HIV goes up!

- Do most people who have an STD have any symptoms?
 - Answer: No.
- What is the only way to really know if you have an STD?
 - Answer: Get tested.

▶ Slide 26.

- The good news is that if you get tested and have an STD, you can get treated. Your pink parts get healthy again and your resistance goes back up.
- Now your chances of getting HIV are lower.
- So, does getting tested and treated for STDs increase or decrease your chance of getting HIV?
 - Answer: Decrease.

▶ Slide 27.

- So, you see, your chances of getting HIV depend on a combination of these factors.
 - Dose—How much germ you are exposed to.
 - Exposure—How long your pink parts are in contact with the germ, how many times, and the chances your partner has HIV.
 - Resistance—The health of your pink parts.
- In order to prevent HIV, we must do things that will decrease dose, reduce exposure, and increase resistance.
- In the beginning of our next session together, we will use this information to build a menu of options that will help us to prevent getting HIV or any other STD.

3. Ask participants what additional questions they have about the presentation
4. Summarize this exercise
 - ▶ We now have a better understanding of all the things that affect our risk for getting HIV and other STDs, including the amount of germ, the length and number of times we are exposed to the germ, and the health of our pink parks.
 - ▶ You can see that both Bottoms and Tops are at risk depending on the three factors we have discussed.
 - ▶ These three factors that determine our chances of getting HIV or another STD through sex can also help us to prevent getting HIV or another STD through sex.
 - ▶ In Session 3, we will use this knowledge to build a menu of prevention options so that we can see all the choices we have to reduce our risk and prevent getting HIV and STD infections.

Exercise 2.7 Session Summary

Purpose: Participants provide feedback on the session, and facilitators preview Session 3.

Time: 10 minutes

Materials:

- Prepared newsprint: PARKING LOT

1. Check in with participants

- ▶ Do you have any questions about Session 2?
- ▶ Does anyone want to share any feelings or thoughts about anything covered in Session 2?

2. Review the Parking Lot

- ▶ Answer any questions on the Parking Lot. Tell participants that any questions not answered now will be answered in the next session.

3. Review the Ties That Bind

- ▶ We started to discuss the roles and behaviors and power of Tops and Bottoms and how they relate to the STD/HIV risks for black gay men.
- ▶ We have learned about some STDs we may have never heard of before and how some can be cured (bacterial) and some can't (viral).
- ▶ We learned how you can have an STD and not even know it and how having an STD makes us more vulnerable to getting HIV or giving it to a partner.
- ▶ We also had a fun experience figuring out the connection between STDs and HIV.
- ▶ Lastly, we learned about the Transmission Puzzle and how all three pieces help us to understand our chances of getting or giving an STD or HIV.
- ▶ In our next session, we will use all that we have learned to build a menu of prevention options and talk more about our personal stuff.
- ▶ Remember our next session is (____) and we start promptly at (____).
- ▶ (Facilitators) are here if you have any questions.

STD 101

The tables below provide information about the most common sexually transmitted diseases (STDs). Each table includes the STD's signs and symptoms IF PRESENT, treatment, HIV interrelationship issues, and prevention information. You can also find a glossary at the end of this document with definitions of terms, along with a list of Web sites where you can go for more information about STDs and HIV.

BACTERIAL INFECTIONS

These STDs are curable with antibiotics (medications that kill bacteria).

STD	Chancroid—Infects external genital tissue
Complications	Swollen glands may burst and drain; sores get quite large on genitals
Transmission	Contact between (mouth, penis, vagina, rectum) and chancroid ulcer on penis, vagina, or rectum or chancroid germs in mouth
Signs/Symptoms	Painful genital or anal area sores (ulcers) with a small amount of yellowish discharge; may also have swollen, painful glands in groin area
Treatment	Antibiotic: Ceftriaxone injection <i>OR</i> azithromycin tablets—provided in a one-time dose
Prevention Concerns	Condoms can help prevent infection, but may not cover all of the infected sites
Comments	Significantly increases chances of getting or giving HIV to a sexual partner

STD	Chlamydia—Infects pink parts inside urethra, rectum, etc.
Complications	<ul style="list-style-type: none"> • Females: Pelvic inflammatory disease (infected uterus, tubes) and infertility • Males: Proctitis and epididymitis (infection in the rectum or testicles) and infertility • Can also infect the eyes
Transmission	Contact between pink parts (mouth, urethra, vagina, rectum) and infected discharge from penis or vagina or rectum
Signs/Symptoms	Often there are no obvious signs/symptoms; females and males can be infected for years and not know it <ul style="list-style-type: none"> • Females: May have abnormal vaginal discharge (yellowish or sometimes bloody), later on may develop lower abdominal pain • Males: May have urethral discharge (whitish) and/or burning, later on may have pain in testicle area
Treatment	Antibiotic: Usually a tetracycline (e.g., doxycycline) in tablet form <i>OR</i> azithromycin tablets <i>OR</i> ofloxacin <i>OR</i> levofloxacin
Prevention Concerns	Condoms are very effective in prevention because it is transmitted by genital secretions; oral sex can result in transmission of chlamydia
Comments	Increases chances of getting or giving HIV to a sexual partner

STD	Gonorrhea—Infects pink parts inside throat, urethra, rectum, and vagina; can infect mucous membranes around eyes
Complications	<ul style="list-style-type: none"> • Females: Pelvic inflammatory disease (infected uterus, tubes) and infertility • Males: Proctitis and epididymitis (infection in the rectum or testicles) and infertility
Transmission	Contact between pink parts (mouth, urethra, vagina, rectum) and infected discharge from penis, vagina, or rectum
Signs/Symptoms	May be no obvious signs/symptoms, particularly for females <ul style="list-style-type: none"> • Females: May have abnormal vaginal discharge (greenish), later on may develop lower abdominal pain • Males: May have urethral discharge (greenish) and/or burning, and later on may develop pain in testicle • This infection often occurs together with chlamydia
Treatment	Antibiotic: Ceftriaxone injection <i>OR</i> cefixime tablet—a one-time dose, usually accompanied by another medication (such as doxycycline or azithromycin <i>OR</i> ofloxacin <i>OR</i> levofloxacin) for 7 days to cover for coexisting chlamydia infection
Prevention Concerns	Condoms are very effective to prevent transmission because genital secretions transmit gonorrhea; oral sex can result in transmission of gonorrhea
Comments	Increases chances of getting or giving HIV to a sexual partner

STD	Trichomoniasis—Actually a protozoan infection but is curable with antibiotics, just like bacterial STDs
Complications	See Signs/Symptoms
Transmission	Contact between some of the pink parts (only the vagina or urethra) and infected discharge from penis or vagina
Signs/Symptoms	<ul style="list-style-type: none"> Females: May have greenish-yellowish vaginal discharge—sometimes with a foul odor—accompanied by vaginal itching; if it enters the urethra and bladder, it may cause urinary burning and frequent urination Men: Usually few or no symptoms; occasionally have urethral burning and rarely, whitish urethral discharge (if present, only a small amount)
Treatment	Metronidazole tablets—either several at one time or fewer at a time over the course of a week
Prevention Concerns	Condoms are very effective to prevent transmission
Comments	Increases chances of getting or giving HIV to a sexual partner

STD	Syphilis—Infects genital tissue of penis, rectum, vagina, and mouth and then goes into lymph system, bloodstream, and brain fluid, very much like HIV
Complications	Neurosyphilis—infection of the brain; also, syphilis can be passed to babies and these babies will have many problems; over time, tertiary syphilis can develop, which is often fatal
Transmission	<ul style="list-style-type: none"> Contact between pink parts (mouth, urethra, vagina, rectum) or skin and infected ulcer or lesions of the mouth, penis, vagina, or rectum In gay men, syphilis is easily spread by oral sex as well as rectal sex
Signs/Symptoms	<p>Most have no obvious signs/symptoms—need a blood test to tell if you have syphilis</p> <p>There are different stages of syphilis:</p> <ul style="list-style-type: none"> Primary: May have painless ulcer (called chancre) at site where infection occurred (mouth, anus, genitals) Secondary: May have body rash, wartlike genital/anal lesions; patches on mucous membranes Latent: A person is infected and can pass syphilis to others but has no symptoms; similar to asymptomatic stages of HIV Tertiary: Occurs after many years: dementia, blindness, scattered body ulcers, balance problems

STD	Syphilis—Infects genital tissue of penis, rectum, vagina, and mouth and then goes into lymph system, bloodstream, and brain fluid, very much like HIV (continued)
Treatment	Antibiotic: Long-acting benzathine penicillin injections (one to three over 1 to 3 weeks), depending on stage; even though the syphilis can be cured in the tertiary stage, the signs/symptoms will not likely be reversed
Prevention Concerns	Condoms can help prevent syphilis infection, but condoms do not always cover the areas of infected sores or other infected areas; also, syphilis is easily spread by oral sex and condom use could prevent this
Comments	Significantly increases chances of getting or giving HIV to a sexual partner; often is passed together with HIV; about 50% of gay men with early syphilis these days also have HIV infection

VIRAL INFECTIONS

These STDs are not curable but can be treated to help manage symptoms.

STD	Herpes Simplex Virus (HSV)—Infects external genital tissue and the rectum; permanent infection with intermittent flare-ups (or recurrences) of genital sores; there are also times in which there are no flare-ups, but a person can still pass HSV to a sexual partner
Complications	Proctitis (painful infection of the rectum), infections of the eye; also can cause severe illness or death in a newborn
Transmission	Contact between pink parts (mouth, urethra, vagina, rectum) or skin and infected ulcers or lesions of the mouth, penis, vagina, or rectum
Signs/Symptoms	<ul style="list-style-type: none"> • Many people have no obvious symptoms (up to 70% of those infected) • If symptoms do occur, they could include painful, itchy, or tingly sores in the genital or anal area; these sores start out as small pink bumps, then these become small blisters, then they usually break and become crusted (scabbed); these lesions often occur in small clusters; there may also be swollen glands in groin area <p>There are 2 different strains of HSV:</p> <ul style="list-style-type: none"> • HSV 1, which primarily affects the tissue around the mouth and can infect the genitals though oral sex • HSV 2, which primarily affects the tissue around the genitals/anal area and can infect the mouth through oral sex
Treatment	<ul style="list-style-type: none"> • Antiviral medication—there are three oral medications but they are similar (in different formulations): acyclovir, famciclovir, and valacyclovir • For people with repeated recurrences (usually considered more than three per year), these medications can be taken every day to reduce outbreaks
Prevention Concerns	<ul style="list-style-type: none"> • Condoms can prevent infection, but condoms do not always cover all the potentially infected sites; oral sex can result in transmission of HSV • Transmission of HSV can occur even when no sores are visible
Comments	Significantly increases chances of getting or giving HIV to a sexual partner

STD	Human Papilloma Virus (HPV)
Complications	HPV causes some genital cancers—cervical cancer in women and penile/anal cancer in men
Transmission	Contact between skin and infected pink parts (penis, vagina, mouth, rectum)
Signs/Symptoms	<ul style="list-style-type: none"> • Most people have no obvious bumps (warts); if warts do appear, they are usually painless; occasionally they may be slightly itchy or tingly • For those with the infection, but no visible lesions, there are no signs/symptoms • There are no good tests for HPV; if warty lesions are seen, then a diagnosis of genital HPV may be made; a Pap smear (which is a test for cervical cancer) can reliably detect evidence of HPV even when there are no visible lesions; anal Pap smears are sometimes used to test for HPV in men
Treatment	The body's immune system will fight HPV but it may never eliminate the virus; there are several treatments, all designed to stimulate the immune system to work harder against the HPV; treatments include patient-applied prescription medications (imiquimod <i>OR</i> condylox) and/or provider-applied treatments (mild acid, freezing treatments, laser)
Prevention Concerns	<ul style="list-style-type: none"> • Condoms can prevent infection, but condoms do not always cover all parts of the genitals infected with HPV; oral sex can result in transmission of HPV • Transmission of HPV can occur even when no sores are visible
Comments	If lesions are inflamed, this could increase susceptibility to HIV

STD	Viral Hepatitis—There are several types, each with a letter designation
Three Types of Viral Hepatitis	<ul style="list-style-type: none"> • Hepatitis A Virus (HAV) • Hepatitis B Virus (HBV) • Hepatitis C Virus (HCV) <p>There are a few others, but they are not common in the United States</p>
Complications	HBV can become chronic and, if it does, it can lead to the development of liver cancer or severe liver failure (usually after many years); likewise, HCV can lead to liver cancer or severe liver failure
Transmission	<ul style="list-style-type: none"> • HAV: Transmitted by touching food or one's mouth with hands that have been contaminated with fecal material (poor handwashing after using the bathroom); for gay men, rimming or any anal-oral contact is a common way to get HAV • HBV: Transmitted by blood or body fluids (even saliva); easily transmitted by sharing needles/works and through sexual activities (possibly even by kissing) • HCV: Transmitted through blood and body fluids, thus by sharing needles/works and through sexual activity (the mechanism for sexual transmission is unclear)

STD	Viral Hepatitis—There are several types, each with a letter designation (continued)
Signs/Symptoms	<ul style="list-style-type: none"> • HAV: If symptomatic, may have flulike symptoms and abdominal pain, often with nausea and vomiting, and skin may have yellowish discoloration (called jaundice) • HBV and HCV: Often do not have clear signs/symptoms during the acute illness; if there are signs/symptoms, they would be similar to HAV, noted above • If infected with chronic HBV or HCV, it is important to be in care, so that signs and symptoms of liver cancer or failure can be detected (care would include blood tests to assess liver function; also sometimes a liver biopsy) • If there is liver cancer or failure, there is usually abdominal pain, jaundice, and swelling of the abdomen (but all these may occur only after either problem is advanced)
Treatment	<ul style="list-style-type: none"> • Testing is by a blood test specific to the different hepatitis viruses (HAV, HBV, HCV) • The body's immune system will fight HAV and it will eliminate the virus; most people feel sick for a few weeks, but recover without problems • Chronic HBV or HCV treatments might not be treated, or can possibly be treated with interferon injections and ribavirin (pills)—each for many months; treatment failure occurs with many people • The other treatment for HCV if the liver is damaged and/or if medication did not work is liver transplant • There are vaccines for HAV and HBV—thus, prevention through vaccination is possible; there is no vaccine for HCV
Prevention Concerns	<ul style="list-style-type: none"> • Condoms can prevent infection, but condoms do not always cover all parts of the genitals infected with HPV; oral sex can result in transmission of HPV • All gay men should get HBV vaccine and HAV vaccine • Not sharing personal hygiene items (e.g., razors, toothbrushes) can prevent transmission of HBV and HCV; also, tattooing only with a sterile technique is preventive • Good handwashing is needed to prevent spread of HAV as well as the other types • HAV can be transmitted through oral-anal sexual practices, thus a barrier (e.g., dental dam) can help to prevent transmission • Condoms may help to prevent HBV and HCV infection because these infections are in blood and body fluids • Avoiding sharing needles/works is one of the most important ways to prevent HCV and will also help to prevent the spread of HBV (and even HAV)
Comments	None

GLOSSARY OF TERMS

Term	Definition
Antibiotic	A type of medication that kills bacteria (and occasionally other types of germs, including protozoa)—it may be given as a pill or as an injection. Antibiotics work in different ways on different germs. To work, the right antibiotic needs to be matched to the right germ.
Bacteria	A type of germ that is self-reproducing and can be killed by the right antibiotic medicine.
Cervical Secretions	The cervix produces mucus (discharge), which changes over the course of the menstrual cycle. This mucus goes into the vagina. A female normally has discharge in the vagina, which is from the cervix. Cervico-vaginal secretions are normally clear to whitish and do not have an odor.
Cervix	The lower end of the uterus (womb), which is found at the inside end of the vagina. It is where menstrual flow leaves the uterus and where sperm find access to the uterus. It is also the part of the uterus that must dilate (open) for the passage of a baby at childbirth. Many STDs can cause infection of the cervix (e.g., chlamydia, gonorrhea, HPV), which can lead to infections of the uterus, complications in pregnancy, and infections in newborns.
Congenital	Born with (e.g., a congenital infection means that a baby was born with the infection).
Hepatitis	Inflammation of the liver. It can be caused by infection (e.g., HAV, HBV, HCV) or by chemicals (e.g., medications and illegal drugs).
Inflammation	A bodily response to some irritant, injury, or infectious germ. Inflammatory responses include an increase in different types of white blood cells at the surface of the mucous membranes, which leads to swelling, redness, increased heat, and pain (pain may not always be apparent).
Jaundice	A yellowish discoloration of the skin, mucous membranes, and the sclera (white parts of the eye). Jaundice occurs when the liver is inflamed or malfunctioning and the bile (which is normally processed by the liver) builds up in the system.
Mucous Membrane (pink parts)	Pink, moist tissue that lines the rectum, mouth, vagina, and inside of the penis. Different types of cells line the mucous membranes (some of these cells are called squamous, which are closer to the outer surface of the body, and others are called columnar, which are deeper within). Some STDs infect either one or both types of mucous membrane cells, and some STDs can only infect one or the other.
Mucus	The clear, stretchy discharge produced by mucous membranes to provide moisture and protection (it contains natural killer cells, antibodies, and protective white blood cells).

Term	Definition
Pap Smear	A test for cancer of the cervix, not for STDs. However, the Pap smear test can detect HPV infections. When a female has a routine pelvic examination, the usual purpose is to collect the Pap smear and to examine the uterus and ovaries. Most health care providers do not routinely do STD testing during the pelvic examination. If STD screening is desired, it may need to be requested.
Protozoa	Germs that are actually single-celled life forms that can cause human diseases. Antibiotics can cure many protozoan infections.
Red Blood Cell (RBC)	One type of cell in the bloodstream whose function is to transport oxygen and carbon dioxide throughout the body.
Semen	The fluid that comes out of the penis when a male ejaculates. Semen consists of sperm, certain types of white blood cells (see below), and mucus.
Serum (also called plasma)	The fluid part of the blood. It contains many minerals (e.g., sodium or potassium), different kinds of protein, antibodies, and may contain infection (e.g., HIV or HCV).
Urethra	The tube inside of the penis that urine comes out of during urination. This tube goes from the penis through the prostate gland to the bladder and then down to the testicles. Therefore, when a male “comes” (ejaculates), the semen passes through the urethra. The urethra is lined with mucous membranes that can be infected with some STDs.
Vertical Transmission	Transmission of an infection from a pregnant woman to an unborn embryo or fetus.
Viral Load (a test)	Viral infections that can be detected in the blood (e.g., HIV or HCV is often tested to actually count the amount of virus present in the blood). For HIV, HBV, and HCV, the viral load studies are done on the serum (also called plasma) portion of the blood (i.e., not the blood cells).
Virus	A type of germ that is unable to reproduce without the help of a host cell because it does not generate all of the genetic material it needs to reproduce. The host may be a human, plant, or animal cell. Antibiotics cannot destroy viruses, although there are some medications for some viruses.
White Blood Cell (WBC)	Type of cell in the bloodstream. There are many different kinds of WBCs, including those that have CD-4 receptors (the receptor to which HIV connects). The main function of all the WBCs is to fight infection and other irritants in the body. Under most circumstances, WBCs are also present in other body fluids (e.g., semen or cervico-vaginal secretions). Body cavities (e.g., nose, mouth, or genital cavities) will also usually contain a small number of specific types of WBCs. They would be in these cavities to be ready to destroy foreign bodies, such as infectious germs, dusts, or other irritants.

HIV AND STD INFORMATION WEB SITES

Web Site	Information	Comments
http://www.AIDSinfo.nih.gov	Current information on treatment, clinical trials, vaccines	Sponsored by the National Institutes of Health (NIH); many links provided
http://chipts.ucla.edu/	Information on treatment, prevention, programs	Sponsored by the University of California
http://www.caps.ucsf.edu	Information on treatment, prevention, programs	Sponsored by the University of California
http://www.cair.mcw.edu	Information on treatment, prevention, programs	Sponsored by the University of Wisconsin
http://www.cdc.gov/nchhstp/std	Consumer fact sheets, current prevention research, health and disease information, search for STD and for HIV prevention	Sponsored by the Centers for Disease Control and Prevention (CDC)
http://www.effectiveinterventions.org	Training information for prevention and clinical providers on prevention interventions from CDC	Sponsored by CDC
http://www.urmc.rochester.edu/chbt	Training and care information for prevention and clinical providers on STD and HIV care and prevention	Sponsored by University of Rochester, with funding from CDC and AIDS Institute (New York State Department of Health), and Monroe County Department of Health, New York
http://www.hivguidelines.org	Current information on treatment, clinical trials	Sponsored by New York State Department of Health—AIDS Institute
http://www.aidsetc.org	Training and care information for clinicians on HIV care	Sponsored by Health Resources and Service Administration (HRSA)
http://www.cdc.gov/mmwr/	Current information on national guidelines for STD, HIV, and hepatitis (as well as many other topics)	Sponsored by CDC (provides medical and nursing continuing education credits/units)
E-mail: HIVpubs@health.state.ny.us	Information on publications, consumer fact sheets, guidelines	Sponsored by AIDS Institute (New York State Department of Health)

STDS: GET THE FACTS. GET TESTED. GET TREATED.

THE FACTS

These days, people know more about HIV than about other sexually transmitted diseases (STDs), even though the other STDs are much more common and can cause serious illness and death. Also, having an STD can put you at higher risk for getting HIV.

Consistent and correct use of the male latex condom reduces the risk STD and HIV transmission. However, condom use cannot provide *absolute* protection against all STDs. The most reliable ways to avoid transmission of STDs are to abstain from sexual activity or to be in a long-term, mutually monogamous relationship with an uninfected partner.

The following table lists some of the major STDs and their symptoms. If you have any of these symptoms, go see a doctor immediately. **Remember, you may not have any symptoms and still have an STD!** That is why it is important that you get tested for STDs regularly. The earlier you get tested, the earlier you can protect your life and the lives of your partners.

STD	Signs and Symptoms
Chancroid	Painful genital or anal area sores (ulcers) with a small amount of yellowish discharge; may also have swollen, painful glands in groin area
Chlamydia	Penis may have discharge (whitish) and/or burning; later on may have pain in testicles
Gonorrhea	Penis may have discharge (greenish) and/or burning; later on may have pain in testicles
Herpes Simplex Virus	Painful, itchy, or tingly sores in the genital or anal area; these sores start out as small pink bumps, then these become small blisters, then they usually break and become crusted (scabbed); there may also be swollen glands in groin area
Human Papilloma Virus (Genital Warts)	Most people have no obvious bumps (warts); if warts do appear, they are usually painless
Syphilis	Painless ulcer/sore at site where infection occurred (mouth, anus, genitals); may have body rash, wartlike genital/anal lesions/bumps; patches on pink parts
Viral Hepatitis	Flulike symptoms and abdominal pain, often with nausea and vomiting, and skin may have yellowish discoloration

Get Tested. Get Treated.

Here are some places you can go to get tested and treated for STDs.

Type in addresses and phone numbers of local STD and community health clinics.

STD 101:

Common Sexually Transmitted Diseases for Black Gay Men

**GET TESTED,
GET TREATED,
GET CURED,
GET THE VACCINES!**

STIs/STDs

Bacterial

- ▶ Gonorrhea
- ▶ Chlamydia
- ▶ Syphilis

Viral

- ▶ Herpes
- ▶ Hepatitis
- ▶ HPV
- ▶ HIV

Gonorrhea (GC)

Disparities: In the United States, what percentage of cases of GC in men occur in black men?

Is it curable?

Bacteria: Gonorrhea (GC)

- ▶ Gonorrhea (sometimes called clap, drip, dose, etc.) is curable
- ▶ A person can easily pass it on to sex partners and mothers can pass it to babies during childbirth
- ▶ Black gay men can have GC in the throat, penis, or rectum
- ▶ Symptoms can develop in 1 to 14 days after infection—often there are NO symptoms

Gonorrhea (GC) Symptoms in Men

- ▶ Discharge from the penis (may be thick, milky white, yellowish, or greenish)
- ▶ Burning on urination
- ▶ Does a person always have symptoms?



Source: CDC/NCHSTP/Division of STD Prevention, STD Clinical Slides

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Complications of Gonorrhea (GC)

- ▶ Swollen or tender testicles (epididymitis)
- ▶ Infection in the blood stream—disseminated gonococcal infection (DGI)



Source: CDC/NCHSTP/Division of STD Prevention, STD Clinical Slides

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Gonorrhea (GC)

- ▶ How do you get tested for GC?
 - Urine test
 - Swabs
- ▶ Is the urine test for GC the best option for black gay men?
 - What percentage of GC in black gay men would be missed?
 - Why?

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Chlamydia (CT)

**Disparities: In the United States,
what percentage of cases of CT in
men occur in black men?**

Is it curable?

Chlamydia (CT)

- ▶ A person can pass CT to a sexual partner and mothers can pass it to newborn babies during delivery
- ▶ Caused by a bacteria—curable
- ▶ Symptoms may appear in 2 to 3 weeks
 - Small amount of discharge from penis
 - Burning on urination
- ▶ What percentage of men with CT have no symptoms?

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Complications of Chlamydia (CT)

In women

- ▶ Pelvic inflammatory disease (PID)
- ▶ Ectopic pregnancy
- ▶ Sterility

In men

- ▶ Swollen and tender testicles (epididymitis)
- ▶ Sterility

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Chlamydia (CT)

- ▶ How do you get tested for CT?
 - Urine test
 - Swabs
- ▶ Is the urine test for CT the best option for black gay men?
 - What percentage of CT would be missed?
 - Why?

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Syphilis

Disparities: In the United States, what percentage of cases of syphilis in men occur in black men?

Is it curable?

What percentage of black gay men who get syphilis already have HIV?

Why?

Syphilis

- ▶ Sometimes called bad blood, pox, lues, or a zipper cut
- ▶ A person can pass it to a sexual partner and mothers can pass it to unborn babies during pregnancy
- ▶ Caused by a bacteria—curable

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Syphilis (continued)

- ▶ First symptom may appear in 10 to 90 days
 - Small sore on penis or anus
 - Rash on body, white spots on mouth, wartlike bumps on genitals
- ▶ Sores come and go for about 6 to 9 months
- ▶ What percentage of men with syphilis have no symptoms?

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Primary Syphilis Chancre in a Man



Source: CDC/NCHSTP/Division of STD Prevention, STD Clinical Slides

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Oral Primary Syphilis Chancre



Source: CDC/NCHSTP/Division of STD Prevention, STD Clinical Slides

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Symptoms of Syphilis Secondary Stage

- ▶ Skin rash lasting 2 to 6 weeks (average of 4 weeks) on the palms of the hands, bottoms of the feet, or any part of the body
- ▶ Rash starts as reddish spots, then becomes raised and scaly
- ▶ Other symptoms may include fever, swollen lymph glands, headache, and hair loss
- ▶ Symptoms will go away without treatment

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Secondary Syphilis Body Rash

On black skin, rash looks like darker brown spots



Source: CDC/NCHSTP/Division of STD Prevention, STD Clinical Slides

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Secondary Syphilis Face Rash



Source: Cincinnati STD/HIV Prevention Training Center

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Secondary Syphilis Palm Rash



Source: CDC/NCHSTP/Division of STD Prevention, STD Clinical Slides

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Complications of Untreated Syphilis Late Stage

- ▶ Paralysis
- ▶ Insanity
- ▶ Blindness
- ▶ Damage to knee joints
- ▶ Personality changes
- ▶ Impotency
- ▶ Aneurysm (ballooning of a blood vessel)
- ▶ Tumor on the skin or internal organs
- ▶ Death

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Testing and Treatment for Syphilis

- ▶ Easily detected by a blood test
- ▶ Easily cured with antibiotics



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Herpes Simplex Virus (HSV)

Herpes

- ▶ **There are two common kinds of herpes**
 - Oral herpes (called a cold sore or fever blister)
 - Genital herpes (on the penis or rectum)
- ▶ **There are two types of herpes virus**
 - Herpes 1 and herpes 2
- ▶ **How can cold sores cause genital herpes?**

Symptoms of Genital Herpes

- ▶ May have some small, painful, blister like sores
 - On the penis, vagina, anus, buttocks, mouth—sometimes on the fingers
 - Sores can last a few days to up to 3 weeks, go away and come back

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Herpes in a Man



Source: Cincinnati STD/HIV Prevention Training Center

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You Can Get Herpes on Skin if There Is a Break



Source: Cincinnati STD/HIV Prevention Training Center

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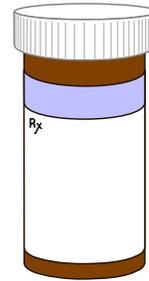
Genital Herpes Without Symptoms

- ▶ Many people with herpes do not have any symptoms or do not recognize that they have symptoms
- ▶ People with herpes can pass the virus to sex partners even when they do not have symptoms—**asymptomatic shedding**

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Testing and Treatment for Genital Herpes

- ▶ Can be detected by
 - Swab of lesion
 - Blood test
- ▶ Herpes cannot be cured, but symptoms can be treated with medicines called antivirals
- ▶ Taking antiviral medicine will reduce the chances of passing to a partner—but not eliminate it!



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Human Papilloma Virus (HPV)

Human Papilloma Virus (HPV)

- ▶ Many types of HPV that infect the genital area
- ▶ Incubation period unclear
- ▶ A person can easily pass it on to sex partners and a woman can pass it to a baby during delivery
- ▶ Many people clear the infection over time

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Symptoms of Genital HPV Infection

- ▶ HPV causes genital warts
 - Firm bumps on the penis, vagina, anus, or urethra
 - May go away on their own, stay about the same, or get worse
- ▶ Many times a person with HPV has no symptoms

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HPV Penile Warts



Source: Cincinnati STD/HIV Prevention Training Center

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Treatment for HPV

- ▶ Genital warts can be removed
 - Freezing, cauterization, or creams
 - Removing the warts does not get rid of the virus
 - Warts may come back until one's immune system inactivates the virus
- ▶ Major breakthrough—there is a safe and very effective vaccine to prevent HPV and it is now recommended for males!

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Complications of HPV

▶ Anal or rectal cancer

- Pap smears are starting to be used to detect HPV
- Treatment is unclear at this point

▶ Cervical cancer

- Regular Pap smears are best way to detect serious lesions and prevent cervical cancer
- Pap smear screening is recommended for all sexually active women

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Hepatitis A, B, and C

Hepatitis Virus

- ▶ Common types of hepatitis :A, B, and C
- ▶ Infects the liver
- ▶ Hepatitis A: oral/rectal contact
 - Food, some types of sex (rimming)
- ▶ Hepatitis B, C
 - Sex and needle-sharing

37

Hepatitis Virus (continued)

- ▶ Hepatitis A
 - One's body will clear this infection after several weeks
- ▶ Hepatitis B and C
 - Often cleared by the body after several weeks
 - A percentage of people can't clear the infection and become chronic carriers

38

Complications of Hepatitis B, C

- ▶ If a person becomes a chronic carrier
 - Liver cancer
 - Other liver disease—liver failure

39

Treatment for Hepatitis

- ▶ Some treatments for Hepatitis B and C carriers
- ▶ Hepatitis A and B—totally preventable with hepatitis vaccines recommended for all black gay men
- ▶ How many black gay men do you think have received the Hepatitis A and B vaccines?

40

Disparities—for the Community

How do high rates of STDs contribute to the high rates of HIV for black gay men?

How can the high rates of STDs for black gay men be reduced?

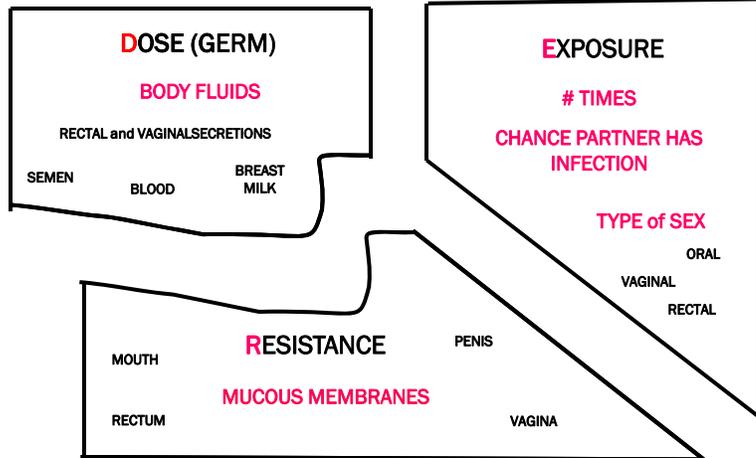
**BE TESTED,
BE TREATED,
BE CURED,
BE VACCINATED!**

The Transmission Puzzle and STD-HIV Connection

Understanding Risk

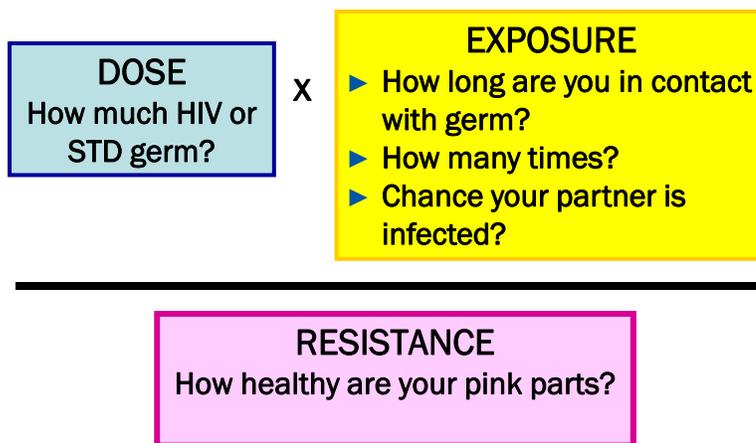
- ▶ What are my chances of getting HIV or other STDs through sexual contact?
- ▶ How does having an STD increase my chances of getting HIV?

The Transmission Puzzle



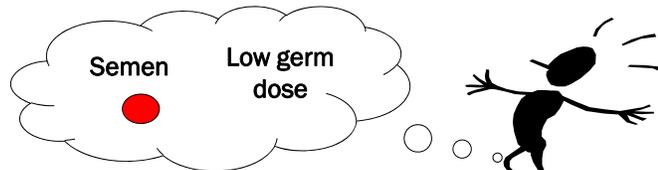
3

The Transmission Puzzle (continued)

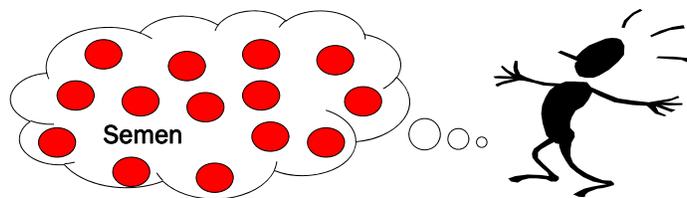


4

DOSE—How Much Germ?



High germ dose - INCREASES risk



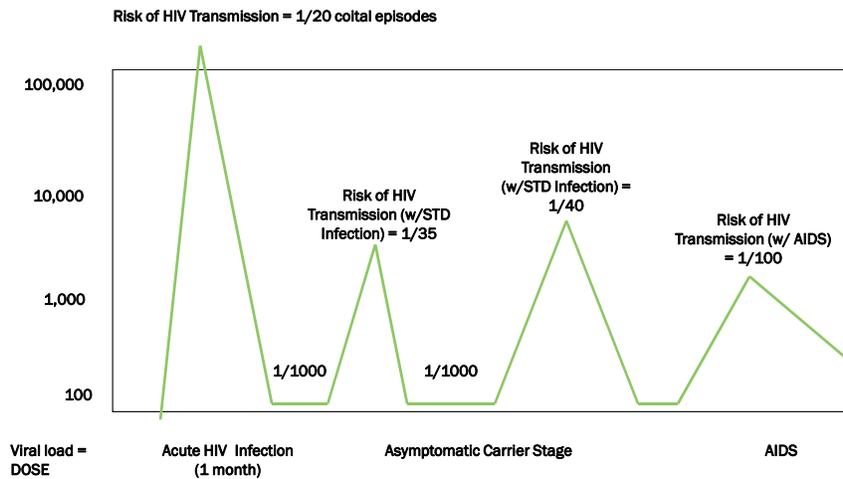
5

Dose—How Much Germ Depends On:

- ▶ Which fluid
 - Semen, blood, rectal and vaginal secretions, breast milk
- ▶ Which stage of HIV a person living with HIV/AIDS (PLWHA) is in
 - Acute HIV, carrier, AIDS
- ▶ Whether the PLWHA also has another STD
 - Another STD will increase HIV viral dose

6

Dose Depends on Stage of HIV (estimates, Cohen, 2005)

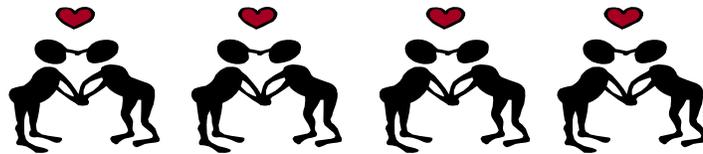


Dose—Depends on Whether PLWHA Also Has an STD

- ▶ If a PLWHA has an STD, the amount of HIV in his semen and rectal secretions increases—**even though the viral load in the blood may be undetectable**
- ▶ Most persons with STDs have no symptoms

Exposure Depends On:

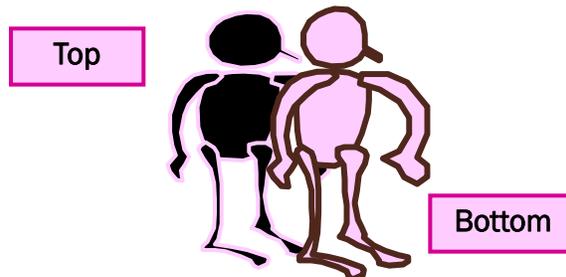
- ▶ Type of sex you have (how long you are in contact with the germ)
- ▶ How many times
- ▶ How likely it is that your partner has HIV or another STD



9

Exposure—Depends on the Type of Sex You Have

- ▶ How long is the germ in my body?
 - For rectal, vaginal, or oral sex
- ▶ Depends on who has the semen in their body after sex



10

Exposure—Depends on How Long the Germ Is in Your Body

Germs can live in semen inside the rectum (and vagina) for:

- ▶ STDs = up to 3 days after sex
- ▶ HIV = up to 12–24 hours

So, you can be exposed to STD or HIV germs for ½ to 3 days each time there is an ejaculation

11

Exposure—Depends on How Long the Germ Is in Your Body (continued)

The longer the germ is in the body, the greater the risk:

- ▶ Bottoms: Semen in rectum—hours to days
- ▶ For women: Semen in vagina—hours to days
- ▶ Tops: Penis in rectum—minutes
- ▶ For straight men: Penis in vagina—minutes
- ▶ Penis in mouth or mouth in vagina—minutes

12

Exposure—Depends on How Many Times You Have Sex

- ▶ The more times you have unprotected sex with partners whose HIV/STD status is unknown to you, the greater the chances of infection
- ▶ Tops are at less risk for HIV for one episode of rectal sex
 - HOWEVER, the more times they have unprotected rectal sex, the higher their risk

13

Exposure—Depends on Chance Your Partner Is Infected

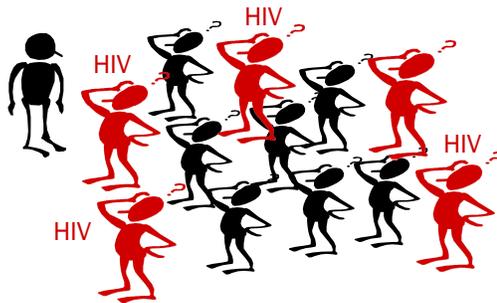
What are the chances?

Partner A		No high-risk behaviors Recently STD/HIV tested negative Discussion	
Partner B		High-risk behaviors Never STD/HIV tested No discussion	

14

Exposure—Depends on Chance Your Partner Is Infected (continued)

Why monogamy may not be low risk:



Sex once/week with 13 one-night stands (different partners) over 3 months = 5 chances to get HIV

15

Exposure—Depends on Chance Your Partner Is Infected (continued)

If mutually monogamous:

- ▶ Both you and your partner are tested negative for STDs/HIV
- ▶ And you repeat the testing in 3 months to account for the “window period”

Then, mutual monogamy with an uninfected partner is a recommended prevention option

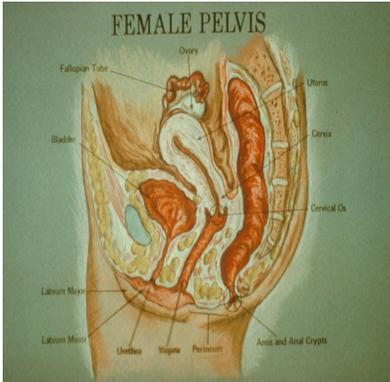
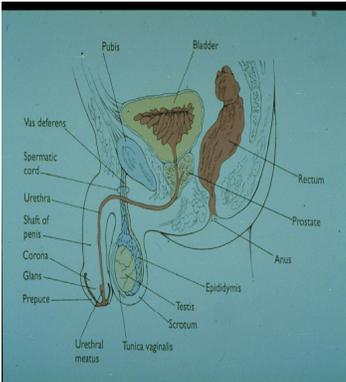
16

Resistance



How healthy are my pink parts?
That is, the tissue (mucous membranes) inside the mouth, rectum, urethra, and vagina

Pink Parts (Mucous Membranes)

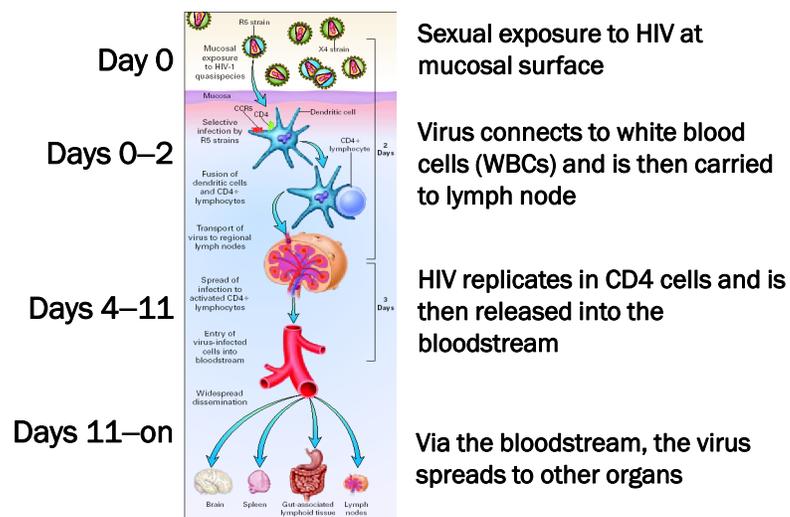


Resistance—Depends on How Many White Blood Cells!

- ▶ HIV infects certain types of white blood cells (WBCs) on pink parts
- ▶ If the WBCs on your pink parts increase in number (due to an STD or inflammation), it is easier to get HIV

19

How Does HIV Get Into Your Body?



20

How Healthy Are My Pink Parts?

Healthy Pink Parts



- ▶ No sores or abrasions
- ▶ No STDs or other source of inflammation—**few WBCs**

Unhealthy Pink Parts



- ▶ Sores—pink parts not intact
- ▶ Has an STD or other source of inflammation—**many WBCs**

21

The Transmission Puzzle—Example

How much
germ
Average

x

Number and type
of exposure
Average

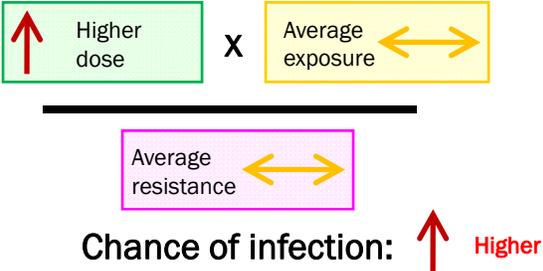
Resistance of pink parts
Average

Chance of infection: **Average** ↔

22

Example—You Don't Have HIV

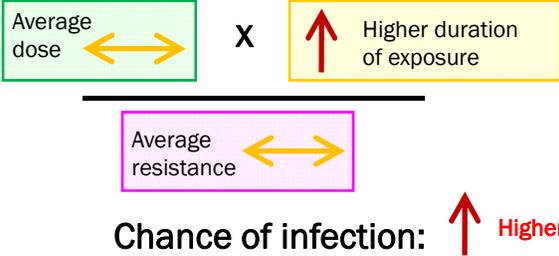
And your partner is in early phase of HIV infection or has an STD:



If your sexual partner has a lot of HIV in his semen, your chance of getting HIV goes up

Example—If You Don't Have HIV

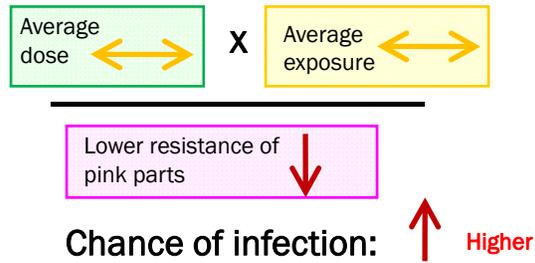
And you are a Bottom:



If you have semen in your rectum, your chance of getting HIV goes up

If You *Don't* Have HIV

And you have an STD:

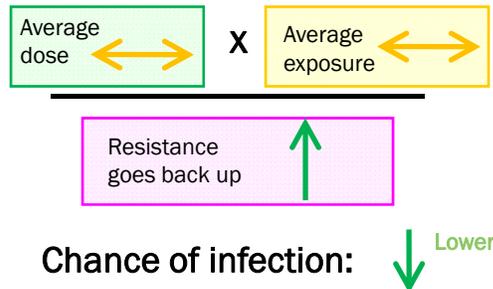


If you get an STD your resistance goes down—
so your chance of getting HIV goes up

25

If You *Don't* Have HIV

And you have an STD, but get it treated:



If you get treated for an STD and recover, your resistance
goes back up—so risk of getting HIV goes down again

26

Transmission Puzzle

- ▶ Reducing your chances of getting HIV means
 - Decreasing dose and exposure
 - Increasing resistance
- ▶ You can use the Transmission Puzzle to help you **PREVENT** getting HIV and other STDs
- ▶ Stay tuned for Session 3!

SESSION 3: STD/HIV RISK ASSESSMENT AND PREVENTION OPTIONS

PURPOSE

The purpose of Session 3 is to discuss and explore STD prevention and harm reduction options while increasing participants' perception of their own risk and susceptibility to STD/HIV.

SESSION OBJECTIVES

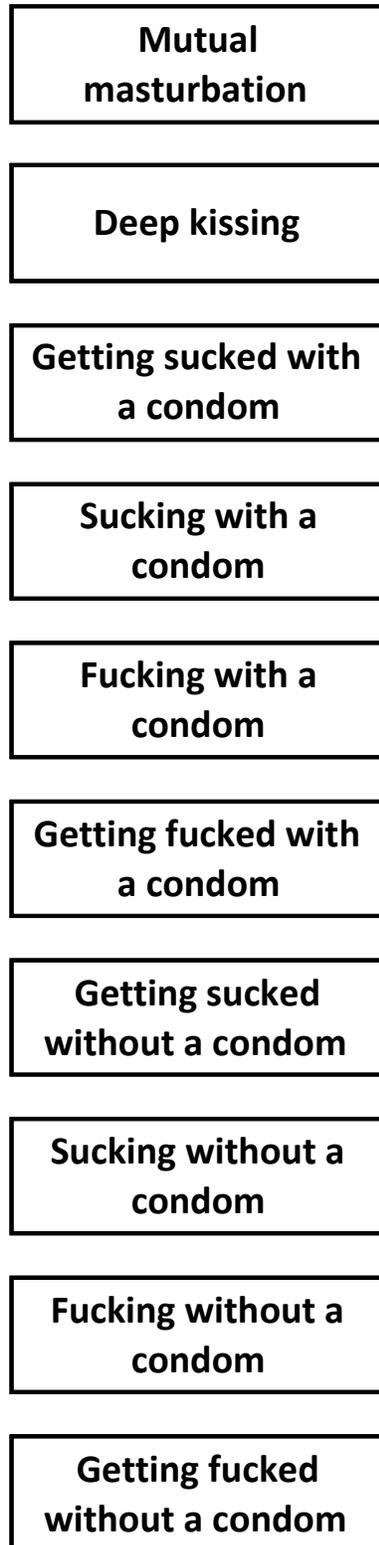
Facilitators will help participants to accomplish the following:

- ▶ Use the Transmission Puzzle to create a menu of prevention options for individuals (Menu 1) based on a harm reduction philosophy
- ▶ Understand how their personal sexual choices relate to their STD/HIV risk behavior
- ▶ Increase their awareness of how partner selection relates to their HIV risk behavior decisions and how their decisions are related to their beliefs about what kind of partners are risky
- ▶ Increase their perceived risk (susceptibility) of getting STD/HIV

FACILITATOR TIPS

- ▶ Before the session, it is important for facilitators to review Sex in the City and the Transmission Puzzle. This session builds on the content in Session 2; therefore, it is very important for facilitators to have a thorough understanding of Sex in the City, the Transmission Puzzle, and STD/HIV interrelationships.
- ▶ The wall signs for Exercise 3.3 should hang on a wall with the sexual behaviors taped vertically from lowest to highest risk (top to bottom) (see Figure 1).
- ▶ This session has several handouts. Facilitators should be ready to deal with issues of low literacy by reading handouts to participants and explaining the content by using very accessible language.

Figure 1



Session 3 At-a-Glance

Session	Activities	Time (minutes)	Purposes	Materials
3.1	Session Preview	5	Welcome participants to Session 3, recap what was covered in the previous session, and provide an overview of what will be covered in Session 3.	<ul style="list-style-type: none"> • Sign-in sheet • Name tags • Pens or pencils • Prepared newsprint: PARKING LOT • Sticky notes for PARKING LOT
3.2	Creating a Menu of Options for STD/HIV Prevention	35	Participants are guided to use information from Exercise 2.3 STD Overview and Exercise 2.6 Transmission Puzzle to create their own Menu of Options for STD/HIV Prevention (handout), including harm reduction options and health-promotion options. This menu (handout) is used in Exercise 4.3 Choosing to Act.	<ul style="list-style-type: none"> • Transmission Puzzle slides • Handout: Transmission Puzzle Review • Handout: Building a Menu of Options • Prepared newsprint: REDUCE DOSE • Prepared newsprint: REDUCE EXPOSURE • Prepared newsprint: INCREASE RESISTANCE
3.3	Take Your Own Inventory	30	Participants increase their perception of risk by recognizing that type of partner and one's relationship with that partner influence one's decision making about risk; what one is willing to do sexually; and therefore, one's chances of getting HIV or another STD.	<ul style="list-style-type: none"> • Handout: My Personal Inventory Chart—What Would You Do With Whom? • Sexual Practices wall signs

Session 3 At-a-Glance (continued)

Session	Activities	Time (minutes)	Purposes	Materials
3.4	My Personal HIV/STD Risk Behaviors	30	Participants increase their recognition of perception of personal risk in relation to their sexual, substance-using, and health-promotion behaviors and those of their partner(s). This list of personal risk behaviors is used in Exercise 4.3 Choosing to Act.	<ul style="list-style-type: none"> Handout: My Personal HIV/STD Risk Behaviors Are... Prepared newsprint: PERSONAL HIV/STD RISK BEHAVIORS
3.5	Session Summary	10	Participants provide feedback on the session, and facilitators preview Session 4.	<ul style="list-style-type: none"> Prepared newsprint: PARKING LOT
Session 3 Primary Behavioral Determinants				
<ul style="list-style-type: none"> Lack of knowledge of risk-reduction options and protective behaviors (e.g. reducing the number of sexual partners, getting tested for STDs) Low perception of risk for acquiring STDs and HIV 				

Session 3: STD/HIV Risk Assessment and Prevention Options

Materials Checklist

Prepared Newsprints:

- PARKING LOT
- REDUCE DOSE
- REDUCE EXPOSURE
- INCREASE RESISTANCE
- PERSONAL HIV/STD RISK BEHAVIORS

Session Handouts:

- TRANSMISSION PUZZLE REVIEW
- BUILDING A MENU OF OPTIONS
- MY PERSONAL INVENTORY CHART—WHAT WOULD YOU DO WITH WHOM?
- MY PERSONAL HIV/STD RISK BEHAVIORS ARE...

Facilitator Materials:

- TRANSMISSION PUZZLE SLIDES
- SEX IN THE CITY (FOR REVIEW)
- SEXUAL PRACTICES WALL SIGNS
- 3MV FACILITATOR'S GUIDE
- SIGN-IN SHEET
- LAPTOP
- LCD PROJECTOR
- NAME TAGS
- PENS/PENCILS
- STICKY NOTES FOR PARKING LOT

Advanced Preparations:

- Prepare the above newsprints
- Copy participant handouts

Exercise 3.1 Session Preview

Purpose: To welcome participants back to Session 3, recap what was covered in the previous session, and provide an overview of what will be covered in Session 3.

Time: 5 minutes

Materials:

- Sticky notes for PARKING LOT
- Prepared newsprint: PARKING LOT
- Prepared newsprint: GROUND RULES
- Sign-in sheet
- Pens/pencils
- Name tags

Procedures

1. Welcome

- ▶ Welcome participants back to Session 3.

2. Review the questions from the Parking Lot

- ▶ Answer any unanswered questions from Session 2.

3. Preview Session 3

- ▶ In Sessions 1 and 2, we talked about what the problems are (i.e., unique risk behaviors of black gay men). In this session, we will begin to talk about the solutions.
- ▶ We can do things to prevent HIV/STD infections. In this session, we are going to create a menu of prevention options you can use to reduce your chances of getting HIV and other STDs.
- ▶ This session will last about 2 hours.
- ▶ Answer any questions.

Exercise 3.2 Creating a Menu of Options for STD/HIV Prevention

Purpose: Participants are guided to use information from Exercise 2.3 STD Overview and Exercise 2.6 Transmission Puzzle to create their own Menu of Options for STD/HIV Prevention (handout), including harm reduction options and health-promotion options. This menu (handout) is used in Exercise 4.3 Choosing to Act.

Objective: Participants will create a menu of prevention and harm reduction options for safer sex.

Time: 35 minutes

Materials:

- Transmission Puzzle slides
- LCD projector
- Laptop
- Prepared newsprint: REDUCE DOSE
- Prepared newsprint: REDUCE EXPOSURE
- Prepared newsprint: INCREASE RESISTANCE
- Handout: Transmission Puzzle Review
- Handout: Building a Menu of Options

Notes on Exercise 3.2

This exercise builds off of the Transmission Puzzle and Sex in the City done in Session 2. It is a good idea to review both before facilitating the exercise. If participants have a low literacy level, facilitators should be prepared to read the Building a Menu of Options handout to those participants.

Procedures

1. Introduce the concepts of prevention options and harm reduction options

- ▶ Prevention options are the most effective way to reduce the chances of getting or transmitting STD or HIV.
- ▶ Harm reduction options are practical methods to reduce risk and the chances of getting an STD or HIV.
 - These options are for persons who are not ready for the prevention options.
 - They are not as effective as the prevention options. For many, they are a first step toward behavior change.

FACILITATOR'S NOTE ON HARM REDUCTION

If participants are familiar with the concept of harm reduction in a substance-use context, tell them that in 3MV, the principles of harm reduction are being applied to STD/HIV risk reduction.

2. Discuss the Transmission Puzzle Review handout

- ▶ Distribute the Transmission Puzzle Review handout to participants.
- ▶ Show Transmission Puzzle Slide 3.
- ▶ The Transmission Puzzle helps us to understand the important roles dose, resistance, and exposure play in the transmission of STDs and HIV. Review the following key points.
- ▶ Ask participants whether they understand the role GERM (DOSE) plays in the puzzle.
 - How much germ you are exposed to depends on the amount of HIV germ your sexual partner has at any given time and how much gets into your body.
 - The amount also depends on which fluid you are exposed to (semen, vaginal secretions, or blood).
 - The amount of germ also depends on whether or not your partner has an STD.
 - If a person living with HIV/AIDS says his viral load is undetectable, does that mean the amount of HIV in his semen is low? Why or why not?
 - What would reduce how much germ you come into contact with?

- ▶ Ask participants if they understand the role EXPOSURE plays in the puzzle.
 - Exposure depends on how long the germ is in your body.
 - Exposure also depends on how many times you were exposed.
 - For black gay men, exposure depends mainly on what kind of sex you have and who is left holding the semen.
 - What would reduce how long the germs stay in your body?
 - Exposure also depends on the chances that your sex partner has HIV.
 - How do you determine this?

- ▶ Ask participants if they understand the role RESISTANCE plays in the puzzle.
 - Resistance depends on how many white blood cells you have on your pink parts.
 - What kinds of things lower your resistance?
 - STDs.
 - Other causes of inflammation.
 - What would keep your pink parts healthy?

FACILITATOR'S NOTE ON THE TRANSMISSION PUZZLE

It is important that participants understand the roles that dose, exposure, and resistance play in transmission so they can properly assess how their (and their partners') sexual and substance-use behaviors put them at risk. This knowledge can also help participants to reduce their risk.

3. Brainstorm options to reduce sexual risk

- ▶ Ask participants to brainstorm options they can do to reduce the chances of acquiring STD or HIV.

- ▶ Refer to three prepared newsprints and ask the following questions:
 - What can we do to lower dose (How much germ we are exposed to)?
 - What can we do to lower exposure?
 - How long the germ is in our body.
 - How many times we are exposed.
 - The chances that we are having sex with a person living with HIV/AIDS (PLWHA).

- What can we do to increase resistance of our pink parts and eliminate STDs and other causes of inflammation (white blood cells) on our pink parts?

▶ Record participants' responses on newsprint.

4. Distribute and discuss the Building a Menu of Options handout

- ▶ Note that all these options are based on the science of the Transmission Puzzle and include both prevention and harm reduction options.
- ▶ Review the prevention options (the ABCs).
 - A—Avoid Sexual Intercourse (Sexually Inactive [SI]).
 - Can do a nonpenetrative sexual practice, such as mutual masturbation or dry humping.
 - B—Be in a Mutually Monogamous Relationship With an Uninfected Partner (MMUP).
 - C—Condoms (Safer Sex [SS]).
 - Use every time with every partner for anal and vaginal intercourse.
- ▶ Review the harm reduction options.
- ▶ Review and discuss the participants' brainstorm and compare the options listed with the options on the Building a Menu of Options handout in 10 minutes.
- ▶ Answer any questions.

FACILITATOR'S NOTE ON THE BUILDING A MENU OF OPTIONS HANDOUT

Before conducting the session, review all the harm reduction options and prepare to answer any questions.

Exercise 3.3 Take Your Own Inventory

Purpose: Participants increase their perception of risk by recognizing that type of partner and one's relationship with that partner influence one's decision making about risk; what one is willing to do sexually; and therefore, one's chances of getting HIV or another STD.

Objective: To help participants see how their risk behaviors and decision making are influenced by the type of sexual and substance-using partners they select and the kind of relationships they have with those partners.

Time: 40 minutes

Materials:

- Prepared newsprint: MY PERSONAL HIV/STD RISK BEHAVIORS ARE...
- Handout: My Personal Inventory Chart—What Would You Do With Whom?
- Sexual Practices wall signs

Notes on Exercise 3.3

This is the first exercise to address the role and influence of partners (sexual and substance use) on risk behaviors and makes the connection between risk behavior and partner type.

For participants with low literacy levels, facilitators should be prepared to read, review, and help participants complete the My Personal Inventory Chart—What Would You Do With Whom? handout.

Procedures

1. Introduce the exercise

- ▶ We are going to discuss how our risks and decisions about prevention are influenced by our sexual and substance-using partners' risk behaviors and our relationship with those partners.

2. Tape the Sexual Practices wall signs up around the room in order from the lowest to the highest risk for getting HIV

- ▶ Review the order of the ranking from lowest to highest.
 - Ensure participants have a clear understanding of what sexual behaviors are the least risky (lowest risk), most risky (highest risk), and why.
- ▶ Answer any questions.

FACILITATOR'S NOTE

The sexual practices are listed below from lowest to highest risk for getting HIV:

- Mutual masturbation
- Deep kissing
- Getting sucked with a condom
- Sucking with a condom
- Fucking with a condom
- Getting fucked with a condom
- Getting sucked without a condom
- Sucking without a condom
- Fucking without a condom
- Getting fucked without a condom

Other behaviors participants might mention include fingering, fisting, or rimming (oral to anal contact). These are relatively low-risk behaviors when it comes to HIV transmission. Rimming may have the same the HIV/STD risk as sucking without a condom.

3. Distribute two copies of My Personal Inventory—What Would You Do With Whom? handout

- ▶ Tell participants the handout is an inventory of what you would do with whom, where you indicate the level of risk you are willing to assume with various kinds of partners and in different kinds of relationships.
- ▶ Ask participants to complete both copies. Tell participants they have 10 minutes to complete both copies.
 - One copy is to keep and the other copy is to be handed to the facilitators.
 - Participants do not need to put their names on the handouts.
- ▶ Collect one of the completed copies. Participants should put the other copy away.
- ▶ Shuffle all the handouts and redistribute them to the participants. Reassure participants that no one will get back their original handout.

4. Ask participants to share the responses on the handout. Discuss the kinds of sex and relationship types in 10 minutes

- ▶ Generate a discussion about the kinds of sex participants said they would have with intimate partners (e.g., HIV-positive lover; Man of My Dreams).
 - Ask participants, in thinking about their own choices, why they would have that kind of sex with intimate partners.
 - Ask participants what influenced their decisions.
- ▶ Generate a discussion about the kinds of sex participants said they would have with casual partners (e.g., one-night stand; person who says he's HIV-negative).
 - Ask participants, in thinking about their own choices, why they would have that kind of sex with casual partners.
 - Ask participants what influenced their decisions.
- ▶ Generate a discussion about the kinds of sex participants said they would have with substance-using partners (e.g., person who uses cocaine; injection drug user).
 - Ask participants, in thinking about their own choices, why they would have that kind of sex with substance-using partners.
 - Ask participants what influenced their decision.

5. Discuss the influence of relationships on sexual decision making in 10 minutes

- ▶ Generate a discussion about which relationship (e.g., Man of My Dreams; injection drug user) has a greater risk for HIV-transmission? Several one-night stands or sex with only one partner who has an infection?
 - Remind participants to think about dose, exposure, and resistance when answering the question.
- ▶ Generate a discussion on how the type of relationship you have with a partner can influence your sexual decision making.
- ▶ Generate a discussion on the connection between relationships and risk taking.
- ▶ Generate a discussion on the following question:
 - Given that unprotected sex with only one partner who has an STD or HIV is riskier, why do we feel safer with our regular partner or someone we know?
- ▶ Generate a discussion about what might have an impact on your decision to do what with whom.
- ▶ Remind participants that the decisions we make to have sex (including the kind of sex we have) with different types of partners are often influenced by the kind of relationships we have with those partners.

FACILITATOR'S NOTE ON THE MY PERSONAL INVENTORY— WHAT WOULD YOU DO WITH WHOM? HANDOUT

Participants should clearly understand the factors that influence their sexual decision making: (1) what they know of their sexual partners' HIV status; (2) what they know about their partners' risk behavior; and (3) the kind of relationships they have with those partners. In more intimate and established relationships, people generally engage in sexual practices that are very risky. In more casual relationships, people usually engage in sexual practices that are not as risky.

Exercise 3.4 My Personal HIV/STD Risk Behaviors

Purpose: Participants increase their recognition of perception of personal risk in relation to their sexual, substance-using, and health-promotion behaviors and those of their partner(s). This list of personal risk behaviors is used in Exercise 4.3 Choosing to Act.

Objective: Participants will identify their personal risk behaviors for HIV and STD.

Time: 30 minutes

Materials:

- Handout: My Personal HIV/STD Risk Behaviors Are...
- Prepared newsprint: PERSONAL HIV/STD RISK BEHAVIORS

Procedures

1. Review the following types of behaviors

- ▶ **Sexual risk behaviors** are having unprotected oral, anal, and vaginal sex. These behaviors were discussed in Sessions 1 and 2.
- ▶ **Substance-use risk behaviors** are sharing dirty needles; abusing alcohol; abusing prescription drugs; or using party drugs such as ecstasy, GHB, or methamphetamine.
- ▶ **Health-promotion behaviors** are designed to minimize health risks and increase healthy behaviors. Those behaviors include getting an STD and HIV test.
- ▶ **Partner's risk behaviors** are those risk behaviors including sexual, substance using, and others. Partner's risk behaviors also include their partner's health-promotion behaviors.
- ▶ Ask for and answer any questions.

2. Distribute two copies of My Personal HIV/STD Risk Behaviors Are...handout and have participants complete them in 10 minutes

- ▶ Tell participants the handout is used to list their and their partner's HIV and STD risk behaviors.
- ▶ Tell participants the handout has examples of risk behaviors.
- ▶ Tell participants to complete this handout on the basis of what their risk behaviors were the day they started the intervention.
 - They should include the health-promotion behaviors that they are currently doing as well as those they are not doing (i.e., getting an HIV test or an STD exam).
- ▶ Ask participants to complete both copies of the handout.
 - One copy is to keep and the other copy is to be handed to the facilitators.
 - Participants do not need to put their name on the handouts.
- ▶ Collect one of the completed copies. Participants should put the other copy away.
- ▶ Shuffle all the handouts and redistribute them to the participants. Reassure participants that no one will get their original handout.

3. Ask participants to share the responses on the handout in 15 minutes

- ▶ Record the responses on the prepared newsprint: MY PERSONAL HIV/STD RISK BEHAVIORS ARE...
 - Record all the sexual risk behaviors in the SEXUAL column.
 - Record all the substance-use risk behaviors in the SUBSTANCE USE column.
 - Record all the partner's risk behaviors in the PARTNER'S RISK BEHAVIORS column.
 - Record all the health promotion behaviors in the HEALTH PROMOTION column.
 - Record all the other risk behaviors in the OTHER column.

FACILITATOR'S NOTE ON MY PERSONAL HIV/STD RISK BEHAVIORS ARE...

You may need to use more than one piece of newsprint to capture all of the columns. The partner-related risk behaviors are the risk behaviors of participants' sexual and/or substance-using partners.

- ▶ Ask if there are any volunteers who would like to discuss their responses with the group. During this discussion, review all the behaviors according to type (sexual, substance use, partner's, and health promotion).
 - How was the experience of writing your risk behaviors?
 - Did you see some risks on the newsprint that could also apply to you?

Exercise 3.5 Session Summary

Purpose: Participants provide feedback on the session, and facilitators preview Session 4.

Time: 10 minutes

Materials:

- Prepared newsprint: PARKING LOT

Procedures

1. Check in with participants

- ▶ Do you have any questions about Session 3?
- ▶ Does anyone want to share any feelings or thoughts about anything covered in Session 3?

2. Review the Parking Lot

- ▶ Answer any questions on the Parking Lot.
 - Tell participants that any questions not answered now will be answered in the next session.

3. Review the Ties That Bind

- ▶ We got into some of our own personal stuff—what we do with whom and our personal risk behaviors.
- ▶ We have learned of some risks that we were not aware of and how those risks relate to some of our behaviors.
- ▶ We also learned more about what we can do to protect ourselves; we created a menu of prevention and harm reduction options. Some of these involve changing a sexual behavior or using drugs and alcohol differently. Some involve going for a checkup (having a test for STDs and HIV).
- ▶ During our next session we will discuss how we can make it happen—change some things that we are or aren't doing. We will talk about how behavior change happens.
- ▶ Just a reminder: Session 4 will take place (____) and will begin promptly at (____).

TRANSMISSION PUZZLE REVIEW

This handout is a review of the Transmission Puzzle.

The Transmission Puzzle helps us to understand how the transmission of STDs and HIV depends on three factors—GERM, EXPOSURE, and RESISTANCE.

GERM:

- ▶ GERM refers to the amount of GERM (STD or HIV) your sexual partner has and how much gets into your body.
- ▶ The amount of GERM also depends on which fluid you are exposed to (semen, vaginal secretions, or blood).
- ▶ What would reduce how much GERM you come into contact with?

EXPOSURE:

- ▶ EXPOSURE depends on how long the GERM is in your body.
- ▶ For a black gay man, this depends mainly on what kind of sex you have and who is left “holding the semen.”
- ▶ What would reduce how long the GERM stays in your body?
- ▶ EXPOSURE also depends on how many times you were exposed to the GERM.
- ▶ EXPOSURE depends on the chance your partner has the GERM.
- ▶ What would reduce the chance your partner has STD or HIV?

RESISTANCE:

- ▶ RESISTANCE depends on how healthy your pink parts (tissue inside your penis, rectum, and mouth) are.
- ▶ What would keep your PINK PARTS healthy?

BUILDING A MENU OF OPTIONS (MENU 1)

This handout lists some of the prevention and harm reduction options you can choose to reduce your chances of getting an STD and/or HIV through sex or drug use. The best way to decrease your risk is to choose a prevention option. If you are not ready for a prevention option, you can still reduce risk by doing a harm reduction option.

PREVENTION OPTIONS FOR SEX—THE BEST APPROACH

- A—Avoid rectal and vaginal intercourse.** May choose to use other (outercourse) sexual techniques.
- B—Be in a mutually monogamous relationship with an uninfected partner,** in which both partners get tested and have negative results for STDs and HIV.
- C—Condoms used EVERY time with EVERY partner** for anal and vaginal intercourse.

HARM REDUCTION OPTIONS FOR SEX—THE BETTER APPROACH

Reduce the amount of HIV and STD GERM you are exposed to:

- Get tested and treated for STDs every 3 to 6 months, including throat testing (for gonorrhea), to help reduce the amount of STDs in your body.
- Use plastic wrap/dental dam for rimming (mouth-to-anal contact).
- Swish and spit—rinse mouth with mild mouthwash (or even water) and spit out right after oral sex—even if no semen (cum) is in your mouth.
- Avoid unprotected sex in the first 3 months of a relationship with a partner who is not known to be HIV-negative.
- No semen (cum) in anus, vagina, and/or throat.
- Wash skin of penis and urinate within a few minutes after penetrative oral, vaginal, or rectal sex. If uncircumcised, be sure to pull back and clean under the foreskin with mild soap—no harsh soaps or solutions and no powders except for plain cornstarch.
- Others...

Reduce the number of times you are EXPOSED and the chances that your partner has STD or HIV:

- Reduce the number of sexual partners.
- No sharing of sex toys, or clean them between uses.
- Look at partner's genitals (including anus) for sores, irritated skin, or discharge before having sex—and do not have sex if these are seen.
- Feel arms for needle scars and feel for swollen gland (lymph nodes) in groin and neck—if felt, avoid having sex with this partner.
- Avoid risky partners—trade, persons who exchange sex for drugs (cocaine, ecstasy, methamphetamine), and persons with multiple partners.
- Know your partner's HIV status.
- Know your partner has been tested for STDs.
- Others...

Make your PINK PARTS (immunity) healthier:

- Get tested and treated for STDs every 3 to 6 months, including throat (for gonorrhea)—keep the PINK PARTS healthy.
- Get tested for HIV every 3 to 6 months.
- Get Hepatitis A and B vaccines.
- Get HPV vaccine.
- Avoid unprotected oral sex if you're sick, throat is sore, gums are bleeding, etc.
- Avoid anal douching or enemas before or after sex. Use glycerin suppositories because they are gentle and lubricate.
- Avoid unprotected insertive oral, vaginal, or anal sex if skin of penis is cut, chafed, or irritated.
- If uncircumcised, pull foreskin back and wash and completely dry every day (as above, with mild soap). Put plain cornstarch (not talcum or baby powder) under foreskin to keep it dry and nonirritated.
- If you have irritated hemorrhoids, avoid receptive anal sex until they are better.
- Others...

PREVENTION OPTIONS FOR DRUG USE—THE BEST APPROACH

- Stop using drugs and alcohol on your own.
- Get into a substance-use treatment program.
- Avoid sharing needles or works.

HARM REDUCTION OPTIONS FOR DRUG USE—THE BETTER APPROACH

Reduce the amount of HIV GERM:

- Use a syringe exchange program to get clean needles and works.
- Clean works using bleach and water or boil for 10 minutes.

Reduce the number of times you are EXPOSED:

- Switch to noninjecting drugs—or use in other ways (e.g., snort, sniff).
- Use drugs or alcohol at home ALONE to reduce the chance of unsafe sex when you're high.

How to increase the health of your PINK PARTS:

- Get tested and treated every 3 to 6 months (for STDs and HIV).

MY PERSONAL INVENTORY CHART—WHAT WOULD YOU DO WITH WHOM?

Put a Y or an N in each box (Yes/No)	Mutual Masturbation	Deep Kissing	Getting Sucked	Sucking With a Condom	Fucking With a Condom	Getting Fucked With a Condom	Sucking Without a Condom	Sucking With a Condom	Fucking Without a Condom	Getting Fucked Without a Condom
Person living with AIDS										
Person who tells you he is HIV-positive										
Person who tells you he is HIV-negative										
Man of your dreams										
A lover who tells you he is HIV-negative										
A lover who tells you he is HIV-positive										
A lover with whom you have never discussed HIV test results										
One-night stand										
Trade										
Person who uses cocaine (or other drugs)										
Person who injects drugs or other substances										
Black woman										
Friend who says he is HIV-negative										
White man										

MY PERSONAL STD/HIV RISK BEHAVIORS ARE...

In the boxes below, list your and your partner's STD/HIV risk behaviors and health-promotion behaviors.

STD/HIV Risk Behaviors		Health-Promotion Behaviors	
Me	Partner	Me	Partner
<i>Sexual</i>			
<i>Substance Use</i>			
<i>Other</i>			

SUPPLEMENTAL MATERIALS

HARM REDUCTION PRINCIPLES

Harm reduction (HR) is a philosophy that risk reduction strategies should be individualized and based on a client's starting point and readiness to change a risk behavior. In this way, HR philosophy is compatible with stages of change/transtheoretical model of behavior change theory. The following are some of the basic principles of harm reduction as it relates to the Many Men, Many Voices (3MV) intervention.

Harm reduction is a set of practical strategies designed to reduce negative consequences of risk behaviors, including substance use and sexual behaviors, and promote healthy behaviors. In relation to substance use, harm reduction promotes a spectrum of strategies from safe use to managed use to abstinence. In relation to sexual risk behavior, harm reduction strategies may include increasing the frequency of condom use or substituting unprotected oral sex for unprotected vaginal/rectal sex.

Harm reduction strategies meet individuals where they are and promote incremental change. A hierarchy of goals is established, with the more immediate and realistic ones to be achieved as first steps toward greater risk reduction. Any reduction in harm is a step in the right direction.

In 3MV, harm reduction principles are applied to reducing the amount of GERM to which an individual is exposed, reducing the type and number of times an individual is EXPOSED to a GERM, and maintaining the health of an individual's PINK PARTS. In 3MV, a menu of options for HIV/STD prevention is developed on the basis of harm reduction principles.

Harm Reduction Coalition. Principles of harm reduction. New York: Author. Retrieved March 8, 2010, from <http://www.harmreduction.org/article.php?list=type&type=62>

Riley, D. (1993). The Harm Reduction Model: Pragmatic approaches to drug use from the area between intolerance and neglect. Ottawa, ON: Canadian Centre on Substance Abuse. Retrieved March 8, 2010, from http://epe.lac-bac.gc.ca/100/200/300/ccsa-cclat/harm_reduction_model-e/harmred.htm

SESSION 4: INTENTIONS TO ACT AND CAPACITY FOR CHANGE

PURPOSE

The purpose of Session 4 is to help participants understand that behavior change often occurs in stages and that addressing ambivalence and barriers to change is a first step toward less-risky behavior. Participants will identify a behavior they want to change and will develop a plan for changing that behavior.

SESSION OBJECTIVES

Facilitator will help participants to:

- ▶ Learn more about how behavior change occurs, including the stages of change and spiral pattern involving relapse and slips
- ▶ Recognize that ambivalence is normal and recognize their own personal ambivalence and barriers for change
- ▶ Form intentions and agree to act on one prevention option of their choice
- ▶ Provide social support to other group participants about their choices to help them work through ambivalence and increase confidence in their ability to do their chosen prevention options
- ▶ Identify a first step and develop and practice new skills related to their chosen options

FACILITATOR TIP

- ▶ Before the session, facilitators need to complete additional readings on stages of change/transtheoretical model of behavior change theory (see Session Materials tab) to more effectively conduct the exercises.

Session 4 At-a-Glance

Session	Activities	Time (minutes)	Purposes	Materials
4.1	Session Preview	10	Welcome participants to Session 4, recap what was covered in the previous session, and provide an overview of what will be covered in Session 4.	<ul style="list-style-type: none"> • Prepared newsprint: GROUND RULES • Prepared newsprint: PARKING LOT • Sign-in sheet • Pens/pencils • Sticky notes for PARKING LOT
4.2	Stage Yourself—How Ready Are YOU for Change?	50	Participants increase their understanding of the process of behavior change and that relapse is a normal part of behavior change. Participants assess their individual readiness to change. This concept of readiness is used in Exercise 4.4 Barriers and Facilitators of Change.	<ul style="list-style-type: none"> • Prepared newsprint: STAGE OF CHANGE: "NO WAY" • Prepared newsprint: STAGE OF CHANGE: "YES, BUT..." • Prepared newsprint: STAGE OF CHANGE: "READY TO TRY IT" • Prepared newsprint: STAGE OF CHANGE: "BEEN DOING IT..." • Prepared newsprint: STAGE OF CHANGE: "BEEN LIVING IT..." • Prepared newsprint: STAGE OF CHANGE: "DID IT AND STOPPED" • Handout: Building a Menu of Options
4.3	Choosing to Act	20	Participants are guided in selecting a prevention or harm reduction option from Menu 1, which they created in Session 3. Each participant's choice is used as the focus for Exercises 4.3, 4.4, and 4.5.	<ul style="list-style-type: none"> • Handout: Building a Menu of Options (Menu 1)

Session 4 At-a-Glance (continued)

Session	Activities	Time (minutes)	Purposes	Materials
4.4	Barriers and Facilitators of Selected Change	45	Participants identify their own perceived barriers and facilitators to the prevention or harm reduction option they selected in Exercise 4.3. Creates an environment where participants receive social support for behavior change from their peers.	<ul style="list-style-type: none"> Handout: The Barriers and Facilitators of Change
4.5	Getting Ready for Action—Taking the First Step	30	Participants develop a plan for the behavior change option they chose in Exercise 4.3. Participants identify and agree to take a first step toward trying the prevention or harm reduction option they selected and practice it before the next session.	<ul style="list-style-type: none"> Handout: Getting Ready for Action
4.6	Session Summary	15	Participants provide feedback on the session, and facilitators preview Session 5.	<ul style="list-style-type: none"> Prepared newsprint: PARKING LOT
Session 4 Primary Behavioral Determinants				
<ul style="list-style-type: none"> Lack of knowledge of the process and steps involved in purposeful behavior change Lack of intentions to use condoms consistently during anal sex or adopt other prevention options Low self-efficacy to engage in safer behaviors (e.g., consistent condom use with partners) 				

Session 4: Intentions to Act and Capacity for Change

Materials Checklist

Prepared Newsprints:

- GROUND RULES
- PARKING LOT
- STAGES OF CHANGE: “NO WAY”
- STAGES OF CHANGE: “YES, BUT...”
- STAGES OF CHANGE: “READY TO TRY IT”
- STAGES OF CHANGE: “BEEN DOING IT...”
- STAGES OF CHANGE: “BEEN LIVING IT...”
- RELAPSE: “DID IT AND STOPPED”

Session Handouts:

- BUILDING A MENU OF OPTIONS (MENU 1)—FROM SESSION 3
- BARRIERS AND FACILITATORS OF CHANGE
- GETTING READY FOR ACTION

Facilitator Materials:

- 3MV FACILITATOR'S GUIDE
- SIGN-IN SHEET
- NEWSPRINT
- MARKERS
- TAPE
- PENS/PENCILS
- STICKY NOTES FOR PARKING LOT

Advanced Preparations:

- Prepare the above newsprints
- Post the above newsprints on six wall spaces or easels
- Photocopy the participant handouts

Exercise 4.1 Session Preview

Purpose: Welcome participants to Session 4, recap what was covered in the previous session, and provide an overview what will be covered in Session 4.

Time: 10 minutes

Materials:

- Sticky notes for PARKING LOT
- Prepared newsprint: PARKING LOT
- Prepared newsprint: GROUND RULES
- Pens/pencils
- Sign-in sheet
- Name tags

Procedures

1. Welcome participants to Session 4 and review key points from Session 3

- ▶ During the last session, we talked about what we can do to protect ourselves and we created a menu of prevention options for individuals (Menu 1), including harm reduction options.
- ▶ We have learned that the prevention options are the most effective ways to eliminate risk, but the harm reduction options can often be a first step in reducing your risk.
- ▶ Some of the options involve changing a sexual behavior or using drugs and alcohol differently. Some involve going for a checkup or having tests for STDs and HIV.
- ▶ All of them involve some kind of change! And we know change can be challenging for all people.
- ▶ In this session, each of you will begin the process of behavior change.
- ▶ This session will last about 3 hours.

2. Review and answer any question on the Parking Lot

3. Preview Session 4

- ▶ In this session, we are going to discuss the stages of behavioral change—what the process is that people go through when they stop doing something and start doing something else.

Exercise 4.2 Stage Yourself—How Ready Are YOU for Change?

Purpose: Participants increase their understanding of the process of behavior change and that relapse is a normal part of behavior change. Participants assess their individual readiness to change. This concept of readiness is used in Exercise 4.4 Barriers and Facilitators of Change.

Objective: Participants will be able to describe the stages of the behavior change process and assess their readiness to get tested for HIV and STDs.

Time: 50 minutes

Materials:

- Handout: Building a Menu of Options (Menu 1)
- Prepared newsprints:
 - STAGE OF CHANGE: “NO WAY”
 - STAGE OF CHANGE: “YES, BUT...”
 - STAGE OF CHANGE: “READY TO TRY IT”
 - STAGE OF CHANGE: “BEEN DOING IT...”
 - STAGE OF CHANGE: “BEEN LIVING IT...”
 - RELAPSE: “DID IT AND STOPPED”

Notes on Exercise 4.2

This exercise is designed to help participants understand how behavior change occurs in stages and how people can move between stages. The informal terms written on the prepared newsprints should be used to describe what each stage represents (e.g., “NO WAY” represents Precontemplative). You will not need to include the technical term used in the theoretical model to describe each stage unless you think it would be helpful to participants. You will need to tape the prepared newsprints around the room before the session starts.

Procedures

1. Provide a brief overview of the behavior change process

- ▶ In Session 1, we discussed behavior change, what we thought was difficult about changing a behavior, and what we thought would help us change that behavior.
- ▶ There has been a great deal of research done on behavior change in the past 20 years. We know what we should do to stay healthy, but at any given time we are not ready to do all of those things.
- ▶ It is known that people go through various stages when it comes to changing a behavior.
- ▶ According to a theory called stages of change, behavior change is a process that often occurs in a series of five stages.

2. Review the five stages and relapse and use the related examples

- ▶ Precontemplative (“NO WAY”).
 - This is the stage in which a person sees no need to make the change.
 - This may be because a person is unaware of a need to change or has a fixed emotional resistance to giving up a particular behavior.
 - In the case of HIV, a person may be unaware that this particular behavior poses a serious level of risk for getting HIV.
 - Another example is a person who is in denial about needing to lose weight because overeating is a way he manages his stress and he thinks he can't change.
- ▶ Contemplative (“YES, BUT...”).
 - This is the stage in which a person sees the need for change but has significant barriers to making that change.
 - He can be said to be on the fence. A person in contemplation feels two ways about the same change. He wants to change because ... and he doesn't want to because ...
 - For example, a person knows he will need to exercise more but is too exhausted when he gets out of work every day to go to the gym.

- ▶ Ready for Action (“READY TO TRY IT”).
 - This is the stage in which someone has not only made a commitment to change a particular behavior but has also taken necessary steps to start the change.
 - For example, a person is now willing to go on a diet to lose weight. He takes a first step by setting up an appointment with a nutritionist for next week.

- ▶ Action (“BEEN DOING IT”).
 - This is the stage in which a person has made the change and is actively working to not return to his old ways.
 - For example, the person who wants to lose weight now works out at the gym three times a week and is eating healthier foods over a 3- to 6-month period. This person may also seek support from friends to help him maintain his new lifestyle.

- ▶ Maintenance (“BEEN LIVING IT”).
 - This is the stage in which a person has made the change and is doing it so long it feels more like a new habit. He also works to minimize potential opportunities for relapse.
 - For example, the person has started a diet and has been keeping to it for more than 6 months.

- ▶ Relapse (“DID IT AND STOPPED”).
 - This occurs when a person stops trying to maintain his behavior change and goes back to an earlier behavior. A person can relapse at any point in the five stages and go back to an earlier stage.
 - For example, the person who was dieting goes on a cruise and gives up his diet and eats everything in sight. Then he feels so discouraged that, when the cruise is over, he goes back to overeating to manage his stress.

- ▶ When people are trying to make a change to reduce their chances of getting HIV/STDs, they go through the same process.

FACILITATOR'S NOTE ON STAGE OF CHANGE EXERCISE

It is important for participants to feel comfortable sharing with the group their feelings about changing a behavior. Before the activity begins, be sure to explain to participants that it is okay if any of them are in the precontemplative ("NO WAY") or contemplative ("YES, BUT...") stages because people often are in these stages regarding many different behaviors. It is also important to remind participants that it is okay and not considered a failure if anyone in the group has relapsed ("DID IT AND STOPPED") because it is a natural part of the behavior change process.

Remind participants that their honesty about their feelings and experiences regarding getting tested for HIV and STDs will help them to accurately determine where they are in the change process. It will also help their peers who might be feeling the same way.

- ▶ Let's do an activity where you all assess your own readiness to do one thing on our menu—to get STD testing every 6 months.
 - To help you accurately assess your readiness to get STD testing every 6 months, think for a minute about all the steps involved in getting the testing.
 - To get tested for all STDs, you have to:
 - Go to a doctor's office or clinic.
 - Tell your medical provider you are a person who has sex with men.
 - Have an examination of your mouth, skin, genitals, and rectum.
 - Have swabs taken from your mouth, genitals, and rectum.
 - Have blood samples taken.
- ▶ Think about it and be honest with yourself, and then go and stand under the sign that most closely represents how ready you are to go for STD testing every 6 months. Remember, be honest. It is okay and normal to be in any of the stages.
- ▶ Point out and quickly review each sign/stage (including relapse). Give participants a minute to move to a stage.
- ▶ After they have placed themselves at their stage, ask each participant to explain why he is at that particular stage. Discuss their responses with the group.
- ▶ Ask those in the Ready to Action stage whether they ever felt the way the participants in the Contemplation stage feel. What moved you to your current stage?
- ▶ Ask those in the Action stage whether they ever felt the way that the participants in the Precontemplative stage feel. What moved you to your current stage?

3. Review the Building a Menu of Options (Menu 1) handout

- ▶ Ask participants to take out the Building a Menu of Options (Menu 1) handout you distributed in Session 3.
- ▶ Review the differences between the prevention and harm reduction options listed on the handout. Depending on their stage of readiness, some participants may not be ready for preventions (e.g., being sexually inactive).
- ▶ Highlight the benefits of adopting harm reduction options if they are not ready to implement one of the prevention goals.
- ▶ Ask for and answer any questions about the stages of change.

FACILITATOR'S NOTE

You may need to reproduce and distribute additional copies of the Building a Menu of Options (Menu 1) handout used Session 3 if participants do not bring them to Session 4.

Exercise 4.3 Choosing to Act

Purpose: Participants are guided in selecting a prevention or harm reduction option from Menu 1, which they created in Session 3. Each participant's choice is used as the focus for Exercises 4.3, 4.4, and 4.5.

Objective: Participants will be able to select an option from the menu of prevention and harm reduction options handout and practice implementing that option over the next few weeks.

Time: 20 minutes

Materials:

- Handout: Building a Menu of Options (Menu 1)

Procedures

1. Tell participants to choose one prevention or harm reduction option that they will commit to try that they are not already doing
 - ▶ Instruct participants to take 5 minutes to review Building a Menu of Options (Menu 1) before they choose their option.
 - ▶ Ask participants to pick an option they are not currently doing. Participants will need to pick an option that they are ready to try over the next 2 weeks.
 - ▶ Ask participants to choose an option from Menu 1.
 - ▶ Congratulate the participants and let them know they have just taken an important first step in protecting themselves and their community.

2. Discuss with participants the options they selected
 - ▶ Ask a few volunteers to share the options they picked with the group, if they feel comfortable doing so.
 - ▶ Emphasize that they don't ever have to share what they chose with the group if they don't want to.
 - ▶ What are your feelings about trying your option?
 - ▶ We will talk more about things that will help and prevent you from changing your behavior in the next session.
 - ▶ You should try the option over the next week and, during Session 5, we will follow up and ask about how it worked out for you.

FACILITATOR'S NOTE

If no participants volunteer to share the options they picked, you can select one of the prevention or harm reduction options you think most of the group would be ready to try and discuss that option.

Exercise 4.4 Barriers and Facilitators of Selected Change

Purpose: Participants identify their own perceived barriers and facilitators to the prevention or harm reduction option they selected in Exercise 4.3. Creates an environment where participants receive social support for behavior change from their peers.

Objective: Describe at least one barrier and one facilitator to implementing the selected option behavior.

Time: 45 minutes

Materials:

- Handout: Barriers and Facilitators of Change

Procedures

1. Distribute Handout: Barriers and Facilitators of Change

2. Explain the concept of ambivalence

- ▶ Part of the process of making a behavior change is to deal with a natural response to change—ambivalence.
- ▶ Ambivalence is when a person has mixed or conflicting emotions about something or someone.
- ▶ In other words, to feel ambivalent is to feel two ways about something or someone at the same time. Sometimes when a person is ambivalent, he may feel uncertain or indecisive.
 - For example, you may hear people say they both love and hate a person.
 - You may also have heard a person being described as having cold feet or sitting on the fence.
 - These are examples of feeling ambivalent.

3. Explain the exercise

- ▶ In this exercise, we are going to discuss how to work through your ambivalence about the options you chose. As we saw in the STD testing example, what will it take to move you?
- ▶ To do this, we want you to think about what barriers you might encounter in the options you chose. Also, think about what could help you to do the options you choose (facilitators to making the change).
- ▶ Take 5 minutes to list on the handout what you think will be barriers (things that would make it difficult to do your option) and facilitators (things that will make it easier to do your options).
- ▶ We are going to discuss your responses after you complete the handout.

4. Divide the participants into groups of threes and have them discuss their responses

- ▶ We are now going to work in small groups to stage and discuss the behaviors you selected and the barriers and facilitators you identified.
- ▶ Take turns in your group and discuss the positive and negative feelings you have about those selected options.
- ▶ Discuss the barriers and facilitators.

- ▶ Discuss ways each person could address the barriers.
- ▶ Discuss how peers can provide support in helping you do your selected option.
- ▶ Take 30 minutes (10 minutes for each participant) to complete the activity.
- ▶ After participants finish sharing in their small groups, have them come back together as a large group.
- ▶ Ask for a few volunteers to share with the large group the barriers and facilitators their group identified, strategies to overcome these barriers, and ways peers can support each other.

5. Ask the large group to share

- ▶ Ask a few volunteers to:
 - Share their selected options with the two other members of their groups.
 - Stage themselves on their readiness to act on the options they selected (“NO WAY”; “YES BUT”; “READY TO TRY”; “BEEN DOING IT”; “BEEN LIVING IT”).

6. Facilitate a discussion on ambivalence and how it affects behavior change

- ▶ What were some of the reasons you discussed in your small groups about why you might have conflicting feelings (i.e., positive and negative) about the options you chose?
- ▶ After several participants provide examples, point out that feeling two ways about something (e.g., that you feel good about using condoms to protect yourself but bad about not being able to enjoy direct skin-to-skin contact with a partner using a condom) is a normal part of the behavior change process.
- ▶ Ask participants if any of them have heard of the term ambivalence and ask them to share what they know about the term and what it means.
- ▶ Record participants' responses on the newsprint and discuss. Be sure to affirm correct responses.
- ▶ Restate the definition of ambivalence.
 - Ambivalence is when a person has mixed or conflicting emotions about something or someone. In other words, to feel ambivalent is to feel two ways about something or someone at the same time.
- ▶ Ask for a few volunteers to describe their thoughts about how ambivalence may affect their ability to change their behavior.

- ▶ Recall the discussion in Session 1 about how what we think, believe, or feel (THINGS ON THE INSIDE) affect how we behave. If we are ambivalent about our personal risk for HIV/STD, we may or may not make changes in our behaviors that put us at risk.
- ▶ Ambivalent feelings are a common experience and a normal part of behavior change. Many people struggle with it. It is okay if you feel ambivalent about implementing a new HIV/STD prevention or harm reduction behavior.

7. Facilitate a discussion on how participants can overcome ambivalence and other barriers

- ▶ Ask for any suggestions on how to overcome barriers, deal with ambivalence, and support peers in making changes.
- ▶ Provide additional recommendations and resources for addressing barriers, dealing with ambivalence, and building peer support.
 - For example, if a participant says obtaining free condoms and finding out how to use them are barriers, share information about local community resources where he can get condoms and/or learn how to use them correctly.
 - If you do not have the information during the session, let participants know that you can get the information they need by the next session.
- ▶ Tell participants ambivalence can be overcome by:
 - Identifying the facilitators (pros) and barriers (cons) to change.
 - Identifying social support to support change.
 - Identifying and planning the first step towards behavior change.
 - Asking and answering any questions about overcoming ambivalence.

Exercise 4.5 Getting Ready for Action—Taking the First Step

Purpose: Participants develop a plan for the behavior change option they chose in Exercise 4.3. Participants identify and agree to take a first step toward trying the prevention or harm reduction option they selected and practice it before the next session.

Objective: Increase participants' self-efficacy to practice implementing the selected prevention goal or harm reduction option before the next session.

Time: 30 minutes

Materials:

- Handout: Getting Ready for Action

Procedures

1. Distribute and review Getting Ready for Action handout

- ▶ Hopefully you are now ready to try your behavior options before the next session. We call this step Getting Ready for Action.
- ▶ Ask participants to write down the following on their handout:
 - Their selected behavior options.
 - At least two things that will help them to overcome their barriers to trying this option.
 - At least one way they can seek support from peers to help them with their option.
 - The first step to making the change—the first thing they will do to make the change happen.
- ▶ You can use the handout as a reminder of what you will try to do before the next session. We will follow up with you during the next session to see how your first step turned out.

2. Summarize the exercise

- ▶ In this exercise, we talked about the barriers and facilitators to trying a new behavior.
- ▶ We discussed ambivalence and reviewed reasons why we may feel ambivalent about the options we selected.
- ▶ We also discussed strategies to address barriers as well as ways we can support each other as peers.
- ▶ Finally, we made a commitment to take the first step to change a behavior and will report our progress during the next session.

Exercise 4.6 Session Summary

Purpose: Participants provide feedback on the session, and facilitators preview Session 5.

Time: 10 minutes

Materials:

- Prepared newsprint: PARKING LOT

Procedures

1. Check in with participants

- ▶ Do you have any questions about Session 4?
- ▶ Does anyone want share any feelings or thoughts about anything covered in Session 4?

2. Review the Parking Lot

- ▶ Answer any questions on the Parking Lot. Tell participants that any questions not answered now will be answered in the next session.

3. Review the Ties That Bind

- ▶ During this session, we reviewed the menu of prevention and harm reduction options for individuals.
- ▶ We discussed how behavior change happens. We learned that it is a process, not an event.
- ▶ We also learned that people go through stages of change and that it is normal to have slips and relapses. We need to apply this to ourselves so that we do not judge ourselves negatively when we have trouble with making a change.
- ▶ We discussed what it means to be ambivalent and how ambivalence can play a role in making decisions about changing our behaviors.
- ▶ We discussed the barriers and facilitators to trying out the options we selected. We also talked about ways we can overcome our barriers and how it helps to get support from our peers.
- ▶ Finally, we made a commitment to practice implementing our selected options before the next session.
- ▶ During our next session, we are going to revisit the issue of Tops and Bottoms and focus on how we deal with communicating and negotiating choices with our partners.
- ▶ Remember, our next session is (____) and we start promptly at (____).

BARRIERS AND FACILITATORS OF CHANGE

LIST THE RISK REDUCTION OPTION YOU CHOSE AND WHAT WOULD HELP AND WHAT WOULD MAKE IT DIFFICULT TO DO YOUR OPTION

My chosen STD/HIV risk reduction option is:

1.

Things that would help me (facilitators) to do my option:

1.

2.

3.

Things that would make it difficult for me (barriers) to do my option:

1.

2.

3.

Some potential solutions to overcome my barriers are:

1.

2.

3.

I need the following support:

GETTING READY FOR ACTION

LIST YOUR RISK REDUCTION OPTION, BARRIERS TO MAKING THE CHANGE, AND HOW YOU PLAN TO OVERCOME THOSE BARRIERS

The option I choose to try for STD/HIV risk reduction is:

1.

What will be hard for me in making this change? What are the barriers to change?

1.

2.

3.

What will help me to make the change? What can I do to overcome the barriers?

1.

2.

3.

First step to making the change:

1.

SUPPLEMENTAL MATERIALS

STAGES OF CHANGE

Premise

The transtheoretical model,¹ sometimes called the stages of change, developed by Prochaska and DiClementi,² describes behavior change as a process, not an event.³ As persons attempt to change their behavior, they move through a series of five stages.

Key Components

1. **Precontemplative:** Persons in this phase have no intention of changing their behavior. They may be either unaware of their risky behavior (uninformed), believe that their behaviors do not expose them to risk, or be unwilling to change their behaviors. They don't see a need to change the behavior.

"No way!" "I am not even thinking about it." "I know I have a lot of sexual partners, but I don't need to use condoms because my partners aren't at risk."

2. **Contemplative:** Persons recognize that their behaviors place them at risk and may be thinking about changing but have not made a commitment at this time. They see the need to change the behaviors, but have barriers to doing so.

"Yes I know I need to ..., but I can't right now because ...!" "What I do is a way of life for me." "I'm scared of getting infected, and I've thought about getting my partner tested for HIV, but I just don't know how he would react if I asked him ..."

3. **Preparation:** Persons see the need for change and are ready to try to make the change. They may be making plans and gathering support to make a change in the next 30 days.

"I just bought some condoms, and I'm going to talk to my partner about using them, before we have sex."

4. **Action:** Persons in this stage have just recently changed a particular behavior, such as using condoms consistently for a few months. People in this stage have usually changed a behavior within the past 6 months.

"My partner and I started using condoms and it wasn't bad at all."

¹ STD/HIV Prevention Training Centers. (2005). Bridging Theory and Practice trainer's guide (August ed.).

² Prochaska, J. O., DiClementi, C. C., & Norcross J. C., (1992). In search of how people change: Application to addictive behaviors. *American Psychologist* 47, 1102–1114.

³ National Cancer Institute. (2005). Theory at a glance: A guide for health promotion practice (2nd ed.).

5. **Maintenance:** People in this stage have consistently performed a behavior for more than 6 months and are relatively comfortable with the change; it has become a routine part of their lives.

“Using condoms is no big deal anymore; my partner and I have our routine down and always use them.”

Key Points for Discussion

Nonlinear: This model describes behavior change as a spiral process; behavior change can happen in a circular fashion. Persons can go from Precontemplative to Contemplative to Preparation and then back to Contemplative, for example. The length of each stage will vary for each individual, and people move back and forth between the stages.

Relapse: Behavior change is seen as a spiral because relapse often will occur and is seen as a normal part of the process of change. If relapse occurs, it doesn't mean one has failed and should therefore give up. Relapse indicates that one may need to continue developing skills, support, self-efficacy, or other factors that positively affect behavior to build a solid enough base so that behavioral goals can be reached and maintained.

SESSION 5: RELATIONSHIP ISSUES— PARTNER SELECTION, COMMUNICATION, AND NEGOTIATION OF ROLES FOR BLACK MSM

PURPOSE

The purpose of Session 5 is to discuss how we define the roles of Tops and Bottoms in relationships; power dynamics; and different kinds of power used in relationships. Another purpose of Session 5 is to discuss communication and negotiation with partners.

SESSION OBJECTIVES

Facilitators will help participants to:

- ▶ Identify what kinds of relationships participants prefer
- ▶ Explore how Tops and Bottoms are often assigned relationship roles that can create power and control issues within the relationships of black gay men
- ▶ Explore attitudes toward gender roles and power in black communities
- ▶ Recognize the origins of the typical relationship roles assigned to Tops and Bottoms and that these roles reflect stereotyping and sexism; may not fit the needs of black gay men; and may not result in a relationship that is preferred
- ▶ Explore how these relationships dynamics for black gay men affect decision making and STD/HIV risk-taking behaviors
- ▶ Recognize how communication skills and role negotiation skills influence one's ability to practice risk reduction options
- ▶ Continue to develop skills in partner selection, communication, and negotiation of role

FACILITATOR TIP

- ▶ This session can elicit strong emotional responses (e.g., crying), especially during Exercise 5.2. Facilitators should be prepared to deal with participants' responses and have a separate private space ready for any participant who needs a break from the group.

Session 5 At-a-Glance

Session	Activities	Time (minutes)	Purposes	Materials
5.1	Session Preview	10	To welcome participants to Session 5 and preview what will be covered in Session 5.	<ul style="list-style-type: none"> • Sign-in sheet • Pens or pencils • Prepared newsprint: PARKING LOT • Sticky notes for PARKING LOT
5.2	The Man of My Dreams	30	Participants recognize what they want sexually and emotionally in romantic and sexual relationships. They define sexism and stereotyping, concepts that are applied in Exercise 5.4.	<ul style="list-style-type: none"> • Prepared newsprint: SEXISM • Prepared newsprint: STEREOTYPING
5.3	Who's Got the Power	60	Discussion continues from Session 2 with a focus on the power dynamics of Tops and Bottoms and how participants have experienced power in their previous sexual relationships. Participants recognize that while Tops are often seen as having more power in relationships (referred to as authoritative power), Bottoms also have power of a different kind (referred to as nurturing power).	

Session 5 At-a-Glance (continued)

Session	Activities	Time (minutes)	Purposes	Materials
5.4	Why We Choose the Ones We Choose	30	Participants recognize that the roles of Tops and Bottoms of black gay men were created from their perceptions of heterosexual couples. Then, participants are guided to recognize that assigning those roles to black gay men is a form of stereotyping and sexism as defined previously in Exercise 5.2. Participants learn that the social norms of how Tops and Bottoms are supposed to behave in a relationship may not match what they said they want in the ideal relationship(s) they described in Exercise 5.2. Participants recognize the need to reject the stereotypical roles of Tops and Bottoms and communicate verbally about power dynamics and their needs in their relationships. Finally, participants choose an option from the second Menu of Prevention Options for Partners involving communication and negotiation with a partner.	<ul style="list-style-type: none"> • Handout: Prevention Options for Partners—Menu 2 • Prepared newsprint: SEXISM • Prepared newsprint: STEREOTYPING
5.5	Session Summary	10	Participants provide feedback on the session, and facilitators preview Session 6.	<ul style="list-style-type: none"> • Prepared newsprint: PARKING LOT
Session 5 Primary Behavioral Determinants				
<ul style="list-style-type: none"> • Low self-efficacy to communicate with sexual partners and negotiate condom use with sexual partners • Lack of peer and social support for behavior change 				

Session 5: Relationship Issues: Partner Selection, Communication, and Negotiation of Roles for Black MSM

Materials Checklist

Prepared Newsprints:

- SEXISM
- STEREOTYPING
- PARKING LOT

Session Handout:

- PREVENTION OPTIONS FOR PARTNERS (MENU 2)

Facilitator Materials:

- 3MV FACILITATOR'S GUIDE
- SIGN-IN SHEET
- NEWSPRINT
- MARKERS
- TAPE
- PENS/PENCILS
- STICKY NOTES FOR PARKING LOT

Advanced Preparations:

- Prepare the above newsprints
- Photocopy participant handouts

Exercise 5.1 Session Preview

Purpose: To welcome participants to Session 5, recap what was covered in the previous session, and provide an overview of what will be covered in Session 5.

Time: 10 minutes

Materials:

- Sticky notes for PARKING LOT
- Prepared newsprint: PARKING LOT
- Prepared newsprint: GROUND RULES
- Pens/pencils
- Sign-in sheet
- Name tags

Notes on Exercise 5.1

During this exercise, it is important to review participants' experience with the Building a Menu of Options (Menu 1) handout. Participants may be a little nervous about sharing. Facilitators should be ready to use probes and questions to get participants to discuss their experiences.

Procedures

1. Welcome participants back to Session 5
2. Review and answer any question on the Parking Lot
3. Ask for volunteers to share their experiences with their first attempt at their chosen risk reduction option from Menu 1
 - ▶ How did it feel to try what you selected?
 - ▶ What were the things that made it easier to try?
 - ▶ What were some of the barriers you encountered?
 - ▶ How did you deal with those barriers?
4. Preview Session 5 using the following talking points
 - ▶ We have talked about and have started to experience the challenge of behavior change. When it comes to sexual behavior, part of the challenge is that you can't have risky sex alone.
 - That is, at any given time, there is another person involved. So in order to stay safe, you also have to influence the behavior of that person.
 - That person may not be as ready as you are to practice prevention options.
 - ▶ Remember in Session 2, we talked about how the kind of relationship you have with that person can influence your decision making about protecting yourself.
 - ▶ So, how do we learn to deal with that person so we can get what we want and not risk getting infected with HIV or other STDs?
 - ▶ In this session we are going to discuss the Man of Your Dreams and your ideal relationship.
 - We are also going to define power and discuss how it is used in relationships.
 - We will discuss power as it pertains to Tops and Bottoms, the relationship dynamics of black gay men, and our ability to protect ourselves.
 - This session will last about 2.5 hours.
 - ▶ Ask for and answer any questions.

Exercise 5.2 The Man of My Dreams

Purpose: Participants recognize what they want sexually and emotionally in romantic and sexual relationships. They define sexism and stereotyping, concepts that are applied in Exercise 5.4.

Objective: Participants will describe and discuss what they want in their ideal man and ideal relationship and compare that with their previous relationship experiences.

Time: 25 minutes

Materials:

- Prepared newsprint: SEXISM
- Prepared newsprint: STEREOTYPING

Notes on Exercise 5.2

This exercise can elicit strong emotional (e.g., crying) responses from participants as they describe their past relationships, hopes for future relationships, and their ideal man. Facilitators need to have a separate private space available for any participant who needs to have some time away from the group.

Procedures

1. Facilitate a discussion on the Man of My Dreams

- ▶ Describe the Man of Your Dreams—what is that man like?
- ▶ What is the relationship like with the Man of Your Dreams? How does he make you feel?
- ▶ Who's the strong person in your ideal relationship?
- ▶ Who decides things in your ideal relationship?
- ▶ Is your relationship with him romantic or sexual or both?

2. Facilitate a discussion on participants' previous experiences in their relationships

- ▶ What kinds of relationships have you had in the past?
- ▶ What did you like about your previous relationships?
- ▶ What did you not like about your previous relationships?
- ▶ Did you always feel safe in your previous relationships?
- ▶ In what ways did your previous relationships affect whether or not you could practice the HIV/STD prevention and harm reduction options?

3. Define sexism and stereotyping

- ▶ We are going to define a few terms that will be used later for a different exercise. I want you to define two terms:
 - Sexism—what does it mean? Do you think it is a good or bad thing?
 - Stereotyping—what does it mean? Do you think it is a good or bad thing?
- ▶ Record participants' responses on prepared newsprints: SEXISM and STEREOTYPING.
- ▶ Put prepared newsprints away until Exercise 5.4.

DEFINITIONS OF SEXISM AND STEREOTYPING

Sexism—an attitude and belief (or way of thinking) that a certain gender is less than (less strong, less capable, less deserving, less powerful) another gender. Example: Women are not as capable as men of being in a leadership position because they are not as emotionally strong.

Stereotyping—an attitude and belief (or way of thinking) held in common by members of a group that a person should feel, think, or behave in a certain way based on their role or other characteristics (such as race/ethnicity, gender, age, etc.). Example: White men can't dance.

Exercise 5.3 Who's Got the Power

Purpose: To discuss the power dynamics in the relationships participants have seen in their families and communities and how that relates to what they have experienced in their own relationships.

Objective: Participants will discuss their attitudes and beliefs about power in relationships and recognize that there are different kinds of power used in relationships.

Time: 30 minutes

Procedures

1. Provide the definitions of power and power dynamics

- ▶ Power is the ability to do or act; the capability of doing or accomplishing something. It can also be a person or thing that possesses or exercises authority or influence.
- ▶ Power dynamics are how power is used in relationships, or how decisions are made.
- ▶ All sexual and personal relationships for all people have power dynamics.
- ▶ Ask for and answer any questions.

FACILITATOR'S NOTE

Facilitators need to use prompting questions to get at the issues of sexism and stereotyping that the participants saw in their families, black community, and black church while growing up.

2. Facilitate a discussion on the power dynamics participants saw in the black community, their families, and the black church using the following questions

- ▶ In the black community:
 - Who had the power?
 - What kind of power did the men have?
 - How were the men supposed to behave?
 - What kind of power did the women have?
 - How were the women supposed to behave?
 - Why did they have these kinds of power and roles?
 - Explore issues of stereotyping and sexism here without using the terms.
- ▶ In the household in which they grew up:
 - Who held the power in the household?
 - Men/father/stepfather/mother's boyfriend.
 - Women/mother/stepmother/father's girlfriend.
 - What kind of power did the man/men have?
 - How was the man/men supposed to act?

- How was the man/men expected to act?
 - What kind of power did the woman/women have?
 - How was the woman/women expected to act?
 - How was power used in relation to you?
- ▶ In the households familiar to you:
- Who held power?
 - Was it similar to the power in the household in which you grew up?
 - What kind of power did women have?
 - What kind of power did men have?
 - How was power used?
- ▶ In faith/religious institutions:
- Who held power?
 - What kind of power did women have?
 - What kind of power did men have?
 - How was power used?

3. Summarize the discussion

- ▶ Understanding how these power dynamics have influenced you will help you to understand the roles you take on and the ones you are assigned in a relationship.
- ▶ There are different kinds of power in every relationship, and that power can influence our behaviors.
- For example, you said your father (male parental figure) had the power and what he said was how it went. Did you always do what he told you to do? Why or why not?
 - What about your mother (female parental figure)? You said she did what your father said. Did you always do what your mother asked you to do? Why or why not?

4. Discuss authoritarian power

- ▶ Authoritarian power is power that is controlling and dominant. Often in a relationship, the partner does what the person with authoritarian power wants because he fears the authoritarian partner's reaction.

- ▶ Ask participants to provide examples of authoritarian power.
 - One example is using something to control your partner's behavior, such as money, sex, or physical strength.
- ▶ Discuss participants' previous experience with authoritarian power.
 - How has authoritarian power been used in your romantic and sexual relationships?

5. Discuss nurturing power

- ▶ Nurturing power is power that is caring and supportive of the emotional needs of another. Often in a relationship, the partner does what the person with nurturing power wants because they want to continue being nurtured and cared for.
- ▶ Ask participants to provide examples of nurturing power.
 - One example is caretaking, such as cooking meals, doing laundry, and cleaning the house.
 - Another example is providing emotional support for your partner; being there for him in tough times.
- ▶ Discuss participants' previous experience with nurturing power.
 - How has nurturing power been used in your romantic and sexual relationships?

FACILITATOR'S NOTE

It is very important to emphasize that how participants use power in their sexual and romantic relationships is influenced by how they saw power in their homes, churches, and communities.

6. Summarize this activity

- ▶ Remind participants that power can be used to nurture, support, or care for someone.
- ▶ Power can also be used to control and dominate.
- ▶ How we understand and use power in relationships is often related to how we saw power used in our families and communities.
- ▶ Ask for and answer any questions.

Exercise 5.4 Why We Choose the Ones We Choose

Purpose: To help participants understand the power dynamics that exist in black gay relationships and understand how the assigned roles of Tops and Bottoms can influence them. Participants will also understand how relationship roles can influence risk-taking behaviors.

Objective: Participants will learn how sexual and relationship roles can influence the power dynamics in their relationships.

Time: 30 minutes

Materials:

- Prepared newsprint: SEXISM
- Prepared newsprint: STEREOTYPING
- Handout: Prevention Options for Partners (Menu 2)

Procedures

1. Discuss the types of power Tops and Bottoms have in relationships

- ▶ Let's think back to what we said about Tops and Bottoms in Session 2.
- ▶ What type of power do Tops have—more authoritative or more nurturing?
 - In sexual relationships?
 - In romantic relationships?
- ▶ How are Tops expected to act in a relationship?
- ▶ What types of power do Bottoms have—more authoritative or more nurturing?
 - In sexual relationships?
 - In romantic relationships?
- ▶ How are Bottoms expected to act in a relationship?
- ▶ What is the connection between the roles of Tops and Bottoms for black gay men and the roles of black men and women in heterosexual relationships?

2. Discuss the definitions of sexism and stereotyping

- ▶ Review the definitions generated by the participants from Exercise 5.2.
- ▶ How do sexism and stereotyping affect Tops?
 - Tops are expected to be authoritarian.
 - Tops are in control and have power.
 - Tops are the men.
 - What is the relationship role for Tops?
- ▶ How do sexism and stereotyping affect Bottoms?
 - Bottoms are expected to be nurturing.
 - Bottoms are thought to have less power.
 - Bottoms are the women.
 - What is the relationship role for Bottoms?

- ▶ How do sexism and stereotyping affect black gay men's:
 - Sexual relationships?
 - Romantic relationships?
- ▶ How can stereotyped relationship role assignments affect STD/HIV risk-taking behaviors?
 - How does this affect Tops?
 - How does this affect Bottoms?
- ▶ Ask participants if they think assigned roles of Tops and Bottoms match their vision of the kind of relationship they want with the man of their dreams.
 - What happens when your sexual role conflicts with your relationship role?
 - For example, what happens when the Tops want to be the submissive ones in the relationship or Bottoms want to sometimes be in charge and make decisions?
 - How can you move beyond the assigned roles of Tops and Bottoms in order to get the relationship you want with the man of your dreams?
 - Note that without communication, black gay men are often stuck playing the role of either Top or Bottom.
- ▶ Who teaches black gay men how to develop and nurture relationships?

FACILITATOR'S NOTE ON SEXISM AND STEREOTYPES

The take-home message of this discussion is that in some black gay relationships Tops are considered to be better, masculine, and have all the power. That attitude and belief is sexist and stereotypes Tops. Likewise, in some black gay relationships Bottoms are considered to be submissive, feminine, and have little or no power. That attitude and belief is sexist and stereotypes Bottoms. These attitudes and beliefs are not always correct; might not fit; and as a result, some people may engage in risk-taking behaviors.

3. Distribute and discuss Prevention Options for Partners (Menu 2) handout

- ▶ Review each option on handout (Menu 2).
- ▶ Ask participants to think about why they choose the ones they choose using the following questions as probes.
 - Is your selection based on sexist and stereotyped beliefs about Tops and Bottoms?
 - Is your selection based on your ability to control and dominate your partner?
 - Is your selection based on your ability to nurture, care for, and support your partner?
 - Is it because he is a Top?
 - Is it because he is a Bottom?
 - Is it because you can communicate with him?
 - Is it because he makes you feel safe?
 - Is it because he practices safe sex?
 - Is it because he respects you?
 - Is it because he allows you to be authoritative?
 - Is it because he allows you to be nurturing?
 - Is it because of how power is used? And shared?
- ▶ Tell participants that this handout can be used to start a conversation with their partners. The options on this handout would help participants to prevent using sex to resolve issues in a relationship and encourage partner communication and negotiation.
- ▶ Ask participants to select an option (e.g., talking with your partner about your relationship; talking to your partner about safer sex practices) from the handout (Menu 2) to practice before the next session.
 - Tell participants that Session 6 will begin with volunteers discussing their experiences practicing what they selected.
- ▶ Ask for and answer any questions.

Exercise 5.5 Session Summary

Purpose: Participants provide feedback on the session, and facilitators preview Session 6.

Time: 10 minutes

Materials:

- Prepared newsprint: PARKING LOT

Procedures

1. Check in with participants

- ▶ Do you have any questions about Session 5?
- ▶ Does anyone want to share any feelings or thoughts about anything covered in Session 5?

2. Review the Parking Lot

- ▶ Answer any questions on the Parking Lot.
- ▶ Tell participants that any questions not answered now will be answered in the next session.

3. Review the Ties That Bind

- ▶ During our time together, we discussed why black gay men have Top and Bottom roles—where this comes from and what sexism and stereotyping have to do with it.
- ▶ We have learned that there are different kinds of power and that one is not better than the other. Also, Tops and Bottoms can have different kinds of power.
- ▶ We also learned that the assigned roles of Tops and Bottoms in relationships may not fit us and may not be giving us what we really want.
- ▶ We learned how we can get what we really want by choosing different partners or communicating with our partners. You can't get what you want until you know what you want.
- ▶ Finally, we reviewed the Prevention Options for Partners (Menu 2) and we will try an option from the menu with our partners.
- ▶ Just a reminder: Session 6 will take place (____) and will begin promptly at (____).

PREVENTION OPTIONS FOR PARTNERS (MENU 2)

Select an option from this list to discuss and try with your partner.

a) Talk with your partner about your relationship:

- The things you like in a relationship
- The things you don't like in a relationship
- Ask him to share his feelings about the things he likes and does not like in a relationship

b) Talk with your partner about HIV and STDs:

- What he knows about STDs and HIV
- How worried he is about getting an STD or HIV
- His feelings about condom use for anal and oral sex
- Getting screened for STDs and HIV
- Getting treated for STDs
- Getting Hepatitis A and B vaccines
- Going together and sharing results with each other

c) Talk with your partner about safer sex practices:

- What safer sex means
- How to negotiate safer sex
- Past experiences with safer sex
- How to use condoms and dental dams properly
- How to make safer sex sexy

d) Talk with your partner about sexual roles:

- What being a Top means to him and you
- What being a Bottom means to him and you
- Each partner's role preferences
- Negotiate and adhere to guidelines about sex outside the relationship

e) **Talk with your partner about relationship roles:**

- How you both handle power within your relationships
- Each partner's role preferences (e.g., nurturing, authoritarian)

f) **Talk with your partner about personal space and communication:**

- Your need for personal space
- His need for personal space
- How to communicate that with each other

g) **Consider postponing sex for a while when you first meet:**

- Make a date (movies, comedy club, coffee, dinner, go for walk, shopping, exercise, museum, planetarium, hobbies, local events, etc.)
- Try and get to know each other better by talking and sharing
- Work out some expectations about your relationship roles before getting sexually involved

SESSION 6: SOCIAL SUPPORT AND PROBLEM SOLVING TO MAINTAIN CHANGE

PURPOSE

The purposes of Session 6 are to build skills to use condoms, communicate, and negotiate with partners and prevent and respond to relapse when it occurs.

SESSION OBJECTIVES

Facilitators will help participants to:

- ▶ Provide positive reinforcement of behavior change efforts of others
- ▶ Discuss each participant's experience with his chosen behavior change option
- ▶ Build skills in correct condom use
- ▶ Build skills in how to communicate and negotiate with partners
- ▶ Build skills in problem solving by sharing ideas from other participants
- ▶ Continue to establish an ongoing support system to maintain change

FACILITATOR TIPS

- ▶ Session 6 is designed to give participants an opportunity to practice and apply the skills discussed (e.g., partner communication; negotiation) and learned in the previous sessions.
- ▶ Exercise 6.2 has two options. The first option is to use *The Party* to build and enhance participants' skills. *The Party* is a video with 11 scenes of risky situations. We suggest you select four or five scenes to freeze, role-play, and discuss. The second option is to use the vignettes to build and enhance participants' skills. There are five vignettes that cover some of the same situations presented in *The Party*.
- ▶ If you use *The Party*, it is important to set up the video and tell participants the video is older and some of the fashions, dancing, and language might distract from the video's purpose. It is critical that facilitators keep participants focused on the purpose of the video.

Session 6 At-a-Glance

Session	Activities	Time (minutes)	Purposes	Materials
6.1	Session Preview	10	To welcome participants back to Session 6, recap what was covered in the previous session, and provide an overview what will be covered in Session 6.	<ul style="list-style-type: none"> • Sign-in sheet • Pens or pencils • Prepared newsprint: PARKING LOT • Sticky notes for PARKING LOT
6.2	Play Your Own Scene	70	Participants practice partner negotiation and communication skills, practice problem solving, and receive social support for behavior change from their peers. Participants see a demonstration of proper condom use skills.	<ul style="list-style-type: none"> • <i>The Party</i> • DVD player • DVD remote
6.3	Falling Off the Wagon	35	Participants discuss relapse and develop skills to deal with relapse and problem solve.	<ul style="list-style-type: none"> • Prepared newsprint: PREVENT RELAPSE • Prepared newsprint: RELAPSE SITUATIONS • Handout: R.I.B.E.Y.E.
6.4	Session Summary	10	Participants provide feedback on the session, and facilitators preview Session 7.	<ul style="list-style-type: none"> • Prepared newsprint: PARKING LOT
Session 6 Primary Behavioral Determinants				
<ul style="list-style-type: none"> • Lack of HIV risk-reduction behavioral skills (e.g., technical skills related to condom use; self-management skills relating to addressing other issues in one's life that influence HIV risk behavior; etc.) • Low self-efficacy to communicate with sexual partners and negotiate condom use with sexual partners • Lack of peer and social support for behavior change 				

Session 6: Social Support and Problem Solving to Maintain Change

Materials Checklist

Prepared Newsprints:

- PREVENT RELAPSE
- RELAPSE SITUATIONS
- PARKING LOT

Session Handout:

- R.I.B.E.Y.E

Facilitator Materials:

- 3MV FACILITATOR'S GUIDE
- MARKERS
- NEWSPRINT
- TAPE
- STICKY NOTES FOR PARKING LOT
- SIGN-IN SHEET
- PENS/PENCILS

Advanced Preparations:

- Prepare the above newsprints
- Photocopy participant handout
- If showing *The Party*, set up TV and DVD player

Exercise 6.1 Session Preview

Purpose: To welcome participants back to Session 6, recap what was covered in the previous session, and provide an overview what will be covered in Session 6.

Time: 10 minutes

Materials:

- Sticky notes for PARKING LOT
- Prepared newsprint: PARKING LOT
- Prepared newsprint: GROUND RULES
- Pens/pencils
- Sign-in sheet
- Name tags

Notes on Exercise 6.1

During this exercise, it is important to review participants' experience of trying something from the Prevention Options for Partners (Menu 2) handout. Participants may be a little nervous about sharing. Use the probes to get participants to discuss their experiences.

Procedures

1. Welcome

- ▶ Welcome participants back to Session 6.

2. Review the questions from the Parking Lot

- ▶ Answer any unanswered questions from Session 5.

3. Preview Session 6

- ▶ In this session, we are going to practice all the skills learned in the previous session.
- ▶ We will also discuss relapse and how to prevent relapse.
- ▶ Finally, we will discuss problem solving and how it can be applied in relapse prevention.
- ▶ This session will last about 2 hours.
- ▶ Ask for and answer any questions.

4. Discuss participants' experience of trying something from Prevention Options for Partners (Menu 2) handout

- ▶ Ask volunteers to share their experiences of trying an option from Menu 2.
 - How did it feel to try what you selected?
 - How did your partner respond?
 - Was this easier or more difficult than the prevention and/or harm reduction options from Menu 1?
 - What made doing what you selected easier?
 - What barriers did you encounter?

Exercise 6.2 Play Your Own Scene

Purpose: Participants practice partner negotiation and communication skills, practice problem solving, and receive social support for behavior change from their peers. Participants see a demonstration of proper condom use skills.

Objective: Participants will practice negotiation and communications skills.

Time: 75 minutes if using *The Party* or 60 minutes if using the vignettes and 10 minutes for the condom demonstration

Materials:

- *The Party* (if used)
- DVD player (if *The Party* is used)
- DVD remote (if *The Party* is used)
- Condoms
- Male anatomical model
- Lubricant
- Paper towels

Notes on *The Party*

There are two options for this exercise. Option 1 is using *The Party* to practice skills learned in previous sessions. If you are going to show *The Party* video, be sure to set up the video and follow the instructions about the freeze frames. We suggested limiting *The Party* to four or five scenes. Option 2 is to use role-play vignettes to practice skills learned in previous sessions.

Procedures

1. Introduce this exercise

- ▶ Tell participants that in this exercise, we will have the opportunity to practice all the skills we learned in the previous sessions.
- ▶ If you are going to use *The Party*, tell participants we will watch a video and at certain points we will freeze the action. You will have a chance to practice the skills demonstrated in the scene by role-playing the scene. We will have a discussion after each role-play.
- ▶ If you are going to use the vignettes, tell participants we will role-play a series of vignettes. You will have the opportunity to practice skills and discuss the role-play. If you choose to use the vignettes instead of the video, you may skip ahead to page 183.

2. Introduce *The Party* (Option 1)

- ▶ Tell participants that *The Party* is a video that tells the story of Paul and his friends and how they deal with risky situations during a party.
- ▶ The video is designed to get you to think about what you would do if you were in that situation.
- ▶ *The Party* will show the kinds of risky situations we have previously discussed. You will practice the risk reduction skills we learned in the previous sessions.
- ▶ We will play a scene and then freeze the action. At that point we will ask for volunteers to get into the action and role-play how they would have handled the situation. After the role-play, we will discuss the action.
- ▶ Provide participants with these instructions regarding *The Party*.
 - We will introduce each scene.
 - After we watch the scene, we will do a brief recap.
 - We will ask two volunteers to jump into the action and role-play the scene.
 - We will ask the volunteers to limit the role-play to 3 minutes.
 - We want you to focus on the content of the scene and not overact.
 - If the scene is about a sexual situation, you can describe it but do not touch each other inappropriately.

3. Scene 1—Slip/Relapse and Response

- ▶ Summary: Aaron comes to Paul's apartment and is very upset, telling his friend Paul that he had unsafe sex with an unknown partner in a park—a slip—because he is usually very careful. He feels stupid and guilty.
- ▶ Characters.
 - Paul.
 - Aaron.
- ▶ Skills to practice.
 - Providing social support to a friend.
 - Dealing with relapse.
- ▶ Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play the scene?
 - What did you like about your version of the scene?
 - Why did you play the scene the way you did?
 - Why did you suggest the strategies you did?
 - For participants who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?

4. Scene 2—Partner Negotiation

- ▶ Summary: Bryan wants to have unprotected sex with Paul—skin-on-skin contact—and pressures Paul, telling him he will find someone else at the party if Paul refuses to have unprotected sex.
- ▶ Characters.
 - Paul.
 - Bryan.
- ▶ Skills to practice.
 - Partner communication.
 - Partner negotiation.

- ▶ Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play the scene?
 - What did you like about your version of the scene?
 - Why did you play the scene the way you did?
 - How did it feel to negotiate safer sex in this situation?
 - How did it feel to communicate your needs to your partner in this situation?
 - Ask participants who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?
- ▶ Scene 3 is a transition scene. There is no freeze frame or role-play for this scene.

5. Scene 4—Condom Demonstration

- ▶ Character.
 - Transgender woman.
- ▶ Skills to practice.
 - Condom demonstration.
- ▶ Discussion points.
 - There is no discussion. Participants can practice putting condoms on an anatomical model.

6. Scene 5—Younger/Older Men Who Have Sex With Men (MSM) Dynamics

- ▶ Summary: Everyone is dancing and Antoine comes in with a younger man and takes him into a bedroom.
- ▶ Characters.
 - Antoine (older MSM).
 - Steve (younger MSM).
- ▶ Skills to practice.
 - Power dynamics (sexual).

- ▶ Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play this scene?
 - What did you like about your version of the scene?
 - Why did you play the scene the way you did?
 - Who had the power? How did Antoine feel using his power as an older man? How did Steve feel using his power as the object of Antoine's sexual desire?
 - Ask participants who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?

7. Scene 6—Power Dynamics and Partner Negotiation

- ▶ Summary: Bryan is dancing with a man at the party and Paul asks to speak with him privately. During their conversation, Bryan repeats his ultimatum.
- ▶ Characters.
 - Paul.
 - Bryan.
- ▶ Skills to practice.
 - Partner communication.
 - Safer sex negotiation (with an emphasis on refusal skills).
- ▶ Discussion points.
 - Ask participants in the role-play:
 - What are the power dynamics in this scene?
 - How did it feel to role-play the scene?
 - What did you like about your version of the scene?
 - Why did you play the scene the way you did?
 - Paul, how did it feel to refuse Bryan?
 - Bryan, how did it feel to pressure Paul for sex?

- Ask participants who watched the scene:
 - How did it feel to watch the role-play?
 - What would you have done differently?

8. Scene 7—Younger/Older MSM Dynamics

- ▶ Summary: Antoine comes out of the bedroom bragging about the sex with the younger man.
- ▶ Characters.
 - Quiana.
 - Vernon and Lonnie (couple).
 - Antoine.
- ▶ Skills to practice.
 - Communication (how to discuss safer sex with a casual partner).
- ▶ Discussion points.
 - Ask participants in the role-play:
 - What are the power dynamics in this scene?
 - How did it feel to role-play the scene?
 - What did you like about your version of the scene?
 - Why did you play the scene the way you did?
 - Did you find it easy to discuss safer sex with a casual partner?
 - Is safer sex always fun?
 - Ask participants who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?

9. Scene 8—Outercourse

- ▶ Summary: For this role-play, participants are asked to stand or sit and talk about how they would negotiate a safer-sex activity, such as outercourse. **Participants are not to touch or role-play any overt sexual contact.**
- ▶ Characters.
 - Duane.
 - Curtis.
- ▶ Skills to practice.
 - Partner negotiation—safer sex.
 - Partner communication—safer sex.
- ▶ Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play the scene?
 - What did you like about your version of the scene?
 - Why did you play the scene the way you did?
 - Ask participants who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?

10. Scene 9—Taking Personal Responsibility

- ▶ Summary: A group of friends are playing cards in the living room. Kofi comes in and announces he had sex with Derek. The rest of the group berate him for not using condoms.
 - Characters.
 - Paul.
 - Quiana.
 - Vernon.
 - Lonnie.
 - Kofi.

- ▶ Skills to practice.
 - Communication (disclosure of STD and HIV status).
 - Partner communication.
- ▶ Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play the scene?
 - What did you like about your version of the role-play?
 - Why did you play the scene the way you did?
 - Kofi, why were you mad with your friends for not telling you about Derek?
 - Ask participants who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?

11. Scene 10—Partner Communication

- ▶ Summary: Bryan demands an answer from Paul: “Are we going to have unprotected sex?”
- ▶ Characters.
 - Paul.
 - Bryan.
- ▶ Skills to practice.
 - Partner communication.
 - Partner negotiation.
- ▶ Discussion points.
 - Ask those in the role-play:
 - How did it feel to role-play the scene?
 - What did you like about your version of the role-play?
 - Why did you play the scene the way you did?
 - Paul, how did it feel to refuse Bryan again?
 - Bryan, how did it feel to attempt to force Paul to have unprotected sex again?

- Ask those who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?

12. Scene 11—Need for Social Support

- ▶ Summary: Aaron finally arrives at the party. He is feeling better and Paul welcomes him to the party.
- ▶ Characters.
 - Paul.
 - Aaron.
- ▶ Skills to practice.
 - Providing social support.
 - Providing support to those dealing with relapse.
- ▶ Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play the scene?
 - What did you like about your version of the role-play?
 - Why did you play the scene the way you did?
 - Paul, how did it feel to provide support to Aaron when you were dealing with Bryan's ultimatums?
 - Aaron, how did it feel to get supported by Paul?
 - Ask participants who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?

OR

13. Introduce the vignettes (Option 2)

- ▶ Tell participants we are going to do a series of vignettes on a variety of subjects.
- ▶ The vignettes are designed to get you thinking about what you would do if you were in that situation.

- ▶ The vignettes will also provide you with an opportunity to practice some new skills.
- ▶ We will set up the vignette. Two volunteers will role-play the vignette. We will discuss the action and other ways to handle the situation.
- ▶ Provide participants with these instructions.
 - The volunteers will do the role-play. The role-play should not last longer than 3 minutes.
 - After the role-play is finished, we will discuss it. We will focus on the content of the role-play and not the acting.
 - We ask the volunteers doing the role-play to not overact. Focus on the content of the vignette.
 - If the scene is about a sexual situation, you can describe it but do not touch each other inappropriately.
 - If the role-play takes longer than 3 minutes or if it becomes inappropriate, the facilitators will stop the action.
- ▶ Tell participants that you will demonstrate the first role-play to model how role-plays should happen.
 - Answer any questions.
 - Role-play one of the vignettes.

FACILITATOR'S NOTE ON ROLE-PLAYS

For each vignette, ask for two participant volunteers to act the scene. You will describe the scene, the characters, and their motivation to all participants, including those just observing. Stress the importance that the actors' characters have specific motivations and the actors should not stray too far from the original topic or motivation.

14. Do the vignettes

- ▶ Vignette 1—Disclosure of STD Status ...I've Got the Clap!
 - You've been flirting with a new guy at your gym for about a month. He sometime hangs out with you and some other friends from the gym on Saturday nights at the bar or club. For the past week, you have been treated for gonorrhea. That Saturday, you two hit off at the club and are back at his place. You find yourself on his couch kissing and he starts to unzip your pants. You want to disclose that you have the clap (gonorrhea). You really like this guy and don't want to ruin a chance at a relationship. You say ...

- Characters' motivation.
 - Role-play actor with gonorrhea is trying to disclose having an STD and attempting to negotiate a low-risk sexual behavior such as mutual masturbation or dry humping. You like the guy at your gym a lot and don't want him to be turned off and no longer be interested in you.
 - Role-play actor (new guy at gym) is trying to have with sex with the other role-play actor. This actor should be aggressive and suggestive. This actor should also listen when the disclosure is made and think about the option presented. This actor also is possibly interested in having a relationship that is more than a one-night stand.
- Skills to practice.
 - Disclosure.
 - Partner communication.
 - Negotiation of safer sex.
- Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play the scene?
 - What did you like about your version of the scene?
 - Why did you play the scene the way you did?
 - Ask participants who watched the role-play
 - How did it feel to watch the role-play?
 - What would you have done differently?
- ▶ Vignette 2—Damn, He's Fine ...
 - You've had a scare a while back when you last got tested for HIV. Fortunately, it came back negative, but you have vowed to yourself to use a condom during anal sex. You are at your favorite place to meet men. You have been flirting with this really, really fine man and he's been flirting back. He walks over to you and says, "Why don't we get out of here and go back to my place? I want to feel you raw." What do you say and do?

- Characters' motivation.
 - Role-play actor attempting to initiate sex should be aggressive, flirtatious, and clear that he wants to have sex with the other actor. He wants to have unprotected sex, but could be open to other options.
 - Role-play actor on the receiving end of the aggressive sexual behavior should flirt with the other actor. He is really attracted to the other actor and he wants to go back with him. He is open to having protected sex, as well as to other options that don't involve anal sex.
- Skills to practice.
 - Negotiation of safer sex.
 - Partner communication.
- Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play the scene?
 - What did you like about your version of the scene?
 - Why did you play the scene the way you did?
 - Ask participants who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?
- ▶ Vignette 3—Picking Up Trade.
 - You used to pick up trade regularly. You now see the need to engage men in a different way. One night, however, you are walking alone down the street where you used to pick up trade. The street is lined with trade and you see a really hot piece. He's strong, masculine, tough, and appears straight. He calls you over. As you walk over, you remember your promise to yourself, but you really, really want him. What do you do? What do you say to yourself?
 - Characters' motivation.
 - Role-play actor approaching trade should be ambivalent about being in the neighborhood where he used to pick up trade. This actor should also be ambivalent about engaging in sexual activity with trade.

- Role-play actor portraying trade should be aggressive in his attempts to pick up the other actor. This actor should be flirtatious, sly, and suggestive. This actor should make it difficult for the other actor to refuse the invitation for sexual activity.
- Skills to practice.
 - Relapse prevention.
- Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play the scene?
 - What did you like about your version of the scene?
 - Why did you play the scene the way you did?
 - Ask participants who watched the role-play
 - How did it feel to watch the role-play?
 - What would you have done differently?
- ▶ Vignette 4—I'm Gay...Pass the Turkey.
 - You go home for Thanksgiving. You haven't been home for several years. Your parents suspect that you are gay, but they have never said anything to you. You are fearful of their reaction, especially your father's. Before dinner, your father is watching the football game and sitting in his favorite chair. You ask him to turn off the game because you want to say ...
 - Characters' motivation.
 - Role-play actor playing the parent should be cool, calm, and collected. This actor should listen to the actor disclosing their sexual orientation and refrain from yelling or aggressive or intimidating behavior.
 - Role-play actor disclosing his sexual orientation should clearly communicate this to the other actor. He should try to avoid being too excited or having an extreme emotional response.
 - Skills to practice.
 - Disclosure of sexual orientation.
 - Communication.

- Discussion points.
 - Ask participants in the role-play:
 - How did it feel to role-play this scene?
 - What did you like about your role-play (your version of the scene)?
 - Why did you play the scene the way you did?
 - How did it feel to share this information about yourself? How did it feel for your son to come out?
 - Ask participants who watched the role-play:
 - How did it feel to watch the role-play?
 - What would you have done differently?
 - What do you think is the connection between disclosing your sexual orientation to your parents and the high rates of HIV among black gay men? Do you think negative reactions from your parents can result in risky sexual behavior? If so, how? How would a positive reaction from your parents influence your sexual and substance-using behavior?

15. Conduct a condom demonstration in 10 minutes

- ▶ Ask participants, “What is the proper way to put on a condom?”
- ▶ Record the steps listed by participants on a newsprint.
- ▶ Review and demonstrate the correct methods to put a condom on an anatomical model.
- ▶ If there is extra time, ask for a volunteer to practice putting the condom on the anatomical model.
- ▶ Ask and answer any questions.

16. Check in with participants

- ▶ Tell participants the role-plays were designed to build their skills to deal with risky situations. For example, practicing how to negotiate safer sex or how to communicate with your sexual partner increases your intention and ability to do these things in risky, highly charged situations.
- ▶ Ask participants if they have any feelings or thoughts they would like to share about the role-play (or *The Party*).

Exercise 6.3 Falling Off the Wagon

Purpose: Participants discuss relapse and develop skills to deal with relapse and problem solve.

Objective: Participants will learn how to prevent and respond to relapse.

Time: 35 minutes

Materials:

- Prepared newsprint: PREVENT RELAPSE
- Prepared newsprint: RELAPSE SITUATIONS
- Handout: R.I.B.E.Y.E.

Procedures

1. Introduce this exercise

- ▶ In this exercise, we will discuss relapse and how to deal with relapse, if it occurs.
- ▶ We will also discuss problem solving and how it can be applied to prevent relapse.
- ▶ You will practice applying problem-solving techniques to risky scenarios and to responding to relapse.

2. Define the term relapse

- ▶ When talking about health behavior, relapse means falling back into doing the old behavior that you were trying to change.
 - For example, you had been using condoms consistently for 8 months and then you stopped using condoms and began having unprotected sex.
- ▶ Relapse is a normal part of the behavior change process. Everyone relapses at some point.
 - How many of you have tried to go on a diet or exercise more regularly and found that you were back to your old ways of eating or exercising after some time?
- ▶ Do you have any questions about what we mean by relapse?

3. Discuss ways to prevent relapse

- ▶ There are a few things that can be done to help prevent relapse.
- ▶ First, it is important to identify and avoid triggers that can lead to relapse. A trigger can be a place, person, or thing. For example, alcohol or other substances can be a trigger for many people's risky behaviors.
 - When some people use meth (methamphetamine), it becomes a trigger for unprotected sex.
- ▶ The second thing you can do is call a friend for support to avoid relapse. If you think you are in a situation that could cause you to relapse, call a friend or trusted person to help you during a time of weakness.
 - For example, if you are home late one evening cruising the Internet for sex and you feel like there is a chance you could relapse and have unprotected sex, you could call a trusted friend to help you avoid relapse.

- ▶ What other ways can you think of to avoid relapse?
 - Record participants' responses on the prepared newsprint: PREVENT RELAPSE.
- ▶ Ask for and answer any questions.

4. Discuss problem solving as a way to prevent relapse

- ▶ Tell participants that another way to maintain your behavior change and prevent relapse is called problem solving.
- ▶ Problem solving is a process that can be used to make good decisions and prevent relapse.
- ▶ Distribute the R.I.B.E.Y.E. handout. Tell participants that the handout lists the steps you take to resolve a problem.
 - The first step is to RELAX. Calm down and try not to become too excited.
 - The second step is to IDENTIFY the problem. When you are relaxed, your ability to identify the problem is enhanced.
 - The third step is to BRAINSTORM possible solutions to the problem identified in the second step. In addition, if you are relaxed your ability to brainstorm solutions is greatly enhanced.
 - The fourth step is to EVALUATE potential solutions. In this step, you will evaluate all the solutions you brainstormed in the third step.
 - The fifth step is to say YES to one of the solutions. In this step, you will select or say yes to one of the solutions you evaluated.
 - The last step is to ENACT or do the solution you selected.
- ▶ Think of R.I.B.E.Y.E.—RELAX, IDENTIFY the problem, BRAINSTORM solutions, EVALUATE solutions, say YES to one of solutions, and ENACT the solution you selected—as a way to prevent relapse.

5. Applying R.I.B.E.Y.E. to real-life situations

- ▶ Ask participants to apply R.I.B.E.Y.E. to the following scenario and identify some ways to avoid relapse.
 - You have been practicing safe sex (using condoms consistently for anal sex) for the past 7 months. One Friday after a long week at work, you and your boys are at Déjà Vu dancing, drinking, and hanging out. While on the dance floor you run into Charles, a guy from your gym. You and Charles always flirt with each other and the sexual tension between the two of you is very intense. After a couple of songs and a couple more drinks, you are back at his place. As you take off his shirt he says, "I want you to hit it raw."
- ▶ In this situation, how do you prevent relapse?
 - Discuss participants' suggestions.

6. Ask participants to come up with real-life scenarios where there is a possibility to relapse

- ▶ Participants' examples should have:
 - A behavior (e.g., condom use, negotiating safer sex).
 - The length of time the behavior has been consistently done. Remind participants that, according to the stages of change, the Maintenance stage is 6 months or longer.
 - A risky real-life situation.
- ▶ Record participants' scenarios on the prepared newsprint: RELAPSE SITUATIONS.
- ▶ Review one or two scenarios using the following questions.
 - In this situation, how do you prevent relapse?
 - Do you have support systems to avoid relapse?
 - Discuss participants' suggestions.

7. Lead a discussion on what participants can do if relapse occurs

- ▶ How many of you have tried to change a behavior but have relapsed into old behavior?
- ▶ How have you handled and responded to relapse in the past?
- ▶ What are some things you can do to respond to relapse?
 - Record their responses on newsprint.
 - Cover the following points if they are not mentioned by participants:
 - Remind yourself that it is okay to relapse. It is normal part of behavior change.
 - Think about what went wrong; why you weren't able to maintain your behavior change.
 - Identify what specifically caused you to relapse.
 - Identify what you can do differently in the future so you won't relapse for the same reasons.
 - Continue to seek support so that you won't give up and so that you try again to change your behavior.

8. Referring to the previous scenarios, lead a discussion on how participants would respond in those situations if they did relapse

- ▶ How could you respond to relapse in this situation?
- ▶ What support systems could you use to respond to relapse?

9. Review the exercise

- ▶ Tell participants relapse is a normal part of behavior change.
- ▶ There are ways to prevent relapse. In this exercise, we discussed how you could use problem solving to avoid relapse.
- ▶ However, it is normal for anyone to relapse. The important thing to remember is to not blame yourself, learn from your mistakes, and try again.
- ▶ Ask participants if they have any feelings or thoughts they would like to share about relapse, relapse prevention, and how to respond to relapse.

Exercise 6.4 Session Summary

Purpose: Participants provide feedback on the session, and facilitators preview Session 7.

Time: 10 minutes

Materials:

- Prepared newsprint: PARKING LOT

Procedures

1. Check in with participants

- ▶ Do you have any questions about Session 6?
- ▶ Does anyone want to share any feelings or thoughts about anything covered in Session 6?

2. Review the Parking Lot

- ▶ Answer any questions on the Parking Lot.
 - Tell participants that any questions not answered now will be answered in the next session.

3. Review the Ties That Bind

- ▶ Throughout the last six sessions you all have done phenomenal work, both in terms of thinking about your own feelings and issues and sharing your thoughts and experiences with the whole group. We all have learned a lot from each other and I think we all feel closer from having had this experience.
- ▶ Today, we practiced and enhanced our skills to avoid risky situations and unhealthy behaviors. We also learned the things we could do to avoid relapse. In our next session, we will discuss the importance of community and how we can maintain the positive behaviors we started in 3MV.
- ▶ Just a reminder. Session 7 will take place (____) and will begin promptly at (____).

R.I.B.E.Y.E.—PROBLEM-SOLVING TOOL

USE PROBLEM SOLVING TO PREVENT RELAPSE

- ▶ Step One: **R**ELAX—Calm down and try not to become excited

- ▶ Step Two: **I**DENTIFY the problem

- ▶ Step Three: **B**RAINSTORM possible solutions to the problem you identified

- ▶ Step Four: **E**VALUATE the potential solutions

- ▶ Step Five: Say **Y**ES to one of the potential solutions

- ▶ Step Six: **E**NACT or do the solution you selected

SESSION 7: BUILDING BRIDGES AND COMMUNITY

PURPOSE

The purpose of Session 7 is to provide participants with an opportunity to discuss their Many Men, Many Voices (3MV) experience and identify what resources they need to continue their behavior change.

SESSION OBJECTIVES

Facilitators will help participants to:

- ▶ Describe their self-development and self-growth resulting from their 3MV experience
- ▶ Identify two ongoing prevention needs
- ▶ List two resources and other services they can access to help with their ongoing prevention needs
- ▶ Use a resource survival handbook designed for black gay men
- ▶ Describe the need for ongoing community development to create an environment in which black gay men feel safe and accepted

FACILITATOR TIPS

- ▶ It is recommended that a mental health professional participate in Exercise 7.3. He or she should have experience working with gay men and communities of color. The purpose is to get the participants acquainted with the services offered by the mental health professional and normalize talking to a mental health professional.
- ▶ You will need to identify or prepare and distribute a survival handbook that lists local services your participants may need to access.
- ▶ Facilitators should debrief with the program manager at the conclusion of the intervention.

- ▶ Facilitators should also have participants complete the knowledge, attitudes, and behavior (KAB) survey and the Participant Satisfaction Questionnaire at the end of the session.
- ▶ It is a good idea to hold a graduation celebration and provide some food, nonalcoholic drinks, and music. You can encourage participants to bring some food or nonalcoholic drinks to share at the graduation.

Session 7 At-a-Glance

Session	Activities	Time (minutes)	Purposes	Materials
7.1	Session Preview	10	Welcome participants to Session 7, recap what was covered in the previous session, and provide an overview of what will be covered in Session 7.	<ul style="list-style-type: none"> • Prepared newsprint: GROUND RULES • Prepared newsprint: PARKING LOT • Sign-in sheet • Sticky notes for PARKING LOT • Pens/pencils
7.2	What Else Do You Need?	30	Participants recognize and learn how to access services for ongoing prevention and related needs.	<ul style="list-style-type: none"> • Prepared newsprint: WHAT ELSE • Handout: Behavior Change Plan
7.3	How Can I Build on This Experience?	30	Participants recognize the need for and the value of ongoing self-development and self-growth.	<ul style="list-style-type: none"> • Prepared newsprint: 3MV EXPERIENCE • Prepared newsprint: TOPICS—INTERESTING • Prepared newsprint: TOPICS—CHALLENGING • Prepared newsprint: LEARNED • Prepared newsprint: PERSONAL GROWTH
7.4	How Can WE Build a Community?	20	Participants identify ways to build a community in which black gay men can feel safe, accepted, and socially supported as opposed to the rejection, isolation, and dual identity discussed in Session 1.	<ul style="list-style-type: none"> • Prepared newsprint: TOOLS AND RESOURCES • Prepared newsprint: US HELPING US

Session 7 At-a-Glance (continued)

Session	Activities	Time (minutes)	Purposes	Materials
7.5	The Survival Handbook for Black Gay Men	10	Participants receive a survival guide for black gay men that lists local resources for services and support.	<ul style="list-style-type: none"> Prepared newsprint: SURVIVAL HANDBOOK Survival handbook
7.6	Session Summary and Graduation	30	Participants celebrate completing 3MV.	<ul style="list-style-type: none"> Prepared newsprint: PARKING LOT KAB Survey Participant Satisfaction Questionnaire Graduation certificates
Session 7 Primary Behavioral Determinants				
<ul style="list-style-type: none"> Lack of HIV risk-reduction behavioral skills (e.g. technical skills related to condom use; self-management skills relating to addressing other issues in one's life that influence HIV risk behavior, etc.) Lack of peer and social support for behavior change 				

Session 7: Building Bridges and Community

Materials Checklist

Prepared Newsprints:

- GROUND RULES
- PARKING LOT
- WHAT ELSE
- 3MV EXPERIENCE
- TOPICS—INTERESTING
- TOPICS—CHALLENGING
- LEARNED
- PERSONAL GROWTH
- TOOLS AND RESOURCES
- US HELPING US
- SURVIVAL HANDOUT

Session Handouts:

- SURVIVAL HANDBOOK
- KAB SURVEY
- PARTICIPANT SATISFACTION QUESTIONNAIRE
- BEHAVIOR CHANGE PLAN
- GRADUATION CERTIFICATES

Facilitator Materials:

- 3MV FACILITATOR'S GUIDE
- STICKY NOTES FOR PARKING LOT
- SIGN-IN SHEET
- PENS/PENCILS

Advanced Preparations:

- Prepare the above newsprints
- Identify and invite a mental health professional to give a brief presentation on his or her services
- Identify or prepare a survival handbook that lists local services your participants may need to access
- Make necessary preparations for graduation ceremony

Exercise 7.1 Session Preview

Purpose: To welcome participants back to Session 7, recap what was covered in the previous session, and provide an overview what will be covered in Session 7.

Time: 10 minutes

Materials:

- Sticky notes for PARKING LOT
- Prepared newsprint: PARKING LOT
- Prepared newsprint: GROUND RULES
- Pens/pencils
- Sign-in sheet
- Name tags

Procedures

1. Welcome participants to Session 7
2. Review and answer any questions on the Parking Lot
3. Preview Session 7
 - ▶ In this session, we are going to discuss your 3MV experience and how it has affected you.
 - ▶ We will discuss what resources and support you will need to maintain behavior change.
 - ▶ We will talk about ways in which we can build a supportive community for black gay men.
 - ▶ Finally, we are going to develop a survival handbook and tell you about the other services we offer.
 - ▶ This session will last about 2 hours.
 - ▶ Since this is our last session, we will have a graduation ceremony to celebrate and honor your completion of 3MV.

Exercise 7.2 What Else Do You Need?

Purpose: Participants recognize and learn how to access services for ongoing prevention and related needs.

Objective: Participants will identify the support they need to maintain behavior change.

Time: 30 minutes

Materials:

- Prepared newsprint: WHAT ELSE
- Handout: Behavior Change Plan

Procedures

1. Introduce the exercise

- ▶ In this exercise, we are going to discuss your reactions to Session 6 and your ongoing needs to maintain behavior change.
- ▶ We will also develop a plan to maintain the changes you began during this program.

2. Ask participants to briefly recap what was discussed and done in Session 6; if not mentioned, be sure to note the following

- ▶ Learned and practiced problem solving using the R.I.B.E.Y.E approach (RELAX, IDENTIFY the problem, BRAINSTORM solutions, EVALUATE the solutions, say YES to one of solutions, and ENACT the solution you selected).
- ▶ Discussed relapse and ways to prevent and cope with it.

3. Facilitate a discussion on what participants' reactions were to Session 6

- ▶ Were you able to use problem solving to avoid any risky situations?
- ▶ Do you think you have the skills to prevent relapse?
- ▶ If relapse occurs, do you have a support system to help you cope?
- ▶ What was the major lesson you learned in Session 6?
- ▶ Point out that the skills learned in Session 6 are needed to successfully change risk behaviors and deal with the stops and starts associated with behavior change.
- ▶ Ask participants what questions they have about Session 6.

4. Ask participants to think about their own behavior change goals and identify what else (e.g., skills, support) they need to maintain behavior change

- ▶ Record participants' responses on prepared newsprint: WHAT ELSE.
- ▶ After you record their responses, tell them you will have a discussion later in the session about how they can access some of the things they identified.

5. Distribute Behavior Change Plan handout, using the following talking points

- ▶ To maintain behavior change, it is important for you to develop a plan.
- ▶ Tell participants that this handout is for them to use in planning how to maintain behavior change.
- ▶ The plan you develop should be realistic and include support from people you trust.
- ▶ The plan you develop should address how you can try or continue doing the prevention or harm reduction option you selected.
- ▶ Before developing the plan, prioritize the changes you want to make. Once you have identified the changes, pick the change (1) you most want to work on and (2) is the most realistic for you to do.
- ▶ Give participants 10 minutes to complete the handout.

6. Discuss the plans the participants developed

- ▶ What tools, resources, or skills do you need to make your plan a reality?
- ▶ Have you developed a similar plan before?
- ▶ What are some barriers you think you might encounter?
- ▶ How can we support and help you with your plan?
- ▶ How difficult was it to begin developing this plan?
- ▶ Do you feel you can carry out your plan?

7. Summarize the exercise using the following talking points

- ▶ This is your plan. We are not going to collect this handout. We want you to take it with you and use it.
- ▶ In this exercise, we developed plans to maintain behavior change. Maintaining behavior change is very important and very difficult.
- ▶ The plan you developed is a road map of how to maintain the positive changes you've started.

Exercise 7.3 How Can I Build on This Experience?

Purpose: Participants recognize the need for and the value of ongoing self-development and self-growth.

Objective: Participants will identify their personal growth, self-development, and emotional development needs.

Time: 30 minutes

Materials:

- Prepared newsprint: 3MV EXPERIENCE
- Prepared newsprint: TOPICS—INTERESTING
- Prepared newsprint: TOPICS—CHALLENGING
- Prepared newsprint: LEARNED
- Prepared newsprint: PERSONAL GROWTH

Notes on the mental health professional's presentation

The purpose of the presentation is to introduce the participants to the mental health professional and provide them with an opportunity to learn about the services he or she offers. When you invite the mental health professional, be sure to brief him or her on 3MV, what you have covered, and the purpose of the presentation.

Procedures

1. Process participants' experience with 3MV using the following questions. Record their responses to each question on the appropriate newsprint (3MV EXPERIENCE, TOPICS—INTERESTING, TOPICS—CHALLENGING, or LEARNED)
 - ▶ What are your feelings about your 3MV experience? How has 3MV affected you emotionally?
 - ▶ What topics did you find interesting?
 - ▶ What topics did you find challenging?
 - ▶ What did you learn during 3MV?
2. Discuss participants' responses on the newsprints in the following order: 3MV EXPERIENCE, TOPICS—INTERESTING, TOPICS—CHALLENGING, and LEARNED
 - ▶ What did you find most valuable about your 3MV experience?
 - ▶ What did you find least valuable about your 3MV experience?
 - ▶ What made topics interesting and/or challenging?
 - ▶ Have you been able to try any of the things (or skills) you learned?
3. Facilitate a discussion on the personal growth participants experienced as a result of participating in 3MV
 - ▶ Some of you may have experienced personal growth from participating in 3MV.
 - ▶ Provide the following definition of personal growth:
 - Personal growth can be defined as changes in your beliefs, thoughts, perceptions, and attitudes that foster healthy behaviors.
 - ▶ Have any of you experienced any personal growth during 3MV and if so, what were the areas of growth?
 - Record participants' responses on the prepared newsprint: PERSONAL GROWTH.
 - ▶ Discuss participants' responses using the following questions.
 - How has this growth affected your life?
 - Do you feel you can make or continue positive behavior changes in your life?

- Are you motivated to make changes in your life? If you are not motivated, what do you need to increase your motivation?

4. Introduce mental health professional

- ▶ Introduce the mental health professional. State that he or she is here to discuss the services he or she offers, how to access those services, and how those services connect to the things that have been discussed.
- ▶ State that he or she has experience working with men on issues of personal growth. He or she has worked both with gay men and communities of color.
- ▶ Note that talking to a mental health professional is a normal and good thing to do. Many people who are trying to make positive health changes often talk to someone like (mental health professional's name).
- ▶ Remind the group that 3MV is designed to improve how we think and feel about ourselves, especially as black gay men; teach us how to use power properly; and communicate with our partners. Talking to (mental health professional's name) can help us with those things.

FACILITATOR'S NOTE

If your population has more substance-use issues, then the mental health professional could be a substance-use counselor or another relevant service provider.

- ▶ State that the mental health professional will be around after the graduation ceremony for private discussions.

5. Have the mental health professional give a brief presentation describing his or her services and how participants can access those services

- ▶ He or she should discuss any experience working with black gay men; issues of isolation, partner communication, dual identity, substance use and abuse; lack of familial support and acceptance for same-sex behaviors; and motivations for behavior change.
- ▶ Ask participants if they have any questions.
- ▶ Provide the mental health professional's contact information.
- ▶ Thank the mental health professional.

Exercise 7.4 How Can WE Build a Community?

Purpose: Participants identify ways to build a community in which black gay men can feel safe, accepted, and socially supported as opposed to the rejection, isolation, and dual identity discussed in Session 1.

Objective: Participants will learn the importance of a community and how to build a caring and supportive community.

Time: 20 minutes

Materials:

- Prepared newsprint: TOOLS AND RESOURCES
- Prepared newsprint: US HELPING US

Notes on Exercise 7.4

This exercise returns to some of the things discussed in Session 1—identity and community. It is designed to help participants think about how to create a supportive and caring community for black gay men.

Procedures

1. Facilitate a discussion on how participants can build a community that supports black gay men, using the following questions

- ▶ How supported do you feel by the black community?
- ▶ Ask participants how supported they feel by the larger gay community.
- ▶ How can we build a visible community that is supportive of black gay men?
 - What kind of tools and resources are needed to build a community?
 - Record responses on the prepared newsprint: TOOLS AND RESOURCES.
 - How can we (everyone in this room) be a community and support each other?
 - Record responses on the prepared newsprint: US HELPING US.

2. Briefly summarize the discussion using the following talking points

- ▶ Community plays an important role in supporting our efforts to be healthy and safe.
- ▶ If the community isn't supportive of us as black gay men, then that disapproval can result in risky behaviors, which can lead to increased STD and HIV rates in our community.
- ▶ We need to live, work, and play in communities in which we are supported regardless of our identity, sexuality, and love interests.

Exercise 7.5 The Survival Handbook for Black Gay Men

Purpose: Participants receive a survival guide for black gay men that lists local resources for services and support.

Objective: Participants will identify support sources and learn about other services the hosting agency provides.

Time: 10 minutes

Materials:

- Survival handbook
- Prepared newsprint: SURVIVAL HANDBOOK

Notes on Exercise 7.5

You will need to prepare and provide a copy of the survival handbook to each participant. The handbook does not need to be fancy and can simply be a piece of paper that lists contact information for local services and programs. Your agency may already have a similar resource that you can use. The handbook should list the following services:

- Community clinics, including HIV and STD testing and treatment programs
- Drug treatment services and support groups
- Mental health services
- Services and support groups for gay men
- Social services, including housing, food, and financial support services

Procedures

1. Distribute copies of the survival handbook

- ▶ To help you maintain some of the changes you started in 3MV, you may need to seek support from other programs and services.
- ▶ This handbook includes contact information for various local services you may find useful.

2. Review the services listed in the survival handbook

3. Ask participants if there are any additional services they need

- ▶ Record responses on the prepared newsprint: SURVIVAL HANDBOOK.
- ▶ Provide them with the information they requested about the additional services. If you do not have the information, tell them you will find that information and give it to them after the session.

4. Discuss services your agency provides and distribute any agency brochures to participants

Exercise 7.6 Session Summary and Graduation

Purpose: Participants celebrate completing 3MV.

Time: 30 minutes

Materials:

- Prepared newsprint: PARKING LOT
- KAB Survey
- Participant Satisfaction Questionnaire
- Graduation Certificates

Notes on Exercise 7.6

The graduation ceremony is designed to honor and celebrate the participants. The quotes used in this ceremony were selected because they inspire black gay men to love themselves and their communities. If you would like to select different quotes, the quotes should inspire, motivate, and challenge the men. We also recommend playing some contemporary, lively music at the end of the ceremony and having refreshments available during the ceremony. Your graduation ceremony should be a fun and positive event. Involve your participants in planning the ceremony. Encourage them to bring food, drinks, and music to share.

Procedures

1. Check in with participants

- ▶ Do you have any questions about today's session?
- ▶ Does anyone want share any feelings or thoughts about anything covered today? About the entire intervention?

2. Review the Parking Lot

- ▶ Answer any questions on the Parking Lot.

3. Distribute the KAB Survey and Participant Satisfaction Questionnaire

- ▶ Ask participants to complete the two surveys.
- ▶ Remind participants that the KAB Survey is the same one they completed in Session 1. The purpose of this survey is to measure any gains in knowledge, skills, attitudes, and behaviors as a result of participating in 3MV.
- ▶ The Participant Satisfaction Questionnaire will provide feedback about their 3MV experience and can help to improve future 3MV sessions.
- ▶ Tell participants to be open and honest when completing the surveys. They do not have to write their names on the surveys.
- ▶ Ask for and answer any questions they have about completing the surveys.
- ▶ Give participants 10 to 15 minutes to complete the surveys. Tell participants where they should put their surveys when they are done.

4. Review the Ties That Bind

- ▶ In this session, we discussed the importance of community and how to keep the momentum going with the positive changes we are making and will continue to make.
- ▶ We also discussed how important it is to have social support when trying to change our behaviors and how mental health and other services can help us in that process.
- ▶ Many Men, Many Voices was designed to help you make positive changes and to create a community of people who are here to support you as you make and maintain behavior change.

- ▶ We are proud of you and your accomplishments. We want to recognize and celebrate your efforts to make positive changes in your lives.

5. Conduct graduation ceremony

- ▶ Ask participants to stand and form a circle. The facilitators should stand in the middle of the circle.
- ▶ Tell participants we are going to honor and celebrate your accomplishment of completing 3MV.
- ▶ In 3MV, we learned how to challenge ourselves, protect ourselves, motivate ourselves, support ourselves, and love ourselves.
- ▶ This ceremony is designed to motivate you to continue the growth and positive changes you began.

6. Read the following quotes

- ▶ Joseph Beam, a black gay rights activist and writer, said, "Black men loving black men is a revolutionary act."
- ▶ Marlon Riggs, a film-maker, poet, educator, and gay rights activist, said, "Silence kills the soul, it diminishes its possibility to rise and fly and explore. Silence withers what makes you human. The soul shrinks, until it's nothing."
- ▶ Bayard Rustin, a community organizer and planner, human rights activist, singer, and thinker, said, "When an individual is protesting society's refusal to acknowledge his dignity as a human being, his very act of protest confers dignity on him."
- ▶ These words should encourage you to embrace your beauty as a black gay man, untie your tongue, and let your presence be known. Use these words to remind you that your life and the lives of your brothers are beautiful, valuable, and worth saving.
- ▶ Use these words to change your life, your community, and your love for each other.

7. Ask participants if they would like to share any final thoughts on their experiences

8. After they have shared their thoughts, read one of the poems on the Graduation Poems handout

9. After finishing the poem, turn on some lively/upbeat contemporary music and distribute the graduation certificates

10. Close out ceremony

- ▶ Thank all for their participation.
- ▶ Give them contact information for any questions or concerns after they leave.
- ▶ Encourage them to invite their friends to a future 3MV session.

BEHAVIOR CHANGE PLAN

DEVELOP A PLAN TO MAINTAIN BEHAVIOR CHANGE

My prevention or harm reduction option is:

I can take the following steps to try or continue doing my prevention or harm reduction option. (Your steps should be realistic, something you are able to do successfully.)

- 1.
- 2.
- 3.
- 4.
- 5.

I need support from the following people to try or continue doing my prevention or harm reduction option.

- 1.
- 2.
- 3.

I need the following skills, resources, or tools to try or continue doing my prevention or harm reduction option.

- 1.
- 2.
- 3.

The following are steps or actions I can take to overcome any barriers I encounter.

- 1.
- 2.
- 3.

SESSION LOG

When to Use:	During the delivery of any 3MV session
Administered by:	Facilitator or observer (e.g., program manager or supervisor)
Completed by:	Facilitator or observer
Instructions:	

- a. ***Do not distribute these instruments to the participants.*** Use this evaluation form to document the delivery of a Many Men, Many Voices (3MV) session as well as each of its activities. The log can capture how well an activity went as well as any changes made. You should use a separate exercise log for each 3MV exercise conducted.
- b. ***Complete the form promptly.*** Complete the form immediately after the session, or within 1 day of presenting the material, so that your experiences are fresh in your mind.
- c. ***Provide as much feedback as possible.*** The more feedback you provide, the more helpful this evaluation tool will be in future 3MV sessions. Be sure to document each session exercise and explain any changes made. Comments and suggestions concerning the program content, structure, and clarity of the materials are particularly helpful and should be shared with your supervisor.

SESSION LOG

Session No.:	Date:	Number of Participants:
Facilitators:		
Location:		
Time Started:	Time Finished:	
Comments on Overall Session:		
Lessons Learned:		

EXERCISE LOG

Name of Session Exercise:	
1. Was this exercise completed as planned?	(Check response a or b) ___ a) Yes ___ b) No
1a. If No, describe what was changed and why you changed it.	
2. How engaged did the participants seem during this exercise?	(Circle a number below: 1 = much less than usual; 3 = average; and 5 = much more than usual) 1 2 3 4 5
3. How well did the participants seem to understand this exercise?	(Circle a number below: 1 = much less than usual; 3 = average; and 5 = much more than usual) 1 2 3 4 5
4. What aspects of this exercise worked the best today?	
5. What aspects of this exercise did not work?	
6. Additional Notes:	

FIDELITY ASSESSMENT FORM

When to Use: During each session

Administered by: Observer (e.g., program manager or supervisor)

Completed by: Observer

Instructions: This tool is used to rate facilitators during the delivery of a Many Men, Many Voices (3MV) session to assess their knowledge of the intervention content and fidelity to the curriculum. Typically, there are four to five exercises per session. The form lists the exercises for each session. The observer is to rate the facilitator, using the high (5) to low (1) scoring system. In addition, the observer may note comments regarding the facilitator for each of the session's exercises.

For each exercise, be sure that you include a fidelity rating, the primary facilitator's name, and additional written comments. You should document and provide verbal feedback on the facilitator's strengths, areas for improvement, and any next steps the facilitator can take to improve future deliveries.



FIDELITY ASSESSMENT FORM—SESSION 1

Exercise	Fidelity Goal	Fidelity Ranking (1 to 5)	Comments	Primary Facilitator's Name
1.1 Welcome and Introductions	Assures introductions for all participants and facilitators. Assures that the Ground Rules are presented and reviewed and that participants understand and agree to them. Distributes and explains Knowledge, Attitudes, and Behavior (KAB) Survey.			
1.2 “Why We Do the Things We Do” Factors That Influence Behavior Change	Provides directions and guidance to the group regarding introductions and personal behavior-change sharing experience; to be done in dyads. Has participants brainstorm and discuss concepts of behavior change in general, then processes the discussion so participants see that many factors are involved with behavior change.			
1.3 BLACK MAN, GAY MAN, BLACK GAY MAN	Assures that the participants brainstorm about black men, gay men, and black gay men; processes the exercise to help participants see the connections from one to the other to help them understand the concept of dual identity.			
1.4 Making the Connection	Connects the information and discussions of the preceding three exercises to help participants see that behavior change in general, dual identity, and a lack of a community of black gay men all may lead to risk-taking behaviors for black men who have sex with men (MSM).			
1.5 Session Summary	Asks for and answers remaining questions from participants. Answers any Parking Lot questions that can be addressed then. Summarizes key points from the day.			

FIDELITY ASSESSMENT FORM—SESSION 2

Exercise	Fidelity Goal	Fidelity Ranking (1 to 5)	Comments	Primary Facilitator's Name
2.1 Recap and Preview	Welcomes participants back. Recaps previous session's main points. Answers any outstanding Parking Lot questions.			
2.2 Roles and Risks for Tops and Bottoms	Assures that participants see the difference between the sexual relationship role and identity of being a top or a bottom and the sexual position (types of sex) and how these affect disease transmission risk.			
2.3 What Do You Know About STDs and HIV for Black Gay Men?	Assures that the participants receive accurate and current sexually transmitted disease (STD) information (viral versus bacterial, transmission modes, treatment) and clarifies misconceptions.			
2.4 How Do You Get an STD or HIV?	Assures that the participants brainstorm about sexual and substance-use practices to produce a list that is relevant and inclusive; then processes how these practices relate to acquisition and transmission of different STDs, including HIV, so that risk of these behaviors can be ranked.			
2.5 Sex in the City: An Inside View	Provides the directions and materials and uses the "Sex in the City" script in correct order and processes each scene before proceeding to the next.			
2.6 Transmission Puzzle	Accurately and clearly presents the transmission puzzle, using visual aids.			
2.7 Session Summary	Asks for and answers remaining questions from participants. Answers any Parking Lot questions that can be addressed then. Summarizes key points from the day.			

FIDELITY ASSESSMENT FORM—SESSION 3

Exercise	Fidelity Goal	Fidelity Ranking (1 to 5)	Comments	Primary Facilitator's Name
3.1 Recap and Preview	Welcomes participants back. Recaps previous session's main points. Answers any outstanding Parking Lot questions.			
3.2 What Are My Chances and What Are My Choices?	Assures that participants see the difference between the harm reduction and prevention goals. Uses the transmission puzzle to make the connection between these and sexual and substance-use practices with respect to STD/HIV acquisition and transmission. Distributes the Prevention Options for Individuals (Menu 1) handout.			
3.3 Take Your Own Inventory	Posts and uses the sexual practice wall signs in correct order (by risk rank) and processes this with the group. Distributes the Personal Inventory Charts (2 copies to each participant) and relationship index cards/sticky notes, providing clear directions for their use. Processes the link between a relationship and sexual practice and how these affect risk-taking.			
3.4 My Personal HIV/STD Risk Behavior	Distributes My Personal STD/HIV Risk Behaviors Handout (two to each participant), with clear directions; then records response—assuring confidentiality—on the newsprint, making the connection between the prior two exercises and what participants in the group might actually be doing through processing of these lists.			
3.5 Session Summary	Asks for and answers remaining questions from participants. Answers any Parking Lot questions that can be addressed then. Summarizes key points from the day.			

FIDELITY ASSESSMENT FORM—SESSION 4

Exercise	Fidelity Goal	Fidelity Ranking (1 to 5)	Comments	Primary Facilitator's Name
4.1 Recap and Preview	Welcomes participants back. Recaps previous session's main points. Answers any outstanding Parking Lot questions.			
4.2 Stage Yourself—How Ready Are YOU for Change?	Provides an explanation of the concepts of the stages of change. Clearly provides directions to the participants as to staging themselves, and processes the self-staging and rationale with respect to their different sexual and substance-use HIV/STD risk behaviors. Distributes and processes the Prevention Options for Individuals (Menu 1) handout, making the connection between Session 3's activities and personal behaviors and choices.			
4.3 Choosing to Act	Reviews the Prevention Options for Individuals (Menu 1) handout, and assures that participants understand the listed options; instructs the participants to choose an option; and tells them that their chosen option will be reviewed at the following session.			
4.4 Barriers and Facilitators of Selected Change	Helps participants identify perceived barriers and facilitators to the prevention or harm reduction option selected using The Barriers and Facilitators of Change handout.			
4.5 Getting Ready for Action—Taking the First Step	Reviews and has participants complete the Getting Ready for Action handout.			
4.5 Session Summary	Asks for and answers remaining questions from participants. Answers any Parking Lot questions that can be addressed then. Summarizes key points from the day.			

FIDELITY ASSESSMENT FORM—SESSION 5

Exercise	Fidelity Goal	Fidelity Ranking (1 to 5)	Comments	Primary Facilitator's Name
5.1 Recap and Preview	Welcomes participants back. Recaps previous session's main points. Answers any outstanding Parking Lot questions.			
5.2 The Man of My Dreams	Directs the participants to fantasize about what the "Man of My Dreams" would look like and what a relationship with him would be like, then processes using the manual's suggested questions; also asks and records (on newsprint), but does not yet process, the definitions of sexism and stereotyping (to be used in Exercise 3).			
5.3 Who's Got the Power	Asks the group to tell who—in their childhood homes, neighborhoods, and churches—held the power, in order, using the manual's suggested questions and guidelines to elicit the responses. Gets the group to process the different types of power held by the different people within these groups, how the power may be different between men and women, and introduces the concepts of nurturing and authoritarian power.			
5.4 Why We Choose the Ones We Choose	Uses the information elicited in the previous exercise to ask the group to identify different kinds of power; uses the definitions of sexism and stereotyping from Exercise 1 to guide the group to see the connection between their life experiences and how this affects how they see their roles as tops and bottoms, their choices in sexual practices, and their relationships; distributes and reviews the Prevention Options for Partners (Menu 2) handout and asks the participants to identify a first step from the list.			
5.5 Session Summary	Asks for and answers remaining questions from participants. Answers any Parking Lot questions that can be addressed then. Summarizes key points from the day.			

FIDELITY ASSESSMENT FORM—SESSION 6

Exercise	Fidelity Goal	Fidelity Ranking (1 to 5)	Comments	Primary Facilitator's Name
6.1 Recap and Preview	Welcomes participants back. Recaps previous session's main points. Answers any outstanding Parking Lot questions.			
6.2 Play Your Own Scene	Conduct role-plays, providing clear directions to participant actors about scene and roles. Processes the role-plays—with input and feedback from the group and how it might work in real life.			
6.3 Falling Off the Wagon	Asks group members to identify their most problematic scenarios and experiences in which relapse had occurred and asks them how they felt. Involves the group in identifying ways to overcome hurdles as the participants share their experiences and records them on newsprint. Processes by reinforcing that relapse is normal and that it can be used to help in the future.			
6.4 Session Summary	Asks for and answers remaining questions from participants. Answers any Parking Lot questions that can be addressed then. Summarizes key points from the day.			

FIDELITY ASSESSMENT FORM—SESSION 7

Exercise	Fidelity Goal	Fidelity Ranking (1 to 5)	Comments	Primary Facilitator's Name
7.1 Recap and Preview	Welcomes participants back. Recaps previous session's main points. Answers any outstanding Parking Lot questions.			
7.2 What Else Do You Need?	Appropriately uses newsprint and Behavior Change Plan handout to facilitate a discussion of participants' ongoing prevention needs.			
7.3 How Can I Build on This Experience?	Process participants' feelings and thoughts about their 3MV experience, covering the suggested topic areas. Properly explains the purpose of having the mental health professional give a presentation.			
7.4 How Can WE Build a Community?	Facilitates a discussion on tools and resources participants need to build a supportive community and records discussion points on newsprint.			
7.5 The Survival Handbook for Black Gay Men	Distributes and reviews survival handbook, linking it to the previous exercise.			
7.6 Session Summary and Graduation	Asks for and answers remaining questions from participants. Answers any Parking Lot questions that can be addressed then. Summarizes key points from the day. Distributes and explains KAB Survey and Participant Satisfaction Questionnaire. Conducts graduation ceremony.			

FACILITATOR OBSERVATION FORM

When to Use: During the delivery of any 3MV sessions

Administered by: Observer (e.g., program manager or supervisor)

Completed by: Observer

Instructions: This tool will help you to assess the quality of a facilitator's basic group facilitation skills, which should be applied at every Many Men, Many Voices (3MV) intervention session. A second tool should be used to assess the fidelity of each 3MV session (i.e., the extent to which the facilitators correctly complete all the exercises). When observing basic group facilitation skills, focus on the facilitator's interactions with the participants as well as their nonverbals. Use active seeing and listening skills, paying particular attention to details.

Be sure that you complete the observation form by including the facilitator's name, your name, date of observation, and session number. You should document and provide verbal feedback on the facilitator's strengths, areas for improvement, and any next steps the facilitator can take to improve future deliveries.

FACILITATOR OBSERVATION FORM

Facilitator Name: _____ Observer Name: _____ Session Number: _____ Date: ____/____/____

Skill Items:	Score (1 to 5)	5 = High	3 = Average	1 = Low
Positive Attitude Toward Role of Group Facilitator as Opposed to Group Educator		Consistently demonstrates positive attitude toward his role as facilitator as opposed to educator; teaches clients by asking questions about the answers and processes their responses rather than lecturing and providing the answers	Intermittently demonstrates positive attitude about facilitator role; sometimes lectures participants and does not allow them to provide answers	Does not demonstrate positive attitude toward his role of facilitator; sees his role as educator who needs to teach clients by lecturing; tells participants what they should know, think, or do
Confidence		Demonstrates high level of confidence in his role as facilitator	Demonstrates moderate level of confidence as facilitator but does not maintain it throughout	Demonstrates low level of confidence in his role as facilitator
Time Management		Demonstrates high level of adherence to agenda and session design and completes all exercises	Demonstrates moderate level of adherence to agenda and session design; completes some of agenda but does not finish all exercises	Demonstrates low level of adherence to agenda and session design; allows clients to take over the agenda
Enforcing Ground Rules		Posts and notes Ground Rules during each session; reminds clients of need to adhere when appropriate	Posts Ground Rules during each session, but does not consistently refer to them when clients are not adhering	Reviews Ground Rules during first session; does not post Ground Rules at sessions or does not refer to them when clients are not adhering

Skill Items:	Score (1 to 5)	5 = High	3 = Average	1 = Low
Communication Skills (Active Listening)		Consistently uses active listening; responds to participants' affect as well as content	Intermittently uses active listening skills; responds to content or affect but not both	Does not demonstrate use of active listening skills
Positive Reinforcement		Consistently reinforces appropriate participant involvement and effort	Intermittently reinforces appropriate participant involvement and effort	Does not reinforce appropriate participant involvement and effort
Summarizing and Redirecting		Consistently uses summarizing and redirecting to adhere to agenda and session design	Intermittently uses summarizing and redirecting to adhere to agenda and session design	Does not use summarizing and redirecting to adhere to agenda and session design
Works as a Team With Cofacilitator		Consistently shares facilitation responsibilities with cofacilitator as decided and allows cofacilitator to interject	Intermittently shares facilitation responsibilities with cofacilitator as decided and intermittently allows cofacilitator to interject	Does not share facilitation with cofacilitator as decided and does not allow cofacilitator to interject
Acts as a Role Model With Peers		Consistently models professional demeanor with peer participants and maintains necessary boundaries	Inconsistently models professional demeanor with peer participants and maintains necessary boundaries	Does not model professional demeanor with peer participants or maintain necessary boundaries
Includes and Engages all Clients		Consistently engages and includes all participants in the exercises and group processing	Inconsistently engages or includes all participants in the exercises and group processing	Does not engage or include all participants in the exercises and group processing

Overall Comments

1. Facilitator strengths:

2. Areas to be improved:

3. Action plan and next steps:

PARTICIPANT SATISFACTION QUESTIONNAIRE

When to Use: At the end of Session 7

Administered by: Facilitator

Completed by: Participants

Instructions: Have participants complete this form the same time they complete the second Knowledge, Attitudes, and Behavior (KAB) Survey at the end of Session 7. Explain that this information will help you to improve future sessions of Many Men, Many Voices (3MV). Tell participants they should feel free to provide honest responses. Reassure them that they can complete this form anonymously because no indentifying information is requested.

PARTICIPANT SATISFACTION QUESTIONNAIRE

Facilitator(s) Name(s): _____

Date: ____ / ____ / ____

Location: _____

Please take a moment to rate how effective we were in presenting information to you. Check the box the best represents your response to the question.

The facilitator(s)...	Strongly Disagree	Disagree	Agree	Strongly Agree
1. Demonstrated expertise in the subject matter.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Clearly answered any questions I had.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Used clear, simple language that I could understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Were comfortable talking about sensitive topics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Gave all group members a chance to contribute and ask questions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Listened carefully to what everybody said.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Used appropriate teaching strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Created a comfortable learning environment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Were nonjudgmental.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Were friendly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Were enthusiastic.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Were respectful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As a participant, I found ...	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The group discussions interesting and informative.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The activities and exercises enhanced my ability to learn the subject matter.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The handouts were helpful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall, how would you rate the performance of the facilitator(s)? *Please circle a number.*

Poor				Okay					Excellent
1	2	3	4	5	6	7	8	9	10

Overall, how would you rate the sessions? *Please circle a number.*

Poor				Okay					Excellent
1	2	3	4	5	6	7	8	9	10

Overall, how would you rate the 3MV Program? *Please circle a number.*

Poor				Okay					Excellent
1	2	3	4	5	6	7	8	9	10

What topics, content, or concepts could have been covered in more detail?

What topics, content, or concepts could have been covered in less detail?

Please share any additional comments you have about your experience.

As a result of participating in 3MV, did you make some positive changes in your life?

No Yes *If yes, please describe the changes you made below.*

Thank you for your participation!

KAB SURVEY

When to Use:	Pre: At the beginning of Session 1 Post: At the end of Session 7
Administered by:	Facilitator
Completed by:	Participants
Instructions:	Distribute a copy of this survey to participants at the appropriate time. Instruct participants to either circle “Pre-Session 1” or “Post-Session 7” at the beginning of the survey.

KNOWLEDGE, ATTITUDES, AND BEHAVIOR (KAB) SURVEY

MANY MEN, MANY VOICES

Circle one: Pre-Session 1 or Post-Session 7

In order to learn how well these group sessions are working, we need your help. **All information gathered from this survey is completely confidential and anonymous.** You do not have to give your name or any other identifying information. Your birth day and month will be used only as a code to make sure we have both of your surveys. Thank you for your help in making our program better.

Date: _____ Location: _____ Birthday: _____ / _____
M M D D

Circle the number that describes your reaction to the following:

1. How much do you feel a part of or connected to the black community?

Not at All Very Connected
1 2 3 4 5 6 7 8 9 10

2. How much do you feel a part of or connected to the gay community?

Not at All Very Connected
1 2 3 4 5 6 7 8 9 10

3. How much do you feel a part of or connected to the black gay community in your area?

Not at All Very Connected
1 2 3 4 5 6 7 8 9 10

4. How much do you value yourself as a black gay man?

Not at All To a Great Extent
1 2 3 4 5 6 7 8 9 10

5. How worried are you about getting HIV/AIDS?

Not at All Worried

Very Worried

1 2 3 4 5 6 7 8 9 10

6. How worried are you about getting an STD (sexually transmitted disease) other than HIV?

Not at All Worried

Very Worried

1 2 3 4 5 6 7 8 9 10

Please circle the response that states how much you agree or disagree with the following:

7. I know how to get a sexual partner to use a condom if I want him to.

Strongly
Disagree

Disagree

Somewhat
Disagree

Somewhat
Agree

Agree

Strongly
Agree

8. I know how to use a condom correctly so that it doesn't break or slip off during sex.

Strongly
Disagree

Disagree

Somewhat
Disagree

Somewhat
Agree

Agree

Strongly
Agree

8. Having an STD (such as syphilis or gonorrhea) increases the chances of getting HIV from a sexual partner.

Strongly
Disagree

Disagree

Somewhat
Disagree

Somewhat
Agree

Agree

Strongly
Agree

9. Condoms should be used with a man when you are a Top during anal sex.

Strongly
Disagree

Disagree

Somewhat
Disagree

Somewhat
Agree

Agree

Strongly
Agree

10. Condoms should be used with a man when you are a Bottom during anal sex.

Strongly
Disagree

Disagree

Somewhat
Disagree

Somewhat
Agree

Agree

Strongly
Agree

11. I feel confident in my ability to get a new partner to use condoms.

Strongly
Disagree

Disagree

Somewhat
Disagree

Somewhat
Agree

Agree

Strongly
Agree

12. In general, I feel I am a part of the black gay community.

Strongly
Disagree

Disagree

Somewhat
Disagree

Somewhat
Agree

Agree

Strongly
Agree

13. Please check the response that best describes your level of confidence to ask your main partner to get tested for STDs regularly (i.e., at least once every 6 months).

I am afraid to ask my main partner to get tested regularly.

I might be able to ask my main partner to get tested regularly.

I have no problem asking my main partner to get tested regularly.

My main partner already gets tested regularly.

I don't have a main partner.

14. Please check the response that best describes your level of confidence to ask your main partner to get tested for HIV regularly (i.e., at least once every 6 months).

I am afraid to ask my main partner to get tested regularly.

I might be able to ask my main partner to get tested regularly.

I have no problem asking my main partner to get tested regularly.

My main partner already gets tested regularly.

I don't have a main partner.

Please indicate which response best describes your plans to do the following:

15. Get tested for STDs on a regular basis (i.e., at least once every 6 months)

- I don't see a need to get tested for STDs.
- I see a need to get tested for STDs, but I am not ready to get tested regularly.
- I am ready to start getting tested for STDs regularly.
- I just started getting tested for STDs.
- I am already getting tested for STDs regularly.

16. Get tested for HIV on a regular basis (i.e., at least once every 6 months)

- I don't see a need to get tested for HIV.
- I see a need to get tested for HIV, but I am not ready to get tested regularly.
- I am ready to start getting tested for HIV regularly.
- I just started getting tested for STDs.
- I am already getting tested for STDs regularly.

17. Use condoms every time I am a Top with any casual partner

- I don't see a need to use condoms every time.
- I see a need to use condoms, but I am not ready to use them every time.
- I am ready to start using condoms every time.
- I have started using condoms every time.
- I have already been using condoms every time.

18. Use condoms every time I am a Top with my main partner

I don't see a need to use condoms every time.

I see a need to use condoms, but I am not ready to use them every time.

I am ready to start using condoms every time.

I have started using condoms every time.

I have already been using condoms every time.

19. Use condoms every time I am a Bottom with any casual partner

I don't see a need to use condoms every time.

I see a need to use condoms, but I am not ready to use them every time.

I am ready to start using condoms every time.

I have started using condoms every time.

I have already been using condoms every time.

20. Use condoms every time I am a Bottom with my main partner

I don't see a need to use condoms every time.

I see a need to use condoms, but I am not ready to use them every time.

I am ready to start using condoms every time.

I have started using condoms every time.

I have already been using condoms every time.

GUIDANCE ON IMPLEMENTING MANY MEN, MANY VOICES (3MV) IN A RETREAT FORMAT

OVERVIEW

This document provides information on how to plan and implement the 3MV intervention in a 3-day retreat structure. Typically, Sessions 1 to 6 are delivered over the course of 3 days during the retreat. Session 7 is delivered 1 to 2 weeks after the retreat as a booster session. It is recommended that you limit the size of your retreat to 10 to 12 participants and 2 facilitators.

The main advantage of delivering 3MV as a retreat is that, except for an occasional unusual experience, there is a high retention rate because all of the participants complete the first six sessions of the intervention. You do not have to worry about following up with participants to ensure they attend each session. Delivering 3MV as a retreat may also allow you to deliver the intervention to people who would be unable to attend 3MV in the weekly format. The main disadvantages of the retreat are the additional planning and costs associated with finding an appropriate location and arranging transportation, lodging, and meals.

It is up to you to decide how you will conduct the retreat—as an overnight or nonovernight retreat.

Nonovernight: A retreat may be held in a room at the sponsoring agency or at a hotel conference facility rented by the agency. The participants receive two or three 3MV sessions during the day and then return home at night. Conducting a retreat in this format can reduce costs and make the intervention more accessible for participants who simply cannot attend for an entire weekend. However, there is a chance that participants may not return for the remaining days/sessions.

Overnight: A retreat may be held at a hotel conference area or a retreat center, where you will provide food and lodging so that participants can stay overnight throughout the entire weekend. Conducting a retreat in this format can improve the chances that participants receive Sessions 1 to 6.

Planning and Preparing

You will need to do the following action items when planning and preparing your 3MV retreat.

1. **Develop retreat budget.** You will need to develop a budget to determine whether you can afford to conduct a retreat. A sample budget is provided below. Please note that costs can vary on the basis of location and time of year, so you will need to determine the costs of your specific retreat. Please note that this sample budget does **not** include labor and other costs associated with implementing 3MV. Please refer to the budget in the Preimplementation section of this manual for additional costs to consider.

Item	Cost
Transportation: A small bus or large van to transport 15 persons and luggage to and from the retreat	\$300
Hotel rooms: \$150 per room for 2 nights for 15 people	\$3,000
Meeting rooms:* <ul style="list-style-type: none"> • 1 large room for 15 people (3 days)—\$350 per day • 1 breakout room for 7 people (2 days)—\$150 per day 	\$1,350
Meals (for 15 people; average cost of \$18 per meal): <ul style="list-style-type: none"> • Day 1—dinner • Day 2—breakfast, lunch, and dinner • Day 3—breakfast, lunch, and boxed dinner 	\$1,890
Incidentals (\$100 per day times 3 days)	\$300
Total	\$6,840

*Meeting room cost does not include renting audiovisual equipment, flip charts or easels, etc.

2. **Find and secure a retreat venue.** You will need to consider the following when selecting a venue for your 3MV retreat:
 - ▶ **Suitable locations:** When planning a retreat, it is important to consider whether the hotel or retreat facility will be a comfortable and safe place for black gay men. Perceived racism and homophobia can be a negative distraction and may inhibit the ability of the participants to share personal information and experiences in the 3MV sessions. The main consideration is that the participants will feel safe and confidential in disclosing private and personal issues. The space must be private and as soundproof as possible. It is desirable that the travel time be less than 3 hours by bus, with consideration of delays due to traffic and winter driving conditions when relevant.

- ▶ Rooming arrangements: Ideally, each participant should have a single room. This allows time for private emotional reactions and personal reflection on the issues covered in the intervention sessions. Participants who attend with a partner may, however, want to share a room. Special accommodations, such as down-free bedding, accessible rooms for people with disabilities, and so forth, should be made in advance. Ideally, the rooms should be near each other, on the same floor, and close to the meeting rooms.
 - ▶ Room reservations: Rooms should be booked at the last possible day allowed by the facility. Most facilities give a large discount if more than 10 rooms are booked. The agency should attempt to negotiate a reduced rate for the number of rooms booked.
 - ▶ Meeting room space: For 12 participants and 2 facilitators, you will need one large room to accommodate up to 15 people for the full-group activities. One smaller, breakout room to accommodate six or seven participants is needed for small-group sessions. Ideally, these rooms should be close to each other and should be accessible to all participants.
 - ▶ Retreat menu: In general, a buffet style is preferred because it provides the most choices for the participants. Alternatively, family style is desirable as a means to provide more choices and varying quantities. Special dietary accommodations, including vegetarian, low sodium, and gluten free, should be made in advance. You should ask participants about their dietary needs during registration.
3. **Schedule transportation.** Arrange transportation with a private company that can provide a small bus to hold up to 15 persons with luggage. The company should have adequate insurance and allow cancellation up until 24 hours before departure, if possible. Ask for references or names of other agencies that have used the service to verify reliability and adequacy of service.
 4. **Recruit and register participants.** Use the same recruitment methods outlined in the Implementation Manual to develop a list of potential participants. Recruiters should screen potential participants for HIV status, age, and willingness to attend a retreat. If a participant is eligible, explain more about the retreat format, location, logistics, and so forth. Create a retreat registration list that includes each participant's name, contact information, lodging and dietary needs, and the dates he is available. If the participant is not available during your retreat dates, put his name on a wait list. Also, if your retreat is full, place the participant on a wait list and tell him he will be contacted if there is a cancellation.
 5. **Provide participants with information packets.** Provide each participant with a written packet of information about the retreat dates, location, and logistics, including phone number of agency staff to call if there is a change in plans. Advise participants that the agency will contact them within 3 days of departure date to confirm reservation. Tell participants to gather at the agency 1 hour before the bus will depart.

6. Prepare materials. You will need to bring the following materials to the retreat:

- ▶ Two standing easels with flip chart paper (four pads)
- ▶ Two laptops with DVD player and PowerPoint and two LCD projectors
- ▶ Rolls of masking tape (six)
- ▶ Markers (two packages)
- ▶ 3MV Facilitator's Guide (two; one for each facilitator)
- ▶ Ties That Bind cards (two sets; one for each facilitator)
- ▶ Sex in the City manual (one set)
- ▶ Slide sets on CD-ROM (one set)
- ▶ *The Party* video on CD-ROM (two sets)
- ▶ Sign-in sheet
- ▶ Daily feedback form
- ▶ 3MV Participant Satisfaction Questionnaire
- ▶ 3MV KAB Survey, to be administered before and immediately after intervention

Implementing the 3MV Retreat

1. Contact participant within 72 hours of departure. Contact participants on your retreat registration list to verify their reservations. If a participant is unable to attend, agency staff should put his name on a wait list for another date. Contacting participants will increase the chances that all participants will show up.

- ▶ Common reasons for a participant to not show up include the following:
- ▶ He is in transient housing and in the process of moving.
- ▶ He is uncomfortable traveling alone and/or distrustful of agency staff.
- ▶ He has family matters to deal with (illness, death, and so forth).
- ▶ He has a work schedule conflict.
- ▶ He is ill.
- ▶ He is not openly gay and is concerned about being seen.
- ▶ He lied about HIV-negative status and knows he is not eligible.

2. **Meet at agency.** Using the 3MV Retreat registration list, check off participants as they arrive. Provide name tags, light refreshments, and activities for the participants while waiting for all to arrive. Consider the use of an icebreaker activity to help participants meet each other. Provide identification tags for all luggage.
3. **Travel to the retreat.** While in transit, it may be possible to cover some introductory material on the agenda. This can save time later in the evening and help the participants to feel more comfortable with the group process. Tell participants what to expect at the facility; some participants may never have been in a similar setting and may have questions about the dress code and other items. Provide each participant with a written agenda for the evening's activities and discuss the timeframe for room check-in, dinner, and Session 1. Participants should not be given a detailed agenda of each session in advance. Cover the Ground Rules and gain agreement from participants to follow them. Discuss the role of the facilitators—not as educators but as processors of the men's responses and participation.
4. **Check in at the retreat.** Upon arrival, have one agency staff member go to lobby to check in while another provides each participant with his room assignment and distributes luggage. Tell participants the time and place to meet for dinner and what time Session 1 starts.
5. **Conduct the sessions.** During the retreat, you will conduct Sessions 1 to 6. A sample agenda is included at the end of this guidance.

You should conduct the sessions as you would if you were conducting them in a weekly format. Since participants will not have the opportunity to do the homework assignment they received at the end of Session 4 (“Getting Ready for Action”), you will need to modify the assignment and tell them they can do it after the retreat. Then, during Session 5, you won't ask them about their experiences doing the homework.

At the end of Session 6, give participants a brief preview of what will be discussed in Session 7 and provide information about when and where it will be held.

6. Establish additional retreat guidance.

- ▶ It will be up to your agency to decide how to handle the possibility that participants may choose to hook up and have sex during the retreat. It will be important for you to address the possibility when discussing the Ground Rules. At this time, make it clear that your agency promotes HIV/STD prevention embodied in the 3MV intervention. Therefore, your agency could provide condoms and lubricant in the participants' packets and encourage participants to use those items and keep themselves and each other safe.
- ▶ Another Ground Rule is that illegal drug use is not allowed and participants who use illegal drugs will not be allowed to continue the 3MV sessions.
- ▶ Sexual contact between 3MV staff and participants should not be allowed. The agency should have a specific, written policy indicating that staff are not allowed to have sex with participants. The policy should include a mechanism for participants to report if they feel staff are coming on to them.
- ▶ You will need to have a plan for providing transportation for participants who have to leave the retreat early, whether it is for a family or medical emergency or for fighting, drug use, or other inappropriate behavior.

After the 3MV Retreat

1. **Follow up with participants.** Within 2 or 3 days after the retreat ends, call participants and check in about their experience, see whether they have any questions, and remind them about attending Session 7.
2. **Conduct Session 7 one or two weeks after the retreat.**

MANY MEN, MANY VOICES (3MV)

AGENDA—RETREAT FORMAT

Friday Evening

Time	Activity	Notes
1:00 to 4:30 p.m.	Travel to the hotel	
5:30 p.m.	Registration	Hand out name tags, participant packets, etc.
6:00 p.m.	Welcome and announcements <ul style="list-style-type: none"> • Welcome the group; thank them for their participation • Introduction of facilitators, coordinators, and observers • Give them a context for the next 3 days: why we are here, how the intervention started, why they are in the room, what role they are expected to play, what they will be taking back to their agency, and so forth • Go over the agenda for the next few days (where you will be expected to be and what you will be doing there) • Introduction of participants • Ground rules • Opening ceremony and invocation 	
6:45 p.m.	Session 1 Who Are We and What Are Our Risky Behaviors? Dual identity and black gay men and STD/HIV risk behaviors	1 hr
7:45 p.m.	Break	15 min
8:00 p.m.	Session 1 continues	1 hr
9:00 p.m.	Closing <ul style="list-style-type: none"> • Review: What impressed you the most during the first session? • Question and answer session (Parking Lot) • What to expect tomorrow 	

Saturday

Time	Activity	Notes
8:45 a.m.	Hospitality	
9:00 a.m.	Welcome and day's opening <ul style="list-style-type: none"> Welcome back Revisit agenda Question and answer session (parking lot/reflections) 	
9:15 a.m.	Session 2 STD/HIV Connection STD/HIV issues for black gay men: the roles and risks for tops and bottoms	1 hr
10:15 a.m.	Break	15 min
10:30 a.m.	Session 2 continues	1.5 hrs
12:00 p.m.	Lunch provided	1 hr
1:00 p.m.	Session 3 What Are My Options for Prevention? <ul style="list-style-type: none"> STD/HIV risk assessment and prevention options 	1.5 hrs
2:30 p.m.	Break	15 min
2:45 p.m.	Session 3 continues	1.5 hrs
4:15 p.m.	Closing <ul style="list-style-type: none"> Review: What impressed you the most during the day? Question and answer session What to expect tomorrow Benediction 	

Sunday

Time	Activity	Notes
8:45 a.m.	Hospitality	
9:00 a.m.	Welcome and day's opening <ul style="list-style-type: none"> Welcome back Revisit agenda Question and answer session (Parking Lot/reflections) 	
9:15 a.m.	Session 4 How Can I Make Changes? <ul style="list-style-type: none"> Intentions to act and capacity for change 	1 hr
10:15 a.m.	Break	15 min
10:30 a.m.	Session 4 continues	1 hr
11:30 a.m.	Lunch provided	1 hr
12:30 p.m.	Session 5 What About My Partner(s)? <ul style="list-style-type: none"> Relationship issues (sexual relationships, skills, self-efficacy) 	2 hrs
2:30 p.m.	Break	15 min
2:45 p.m.	Session 6 Practice Skills <ul style="list-style-type: none"> Problem solving to maintain changes (sexual relationships, skills acquisition, finding substitutes, social support) 	2 hrs
4:45 p.m.	Closing <ul style="list-style-type: none"> Closing ceremony Benediction 	
5:30 to 8:30 p.m.	Travel to agency (drop-off location)	

MANY MEN, MANY VOICES (3MV)

Participants in the Many Men, Many Voices (3MV) facilitators training often ask questions that facilitators should be able to answer. Following is a set of frequently asked questions (FAQs), categorized by session, that facilitators can use to help clarify information about the implementation of 3MV. Answers are based on expert clinician judgment, findings from clinical and behavioral research, behavioral theories, and identified best practices in HIV/sexually transmitted disease (STD) prevention and public health.

GENERAL QUESTIONS

1. What are the core elements of 3MV?

Answer: Core elements are the essential components of an intervention and represent its internal logic. They are thought to be responsible for the intervention's main effects, and are typically identified by the intervention's developers through research and practice. Core elements, which may relate to an intervention's pedagogy, content, or activities, must be implemented with fidelity (i.e., as intended, and as implemented in efficacy trials) to increase the likelihood that implementers will have program outcomes similar to those in the original research.

3MV has the following nine core elements:

1. Enhance self-esteem related to racial identity and sexual behavior
2. Educate participants about HIV risk and sensitize to personal risk
3. Educate participants about interactions between HIV and other STDs and sensitize to personal risk
4. Develop risk-reduction strategies
5. Build a menu of behavioral options for HIV and STDs and risk reduction, including those that one can act on individually and those that require partner involvement
6. Train in risk-reduction behavioral skills
7. Enhance self-efficacy related to behavioral skills
8. Train in partner communication and negotiation
9. Provide social support and relapse prevention

2. My agency does not serve black gay men. Can I still use 3MV with my agency's target population?

Answer: 3MV is an intervention developed for black gay men. The term black gay men is used primarily to reflect that affiliations and connections among members of the target population are organized more around personal, relational, social, and societal characteristics and less around behavioral ones. In the context of 3MV, black refers to the racial or ethnic group of people who are of African descent living in the African diaspora (i.e., African American, African [e.g., Senegalese, Nigerian, Kenyan]; Afro-Caribbean/West Indian [e.g., Jamaican, Trinidadian, Haitian, Guyanese]; and black Latino or Hispanic [e.g., Dominican, Puerto Rican, Cuban]).

3MV was not specifically designed for other racial or ethnic minority groups (e.g., Asian or Pacific Islanders, nonblack Latinos, and Native Americans), but could be adapted for these populations. If an agency is considering adapting 3MV for one or more of these racial or ethnic populations, it is strongly recommended that the agency seek technical assistance from CDC to ensure that appropriate steps will be taken to adapt 3MV successfully. It is

important to ensure that any changes made will maintain fidelity to the original design and will be culturally relevant to the racial/ethnic group of men who have sex with men (MSM) for whom the agency will target 3MV. More information on the adaptation of evidence-based interventions (EBIs) can be found in CDC’s procedural guidance for community-based organizations (CBOs):

http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance/index.htm

Agency staff can also attend the adaptation courses taught by the Centers for Disease Control and Prevention (CDC)-funded Prevention Training Centers (PTCs), or check with CDC capacity building assistance (CBA) provider agencies or CDC Project Officers for additional resources.

3. Is 3MV appropriate for black men who do not identify themselves as gay or bisexual?

Answer: 3MV is appropriate for black MSM who identify as gay, same-gender-loving, bisexual, queer, and so forth, as well as for black MSM who do not identify with any of these terms or labels. 3MV is NOT appropriate for black MSM who do not have sexual or emotional attractions to other men, such as inmates who have situational sex or men who trade sex for money or drugs.

3MV was developed with some men who did not identify themselves as gay or bisexual but who engaged in sex with other men and may or may not have had female sexual partners as well. There may be a difference in the level of comfort for a non-gay-identified man in a group of gay-identified men, but the session participant will need to make the decision whether he is comfortable interacting in such a setting.

4. Is 3MV appropriate for HIV-positive participants?

Answer: 3MV was NOT designed to meet the prevention needs of HIV-positive participants. The Menu of Options for STD/HIV Prevention, which is an integral part of the intervention, is built around options for men who are HIV-negative.

5. Is it okay if couples attend 3MV sessions together?

Answer: It is okay for couples to participate in an agency’s 3MV program. The 3MV intervention includes a Menu of Options for those who are in an ongoing relationship to encourage communication and negotiation between couples. However, it is advisable that couples attend different cycles or sets of 3MV sessions to minimize potential challenges to the overall group dynamic should couples attempt to use sessions to talk about unrelated issues that are not addressed by the intervention.

6. Is it okay for participants who are women, white MSM, or heterosexuals to attend 3MV intervention sessions?

Answer: 3MV is a behavioral intervention. Behavioral interventions are designed to meet the unique prevention needs of a specific population. The prevention needs of one population may not be the same as the prevention needs of another population; one size does not fit all. Therefore, it is not appropriate for individuals who are not members of the target population (i.e., non-black gay men, women, white MSM, and heterosexuals) to participate in intervention sessions because 3MV is not designed to meet the prevention needs of those populations.

There may be times when funders and others with administrative oversight need to observe intervention session activities. In these cases, these individuals can do so, as needed, but they should not participate in any of the intervention session activities. Although participants of the 3MV Level 1 training may not be members of the target population, actual intervention groups should not include individuals who are not members of the target population (i.e., black gay men).

7. My agency serves black gay men, but they are all aged 21 years and younger. Can I still implement 3MV with them?

Answer: Yes. Some of the language and some intervention activities may need to be tailored to reflect the slang and expressions of that target population. 3MV was designed, piloted, and evaluated primarily with adult men aged 22 to 45. As a result, there may be differences between age groups that may affect the relevance of some of the session exercises that are a part of the intervention. Agency staff should take a close look at the 3MV implementation materials to determine the relevance to adolescents and young adults. Agency staff may want to consider pretesting 3MV activities with groups of younger black gay men, assess their reactions, and use the findings to inform adaptations to colloquial terms (slang) used in the material as well as activities such as the role-playing scenarios.

8. How do we know when 3MV needs to be adapted?

Answer: An agency should consider two main types of adaptations for 3MV: (1) those that change a part of the intervention itself and (2) those that change ways in which the intervention is implemented at a given agency. As an example of the first type, you may want to adapt 3MV for Latino gay men, which would involve modifying part of the intervention itself, such as cultural factors, social and behavioral determinants, terminology, slang language, and role-playing scenarios, to ensure they are relevant to this population. When adapting 3MV, it is important to ensure that modifications made to intervention exercises and activities reflect the needs of your agency's target population while keeping the intent or internal logic of the intervention. When adapting the intervention, it also will be important to consider agency resources and capabilities to adapt intervention exercises, activities, and materials.

An example of the second type of adaptation is to change the frequency of 3MV intervention sessions. In the original design, facilitators met with participants once a week for 7 weeks. In the efficacy trial, the intervention was held over a weekend using a retreat format. However, an adaptation could use another format, such as holding intervention sessions twice a week for 4 weeks to allow time between sessions for the participants to process content and practice risk-reduction skills.

Adaptations should not alter 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 develop ownership of the intervention.

9. How do you adapt an intervention?

Answer: If an agency is considering adapting 3MV for a different racial or ethnic group, it is strongly encouraged that the agency seek technical assistance from CDC to ensure that appropriate steps will be taken to adapt 3MV successfully. It is important to ensure that any changes made will maintain fidelity to the original design and be culturally relevant to the racial or ethnic group of MSM for whom the agency will target 3MV. More information on adaptation of evidence-based interventions (EBIs) can be found in CDC's procedural guidance for community-based organizations (CBOs):

http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance/index.htm

Agency staff can also attend the adaptation courses taught by the CDC-funded PTCs, or check with CDC capacity building assistance (CBA) provider agencies or CDC Project Officers for additional resources.

10. We do not have any black gay men working at our agency. Can we still implement the 3MV intervention?

Answer: Ideally, all staff members should have extensive experience working with black gay men. However, for 3MV, it is important to ensure that there is at least one facilitator who is a black gay man. This will help to increase the acceptability of your 3MV intervention among participants and ensure that the intervention is delivered in a culturally appropriate manner. In addition, ensuring that one of the facilitators is a member of the target population will provide participants with an opportunity to see a black gay man model healthy attitudes and behaviors, which can help to increase participants' self-efficacy and influence their intent to change risk behaviors. It is desirable for participants to develop an attitude of "if he can do it and he is like me, then I can do it too." Although 3MV has been successfully delivered with cofacilitators who are not members of the target population, it is not appropriate to attempt to implement 3MV without having at least one facilitator who is a black gay man. This holds true even after adapting 3MV for different populations; at least one of the facilitators should be a member of the target population (i.e., a black gay man).

11. What types of monitoring and evaluation (M&E) do we need to do for 3MV?

Answer: The types of M&E activities your agency will need to conduct will depend largely on the requirements set forth by the funding agency. For 3MV, your agency will need to monitor and evaluate two main areas: (1) your program implementation activities and (2) your session delivery activities. *Program implementation activities* are the things you do that lead up to or support delivery of your 3MV sessions. These include setting goals and objectives, planning, setting up and following a timeline, hiring and training staff, writing protocols and policies, obtaining resources, recruiting and retaining participants, setting up data collection systems, providing feedback to staff and stakeholders, developing and following quality assurance plans, and other capacity-building activities. Monitoring and evaluating your program can help you to understand how well you completed those activities and identify ways to improve them. Your *session delivery activities* focus on what actually happens during your 3MV sessions and their effect on participants. Monitoring and evaluating your 3MV sessions can help you to figure out if you conducted them well and completed the sessions as originally designed. You can also find out whether the 3MV sessions made changes in participants' knowledge, attitudes, and perceptions related to risk reduction and health promotion. Use of information you collect through your evaluation activities can help you to improve the quality of your intervention's delivery by looking at what worked and what did not work.

12. Do we need to do a knowledge, attitudes, and behavior (KAB) survey?

Answer: KAB surveys are a good way to obtain data about changes in knowledge, attitudes, and behaviors that influence a participant's HIV/STD risk and health promotion behaviors, which can be attributed to the intervention. Positive changes reflected in the KAB surveys are good indications of the effectiveness of an agency's 3MV program. A sample KAB survey is included in the 3MV implementation materials and can be used by your agency to collect this information. The collection and maintenance of these data are valuable for identifying ways to improve performance, determine how to use resources more efficiently and effectively, and make key decisions about future activities. These data can also help to provide accurate and useful feedback to staff, stakeholders, and funders.

13. What quality assurance measures do we use for this intervention?

Answer: It is important to identify specific quality assurance measures to help guide M&E efforts and to help you determine whether your agency's 3MV program is working and how well it is working. This will mean your agency will need to assess, most importantly, the quality of intervention delivery. Your agency can assess the quality of intervention delivery in a number of ways, including collecting data on the following:

- ▶ Process objectives achieved
- ▶ Outcome objectives achieved
- ▶ Implementation barriers and facilitators
- ▶ Session delivery (quality and fidelity)
- ▶ Facilitation strengths and weaknesses
- ▶ Facilitation challenges and solutions
- ▶ Participant characteristics (e.g., age, race, level of education)
- ▶ Participant attendance and retention
- ▶ Participant satisfaction
- ▶ Participant outcomes
- ▶ Participant pre- and postintervention knowledge, attitudes, and behaviors

14. Is it okay to change the order of the sessions/exercises as long as we complete them all?

Answer: No. The sessions and exercises are designed in a purposeful order and sequence to be most effective in promoting behavior change. Many of the early sessions are designed to increase the participants' readiness for behavior change. For example, if you implement Session 4 before Session 1 and Session 4 is where participants are asked to choose a prevention option for behavior change such as STD testing and they do not perceive themselves to be at risk for STDs, they may be unlikely to act on that option.

15. How many sessions does a participant need to attend to say he went through the 3MV intervention?

Answer: This is up to your agency to decide. However, it is recommended that participants attend a minimum of at least three consecutive sessions. It is likely that participants who attend fewer sessions will be less successful with behavior change. A participant who has to miss one of the sessions should be encouraged to attend that session in a future group series. To encourage attendance, your agency may decide to offer a certificate of completion, for example, if participants have completed all but one session.

SESSION 1—FREQUENTLY ASKED QUESTIONS

Exercise 1.2. *Why We Do the Things We Do: Factors That Influence Behavior Change*

1. Are participants supposed to share a sexual behavior they tried to change?

Answer: No. This is an opening exercise to help the participants become more comfortable talking one-on-one before they are asked to share in the group. They are asked to share one behavior they have tried to change that is not sexual or sensitive to discuss in any way. The facilitators can give examples of quitting smoking, going to the gym to exercise regularly, going on a diet to lose weight, and so forth.

2. Do we need to use the social and behavioral determinants wall cards?

Answer: Yes. The wall cards are designed to provide a visual of the “things on the inside” and “things on the outside” in an easy-to-see format. They also help to ensure that you cover all of the potential influencing factors. Facilitators should explain and provide examples for each wall card term when they place them on the wall.

Exercise 1.3. *Dual Identity*

3. How many responses do facilitators need to solicit from participants for each brainstorm activity (e.g., black men, gay men, black gay men) in this exercise?

Answer: Facilitators should solicit no more than 12 responses per brainstorm.

4. Is the reference to behavior for black MSM just talking about HIV/STD risk behavior?

Answer: No. The exercise is designed to get participants to think about all behaviors that can result in risk for black gay men. These behaviors range from cruising the park for sexual partners to engaging in unprotected sexual acts. The focus is not specifically about HIV/STD risk behaviors, but about any behaviors that could result in risky situations.

Exercise 1.4. *Making the Connections*

5. To talk about trends in this community, how do we get STD/HIV data?

Answer: You can obtain STD and HIV data from your local and State health departments. CDC also has national STD and HIV data, some of which are broken down by State. In most instances, you can obtain these data free of charge.

6. By focusing so heavily on HIV/STD information on black gay men, are we not further demonizing the community by saying black men are dangerous to have sex with?

Answer: The focus on the STD/HIV rates in the black community is not to demonize or generalize this community as dangerous. It is no different from any other disparity that exists in relation to health outcomes in the black community. This is done in an effort to raise the awareness that the black community has been and continues to be disproportionately affected by HIV and other STDs and that black MSM share that risk. Furthermore, this highlights the need to acknowledge and address the unique set of factors (e.g., social rejection, racism, homophobia) that contributes to the risk of black gay men. We have to address these factors to begin reducing the number of new infections in this community.

SESSION 2—FREQUENTLY ASKED QUESTIONS

Exercise 2.2. Tops and Bottoms: Roles and Risks

1. Do we want participants to disclose if they are a Top, Bottom, or Versatile?

Answer: No, this not necessary or required. Participants may disclose this information and that is okay. However, it is not required of a participant to do so.

2. Are we actually expected to tell people that Tops are less at risk for HIV/STDs than Bottoms?

Answer: No. That statement is an oversimplification of the transmission puzzle, which is based on principles of infectivity and other concepts in infectious diseases and public health. Risk for transmission depends on THREE factors; sexual position is only ONE of those factors. Also, Tops are NOT at less risk of getting many STDs (syphilis, herpes, warts) that are spread by direct contact with mucous membranes (pink parts) and not by semen being deposited into the rectum.

Exercise 2.3. What Do You Know About STDs and HIV for Black Gay Men?

3. How much do we need to know about STDs/HIV to conduct this exercise?

Answer: Enough to feel comfortable processing the exercise and answering questions. You can request technical assistance to have more training about STDs and coaching with these 3MV exercises. You could choose to work with your local health department's STD clinic staff members who have expertise in STDs and HIV. Facilitators are also encouraged to participate in the STD/HIV podcast and Webinars provided by the Center for Health Behavioral Training. In addition, facilitators are encouraged to take classes on HIV/STD interactions offered by the PTCs. Please visit <http://www.depts.washington.edu/nnptc/> for more information.

4. Should our agency just hire a clinician to come do this exercise for us?

Answer: Some programs ask a nurse from their local STD clinic or health department to attend the session and answer questions during this exercise.

5. If you get syphilis once, don't you always have it?

Answer: No. Syphilis is caused by a bacterium and is easily cured with a penicillin injection. The syphilis tests are antibody tests, so a person can have a positive syphilis (antibody) test result after he has been treated and cured.

6. What are the take-home points participants need to get from this exercise?

Answer: Participants need to understand that HIV prevention includes STD prevention, that there are bacterial STDs that can be cured, and that there are many viral STDs (besides HIV) that can be treated but not cured. Also, the risks are different for Tops, Bottoms, and Versatiles, depending on which STD is involved and the three transmission factors. For example, oral sex is very low risk in relation to HIV transmission but is a common way for gay men to get syphilis.

Exercise 2.5. Sex in the City: An Inside View

SPECIAL NOTE: This activity focuses on the following four key points:

1. The presence of an STD makes it easier to contract HIV because more white blood cells (to which HIV attaches) will be on the pink parts.
2. The presence of an STD makes it easier to pass HIV to sexual partners because more of the virus will be on the pink parts.
3. A person living with HIV can reduce the amount of HIV virus at the pink part if he or she gets treated.
4. The most reliable way to really know if you have an STD is to get tested or screened.

7. How are we supposed to do “Sex in the City” if we have a small group?

Answer: Use chairs as the pink parts, so that the participants can play the germs and the white blood cells.

8. If your mouth has pink parts, why are we saying that oral sex is safer than anal sex?

Answer: Oral sex is safer than anal sex depending on which STD or HIV is being discussed. For example, one is less likely to get HIV from oral sex compared with anal sex, but it is very easy to get syphilis from BOTH oral sex and anal sex.

9. Can you get an STD in your mouth?

Answer: Yes.

10. Is it easier for uncircumcised men to contract/pass HIV or other STDs because they have more pink under the foreskin?

Answer: Some studies have shown that uncircumcised men are more likely to get HIV or other STDs from others through unprotected sex. They are not more likely to pass HIV or other STDs to a partner.

Exercise 2.6. Transmission Puzzle**11. Do we have to use the PowerPoint presentation?**

Answer: Yes. The PowerPoint presentation is important because it explains how DOSE, EXPOSURE, and RESISTANCE are all factors that determine one's chances of getting HIV and/or STDs. It is important that participants understand the transmission puzzle's main concepts because they will use that information to help build their Menu of Options in Session 3.

12. Can we skip this exercise if we are running out of time?

Answer: No. We recommend moving this exercise to the beginning of Session 3 if you are running out of time.

SESSION 3—FREQUENTLY ASKED QUESTIONS

Exercise 3.2. Creating a Menu of Options for STD Prevention

1. Why are we telling people to do things that are still putting them at risk for HIV?

Answer: The strategies we discuss in relation to the transmission puzzle are based on harm reduction–philosophy options. It may be uncomfortable for some facilitators to talk about things other than prevention; however, the purpose here is to raise participants’ awareness of other options that can be used when there are barriers to meeting STD/HIV prevention options.

2. Do we have to use the Menu of Options?

Answer: Yes. The Menu of Options is a critical component of this intervention. It is the tool from which participants select their prevention or harm reduction options.

Exercise 3.3. Take Your Own Inventory—What Would You Do With Whom?

3. Can we change the inventory?

Answer: Depending on the population served by your agency, some behaviors or partner types listed on the inventory may be less relevant and there may be a need to add those that are more relevant. In this and similar cases, it is appropriate to make changes to the inventory, remembering that the purpose of the exercise is to demonstrate that the nature/degree of a relationship influences what sexual behaviors people are willing to engage in.

4. Why do people need to fill out two copies of the What Would You Do With Whom handout?

Answer: The inventory asks personal information that the participants are not obligated to share with the entire group. To ensure privacy, participants fill out an identical inventory form and turn it in to the facilitator so that the group can discuss the relationship between behavior and partner type without breaching the privacy of individual participants.

5. Is it necessary to use the What Would You Do With Whom handout?

Answer: Yes. It is critical that participants think through their behavior in relation to the different partner types and relationships on the handout.

Exercise 3.4. My Personal STD/HIV Risk Behaviors Are...

6. What are examples of health care seeking behaviors?

Answer: Examples of health care–seeking behaviors include:

1. STD screening of person and partner
2. HIV antibody testing of person and partner

7. Why do people need to fill out two copies of the My Personal HIV/STD Risk Behavior Are...handout?

Answer: To maintain privacy, participants are asked to complete two handouts.

8. Do participants have to list their health-promotion behaviors?

Answer: Yes. Participants need to know their health-promotion behaviors and receive support and encouragement to enact those behaviors.

SESSION 4—FREQUENTLY ASKED QUESTIONS

Exercise 4.2. Stage Yourself

1. What would be good background reading for stages of change/transtheoretical model (SOC/TTM)?

Answer: The SOC/TTM of behavior change was developed by DiClemente and Prochaska. It may be helpful to read the original publications on the theory. In addition, an article by Patricia Coury-Doniger may provide sufficient background about SOC/TTM as it specifically relates to STD/HIV risk behaviors. Article references are listed below. Other authors have published articles about the application of the SOC/TTM.

DiClemente, C. C., & Prochaska, J. A. (1982). Self-change and therapy change of smoking behavior: A comparison of processes of change in cessation and maintenance. *Addictive Behaviors*, 7(2), 133–142.

DiClemente, C. C., Prochaska, J. A., Fairhurst, S. K., Velicer, W. F., Velasquez, M. M., & Rossi, J. S. (1991). The process of smoking cessation: An analysis of precontemplation, contemplation, and preparation stages of change. *Journal of Consulting and Clinical Psychology*, 59(2), 295–304.

2. Do we need to use the formal SOC theory terms?

Answer: It is the concepts, not the terms, of SOC theory that participants need to understand. Some of your participants may be familiar with the SOC theory and its associated terms; however, your task is to ensure that others who may not understand the terms still understand the concept of SOC theory.

3. Can we just have them choose their own behavior and stage themselves around that?

Answer: For the exercise to be effective, participants should stage themselves around a specific target behavior (getting STD testing) and not a general type of behavior (safer sex). This is difficult to assess if we ask participants to pick their own behavior. In addition, if everyone stages himself on the same behavior, then participants can compare and contrast the reasons why people are at different stages of readiness in relation to the same behavior.

Exercise 4.3. Choosing to Act

4. What if a participant does not need to change a sexual or substance-use behavior?

Answer: Participants who are in the Action or Maintenance stages for meeting HIV/STD prevention goals can write down things they can do (or avoid doing) to maintain their current stage of readiness (Action or Maintenance).

5. What if a participant does not want to change any of his behavior?

Answer: It is important that participants understand that behavior change is a process, which means that they may not see the need to change their behavior during that session (i.e., they are in the Precontemplation stage of behavior change). It is important to review all of the behavior change options and skills they would need to enact changes when they are ready.

6. Do they need to share their behavior option with others in the group?

Answer: It is desirable for participants to share their behavior option with the others in the group. Behavior change theories suggest that public disclosure of a behavior change goal acts to create an informal social pact or contract with the group. The desire to honor this pact or contract significantly increases the chance that the person will actually move toward the behavioral goal.

Exercise 4.4. Barriers and Facilitators of Selected Change

7. Do participants need to work in small groups during the activity?

Answer: Yes. The small groups are important because they build support to help overcome ambivalence and prevent relapse for the selected options. In addition, the small groups are critical to helping participants think through potential barriers to their selected options.

8. Is it necessary to use the Barriers and Facilitators of Change handout?

Answer: Yes. The handout is important to help participants think through the things that can help them to make their behavior change and the things that could prevent them from making their selected change.

Exercise 4.5. Getting Ready for Action

9. Do participants need to write down a first step?

Answer: Yes. Research studies have consistently demonstrated that writing down a first step or a behavioral goal acts to create a contract with the self. The desire to honor this self-contract significantly increases the possibility that the person will actually initiate the step, rather than if he only thought about the behavior.

10. Do we conduct this exercise in a retreat format because people will not get a chance to practice their first step?

Answer: Yes. Agencies that conduct 3MV using the weekend-retreat format will still need to conduct this exercise. However, during the postretreat follow-up session (Session 7), participants will discuss their attempts at behavior change.

SESSION 5—FREQUENTLY ASKED QUESTIONS

Exercise 5.2. The Man of My Dreams

1. What if issues about intimate partner violence (IPV) come up?

Answer: Given the estimated prevalence of IPV in the gay, lesbian, bisexual, and transgender community, it would not be surprising if someone reveals that he has experienced intimate partner violence. The facilitator should remain nonjudgmental and acknowledge the reality of that person's experience. Others may begin to share their personal experiences. This is an opportunity to process IPV in terms of how it could lead black gay men to engage in HIV risk-related behaviors. Facilitators need to provide referrals to community resources for victims of intimate partner violence.

2. Should we just provide the definitions of sexism and stereotyping?

Answer: No. It is important that participants have the opportunity to think about the definitions of sexism and stereotyping. These definitions will be used later in the sessions.

Exercise 5.3. Who's Got the Power

3. What if it is the people's experience that the women in their households or communities have the power?

Answer: That is not a problem. Participants should continue to go through the exercises describing the kind of power that women have.

4. If we ask what kind of power women or men have, aren't we just reinforcing (or creating) stereotypes?

Answer: Yes, that is the point. The facilitators are supposed to help the participants see how roles of Tops and Bottoms are the results of stereotyping and sexism.

Exercise 5.4. Why We Choose the Ones We Choose

5. Is it important to use the Prevention Options for Partners handout for this activity?

Answer: Yes. It is important that participants use this handout to identify and select a prevention option to use with their partners. If a participant does not have a partner, ask him to think about an option he are willing to try with a partner in the future.

6. Does this exercise reinforce old heterosexist ideas of partnering?

Answer: The focus of this activity is to get participants to think about how heterosexual partnering has influenced how black gay men act in romantic and sexual relationships. In addition, the exercise asks participants what to do if those heterosexist ideas do not fit their relationship.

SESSION 6—FREQUENTLY ASKED QUESTIONS

Exercises 6.2. Play Your Own Scene

1. Instead of doing all of the role-play activities, can we just show the video, discuss it, and move on to the next activity?

Answer: No. Role-playing using scenes from *The Party* helps to build participants' self-efficacy to practice risk-reduction behavioral skills. The role-plays also provide participants with opportunities to receive feedback and support to enact specific risk-reduction behavioral skills. It is important that they be able to fully benefit from this important exercise.

2. Can we change the video we use?

Answer: Yes. The video should be conceptually similar to *The Party* so that the same messages are conveyed. Each scene in the video illustrates a particular theme related to the risks faced by black gay men and is used to stimulate skills building when processed by the facilitator. Facilitators should consider using the vignettes before selecting another video.

3. Can we add new vignettes?

Answer: Yes. Any new vignettes should provide participants with the opportunity to practice the same skills identified in the existing vignettes.

Exercises 6.3. Falling Off the Wagon

4. Is it important for participants to come up with real-life scenarios?

Answer: Yes. It is important that participants think through real-life scenarios so they can think about how to avoid relapse.

SESSION 7—FREQUENTLY ASKED QUESTIONS

1. Is Session 7 optional?

Answer: No. You should conduct Session 7. This session plays a crucial role in helping your participants to build a community in which they feel supported and welcomed. It also introduces participants to additional community resources and services that can support their behavior change efforts.



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

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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.

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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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The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION

Centers for Disease Control and Prevention. [Article Title]. *MMWR* 2002;51:[inclusive page numbers].

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Notifiable Disease Morbidity and 122 Cities Mortality Data

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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.

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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.

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MANY MEN MANY VOICES • 3MV • Because I am not a statistic • 3MV • MANY MEN MANY VOICES • 3MV •

Disseminated as part of the Diffusion of Effective Behavioral Interventions (DEBI) Project at the Centers for Disease Control and Prevention:

DEBI Project

Capacity Building Branch, Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention
1600 Clifton Road, MS E40
Atlanta, GA 30333

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MEN MANY VOICES • 3MV • Packaged for Your Protection • 3MV • MANY MEN MANY VOICES • 3MV • A diffe

xy Black • 3MV • MANY MEN MANY VOICES • I deserve to be happy, I deserve to be healthy • 3MV • MANY

a hear • 3MV • MANY MEN MANY VOICES • 3MV • Because I am not a statistic • 3MV • MANY MEN MANY VO

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