

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.