

Implementation Manual



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) Implementation Manual 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, T. Scott Pegues, Russell Patterson, Micah Lubensky, Ezekiel Goodwin, Lorenzo Robertson, and Charles Stephens, who provided feedback on the design elements for the 3MV marketing and recruitment materials that accompany this manual. We also 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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ABOUT THIS MANUAL

WHO IS THIS MANUAL FOR?

This manual was developed for agencies that plan to implement Many Men, Many Voices (3MV), agencies that already implement 3MV, and agencies that require more information to make a decision about whether or not to select 3MV for implementation. Staff members who supervise, manage, and evaluate programs within their agencies will benefit from the information in this manual. The manual is also written for facilitators who conduct 3MV intervention sessions.

WHAT IS THIS MANUAL FOR?

This manual provides guidelines to ensure that the 3MV intervention is a good match for an agency's capacity and the population it serves. It will also help an agency to maintain the intervention over time. The manual includes a description of the intervention and guidelines to help an agency (1) select, prepare, and implement 3MV; and (2) monitor and evaluate 3MV.

This manual is intended to be useful to those implementing 3MV. We intend to keep this manual and its information as current as possible to maximize its use over time. To achieve this objective, we welcome your input. Please contact Dr. Hank Tomlinson, DHAP, CDC, via e-mail at htomlinson@cdc.gov with any comments, questions, suggestions, or concerns.

OVERVIEW OF MANUAL SECTIONS

This manual contains three main sections: (1) Preimplementation: Background and Program Guidelines; (2) Monitoring and Evaluation; and (3) Tools and Materials. The Preimplementation section will help you to determine whether you should select and implement 3MV. If you are already familiar with 3MV, you can use this manual as a refresher before each new intervention cycle or if significant staff changes within your agency will affect your 3MV program. The Monitoring and Evaluation section provides information to help you monitor and evaluate your 3MV program and sessions. The Tools and Materials section contains a variety of information and tools you can use to implement 3MV. You can also use the information in this manual to answer questions from stakeholders, community members, and the media.

NOTE: Detailed instructions for facilitators on how to conduct each 3MV session can be found in the 3MV Facilitator's Guide.

Preimplementation: Background and Program Guidelines

This section is divided into four subsections. Brief descriptions of each of these subsections follow.

1. **Introduction: About 3MV.** This section includes a general description of 3MV, its target population, and benefits of its implementation.
2. **Background.** This section describes the intervention's development and history. It also provides an overview of how 3MV works, describing the theories on which it is based as well as the key behavioral and social determinants, risk factors, and targeted outcomes it addresses. The intervention's core elements and key characteristics are also described.
3. **Is 3MV Right for Your Agency?** This section provides a checklist to help you to determine whether 3MV is a good fit for your agency. It includes key considerations for implementing 3MV, such as ensuring that the goals of 3MV are consistent with an agency's mission; determining the availability of HIV prevention interventions for black gay men in the target area; gaining access to black gay men; and securing community, agency, and other key stakeholder support. Also included are a stakeholder's checklist you can use to enlist support for implementing 3MV and a description of the resources (including a sample budget) and time necessary for successful implementation. The section ends with a table summarizing the steps necessary to complete activities that occur during 3MV's preimplementation, implementation, maintenance, and monitoring and evaluation (M&E) phases.
4. **Getting Started.** This section includes guidelines to plan for and implement 3MV and covers participant recruitment, screening, selection, and retention. It also has a brief discussion on adapting 3MV for different populations or implementing it as a retreat. Strategies for retaining staff, ensuring organizational support, and maintaining funding and resources are included.

Monitoring and Evaluation

The M&E section gives an overview of what M&E is and why it is important. The section also reviews the different types of M&E activities you can conduct, reviews ways in which M&E data can be used for quality assurance purposes, and describes key activities for developing an M&E plan. Tools for conducting M&E activities include a participant screening form, session logs, a fidelity assessment form, facilitator observation and feedback forms, a participant satisfaction questionnaire, and pre- and post- knowledge, attitudes, and behaviors (KAB) surveys.

Tools and Materials

This section of the manual includes M&E planning and data collection tools, guidance for conducting a 3MV retreat and a 3MV efficacy trial research article. Also included are an implementation summary describing the key inputs needed, activities conducted, and outputs generated as a result of implementing 3MV; a behavior change logic model; a sample confidentiality agreement; and a sample 3MV implementation planning tool. This section of the manual also contains marketing and recruitment materials, including a brochure, recruitment cards, and a sample poster. The last two tabs provide a list of references cited in the manual and CDC support materials.

Preimplementation

PREIMPLEMENTATION: BACKGROUND AND PROGRAM GUIDELINES

INTRODUCTION: ABOUT MANY MEN, MANY VOICES

What Is 3MV?

Many Men, Many Voices (3MV) is a seven-session, group-level behavioral intervention that attempts to reduce HIV and sexually transmitted disease (STD) risk behaviors and increase related health-promotion behaviors among black men who have sex with men (MSM). Through a series of facilitator-led discussions, exercises, and presentations, participants learn about factors that may influence their behavior and put them at risk. The factors include challenges related to dual identity as black gay men; the effects of racism and homophobia; cultural and religious norms; lack of familial support and acceptance for same-sex behaviors; the roles and risks related to Tops, Bottoms, and Versatiles; and the interactions between STDs and HIV. Participants also learn about STD/HIV prevention and harm reduction options and discuss their intentions and motivations to try an option. The dynamics of power and control in sexual relationships are discussed, as well as partner communication and negotiation. Participants also practice behavioral skills related to partner communication and condom negotiation. Please see p. 7 for more information about 3MV's goal and objectives.

Who Is 3MV For?

Many Men, Many Voices is an intervention for black MSM. The intervention is appropriate for men who identify as gay, same-gender-loving, bisexual, queer, and so forth, as well as for MSM who do not identify with any of these terms or labels. The intervention is not appropriate for other 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. Although the intervention was designed for and is targeted to a broader range of MSM, the term black gay men is used throughout this manual, 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. MSM is a behavioral classification that may not be personally relevant to members of your community. Significant numbers of participants in your program may not identify as gay; therefore, you will have to make linguistic choices that best suit your programmatic needs.

In the context of 3MV, black refers the racial or 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]). Many Men, Many Voices 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.

Why Target Black Gay Men?

Black gay men account for a significant number of existing and new HIV infections and are the demographic group most disproportionately affected by the virus (Millett, Peterson, Wolitski, & Stall, 2006). From 2001 to 2004, black MSM accounted for 48% of all HIV infections diagnosed among black men (CDC, 2007). A 2008 CDC analysis of trends in HIV diagnoses among MSM in 33 States concluded that between 2001 and 2006, HIV was diagnosed in black MSM at twice the rate of their white MSM counterparts. The results of the analysis also showed a 93% increase in HIV diagnoses among black MSM aged 13 to 24 years (CDC, 2008). In one CDC study of MSM in five U.S. cities, 46% of black MSM study participants were infected with HIV. The results also showed that more than two-thirds of infected black MSM were unaware of their HIV status (CDC, 2005). A more recent report of the National HIV Behavioral Surveillance system's 2008 data from 21 cities stated that among the 8,153 MSM interviewed and tested, black MSM had the highest prevalence rate of HIV (28%). In addition, 59% of black MSM with HIV were not aware of their status (CDC, 2010).

African American communities are also experiencing higher rates of STDs than any other racial or ethnic group within the United States. In 2008, the rate of gonorrhea among African Americans was 20.2 times greater than among whites (CDC, 2009a). Research has also shown that black men have disproportionately higher rates of STDs such as chlamydia. According to a 2008 CDC STD surveillance report, the chlamydia rate among black men was almost 12 times as high as the rate among white men (CDC, 2009a). Infection with certain STDs significantly increases one's risk for HIV. Coinfection with HIV and certain STDs increases a person's chance of spreading HIV infection to sexual partners (CDC, 1998).

Black gay men are at risk for HIV infection due to HIV risk behaviors (e.g., engaging in unprotected anal intercourse) and lower levels of health-promotion behaviors (e.g., seeking treatment for STDs). Various social, cultural, and personal factors influence their behaviors (CDC, 2009b). Many black gay men struggle with a perceived negative self-image and low self-esteem, often as often a result of internalized racism and homophobia as well as other forms of discrimination and isolation. Men who experience homophobia develop varying levels of stress and distress and are more likely to report risky sex behaviors (Bridges, 2007). Many of these men also feel a sense of isolation from their communities, families, and religious organizations and do not have social support systems that help to promote positive self-concept, self-image, and self-esteem.

Many black gay men lack knowledge of STDs, HIV, and their interactions (Sexuality Information and Education Council of the United States, 2001). They may also feel uncomfortable accessing health care services as a result of social, cultural, and personal factors.

Because rates of STDs are disproportionately high among black gay men and STDs are known to facilitate HIV transmission, health-promotion behaviors such as accessing STD testing and treatment and HIV testing are important prevention goals. However, there is little information about the health-promotion behaviors of black gay men. One study (Malebranche, Peterson, Fullilove, & Stackhouse, 2004) examined the health care experiences of black MSM in New York City and Atlanta, GA. The results of the study suggested that social determinants such as race and sexual discrimination influenced whether or not black MSM sought health care. The authors of the study also suggested that barriers to seeking health care, such as HIV testing, were affected by internalized, negative perceptions of the medical establishment based on past experiences when seeking care and communicating with providers (Malebranche et al., 2004). In an analysis by Bernstein et al. (2008) of MSM in New York City, 39% did not disclose their MSM status to their medical provider, and black MSM were much less likely to disclose than white MSM (60% and 19%, respectively).

Despite the existence of numerous interventions focused on HIV prevention, there are few evidence-based interventions (EBIs) developed by or for black gay men that address both STD and HIV risk behaviors and related health-promotion behaviors. There is a critical need for more HIV prevention interventions that specifically address the needs of black gay men. In the United States, reductions in HIV incidence and prevalence rates among black gay men will require a combination of prevention strategies, including the promotion and adoption of culturally specific EBIs tailored to their needs (National AIDS Treatment Advocacy Project, 2009). Many Men, Many Voices was developed with and for black gay men and designed to help address their unique prevention needs. It is currently one of two evidence-based HIV prevention interventions disseminated by CDC specifically designed for black gay men.

Intervention Overview

Goal and Objectives of 3MV

The goal of 3MV is to promote changes that reduce HIV and STD risk and encourage health-promotion behaviors among black gay men. The intervention focuses on helping participants to better understand the social and behavioral determinants (i.e., influencing factors) that put black gay men at increased risk for HIV and other STDs.

The primary objectives of the intervention are to positively influence or increase participants'

- ▶ identity, values, and self-standards as black gay men;
- ▶ perception of personal susceptibility to HIV and STDs;
- ▶ knowledge of STDs and the interrelationships between STDs and HIV;
- ▶ knowledge of risk-reduction and health-promotion behaviors;
- ▶ intentions to reduce their risk and adopt health-promotion behaviors;

- ▶ skills and self-efficacy (i.e., belief about their ability and capacity to engage in a certain behavior) related to consistent condom use, condom negotiation, and partner communication;
- ▶ STD and HIV testing behaviors;
- ▶ consistent condom use.

Intervention Structure and Format

Many Men, Many Voices is a seven-session intervention conducted over a 7-week period. It can also be delivered in a weekend-retreat format (see the Retreat Guidance tab for information about implementing 3MV as a retreat). Regardless of the format used, it is important that 3MV be delivered in a setting that is private, accepted, and considered safe. All 3MV sessions are designed to be delivered by two culturally competent facilitators, one of whom needs to be a member of the target population (i.e., a black gay man). It is recommended that 6 to 12 participants be included in each session. Each session takes 2 to 3.5 hours to complete and is delivered using an interactive, participatory format (i.e., the use of role-play, group exercises and activities, facilitated discussions, and behavioral skills practice). Facilitators guide participants through discussions, exercises, and activities, which are processed using discussion questions and prompts to help participants better understand the information and how it applies to their unique circumstances. Participants are encouraged to share personal experiences, attitudes and beliefs, and emotions. The 3MV intervention curriculum is designed so each session builds upon the discussion and exercises of prior sessions.

Intervention Phases

Many Men, Many Voices is implemented in four phases:

- ▶ **Preparation.** During this initial phase, you will determine whether your agency has the ability and resources to implement 3MV. Next, you will develop detailed plans to implement and evaluate your 3MV program. During this phase, you will identify an appropriate venue or venues for conducting sessions; recruit and train staff to implement 3MV; secure necessary materials and equipment; and identify, recruit, and screen participants.
- ▶ **Implementation and Facilitation.** This phase consists primarily of delivering intervention sessions using either the weekly or weekend-retreat format. You will also collect data on how the facilitators delivered 3MV sessions; participants' satisfaction with the 3MV sessions; and changes in their knowledge, attitudes, and behaviors.
- ▶ **Maintenance.** Primary activities during this phase include monitoring participants during the course of the seven sessions and during any postintervention follow-up activities. While they are not required, if you conduct any postintervention activities it may be helpful to follow up with intervention participants on their progress toward accomplishing

their long-term goals regarding HIV and STD prevention. You may also want to check in with participants on their progress in linking with a supportive network of black gay men locally. During this phase, it may also be useful to seek assistance from intervention participants to recruit new, prospective participants for future intervention cycles.

- ▶ **Monitoring and Evaluation.** M&E activities are implemented before, during, and after your implementation of 3MV. These activities will help you to track and manage your intervention implementation and will provide information that can help you to improve current and future 3MV implementation activities.

Contents of the 3MV Package

The 3MV package contains the following materials to support your agency's implementation of the intervention:

- ▶ **3MV Implementation Manual and 3MV CD-ROM.** The CD-ROM includes printable copies of the intervention materials. It also contains copies of all handouts, slides, and a video titled *The Party* that are used in the sessions; tools for intervention planning, implementation, and monitoring; and marketing materials, including posters and flyers.
- ▶ **3MV Facilitator's Guide.** The Facilitator's Guide provides information on how to conduct each 3MV session. The guide includes descriptions of each session's purpose and objectives, facilitator tips, brief overviews of each session (session-at-a-glance), lists of session materials needed to facilitate each session, and detailed outlines of talking points facilitators can use to help guide session activities.
- ▶ **3MV Marketing and Recruitment Materials.** Included in the package are sample marketing and recruitment posters, cards, and flyers. Agencies can use these materials to recruit participants. Health departments and other funders can use them to market 3MV to agencies working with black gay men.

Benefits of Implementing 3MV

Benefits to Participants

Black gay men who participate in 3MV may assume a more active role in reducing their personal risk for HIV and STDs and engaging in health-promotion behaviors. Specifically, 3MV participants may be more inclined to get tested and screened for HIV and STDs, use condoms consistently during insertive or receptive anal intercourse, and reduce the number of male sex partners. The practice of such behaviors will reduce their risk for HIV and STDs.

As mentioned earlier, black gay men often experience a greater sense of isolation from their families and communities as a result of discrimination and therefore may lack social support. Many Men, Many Voices creates an environment in which participants can form supportive relationships with other black gay men who are also working to change their HIV and STD risk behaviors. The peer-based support networks formed by 3MV participants may continue even after the intervention is over and can help to reduce the sense of isolation many black gay men often feel. This ongoing social support can help to maintain behavior change over time. The small, group-level intervention format also allows experienced peer facilitators to share their experiences and provide support to other black gay men who deal with similar issues about HIV and STD risk behavior. The peer facilitators are often seen as role models, which can help participants maintain their own safe behaviors.

Benefits to the Community

Black gay men who participate in 3MV and eventually take steps to reduce their personal risk behaviors will hopefully translate into reduced HIV and STD incidence and prevalence among members of the population at large. Implementation of 3MV can also help to raise awareness about the importance of STD and HIV prevention, testing, and treatment among black gay men beyond those who participate in the intervention (i.e., partners and friends).

Benefits to Your Agency

Many Men, Many Voices provides your agency with multiple opportunities to build positive relationships with black gay men and increases support for your agency among their communities. Successful implementation of 3MV enhances your agency's reputation among black gay men and opens the door for additional prevention activities with that population.

BACKGROUND

History of 3MV's Development

Initial Development

Many Men, Many Voices was developed by the Center for Health & Behavioral Training (CHBT) at the University of Rochester in partnership with the Men of Color Health Awareness Project (MOCHA) and People of Color in Crisis (POCC), which are community-based organizations (CBOs) serving the HIV and STD prevention needs of black gay men in New York. Gary English, Executive Director of MOCHA and later POCC, and Patricia Coury-Doniger, Director of CHBT, were the codevelopers of 3MV. The CHBT provides STD and HIV prevention services for the Monroe County Department of Public Health in Rochester, NY, and provides training in evidence-based behavioral interventions. In 1998, in recognition of the need for more culturally specific HIV prevention interventions for black gay men, Mr. English, then Executive Director of MOCHA in Rochester, requested technical assistance from CHBT in developing a group-level HIV prevention behavioral intervention that would be culturally appropriate for black gay men. He emphasized the need for black gay men to feel safe to talk about their personal circumstances and behaviors in an interactive format using group exercises, activities, and discussion (Coury-Doniger, English, Jenersen, McGrath, & Scahill, 1998).

To inform the development of the new intervention curriculum, members of CHBT and MOCHA met regularly to identify the unique prevention needs of black gay men. During these meetings, they also discussed how to incorporate lessons learned and best practices based on the experiences of MOCHA staff who work within communities of black gay men (e.g., effective outreach, participant recruitment, and retention strategies). CHBT and MOCHA also conducted a needs assessment to identify key factors that influence HIV and STD risk behaviors of black gay men. In addition to the assessment, CHBT reviewed literature on evidence-based HIV prevention interventions for black gay men; conducted an analysis of current epidemiological data; and conducted focus groups and interviews with black gay men (Coury-Doniger et al., 1998).

CHBT identified and reviewed three HIV/AIDS intervention curricula developed for MSM that had demonstrated positive outcomes. Two of the three interventions reviewed were tested in samples where the majority of participants were white gay men, whereas one was specifically developed for black gay men. Table 1 provides a summary of these interventions.

Table 1. Summary of Three Intervention Models for Men Who Have Sex With Men

Researcher	Kelly	Kegeles	Peterson
Name of Intervention	Behavioral Self-Management and Assertion Skills	Mpowerment	African-American Men's Health Study
Year Published	1989	1996	1996
Research Center	Center for AIDS Intervention Research (CAIR)	Center for AIDS Prevention Studies (CAPS)	Center for AIDS Prevention Studies (CAPS)
Theory	Social cognitive theory	Social cognitive theory; empowerment theory	Social cognitive theory
Model	Behavioral skills acquisition model	Multisystem, multilevel community mobilization and empowerment	AIDS risk reduction model
Essential Elements	<ul style="list-style-type: none"> • HIV risk education and sensitization • Risk reduction strategies • Behavioral skills • Sexual assertiveness • Social support and relapse prevention 	<ul style="list-style-type: none"> • AIDS risk education • Cognitive behavioral skills • Assertiveness skills • Self-identity • Social support • Empowerment 	<ul style="list-style-type: none"> • AIDS risk education • Behavioral skills and commitment • Assertiveness • Self-identity • Social support
Length of Intervention	12 weekly sessions, 75 to 90 minutes each	Ongoing	1 to 3 sessions, 3 hours each
Intervention Curriculum	Yes, available on CAIR Web site, now called <i>Partners in PREVENTION</i> , and condensed to six sessions http://www.mcw.edu/display/docid6269/PartnersinPrevention.htm	Yes, available from CDC via the DEBI program Web site www.effectiveinterventions.org	Yes
Published in CDC's Compendium?	Yes	Yes	No

Several components common to all three intervention models were identified and seen as essential for the development of a culturally specific HIV/STD intervention targeting black gay men—HIV risk education and sensitization, behavioral skills training, sexual assertiveness training, and social support. However, components of the behavioral skills acquisition model (Kelly, St. Lawrence, Hood, & Brasfield, 1989) and the AIDS risk reduction model (Peterson et al., 1996) were initially selected to serve as the framework for this new intervention model because Kelly's intervention had been shown to be effective for MSM and Peterson's addressed some of the factors unique to black gay men (Wilton et al., 2009). It was also believed that a culturally specific HIV intervention targeting black gay men would need to focus on STD risk education and sensitization because black men experience disproportionately higher rates of STDs, which have been shown to facilitate HIV

transmission. In addition, the intervention would need to integrate content that addresses the social and behavioral determinants that put black gay men at risk (e.g., racism; homophobia; dual identity as black gay men; familial, community, and religious norms; and isolation and lack of social support for behavior change). To assess the social and behavioral determinants that put black gay men at risk for HIV and STDs, CHBT used focus groups and interviews with key informants from MOCHA and local communities of black gay men to determine the cultural relevance of the Behavioral Self-Management and Assertion Skills and Mpowerment interventions (Coury-Doniger et al., 1998; Peterson et al., 1996).

On the basis of findings from the literature reviews, epidemiological analysis, interviews, and focus groups, CHBT and MOCHA began development of the 3MV intervention curriculum. Elements of the behavioral skills acquisition model that would serve as the framework for 3MV were tailored to address black gay men and STD risk; the interrelationships between STDs and HIV; family, cultural, and religious norms within black communities; social factors that affect black gay men, such as racism and homophobia; and sexual relationship dynamics specific to black gay men. In addition, the developers of 3MV integrated into the curriculum content that addressed the role of dual identity as black gay men; issues about the self-concept (i.e., self-image, self-esteem, and self-standards) of black gay men and HIV and STD risk behavior; STD treatment as an important HIV prevention strategy; and partner communication and negotiation within the context of sexual-relationship dynamics between black gay men (Coury-Doniger et al., 1998).

The intervention curriculum was written in 1998 and named Many Men, Many Voices (3MV). In early 1998, CHBT staff, with assistance from MOCHA staff, pretested each intervention session. After pretesting, CHBT staff facilitated debriefing meetings with the participants and MOCHA staff members to identify areas for revision. CHBT trained MOCHA staff as 3MV facilitators and piloted the complete intervention to get feedback for additional revisions. Final revisions to the initial intervention curriculum were completed in March 1998, and the first training of 3MV was conducted by CHBT for MOCHA peers during summer 1998. In 1999, under the direction of Mr. English, then Executive Director of POCC in Brooklyn, NY, MOCHA began implementing 3MV on a quarterly basis with approximately 20 participants per intervention cycle. Subsequently, the New York State Black Gay Network endorsed the 3MV intervention model and provided training and technical assistance to member CBOs to encourage the use of 3MV among the network's 10 affiliate organizations. It was diffused to other CBOs that serve black gay men in the United States (Coury-Doniger et al., 1998).

Efficacy Trial

From August 2005 through November 2006, a CDC-supported outcome evaluation study was conducted to assess the efficacy of the 3MV intervention. Facilitators at POCC delivered the intervention in the weekend-retreat format to 164 black gay men (174 were assigned to a wait-list comparison group).

The results of the study showed 3MV to be efficacious in reducing the HIV and STD risk behaviors of black gay men. Intervention participants reported a significant reduction in the frequency of unprotected anal intercourse with casual male partners, a positive trend in

using condoms consistently during receptive anal intercourse with causal partners, a significant reduction in the number of male sex partners, and a significant increase in HIV testing. For more about the 3MV efficacy trial, please review the research article found in the 3MV Information tab.

During the review conducted by CDC's Prevention Research Synthesis (PRS) project, 3MV was determined to meet criteria for a best-evidence intervention and was repackaged for further national diffusion. Many Men, Many Voices is the only integrated STD/HIV prevention intervention with proven efficacy for black gay men in the United States.

Postefficacy Trial Revision to Intervention Materials

As part of the postefficacy trial activities, ICF Macro, an ICF International Company, was contracted by CDC to repackage the existing 3MV materials to enhance CBOs' and health departments' understanding of the intervention's principles, intent, structure, and content. As a part of this effort, ICF Macro collaborated with the 3MV codevelopers (Ms. Coury-Doniger of CHBT and Mr. English), CDC, and other expert consultants to develop a new, comprehensive set of intervention and training materials in a user-friendly format that is clear, culturally competent, and visually appealing. The repackaged materials, while maintaining a consistent and familiar design, provide more detailed content, guidance, and instruction. Specific revisions to the intervention materials include the development or redesign of the following:

- ▶ An Implementation Manual that refines and augments the current 3MV Intervention Manual and provides program guidelines and other information to help agencies prepare, deliver, monitor, and evaluate their implementation of 3MV.
- ▶ A Facilitator's Guide that provides facilitators with the instructions necessary to deliver 3MV's sessions.
- ▶ Culturally appropriate session exercises and group activities (e.g., culturally appropriate group activities that can be used as an alternative to the current intervention video, *The Party*).
- ▶ A 3MV Starter Kit that will help to determine whether 3MV is the right fit for their agencies, target populations, and prevention goals. The Starter Kit also helps agencies to identify the steps to build their capacity for implementing 3MV.
- ▶ A 3MV Training of Facilitators (TOF) curriculum designed to build the knowledge and skills of facilitators to conduct 3MV intervention sessions. This curriculum incorporates adult learning principles and uses a mix of lectures, role-plays, demonstrations, games, icebreakers, and participant teach-back activities, as well as individual and group learning approaches.
- ▶ Updated 3MV intervention support materials (e.g., marketing and recruitment posters and flyers).

How Does 3MV Work?

Theoretical Foundation

The 3MV intervention is based on and supported by three behavioral change theories and models:

- ▶ Social cognitive theory
- ▶ Behavioral skills acquisition model for risk reduction counseling
- ▶ Transtheoretical model of health behavior change and stages of change

SOCIAL COGNITIVE THEORY

Social cognitive theory suggests that human behavior is mostly influenced by a person's environment, how the person thinks (i.e., cognitive processes), the behaviors he observes, and what he believes will be the expected outcomes. According to social cognitive theory, how an individual thinks is affected by his perceptions of reality and values, which are based on information received from the person's environment. These thought processes lead to a set of behaviors based on the individual's expectations of perceived outcomes. Social cognitive theory suggests that, through feedback and observation of anticipated outcomes, an individual's behavior can be better understood, predicted, and changed (Stone, 1998).

BEHAVIORAL SKILLS ACQUISITION MODEL FOR RISK REDUCTION COUNSELING

According to Kelly's (1995) behavior skills acquisition model for risk reduction counseling, several factors challenge HIV counseling for risk reduction. These factors include use of established, effective principles of behavior change to address risk activities associated with HIV infection; the cultural context in which risk-reduction efforts occur; and HIV risk-reduction efforts targeted to individuals who may not seek out behavior-change assistance. The model suggests that there are critical elements to HIV risk behavior change that must be addressed to overcome these challenges. These include a counselor who

- ▶ assesses a person's knowledge of risk behaviors and risk-reduction strategies appropriately;
- ▶ ensures that an individual accurately appraises his personal degree of risk;
- ▶ helps an individual build confidence in his ability to reduce his risk for HIV infection;
- ▶ ensures an individual makes a commitment to change and has the intention to change his behavior;
- ▶ ensures an individual acquires the necessary technical, interpersonal, or self-management skills for behavior change to occur;
- ▶ helps an individual develop strategies to reinforce his own change efforts;

- ▶ incorporates specific counselor characteristics and attitudes such as
 - showing regard for the person being counseled
 - being comfortable with discussing sex and drug use
 - forming an advocacy alliance with a person
 - applying reinforcement through praise, encouragement, commendation, and show of enthusiastic support
 - using active listening skills

TRANSTHEORETICAL MODEL OF HEALTH BEHAVIOR CHANGE AND STAGES OF CHANGE

Unlike many other health-promotion models, which address social or biological factors that influence behavior, the transtheoretical model (TTM) is considered an integrative model of behavior change; that is, it focuses on emotional, cognitive, and behavioral factors that influence an individual's decision to change behavior. Stages of change, a concept central to the TTM, suggests that a person moves through a series of five stages when changing behaviors: precontemplation, contemplation, preparation, action, and maintenance (Velicer, Prochaska, Fava, Norman, & Redding, 1998). This model also identifies processes of change that can help a person move from one stage to another.

Decisional balance, another behavior-change construct integrated into 3MV, suggests that cognitive and motivational factors influence a person's perceptions about making decisions. Decisional balance assumes that behavior change occurs when an individual perceives change as a gain rather than a loss. The balance between the pros and cons will depend on the stage of change in which an individual currently finds himself (Janis & Mann, 1977). In one 3MV exercise, participants assess the potential gains, or pros, of a particular behavior against the potential losses, or cons, of that behavior.

3MV Core Elements and Key Characteristics

Core Elements

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 they 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:

- ▶ Enhance self-esteem related to racial identity and sexual behavior
- ▶ Educate clients about HIV risk and sensitize to personal risk
- ▶ Educate clients about interactions between HIV and other sexually transmitted diseases and sensitize to personal risk
- ▶ Develop risk-reduction strategies
- ▶ Build a menu of behavioral options for HIV and sexually transmitted diseases and risk reduction, including those that one can act on individually and those that require partner involvement
- ▶ Train in risk-reduction behavioral skills
- ▶ Enhance self-efficacy related to behavioral skills
- ▶ Train in partner communication and negotiation
- ▶ Provide social support and relapse prevention

Key Characteristics

Key characteristics are those parts of an intervention (i.e., activities and delivery methods) that can be adapted to meet the needs of the implementing agency, the target population, or both.

3MV has the following key characteristics:

- ▶ Foster positive identity development and self-esteem for black MSM by
 - exploring the dual identity culture of black MSM
 - addressing social influences and family, religious, and cultural norms within the black community
 - exploring the concept of internalized racism and homophobia
- ▶ Discuss sexual relationship roles and risks, addressing knowledge of interactions between HIV and other STDs and transmission risk, and exploring beliefs about those risks
- ▶ Address perceived personal risk and personal susceptibility for infection with HIV and other STDs as well as perceived barriers to remaining HIV-negative

- ▶ Increase skills, self-efficacy, and intentions with regard to protective behaviors
- ▶ Explore the dynamics of sexual relationships, including the dynamics of power and the concept of Tops and Bottoms for black MSM
- ▶ Address the importance of peer support and social influence on maintaining healthy behaviors

In the context of the 3MV intervention, behavioral determinants are factors that influence behavior as described in behavioral theories. In 3MV, risk factors are other behaviors or circumstances that can increase the chances that an HIV risk behavior or an HIV transmission will occur. Social determinants are external factors that can affect peoples' behaviors through their connection (or lack thereof) with their friends, families, communities, and other social networks. Targeted outcomes are the determinants and behaviors 3MV attempts to change. The behavioral determinants, social determinants, risk factors, and targeted outcomes addressed in 3MV follow.

Behavioral Determinants

- ▶ Knowledge of HIV, STDs, and their interrelations
- ▶ Perceived risk of HIV and STD infection
- ▶ Perceived severity of STDs and HIV
- ▶ Personal attitudes and beliefs
- ▶ Perceived self-concept (global, overarching view of the self)
- ▶ Perceived self-image
- ▶ Level of self-esteem
- ▶ Social support for behavior change
- ▶ Identity, values, and self-standards related to internalized racism and homophobia
- ▶ Intention to adopt HIV and STD prevention options
- ▶ Self-efficacy related to behavioral skills
- ▶ Perceived social norms

Social Determinants

- ▶ Cultural, social, and religious norms
- ▶ Degree of connectedness of black gay men to both black and gay communities
- ▶ Sexual relationship dynamics

Risk Factors

- ▶ High rates of STDs
- ▶ HIV/STD interrelations
- ▶ Low levels of health-promotion behaviors

Targeted Outcomes

Immediate

- ▶ Increased knowledge of STD/HIV interrelations
- ▶ Increased perceived risk of HIV/AIDS and other STDs
- ▶ Increased intentions for condom use and partner negotiation
- ▶ Increased skills related to condom use and partner negotiation
- ▶ Increased self-efficacy for condom use and partner negotiation

Intermediate

- ▶ Increased number of participants who engage in protected (i.e., condoms used consistently) insertive and receptive anal sex with their main male partner
- ▶ Increased number of participants who engage in protected (i.e., condoms used consistently) insertive and receptive anal sex with casual male partners
- ▶ Increased number of participants who engage in protected vaginal and anal intercourse (i.e., condoms used consistently) with women
- ▶ Increased number of participants within a mutually monogamous relationship who get tested or screened for HIV and STDs with their partners, and share their results

- ▶ Increased number of participants who get tested for HIV
- ▶ Increased number of participants who get tested and treated for STDs
- ▶ Reduced number of sexual partners among participants

Long-Term

- ▶ Reduced HIV and STD incidence and prevalence among black gay men

Intervention Models

There are several tools to help agencies better understand how the 3MV intervention is implemented. These include a program implementation summary and a behavior change logic model. The program implementation summary (3MV Information tab) describes the key inputs needed, activities conducted, and outputs generated as a result of implementing a 3MV program in a given agency. The behavior change logic model (3MV Information tab) identifies the root of the problem addressed by the intervention and illustrates the relations among behavioral determinants, the intervention's activities, and the anticipated behavioral outcomes. The logic model provides a graphic representation of how 3MV works.

Is 3MV RIGHT FOR YOUR AGENCY?

Before you decide to implement 3MV, you should determine whether 3MV is right for your agency and the target populations it serves. This section will help you think through the structures, processes, and resources needed to successfully implement 3MV activities. Table 2 is a checklist of questions you need to consider before deciding whether you should implement 3MV. This checklist will guide your decisions by stimulating thought and dialogue. If you answer "No" to any of the questions, it will be important to address those areas (e.g., seek additional technical assistance to help build your agency's capacity) before moving forward with implementation.

Table 2. Checklist of Intervention Appropriateness

Question	Yes	No
Has your agency conducted a community assessment and used the results to identify HIV risk factors (e.g., behavioral determinants) of a population of black gay men your agency intends to target with 3MV?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency intend to target black men, both gay- and non-gay-identified, who have sexual or emotional attractions to other men?	<input type="checkbox"/>	<input type="checkbox"/>
Has your agency obtained and reviewed the 3MV intervention materials?	<input type="checkbox"/>	<input type="checkbox"/>
Does 3MV match the HIV prevention needs of the black gay men your agency intends to target?	<input type="checkbox"/>	<input type="checkbox"/>
Are the 3MV intervention materials' content, exercises, and activities appropriate for your agency's norms and values?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have the capacity to identify and recruit black gay men for your 3MV program?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have the capacity and resources (staff, funds, and materials) to conduct 3MV preimplementation, implementation, maintenance, and M&E activities?	<input type="checkbox"/>	<input type="checkbox"/>
Can your agency send two facilitators to the 3MV Training of Facilitators (TOF) course?	<input type="checkbox"/>	<input type="checkbox"/>

Is 3MV's Goal Consistent With Your Agency's Mission?

It will be important to determine whether the goal of 3MV (i.e., to promote changes in risk reduction and health-promotion behaviors among black gay men) complements your agency's overall programmatic focus and intent. This will help to ensure continuity of services your agency delivers, efficient use of agency resources, and more-effective management of your programmatic and administrative activities.

Are There Existing HIV Prevention Interventions for Black Gay Men in Your Area?

You should determine whether 3MV would fill an unmet need and not duplicate or compete with other HIV prevention interventions. If HIV interventions for black gay men, especially group-level interventions, are already available in your area, you may have some difficulty recruiting enough participants. However, 3MV can complement and support other prevention interventions.

Do You Have Access to the Target Population?

Many Men, Many Voices was designed to reach black gay- and non-gay-identified men who have sexual or emotional attractions to other men. It will be important to ensure that recruitment for 3MV does not include other MSM who do not have sexual or emotional attractions to other men, such as inmates who have situational sex and men who trade sex for money or drugs, because these are inappropriate populations for this intervention. It will also be important to ensure black gay men recruited are available to participate in your agency's 3MV session activities, whether sessions are carried out over the course of 7 weeks or in the weekend-retreat format.

Is There Support for 3MV Implementation?

Community Support

If there are communities of black gay men in your area, you will want their members to have a vested interest in the intervention's success. If there is no defined community, you will need to assess interest and support for 3MV within local networks of black gay men.

Agency Support

If you decide that you want to implement 3MV, it is crucial to get the support of agency administrators and to have access to agency resources. The most effective way to obtain support is to identify at least one agency administrator or staff person to champion or advocate for 3MV's integration into the agency's existing services. A *champion* can be one person or a group of people and is typically a mid- to upper-level administrator who can serve as a link between an agency's leaders, administration, and staff members. The champion needs to be adept at answering questions and mediating changes in agency structure and can serve as a negotiator for any necessary tradeoffs or compromises. The champion becomes the intervention's spokesperson, anticipates the reservations of staff members, and answers questions about the intervention's resource needs. The champion must have a thorough knowledge of the intervention to field any questions or concerns.

Regardless of the number of champions, the main issue is to convince both internal and external stakeholders that implementation of 3MV will enhance the quality of your agency's services. In addition, it will be important to convince them that your agency will be capable of implementing 3MV. Stakeholders include your funders, your agency's board of directors or executive board, and all agency staff members who will have a role in the operation of the intervention.

Stakeholder's Checklist

Your agency's champion can use the example stakeholder's checklist in Table 3 to enlist support for implementing 3MV. The checklist lists the steps to take to convince stakeholders that 3MV is an intervention that your agency can and should implement.

Table 3. Stakeholder’s Checklist

Checklist Steps	
Step 1	Assess the community to determine whether its members (e.g., community leaders, black gay men who live and work in the target community, staff from local STD clinics and HIV/AIDS service organizations) will support 3MV.
Step 2	<p>Identify your stakeholders to determine whether they will support 3MV. Stakeholders may include the following. Check the box(es) next to the stakeholder(s) you plan to include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Board of directors or executive board <input type="checkbox"/> Staff members who have a role in implementing 3MV <ul style="list-style-type: none"> <input type="checkbox"/> Administrators who will give support <input type="checkbox"/> Supervisors who may oversee the implementation of 3MV <input type="checkbox"/> Staff who facilitate the delivery of the 3MV intervention <input type="checkbox"/> Staff who will interact with participants at any level <input type="checkbox"/> Other staff: _____ <input type="checkbox"/> Local agencies from which you could recruit participants, facilitators, or both <ul style="list-style-type: none"> <input type="checkbox"/> Agencies offering support groups for black gay men <input type="checkbox"/> Health care providers and mental health professionals serving black gay men <input type="checkbox"/> Social service agencies reaching black gay men <input type="checkbox"/> Organizations of black gay men and organizations that may have members who are black gay men <input type="checkbox"/> Other agencies: _____ <input type="checkbox"/> Organizations that could provide assistance or other resources <ul style="list-style-type: none"> <input type="checkbox"/> Merchants for incentives or refreshments <input type="checkbox"/> Agencies, merchants, printers, publishers, and others that can advertise the intervention <input type="checkbox"/> Businesses that can provide a venue for the intervention <input type="checkbox"/> Agencies that can provide transportation <input type="checkbox"/> Advisers to help adapt the intervention <input type="checkbox"/> Others: _____ <input type="checkbox"/> Agencies with which your agency needs to maintain good community or professional relations <ul style="list-style-type: none"> <input type="checkbox"/> Local health department <input type="checkbox"/> Local medical and mental health associations <input type="checkbox"/> Others: _____

Table 3. Stakeholder's Checklist (continued)

Checklist Steps	
Step 3	<p data-bbox="358 401 1008 432">Get stakeholders informed, supportive, and involved.</p> <ul style="list-style-type: none"> <li data-bbox="402 438 1386 506"><input type="checkbox"/> Inform stakeholders about 3MV. Decide in advance what specific roles you want each stakeholder to play (who you will ask to do each of the following): <li data-bbox="402 512 761 543"><input type="checkbox"/> Provide financial support <li data-bbox="402 550 784 581"><input type="checkbox"/> Identify other stakeholders <li data-bbox="402 588 1357 619"><input type="checkbox"/> Help to adapt the intervention for your target population of black gay men <li data-bbox="402 625 1411 657"><input type="checkbox"/> Identify and provide a venue where the intervention sessions can be delivered <li data-bbox="402 663 1032 695"><input type="checkbox"/> Help to identify participants for the intervention <li data-bbox="402 701 1321 732"><input type="checkbox"/> Supply refreshments for intervention participants during 3MV sessions <li data-bbox="402 739 1406 806"><input type="checkbox"/> Donate small incentives for participants (e.g., gift certificates or cards, coupons for discounts at local retail stores, complimentary train or bus cards) <li data-bbox="402 812 1174 844"><input type="checkbox"/> Speak supportively about 3MV in conversations with peers <li data-bbox="402 850 1378 993"><input type="checkbox"/> Send letters that tell stakeholders about 3MV and its importance; that your agency is (or will be) implementing the intervention; the specific role(s) that they might play in the implementation of the intervention; and a point of contact for learning more about 3MV <li data-bbox="402 999 1403 1121"><input type="checkbox"/> Call stakeholders in 2 weeks and assess their interest and, if they are interested, schedule a time to meet (e.g., one-on-one, lunch-and-learn at your agency with a group of other stakeholders, presentation at their agency for several of their staff or association members) <li data-bbox="402 1127 1321 1194"><input type="checkbox"/> Hold the meeting, show 3MV promotional materials or the intervention package if the setting and time allow, and answer questions <li data-bbox="358 1201 834 1232"><input type="checkbox"/> Get support from the stakeholders <li data-bbox="402 1239 1019 1270"><input type="checkbox"/> Describe several specific roles they could play <li data-bbox="402 1276 1403 1344"><input type="checkbox"/> Emphasize the benefits of their involvement to themselves, their agency, the community, and the community of black gay men, and answer their questions <li data-bbox="402 1350 1403 1493"><input type="checkbox"/> Invite them to commit to supporting 3MV by taking on one or more roles and keep track of their commitments (e.g., obtain formal letters of support, establish formal agreements such as a memorandum of understanding [MOU] between your agency and the respective stakeholder)

Table 3. Stakeholder's Checklist (continued)

Checklist Steps	
Step 3 (continued)	<input type="checkbox"/> Get stakeholders involved <ul style="list-style-type: none"> <input type="checkbox"/> Soon after meeting, send each a thank-you letter that specifies the role(s) to which they committed or, if they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later <input type="checkbox"/> Put persons who committed to roles that are important to preimplementation to work as soon as possible <input type="checkbox"/> Send persons who committed to involvement later in the process brief progress updates and an idea of when you will be calling on their support <input type="checkbox"/> Hold periodic celebratory meetings for supporters to acknowledge your appreciation for and the value of their contributions, update them on the intervention's progress, and keep them engaged

Does Your Agency Have the Resources to Implement 3MV?

To implement 3MV, you will need the following basic resources and supplies:

- ▶ Two or three project staff to identify and recruit black gay men eligible for the intervention (see section on staff recruitment and retention, p. 39).
- ▶ At least two culturally competent staff members to facilitate 3MV in either the 7-week session or weekend-retreat format. One facilitator must be a black gay man. Your agency can also consider contracting with external consultants to facilitate the sessions.
- ▶ Administrative or management staff to supervise, assess fidelity of the intervention sessions, and debrief the facilitators.
- ▶ Meeting space to implement the intervention:
 - large enough for 6 to 14 people and audiovisual equipment such as easels and laptops
 - safe with comfortable seating
 - easily accessible using public transportation and near where black gay men live, work, socialize, and feel safe attending (having the intervention at a place identified as a gay venue is not recommended because non-gay-identified participants may not feel comfortable attending there)
 - private and secure, so confidentiality can be maintained

- quiet and without interruptions (e.g., people entering and exiting the room or outside noise)
- clear and open space big enough to conduct the “Sex in the City” exercise
- ▶ Flyers, brochures, posters, and other marketing materials.
- ▶ DVD player, TV, laptop computer, and LCD projector.
- ▶ Incentives for participants (if needed).
- ▶ Intervention materials and handouts for participants.
- ▶ Refreshments for participants during sessions.
- ▶ Office equipment (e.g., telephones, computers, photocopier).
- ▶ Markers, newsprint, easels, masking tape, poster boards, clothespins, sticky notes, index cards, colored yarn, copy paper.

Sample Implementation Budget

To determine if your agency can afford or acquire the necessary funding to implement 3MV, you should draft a budget and itemize the required equipment, supplies, and personnel. Your agency can use the 3MV sample implementation budget (Table 4) to get a sense of what it might cost to implement 3MV. The sample implementation budget is based on delivering six interventional cycles (weekly format) over a 12-month period and assumes livable wages based on May 2010 estimates. If you already have some equipment and space, you may want to use them if they are available when needed. Otherwise, you should consider purchasing new equipment and securing free or low-cost meeting space.

This sample implementation budget will help you to estimate intervention-specific costs of implementing 3MV in your agency or community. However, you may want to include costs that may be covered by donations, volunteers, or in-kind contributions in case intervention-specific costs do not get covered. The rates included in the budget for fringe benefits for employees and agency overhead expenses vary by agency. If your rates are lower than those published, your costs for implementation may be significantly lower.

Table 4. 3MV Sample Implementation Budget (12-Month)**Budget Assumptions**

- Assumes a projection of six group cycles per year. Costs will vary by geographic location and agency's total budget size.
- The implementing agency will have available space that is sufficient to host group sessions for up to 20 people (e.g., a large meeting or conference room).
- Prevention managers will provide both oversight and, if needed, assistance with recruitment, retention, and intervention support.
- Facilitators should attend the CDC-supported 3MV Trainings of Facilitators.
- Salaries reflect estimates of appropriate and livable wages as of April 2010, but will vary on the basis of the local cost of living.
- This budget is based on weekly implementation of 3MV sessions. Implementation in the retreat format carries additional expenses.

Table 4. 3MV Sample Implementation Budget (12-Month) (continued)

Personnel	Annual Salary (\$)	FTE (%)	Amount (\$)
Executive Director	70,000	5	3,500
Prevention Manager	50,000	15	7,500
Project Coordinator or Group Facilitator	42,500	100	42,500
Group Facilitator or Intervention, Recruitment, and Retention Support	32,500	50	16,250
Total Salaries	TOTAL FTE	1.7	69,750
Fringe Benefit Rate = 25%			17,438
Total Personnel Costs			87,188
Other Direct Costs	Description	Number	Amount (\$)
Program Supplies	\$200 per month	12 months	2,400
Printing (intervention, recruitment, and retention materials)	\$400 per cycle	6	2,400
Furniture and Equipment			2,500
Travel (trainings, conferences, meetings)	\$1,200 per trip	3 trips	3,600
Travel (local mileage)			500
Travel (reimbursement for participant travel to group sessions)	\$420 per cycle	6	2,520
Conference Fees	\$400 per conference	2 registrations	800
Incentives for Participants	\$1,000 per cycle	6	6,000
Postage	\$50 per month	12 months	600
Computer, Computing, and Network Expenses for 1.7 FTE	\$300 per month	12 months	3,600
Telephone for 1.7 FTE	\$100 per month	12 months	1,200
Rent and Utilities for 1.7 FTE	\$850 per month	12 months	10,200
Total Other Direct Costs			36,320
Total Personnel + Other Direct Costs			123,508
Overhead (15% of Personnel + Other Direct Costs)			18,526
Total Budget			142,034

Does Your Agency Have the Time to Implement 3MV?

The time it will take to implement 3MV will depend on the number of participants you want to reach. For example, if you target 75 black gay men within a 12-month period, you will need to implement at least six cycles of the intervention (using the seven-session weekly format). Table 5 summarizes the major activities for each phase of 3MV. Use this as a guide to determine if you have the time to implement 3MV. Please note that some of these activities will occur simultaneously and that some of the preimplementation activities may occur before receiving funding for 3MV.

Table 5. Summary of 3MV's Major Activities

Activity	Person(s) Responsible	Timeline
Preimplementation		
Obtain 3MV intervention kit and become familiar with all its materials	Program staff	6 to 9 months before implementation
Identify and gain access to a population of black MSM to target	Program staff	6 to 9 months before implementation
Determine whether 3MV meets the HIV prevention needs of that target population	Program staff	6 to 9 months before implementation
Assess the applicability and feasibility of implementing 3MV (i.e., agency capacity) <ul style="list-style-type: none"> Determine the number of black gay men you can target and how many cycles of the 3MV intervention you can implement with available resources Assess available resources and probable costs and develop a proposed budget Assess the need to adapt materials and activities from 3MV 	Administrative, management, and program staff	6 to 9 months before implementation
Enlist community support and involvement from gatekeepers <ul style="list-style-type: none"> Begin developing key community relationships Market the intervention to key stakeholders 	Administrative, management, and program staff	6 to 9 months before implementation
Develop job and role descriptions for the 3MV program positions	Administrative and management staff	3 to 6 months before implementation
Identify, recruit, and hire 3MV program staff	Administrative and management staff	3 to 6 months before implementation
Adapt 3MV intervention materials and activities, if needed	Program staff	3 to 6 months before implementation

Table 5. Summary of 3MV's Major Activities (continued)

Activity	Person(s) Responsible	Timeline
Preimplementation		
Develop necessary program policies and procedures	Administrative and management staff	3 to 6 months before implementation
Develop 3MV implementation plans <ul style="list-style-type: none"> Develop participant recruitment plans and procedures Develop a retention plan and procedures Develop a support and maintenance plan 	Program staff	3 to 6 months before implementation
Develop 3MV M&E plans	Program staff	3 to 6 months before implementation
Identify staff training needs to prepare for intervention delivery	Administrative and management staff	3 to 6 months before implementation
Ensure facilitators are trained and have practiced delivery of intervention sessions	Administrative coordinator and intervention facilitators	3 to 6 months before implementation
Ensure staff are trained in other relevant 3MV program-related responsibilities (e.g., documentation, reporting)	Administrative and management staff	3 to 6 months before implementation
Develop brochures, posters, flyers, and other marketing materials	Program staff	1 to 3 months before implementation
Recruit and screen potential intervention participants	Program staff	1 to 3 months before implementation
Plan and prepare the logistics of the 3MV group sessions <ul style="list-style-type: none"> Determine size of 3MV groups and the number of facilitators needed 	Program staff	1 to 3 months before implementation
<ul style="list-style-type: none"> Secure space to conduct 3MV sessions Set dates for the 3MV intervention cycle to begin 		
Have facilitators practice facilitating 3MV with mock participants	Program staff	1 to 3 months before implementation
Plan retention activities <ul style="list-style-type: none"> Consider program incentives at each session Plan to have facilitators make individual phone calls to each participant midweek between sessions Plan for refreshments 	Program staff	1 to 3 months before implementation

Table 5. Summary of 3MV's Major Activities (continued)

Activity	Person(s) Responsible	Timeline
Preimplementation		
Schedule 3MV series for program implementation period (e.g., funding cycle, calendar year)	Program staff	1 to 3 months before implementation
Develop a plan and schedule for intervention sessions	Program staff	1 to 3 months before implementation
Implementation		
Conduct 3MV intervention sessions	Intervention facilitators	After completion of preimplementation phase (ongoing throughout program implementation period)
Maintenance		
Continue identification of new participants for subsequent intervention cycles (if applicable)	Program staff	After completion of the first intervention cycle of 3MV (ongoing throughout program implementation period)
Continue ongoing retention, follow-up, and support activities	Program staff	After completion of the first intervention cycle of 3MV (ongoing throughout program implementation period)
Meet with each facilitator to provide assessments of facilitator's skills and feedback on intervention delivery (debriefing)	Administrative and management staff	After completion of the first intervention cycle of 3MV (ongoing throughout program implementation period)
Coordinate additional training and technical assistance to improve intervention delivery, if needed	Administrative and management staff	After completion of the first intervention cycle of 3MV (ongoing throughout program implementation period)

Table 5. Summary of 3MV's Major Activities (continued)

Activity	Person(s) Responsible	Timeline
Maintenance		
Continue to provide trainings for facilitators to update their knowledge in STD and HIV prevention	Administrative and management staff	After completion of the first intervention cycle of 3MV (ongoing throughout program implementation period)
Train other agency staff as 3MV facilitators to ensure agency capacity even with staff turnover	Administrative and management staff	After completion of the first intervention cycle of 3MV (ongoing throughout program implementation period)
Monitoring and Evaluation		
Conduct process M&E; collect data <ul style="list-style-type: none"> • Monitor intervention participants and session activities • Monitor intervention objectives 	Program staff	During preimplementation, implementation, and maintenance phases
Conduct quality assurance assessment of intervention sessions; collect data <ul style="list-style-type: none"> • Assess adherence to core elements and key characteristics 	Administrative coordinator	After the completion of every intervention cycle
If resources allow, conduct outcome monitoring of 3MV; collect data <ul style="list-style-type: none"> • Assess changes in outcomes 	Program staff	At least 6 to 9 months after several intervention cycles of 3MV have been completed
Analyze collected data	Program staff	Quarterly
Review M&E data and identify intervention areas and activities for improvement	Program staff	Quarterly
Report findings to stakeholders, staff, and funders	Administrative coordinator	At least once every 6 months
Use program monitoring and process evaluation data to analyze, revise, and refine this plan and the intervention between each delivery of the 3MV intervention	Administrative, management, and program staff	Quarterly

GETTING STARTED

Adaptation Considerations

There are two main types of adaptations: (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 changing part of the intervention itself as the cultural factors, social determinants, terminology, slang language, and role-playing scenarios would need to be modified. 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 over 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 over 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. Many Men, Many Voices is designed specifically for black gay men, not for other racial and ethnic groups of MSM (e.g., Asian or Pacific Islanders, white Latinos, and Native Americans). If your agency is considering adapting 3MV for one or more of these racial or ethnic populations, it is strongly encouraged that you 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 or ethnic group of MSM for whom you will target 3MV.

More information on adaptation of EBIs can be found in CDC's procedural guidance for CBOs (http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance/index.htm). You can also attend the adaptation courses taught by the CDC-funded Prevention Training Centers (PTCs), or check with your agency's capacity building assistance (CBA) provider or CDC Project Officer for additional resources.

Develop Organization Policies and Procedures

If they are not already in place, establish organizational policies and procedures before implementing 3MV or hiring staff members. The policies and procedures should detail plans to recruit and retain 3MV program staff and participants. They also should include staff job descriptions and specific roles and responsibilities related to 3MV. Also include hiring processes, data collection and reporting instruments and methods, recordkeeping systems, confidentiality procedures, and procedures for handling disruptive participants. Create a manual to describe your policies and procedures and to help maintain consistent intervention implementation. A manual is also a way to convey performance expectations to staff members and stakeholders. To successfully implement 3MV, your agency should have policies and procedures in place that address the following areas.

Confidentiality

Your policies and procedures manual should clearly state the measures needed to ensure the confidentiality of all participants. These measures include keeping their participation or what they share in the sessions private. It is strongly recommended that confidentiality policies follow Federal privacy regulations, if applicable. They also must follow all State privacy laws that apply in your agency's jurisdiction. At a minimum, these policies should do the following:

- ▶ Name the staff members responsible for ensuring the confidentiality and security of any data collected by your agency. This information is especially important if your funding agency requires the collection of personal data. Data can include participant contact information and results from KAB surveys.
- ▶ Describe the penalties that will result from a violation of your agency's requirements, a breach of confidentiality or security, or both.
- ▶ Specify any limits on confidentiality, such as when a participant is an unemancipated minor, when a participant threatens to harm himself or others, or when duty-to-warn laws apply.
- ▶ List all staff members, by name and job title, who have access to participants' private information.
- ▶ Require all staff members involved in some aspect of 3MV to sign a confidentiality agreement. (The Implementation Tools tab contains a sample confidentiality agreement.)
- ▶ Describe the responsibilities of your agency's staff members. Include a minimum level of conduct that staff members must exercise when collecting, handling, or storing sensitive information about participants.

The establishment of agency policies and procedures for confidentiality allows you to protect your clients, your staff, and your agency and helps you to gain the trust of the people you serve. You also must ensure consistency in terms of practice and training in confidentiality protocols if there is staff turnover.

Staffing

The following elements should be included in the policies and procedures manual:

- ▶ Recruitment procedures
 - Who will recruit?
 - Where?
 - When?
 - What materials will be used?
- ▶ Hiring protocols
 - What is the interview process?
 - Who is responsible for hiring?
 - What is the process after hiring decisions have been made?
- ▶ Position descriptions
 - What are the job roles and responsibilities?
- ▶ Staffing retention strategies
- ▶ Training
 - When and how will staff attend required 3MV and other relevant CDC-sponsored trainings?

Develop Your Program Implementation Plan and Timeline

The sample 3MV Implementation Planning Tool (Implementation Tools tab) will help you to develop your implementation plan. This set of tables lists the tasks or activities for each phase of 3MV, responsible staff members, and timelines. The planning tool will help you to complete your own 3MV implementation plan.

To develop your 3MV implementation plan, follow these steps:

1. Form a team to work on 3MV planning and implementation.
2. Review, in detail, the 3MV materials available online and any that may have been provided during the 3MV training.
3. Review, in detail, the Implementation Planning Tool.
4. Hold a series of meetings to develop specific plans and timelines for creating objectives and completing each of the key tasks and activities of your 3MV intervention.
5. Begin implementing 3MV. Document the progress and completion of tasks and activities in relation to the implementation plan and intervention objectives you developed.
6. Periodically hold team meetings and review the implementation progress. Adjust intervention plans and objectives as needed. Document revisions.
7. Review your implementation plan.

NOTE: For the most part, you should first determine your objectives before developing your intervention plan. However, some objectives will need to be modified before the implementation phase and throughout your 3MV program cycle. For example, you may initially recruit fewer participants than what you identified in your initial program objectives. The next section provides guidance on developing specific, measurable, appropriate, realistic, and time-based (SMART) program objectives.

Develop SMART Objectives

To achieve the goals your agency has established for 3MV, you will need to establish intervention objectives. These should reflect how you will implement all 3MV program activities (known as process objectives) and the anticipated results of these activities (known as outcome objectives).

You will use process objectives to guide and measure the implementation of your 3MV program. Essentially, they will describe what you need to do to achieve your outcome objectives. You will need to develop process objectives for each of the following phases of your 3MV program—preimplementation, implementation, and maintenance.

You will use outcome objectives to measure the specific outcomes achieved as a result of implementing your 3MV program over time. They will help to tell you if your program is working.

If you do not take time to write your objectives, you will not have a solid framework to guide the implementation of 3MV, nor will you be able to effectively monitor your 3MV program's activities and results. Write your objectives using the SMART framework. The following key considerations will ensure that you develop objectives that are specific, measurable, appropriate, realistic, and time-based:

- ▶ A *specific (S)* objective identifies events or actions that will take place. To assess this, you can ask yourself, “Does the objective clearly specify what will be accomplished?”
- ▶ A *measurable (M)* objective tells how many or how much (how many resources or activities or how much change). To assess this, you can ask yourself, “Can you measure the amount?”
- ▶ An *appropriate (A)* objective shows the relevance of the objective to the overall problem and the desired effects of your 3MV intervention. To assess this, you can ask yourself, “Does the objective make sense in terms of what the intervention is trying to accomplish?”
- ▶ A *realistic (R)* objective can be achieved with available resources and the plans for implementation. To assess this, you can ask yourself, “Is the objective achievable given available resources and experience?”
- ▶ A *time-based (T)* objective specifies a time when the objective will be achieved. To assess this, you can ask yourself, “Does the objective specify when it will be achieved?”

Some examples of 3MV process and outcome objectives follow. You will need to modify them and create your own objectives when planning your 3MV program.

Sample Process Objectives

PREIMPLEMENTATION

- ▶ During the first 2 or 3 months before the implementation of 3MV, the agency will identify, recruit, and train one administrative coordinator, two facilitators, and one program assistant to serve as the program staff for the 3MV intervention.
- ▶ During the first 2 or 3 months before the implementation of 3MV, program staff will identify and recruit 30 prospective participants.
- ▶ During the first 2 or 3 months before the implementation of 3MV, program staff will identify three prospective venues for intervention sessions.

IMPLEMENTATION

- ▶ During the first year, facilitators will deliver at least six 7-week intervention cycles of 3MV.
- ▶ During the first year, facilitators will deliver all 3MV intervention sessions to at least 72 participants.

MAINTENANCE

- ▶ During the first year, program staff will document changes made to delivery of session content during all six intervention cycles of 3MV.
- ▶ During the first year, facilitators will conduct KAB surveys with all session participants who complete the 3MV intervention.

Develop Your Evaluation Plan

An evaluation plan is a written document that describes the overall approach for M&E of an intervention. The plan describes what will be done, how it will be done, who will do it, and why it is being done. It also may include the following information:

- ▶ Data sources and data collection protocols for securing data
- ▶ Description of how data will be managed and stored
- ▶ Procedures for analyzing, interpreting, reporting, and presenting findings
- ▶ Description of how the findings will be used to plan and improve your agency's 3MV program
- ▶ Description of how funder input will be used (e.g., CDC's Prevention Program Branch's technical reviews and site visit reports)
- ▶ Description of protocols to ensure the confidentiality of participant information

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

Additional information on developing your 3MV evaluation plan is provided in the Monitoring and Evaluation section.

Staff Recruitment and Retention

Your agency's policies and procedures manual should include guidance on hiring staff. For the successful implementation of 3MV, you will need, at a minimum, the following personnel:

- ▶ One full-time program manager or coordinator whose time is wholly devoted to 3MV
- ▶ One half-time program staff to support recruitment, retention, and other intervention activities
- ▶ Two facilitators, who are often the same two staff persons identified above

Ideally, all staff members should have extensive experience working with black gay men. At least one facilitator should be a black gay man, which can help to increase the acceptability of 3MV among your participants and ensure that the intervention is delivered in a culturally appropriate manner.

The program manager or coordinator will be responsible primarily for overseeing, coordinating, and evaluating the implementation of 3MV. Your intervention facilitators will be responsible for identifying, recruiting, and monitoring intervention participants as well as for organizing and facilitating the 3MV sessions.

When recruiting staff to facilitate 3MV intervention sessions, you will need to identify at least two facilitators. Both need to be skilled in facilitating groups and need to have attended group facilitation courses. In addition, both facilitators must be trained in the specific content of each session or have satisfactorily completed 3MV's Training of Facilitators provided by CDC's PTCs. It is strongly recommended that facilitators complete additional trainings offered by their regional PTC, including a course on group facilitation, Bridging Theory and Practice, and an STD overview for nonclinicians. Each intervention session should be delivered by two facilitators.

The second program staff member can provide support and help coordinate intervention logistics, such as maintaining files, arranging food or snacks, and placing advertisements. The size of your target population and available resources may require this staff person to take on the role of facilitator.

Roles and Responsibilities

Table 6 further describes the specific requirements, roles, and responsibilities of each staff member.

Table 6. Staff Roles and Responsibilities

Position Title	Roles and Responsibilities	Requirements
Prevention Manager	<ul style="list-style-type: none"> • Manage implementation of 3MV program and intervention • Hire staff • Supervise facilitators, arrange for facilitator training, and debrief facilitators • Identify the technical assistance needs of facilitators and project staff; coordinate and secure technical assistance 	<ul style="list-style-type: none"> • Organizational skills • Experience in project management • Project monitoring skills • Ability to supervise and motivate staff (e.g., understands all core elements and activities of the intervention; can monitor facilitators and deliver positive feedback to improve process; can debrief after sessions; can monitor preimplementation and participant recruiting process; knows the importance of regular observation; organized)
Project Coordinator or Group Facilitator	<ul style="list-style-type: none"> • Coordinate implementation of 3MV program and intervention • Coordinate daily activities, such as assigning tasks, monitoring and ensuring progress of activities, and arranging staff meetings • Ensure data collection and management, monitoring, and analysis • Identify and secure session-appropriate space • Monitor expenditures and budget • Plan and facilitate marketing activities • Promote the intervention in the community • Identify and work with community partners and gatekeepers • Plan and conduct intervention sessions • Monitor participants postintervention • Coordinate and conduct follow-up activities • Collect and compile monitoring data • Assist with marketing activities 	<ul style="list-style-type: none"> • Comfortable with sexuality (e.g., able to use sexual terminology, including colloquial terms; able to describe sexual behavior in concrete, specific terms, without being uncomfortable or embarrassed; nonjudgmental and open-minded about all of the possibilities of human sexuality) • Cultural sensitivity (e.g., respectful of others and of differences between people based on ethnicity or culture; empathetic; able to anticipate possible reactions of others to comments or terminology) • Persuasiveness (e.g., able to convey the importance of the intervention to staff, participants, and the community; able to motivate people) • Knowledge of HIV/AIDS and STDs (e.g., has accurate information; understands the impact of HIV and STDs among black gay men) • Ability to inspire trust and motivate (respects confidentiality of group members, does not gossip, is honest) • Ability to understand confidentiality issues and the importance of maintaining confidentiality • Complete 3MV's Level 1 and Level 2 trainings provided by PTCs

Table 6. Staff Roles and Responsibilities (continued)

Position Title	Roles and Responsibilities	Requirements
Project Coordinator or Group Facilitator (continued)	<ul style="list-style-type: none"> • Coordinate implementation of 3MV program and intervention • Coordinate daily activities, such as assigning tasks, monitoring and ensuring progress of activities, and arranging staff meetings • Ensure data collection and management, monitoring, and analysis • Identify and secure session-appropriate space • Monitor expenditures and budget • Plan and facilitate marketing activities • Promote the intervention in the community • Identify and work with community partners and gatekeepers • Plan and conduct intervention sessions • Monitor participants postintervention • Coordinate and conduct follow-up activities • Collect and compile monitoring data • Assist with marketing activities 	<ul style="list-style-type: none"> • Knowledge of and experience with black gay men (e.g., knows local issues and characteristics of black gay men; understands black MSM culture; is comfortable working with black gay men and going to venues frequented by black gay men; is respected by black gay men) • Skills in guiding group processes and dynamics (e.g., able to convey information clearly and simply; able to diplomatically guide group discussions; able to respond to comments or questions; able to elicit participation from all group members and attend to opinion leaders' feelings and behaviors) • Skills in demonstrating and guiding role-playing (e.g., able to choose, describe, and act out realistic and appropriate situations; able to direct and provide constructive feedback during participant role-plays; able to redirect participants if the role-plays lose focus) • Skills in demonstrating and guiding problem solving (e.g., able to help participants identify goals; able to generate alternative strategies; able to provide encouragement after failure)
Group Facilitator or Intervention, Recruitment, and Retention Support	<ul style="list-style-type: none"> • Assist the project coordinator • Identify participants and session venue(s) • Promote the intervention in the community • Identify and work with community partners and gatekeepers • Recruit and screen participants • Secure appropriate materials (e.g., intervention materials, newsprint, paper, markers, binders) • Purchase and arrange incentives (e.g., food or snacks, gifts as decided) 	<ul style="list-style-type: none"> • Comfortable with sexuality (e.g., able to use sexual terminology, including colloquial terms; able to describe sexual behavior in concrete, specific terms, without being uncomfortable or embarrassed; nonjudgmental and open-minded about all of the possibilities of human sexuality) • Cultural sensitivity (e.g., respectful of others and of differences between people based on ethnicity or culture; empathetic; able to anticipate possible reactions of others to comments or terminology)

Table 6. Staff Roles and Responsibilities (continued)

Position Title	Roles and Responsibilities	Requirements
Group Facilitator or Intervention, Recruitment, and Retention Support (continued)	<ul style="list-style-type: none"> • Plan and conduct intervention sessions • Monitor participants postintervention • Coordinate and conduct follow-up activities • Collect and compile monitoring data • Assist with marketing activities 	<ul style="list-style-type: none"> • Persuasiveness (e.g., able to convey the importance of the intervention to staff, participants, and the community; able to motivate people) • Knowledge of HIV/AIDS and STDs (e.g., has accurate information; understands the impact of HIV and STDs among black gay men) • Ability to inspire trust and motivate (respects confidentiality of group members, does not gossip, is honest) • Ability to understand confidentiality issues and the importance of maintaining confidentiality • Complete 3MV's Level 1 and Level 2 trainings provided by PTCs • Knowledge of and experience with black gay men (e.g., knows local issues and characteristics of black gay men; understands black MSM culture; is comfortable working with black gay men and going to venues frequented by black gay men; is respected by black gay men) • Skills in guiding group processes and dynamics (e.g., able to convey information clearly and simply; able to diplomatically guide group discussions; able to respond to comments or questions; able to elicit participation from all group members and attend to opinion leaders' feelings and behaviors) • Skills in demonstrating and guiding role-playing (e.g., able to choose, describe, and act out realistic and appropriate situations; able to direct and provide constructive feedback during participant role-plays; able to redirect participants if the role-plays lose focus) • Skills in demonstrating and guiding problem solving (e.g., able to help participants identify goals; able to generate alternative strategies; able to provide encouragement after failure) • Organization skills (e.g., able to keep track of intervention records and data; able to properly store and secure project supplies and equipment; able to track participant information)

Recruiting and Retaining Effective Facilitators

Use Table 6 to help guide your search and establish criteria for your facilitators. Various approaches and resources can be used to find facilitators. The first place to look is within your own agency to see if you have staff members who are qualified and available to work on 3MV. Suggested ways to find facilitators outside of your agency include the following:

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

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

- ▶ Maintain good and ongoing communication.
- ▶ Involve facilitators in intervention planning and evaluation.
- ▶ Provide training opportunities that address their professional goals.
- ▶ Communicate any intervention achievements and milestones.
- ▶ Have facilitators attend and present at HIV conferences.
- ▶ Make sure that facilitators are not overworked and are comfortable with their given roles.

Training Staff

All staff members, particularly program coordinators and facilitators, should receive training in 3MV. Use the following steps when training 3MV staff members:

- ▶ Identify the training needs (e.g., group facilitation, an STD overview) of the program coordinator, facilitators, and others who will be involved in facilitating the sessions.
- ▶ Ensure that intervention facilitators are trained, at a minimum, to facilitate 3MV intervention sessions. Attendance at an official 3MV Level 2 TOF is recommended for the

program coordinator and facilitators. Training schedules are posted on <http://www.effectiveinterventions.org>.

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

How to Obtain Technical Assistance

If your agency is funded by CDC or a local health department to implement 3MV, you can follow up with your Project Offer to learn about available technical assistance. In addition, your agency can be assigned a CBA provider for additional technical assistance after your facilitators are trained. The CBA Request Information System (CRIS) is used to submit CBA requests (<http://www.cdc.gov/cris>). A user ID and password are required to access this CDC-sponsored Web application. If you are not directly funded by CDC to implement 3MV, you may be able to request and obtain technical assistance from your local or State health department. It also may be useful to network with other CBOs that have successfully implemented 3MV and may be willing to provide peer-based technical assistance.

Participant Recruitment, Screening, Selection, and Retention

Recruitment

The 3MV intervention package includes a sample flyer, recruitment cards, and poster you can use to recruit participants. It is important that any marketing and recruitment materials used by your agency be visually appealing and customized to reflect the interests and information needs of your target population. In addition, the use of multiple marketing strategies (e.g., conducting outreach activities, posting flyers and posters, placing advertisements in local print media, using referral networks of CBOs and health care agencies) will help to raise the visibility of your 3MV program. Successful recruitment is also dependent on whether proposed dates, times, and locations for 3MV intervention activities are appropriate and convenient. It may also be helpful to consider additional ways to make participation more attractive for prospective participants, such as offering incentives for attendance at intervention sessions. You can also increase the likelihood that participants will attend intervention sessions by providing food or services such as child care or transportation.

Screening, Selection, and Tracking

You will need to establish selection criteria and a process for screening participants to determine their eligibility for 3MV. For example, once potential participants are identified, you may want to conduct an initial screening (either by telephone or in person) on the basis of information they provided. Suggested screening criteria can include the following:

- ▶ Identification as a member of the target population (e.g., black gay man, bisexual, same-gender-loving, sexually active with other men, or sexually or emotionally attracted to other men)
- ▶ A specific age range (e.g., aged 18 years or older)
- ▶ Negative or unknown HIV status
- ▶ Ability to participate in the 3MV intervention (i.e., attend all intervention sessions in the format your agency implements [seven-session or weekend-retreat format])

You may also want to conduct a second round of screening interviews to verify the information potential participants provided during the initial screening and further assess their eligibility. Additional eligibility criteria can include willingness to discuss their sexual behavior and substance-use behaviors in groups of black gay men or items that are more specific to the cultural nuances of the black gay men your agency is targeting (e.g., black gay men who currently attend historically black colleges and universities in the metro Atlanta area). If you identify participants who are ineligible on the basis of your agency's criteria, you may want to refer them to other community health care and social services or other HIV/STD prevention programs in your area. If participants are living with HIV/AIDS, they can be referred to other services within the agency.

Once you have selected your participants, you will need to track their participation throughout the intervention. For example, you may want to have participants sign in at the beginning of each intervention session. This information will help you to identify trends in the types and number of sessions missed if participant retention becomes problematic. You may also want to track participants for purposes of reporting and program planning.

Retention

Intervention sessions can be time consuming for participants. However, if your agency's 3MV program is planned carefully and facilitated well, participants may view 3MV sessions as highly relevant, useful, interesting, empowering, and fun. Well-prepared facilitators and well-organized session activities are essential to retaining participants. You can improve participant retention by ensuring they all have opportunities to contribute to discussions, participate in exercises, have their ideas heard, and be affirmed by their peers. In addition, opportunities to socialize before and after sessions can encourage bonding among participants.

Maintain Staff Support

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

- ▶ Maintain ongoing communication and seek their input.
- ▶ Involve facilitators in intervention planning and evaluation.

- ▶ Communicate any intervention achievements and milestones.
- ▶ Provide comprehensive 3MV-related trainings and then assess skills, observe sessions, coach, and help facilitators to practice skills in needed areas (provide access to coaches if needed).
- ▶ Provide resources for questions or problem solving.
- ▶ Develop professional goals for each facilitator beyond 3MV and meet with him or her regularly.
- ▶ Provide training opportunities that address their professional goals.
- ▶ Have facilitators attend and present at HIV conferences.

To maintain staff support for 3MV, staff burnout must be prevented and managed; the intervention must be kept interesting for facilitators and program staff; staff turnover must be dealt with; and 3MV must be made part of your agency's mission.

For facilitators, repeating the same intervention sessions for numerous cycles may become boring. There are several steps you can take to help prevent facilitator burnout. The program coordinator should have open and ongoing communication with the facilitators, involve them in intervention planning and evaluation, and tell them about intervention achievements. The coordinator can hold debriefing meetings after each session and cycle of 3MV to discuss what went well and what could be improved. Another strategy is to involve facilitators and other program staff in decisions about targeting other communities of black gay men.

When facilitator burnout occurs, agency executives and the administrative coordinator can reassess and adjust the facilitators' workload. The facilitators may have many duties on other projects besides 3MV. It may be helpful to recruit additional facilitators if your agency's budget allows so that you can rotate 3MV facilitation responsibilities among staff. Your agency may also have other staff members who can be trained in 3MV and swap tasks with facilitators to give them a short break from the intervention. Facilitator enthusiasm is important to keeping participants engaged in the 3MV intervention sessions, but maintaining enthusiasm for any intervention can be a challenge. Several things can be done to keep 3MV fresh and interesting for facilitators. For example, the cofacilitators can switch which exercises they lead during the sessions, or the administrative coordinator can ask facilitators to write new role-play scenarios, exercises, or activities that are relevant to participants—as long as the new items maintain fidelity to the core elements of Many Men, Many Voices.

Every HIV prevention agency faces staff turnover, and losing trained staff members in the middle of an intervention can be a problem. When a staff member decides to leave, he or she should mentor his or her replacement and pass along lessons learned, best practices,

and other advice. Coordinators should ensure that the staff person leaves all related materials, manuals, notes, and so forth with the agency.

Ensure Organizational Support

Turnover of agency administrators can be an even greater problem for an intervention's continuation. New administrators have their own interests and vision for the agency and may not support existing projects. If an agency takes ownership of 3MV and incorporates it into its mission and regular prevention activities, the intervention is more likely to survive a change in administration. Continued funding, efforts to make sure that 3MV is not undercut by other activities, and formal integration of 3MV implementation activities into staff members' job duties can lead to the institutionalization of the intervention.

Maintain Funding and Resources to Sustain Intervention Delivery

To sustain your 3MV intervention over the long term, you will need to carefully document the impact and success of your intervention through your M&E activities. You can incorporate your M&E data into future proposals. You need to consistently communicate with and maintain the involvement of gatekeepers and community leaders to ensure future support for your intervention. The activities mentioned above also can help you make a case to integrate 3MV into your agency's mission and make it one of your standard interventions.

Monitoring and Evaluation

MONITORING AND EVALUATION

INTRODUCTION

As an implementer of Many Men, Many Voices, you may have several responsibilities, including program planning and implementation; managing resources; and communicating project progress to staff, stakeholders, and funders. To successfully achieve these activities, you need information about your program activities and session deliveries. Monitoring and evaluation (M&E) can help you to better handle and use information about your 3MV activities. More specifically, M&E can help you to

- ▶ improve performance;
- ▶ use resources effectively;
- ▶ make decisions about future activities;
- ▶ provide accurate and useful feedback to staff, stakeholders, and funders.

For 3MV, there are two main areas you will need to monitor and evaluate: (1) your program implementation activities and (2) your session deliveries. **Program implementation activities** are the things you do to 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 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.

This section provides guidance on developing an M&E plan for 3MV, particularly for your program implementation activities and session deliveries. It also includes information on how to use M&E information to improve your program. Finally, this section describes how you can use the various M&E tools included in this manual for collecting useful M&E data.

If you are funded by CDC's DHAP to implement 3MV, you need to carry out the program M&E requirements discussed in the program announcement for your funding. Information on data collection and reporting requirements for DHAP's Program Evaluation and Monitoring System (PEMS) is available from your Project Officer in the Prevention Program Branch and from DHAP's Program Evaluation Branch. The 3MV Field Guide and Instruments, which can be downloaded from <http://www.effectiveinterventions.org/en/Interventions/3MV.aspx>, provide further information and tools for reporting required program data to CDC.

DEVELOPING YOUR EVALUATION PLAN

To ensure that you conduct the necessary M&E activities, you will need to develop and follow an evaluation plan. Your evaluation plan should help you to collect information about the program objectives specified in your program plan, such as the number of 3MV sessions conducted; the number of participants recruited; the number who attended the 3MV sessions; changes in participants' knowledge, skill, or attitudes; and the total number of intervention cycles (i.e., delivery of Sessions 1 to 7) completed.

For each program objective, you will need to write

- ▶ the questions you need answered,
- ▶ the data you need to collect to answer the questions,
- ▶ the data sources and instruments used to collect the data,
- ▶ who will develop and implement the instruments,
- ▶ when the data will be collected,
- ▶ your data analysis—how you will determine if the objective was achieved,
- ▶ your evaluation report—how you will report your results and to whom,
- ▶ your quality assurance plans—how you will use your results to make changes if objectives were not well met.

An evaluation plan template can be found in the M&E Tools tab.

TYPES OF EVALUATION

For 3MV, you might conduct the following types of program M&E:

- **Process Monitoring:** Process monitoring gives a picture of the program activities conducted, clients recruited and retained, and resources used. This involves collecting data that correspond to your performance measures and indicators. Process monitoring is used to conduct process evaluation.
- **Process Evaluation:** Process evaluation involves the use of process monitoring data to assess to what degree you met your program objectives (what you have committed to accomplish in a given time frame). It can help you to gain a better understanding of all aspects of your implementation and identify ways to improve how well your program is functioning. It involves comparing what was planned (objectives) with what actually occurred during implementation.
- **Outcome Monitoring:** Outcome monitoring information allows you to determine changes in clients' knowledge, attitudes, skills, or behaviors. Usually, these changes are measured by collecting data from participants before they start 3MV and immediately after they complete it.
- **Outcome Evaluation:** Outcome evaluation involves using outcome monitoring data to assess to what degree you met your program objectives related to changes in clients' knowledge, attitudes, and behaviors. The data help you to gain a better understanding of your 3MV intervention's effect on your clients. Outcome evaluation can also be used to help you measure changes that occurred in participants after attending the 3MV intervention if you follow them over time.

In most cases, funders that provide resources to implement the intervention do not provide additional resources to evaluate its outcome. Extensive and useful outcome evaluation is often costly, and most funders regard the previous demonstrations of an intervention's efficacy as sufficient.

Developing Evaluation Questions

The first step in developing your M&E plan is to create a list of questions you want to answer about your program implementation activities and session deliveries. Your M&E questions will help you to decide what information you need to collect, how you will collect that information, and how that data will be used to improve programs and communicate program progress to staff and stakeholders. Broadly speaking, answers to these questions will tell you what you actually did during your implementation and session delivery activities and how well these activities worked.

Table 7 provides sample questions and the kinds of information you should collect for monitoring and evaluating your **program implementation activities**.

Table 7: Monitoring and Evaluating Your Program Implementation

Program Implementation: Sample M&E Questions
<ul style="list-style-type: none"> • How many written policies and procedures were developed and in what timeframe? • Was a quality assurance plan developed and implemented? • Were funder-required data collected and reported within required time periods? • Did the 3MV facilitators have an opportunity to practice 3MV sessions with coaching and feedback? • What barriers were experienced by staff in reporting data in the required time period? • When were 3MV staff hired? • What types of trainings did facilitators receive? • Which recruitment activities were most effective in recruiting targeted participants? • Did the intervention reach the intended intervention population?
Program Implementation: Information to Collect
<ul style="list-style-type: none"> • Types of program activities conducted • Timeline for implementation • Program objectives achieved • Implementation barriers and facilitators • Program planning activities (e.g., goals and objectives set; development of a formal program plan) • Staff recruitment and hiring activities • Staff training related to 3MV • Completion of quality assurance plan • Documentation of 3MV quality assurance activities • Documentation of reporting to funder • Recruitment activities • Number of participants recruited • Barriers and facilitators of implementation

Table 8 provides sample questions and the kinds of information you should collect for monitoring and evaluating your **session delivery activities**, participants' satisfaction, and changes in their KAB.¹

Table 8: Monitoring and Evaluating Your Session Delivery and Outcomes

3MV Session Delivery and Outcomes: 3MV Session Delivery and Outcomes
<ul style="list-style-type: none"> • How many participants attended each session? • What are the characteristics of the participants? • How many participants completed all sessions? • What are the reasons why participants drop out of 3MV? • What are participants' levels of knowledge about HIV testing? • How many times have participants had unprotected anal sex in the past 30 days?¹ • How confident are participants in negotiating condom use with a regular partner? • Did participants' attitude about HIV testing change after the intervention? • Were participants more willing to get an HIV test after the intervention? • How satisfied were participants with a particular session? • How satisfied were participants with the entire intervention? • What did participants like about the intervention? What did participants not like about the intervention? • What recommendations do participants have for improving the intervention? • Were there any barriers to delivering the sessions? • What types of things helped facilitators deliver the sessions? • How many series of 3MV sessions were conducted within the timeframe? • How were session exercises delivered? • Were the sessions delivered with fidelity? • What changes were made to the sessions? Why were these changes made? • How well did facilitators deliver the sessions? • In what areas do facilitators need additional help to improve their delivery of the sessions?
3MV Session Delivery and Outcomes: Information to Collect
<ul style="list-style-type: none"> • Number of 3MV interventions provided • Process objectives achieved • Outcome objectives achieved • Implementation barriers and facilitators • Session delivery (quality and fidelity) • Facilitation strengths and weaknesses • Facilitation challenges and solutions • Client characteristics (e.g., age, race, level of education) • Client attendance and retention • Client satisfaction • Client outcomes

¹If you decide to collect information on participants' behavior, it should be collected at least 30 days after they complete their last session. It is often difficult for agencies to collect data on participants' behaviors because it involves more time and resources to track and follow up with participants.

While it would be ideal to answer all these questions, you simply may not have the time or resources to do so. It will be important for you to prioritize which evaluation questions are most important for you to answer

Identifying Required Data and Data Sources

Once you have determined your evaluation questions, you will then need to identify what data you will need to answer them. For example, if one of your questions is, “Was there a change in participants’ attitudes toward getting an HIV test after completing 3MV?” you will need these two pieces of information: (1) their attitude toward HIV testing before starting 3MV and (2) their attitude toward HIV testing after completing 3MV.

Once you identify the data you need, you then identify the best source of the data. Using the previous example, your best source for understanding your participants’ attitudes is the participants themselves. Your facilitators may also have a sense of participants’ attitudes before and after 3MV, but it will be best for you to go to the most direct source so you can get accurate information. For another example, if one of your questions is, “How many series of 3MV sessions were conducted within the timeframe?” you will need to have documentation of the number of times your agency conducted the 3MV intervention. Your program coordinator could be the source of that information.

Planning Data Collection—Instruments, Schedule, and Collectors

Now that you have identified your data and data sources, you will need to develop or identify instruments you can use to collect your data. Continuing with the previous examples, you may decide to use a survey that has a specific question with which participants can rank their attitude toward getting an HIV test. To track how many times 3MV was delivered, you could develop an instrument to keep track of the dates of each session and intervention cycle for each funding year.

For many of the 3MV evaluation questions, you can use the instruments in the M&E Tools tab. Table 9 lists all of the instruments included in this manual, along with the data they collect, when the data should be collected, the data source, and the person(s) responsible for collecting the data. If these instruments do not suit your needs, you can modify them or create your own. If you do create your own, test them out before you use them to collect actual data.

Table 9: 3MV Evaluation Instruments

Instrument	Data Collected	When to Use	Data Source	Administered by
Participant Screening Form	Potential participants' demographics, contact information, and eligibility	During recruitment and screening	Participant	Screeener
KAB Survey	Participants' knowledge, attitudes, and behaviors related to target behavioral determinants	Before Session 1 and after Session 7	Participant	Facilitator
Participant Satisfaction Questionnaire	Participants' satisfaction with 3MV and suggestions for improving it	After Session 7	Participant	Facilitator
Facilitator Observation Form	Quality of facilitators' delivery; their strengths and challenges	During delivery of any session	Observer (manager or supervisor)	Observer (manager or supervisor)
Fidelity Assessment Form	Level of fidelity to session instructions; changes made to curriculum	During delivery of any session	Observer (manager or supervisor)	Observer (manager or supervisor)
Session Log	Information on the session and exercises; session fidelity; reasons for changing an exercise; appeal of an exercise to participants	After delivery of any session	Facilitators	Facilitators

NOTE: Three additional tools—the Intervention Implementation Planning Tool, the Implementation Summary, and the Behavior Change Logic Model—may be helpful as you monitor and evaluate your implementation of 3MV. These tools provide concise summaries of the logic of the interventions and the resources and activities required to produce the desired behavioral change. It is recommended that you refer to these tools during implementation to ensure that your activities maintain fidelity to 3MV's original design. They are included in additional tabs of this manual. They are also found in the Many Men, Many Voices resources and tools section at the Web page <http://www.effectiveinterventions.org/en/Interventions/3MV.aspx>.

You will need to plan when you will collect your data because some data can only be collected at a certain time; otherwise, you may not be able to answer an evaluation question. If you want to measure changes in participants' attitudes toward HIV testing after completing 3MV, you should collect this information before they start Session 1 as well as after the last session. If you did not collect the information before Session 1, you cannot accurately assess the change.

To ensure that data are collected at the right time, you will need to assign people to collect those data. Be sure to communicate to your staff what data they are collecting and how and when they should collect them.

Developing a Data Analysis Plan and Evaluation Reports

You will need to determine how you will manage and analyze your data, as well as how the data will be used and reported to stakeholders. Development of a plan for data analysis and evaluation reports will ensure that you will have the capacity, time, and resources to analyze the data and distribute and implement evaluation reports efficiently and effectively.

Your plan should specify the following:

- ▶ Where will the data be stored? Where will you store hard copies (e.g., pretests, attendance sheets) and electronic data (e.g., database, Excel spreadsheet)?
- ▶ What analysis will you conduct to answer the question? Your analysis can just be a simple summary, such as “Compare posttest with pretest responses and determine average change in score for participants' attitudes toward HIV testing.”
- ▶ When will you analyze the data?
- ▶ Who will analyze the data and compare the results with your program and intervention objectives?
- ▶ How will data be reported? Will you use a table or graph, and will you present the information in person or in a written report? What you decide to do often depends on the needs and expectations of the stakeholders. If you are just going to use your data for internal purposes, you may not need to do a presentation or write a report. Funders often require that you write a report to document to what extent your program and intervention objectives have been met each project year.

Developing a Quality Assurance Plan

To finalize your overall evaluation plan, you will need to consider how you will use the results to improve your program and delivery of the 3MV intervention. It will be important that you plan how your M&E data will be used to inform intervention-related activities. Your quality assurance plan should at least specify the intended and expected uses of the M&E data and when you will review and use your findings. This plan should specify the following:

- ▶ When will you review and use the evaluation results?
- ▶ How will the evaluation results be used?
- ▶ Who will be responsible for making program changes when indicated?
- ▶ Who will be responsible for making changes to the delivery of 3MV sessions when indicated?
- ▶ When will you review whether the changes successfully met the program objective in question?

Implementing Your Evaluation Plan

It is critical to have a plan and system in place to monitor your implementation of 3MV, collect data, and assess outcomes. Your implementation plan provides a framework for M&E activities. You will need to assign a staff person to be responsible for implementing the evaluation plan. This person will need to have protocols in place to ensure that your M&E activities are happening according to your plans. If certain activities are not happening, it will be important for you identify the reasons why and make adjustments to make sure the activities do occur.

Using Monitoring and Evaluation Data

Most importantly, you must remember to implement your quality assurance plan and actually use your evaluation results. There is no point in conducting an evaluation of your intervention if you do not actually use those data. Take the time to look at your data and see what they tell you. Overall, did you meet all your objectives? If so, what worked well? If not, what changes need to be made? What outcomes were achieved with your participants? You can then use the data to improve your intervention and report findings to staff members, community stakeholders, and funders. Remember that your M&E data are only valuable if they are used!

Additional Resources

Please note that this section only provides basic information on M&E. To learn more about M&E, please visit the Web sites listed below. Also, contact your Project Officer or funder about seeking technical assistance for conducting M&E activities.

- ▶ CDC Evaluation Working Group: <http://www.cdc.gov/eval/>
- ▶ American Evaluation Association: <http://www.eval.org/>

Tools and Materials

MONITORING AND EVALUATION PLANNING TABLE

M&E Question	Data Needed	Data Source	Collection Method	Analysis Plan	Responsible Person(s)	Timeframe	Reporting and Use Plan
<p>EXAMPLE: What percentage of participants completed all of the intervention sessions?</p>	<ul style="list-style-type: none"> • Number of participants enrolled in the intervention during each cycle • Number of participants who attended all of the intervention sessions during each cycle 	Sign-in sheets	Review of sign-in sheets	<ul style="list-style-type: none"> • Review sign-in sheets for each intervention cycle • Determine which participants attended every session • Divide the total number of participants who attended all of the sessions in a cycle by the total number of participants enrolled 	<ul style="list-style-type: none"> • Project coordinator (analysis) • Facilitators (data collection) 	Review attendance information after the first five cycles	Presentation at staff meeting

PARTICIPANT SCREENING FORM

When to Use: During participant recruitment

Administered by: Screener

Completed by: Screener

Instructions: Use this form to determine whether someone is eligible and able to participate in your Many Men, Many Voices (3MV) sessions. You may modify this form to fit your agency's needs. At a minimum, participants must be black men who have sex with men (MSM) who are HIV-negative. You will need to develop and follow protocols for how the screening should be conducted and how you will inform participants about their eligibility.



PARTICIPANT SCREENING FORM

Screening Name: _____

Date: ____ / ____ / ____

Location: _____

Read the following statement to the person you are screening:

I will be asking you a few questions to make sure that our program can best meet your needs. Some of the questions can be personal. All of the information you provide will remain confidential, but if there is a question you are not comfortable answering, just say so.

1. What is your name? _____

2. What is your age? _____

3. What best describes your race?

- American Indian or Alaska Native
- Asian
- Black or African American*
- Native Hawaiian or Pacific Islander
- White
- Don't know
- Refused to answer
- Did not ask

4. What is your current HIV status (i.e., HIV-positive or HIV-negative)?

- HIV-positive (HIV+)
- HIV-negative (HIV-)*
- Don't know
- Refused to answer
- Did not ask

5. In the past year, have you engaged in any sexual activity (e.g., kissing; fondling; oral sex; anal sex) with another man?

- Yes*
- No
- Refused to answer
- Did not ask

6. Our Many Men, Many Voices group meets (state information on time, dates, number of sessions, location, etc.). In order to get the most out of it, you should attend the entire intervention. Do you think you will be able to make all the sessions (or participate in the retreat)?

- Yes*
- No, but would like attend at a different time/date*
Specific dates, days of the weeks, times that work: _____

- No
- Don't know
- Refused to answer
- Did not ask

7. Is there a phone number where we can reach you?

- Yes → Phone number: _____
- No
- Refused to answer
- Did not ask

8. Can we send you information about Many Man, Many Voices to your e-mail account?

- Yes → E-mail address: _____
- No
- Did not ask

Thank you. That is all the information I need to collect. Do you have any questions?

Complete After Screening

Is this person eligible?: Yes (all * responses checked) No

When can he attend a 3MV cycle?: _____

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)	

Efficacy of an HIV/STI Prevention Intervention for Black Men Who Have Sex with Men: Findings from the *Many Men, Many Voices (3MV)* Project

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Abstract Black men who have sex with men (MSM) in the United States experience disproportionately high rates of HIV and other sexually transmitted infections (STIs); however, the number of evidence-based interventions for Black MSM is limited. This study evaluated the efficacy of *Many Men, Many Voices (3MV)*, a small-group HIV/STI prevention intervention developed by Black MSM-serving community-based organizations and a university-based HIV/STI prevention and training program. The study sample included 338 Black MSM of HIV-negative or unknown HIV serostatus residing in New York city. Participants were randomly assigned to the *3MV* intervention condition ($n = 164$) or wait-list comparison condition ($n = 174$). Relative to comparison participants, *3MV* participants reported significantly greater reductions in any unprotected anal intercourse with casual male partners; a trend for consistent condom use during receptive anal intercourse with casual male partners; and significantly

greater reductions in the number of male sex partners and greater increases in HIV testing. This study is the first randomized trial to demonstrate the efficacy of an HIV/STI prevention intervention for Black MSM.

Keywords Black MSM · Unprotected anal intercourse · Condom use · HIV and STI testing · Behavioral intervention · Prevention

Introduction

Black communities in the United States (US) have experienced extremely high rates of HIV infection since the onset of the AIDS epidemic (Centers for Disease Control and Prevention [CDC] 2008a; Cohen 1999; Fullilove 2006). During 2006, Blacks accounted for 45% of the estimated 56,300 new HIV infections in the US compared to 35% for Whites and 17% for Latinos (Hall et al. 2008). Of those infections that occurred among Black males, 63% occurred among Black men who have sex with men (MSM; CDC 2008a). Among young MSM aged 13–29, the estimated numbers of new infections among Blacks are 1.6 times greater than those among Whites and 2.3 times greater than those among Latinos (CDC 2008b). In a multi-site epidemiological study of 1,767 MSM conducted in five US cities, 46% of Black MSM tested HIV-positive; of these men, 67% were not aware of their infection (CDC 2005). Similarly, nearly half of the estimated 4,762 new HIV cases in New York city during 2006 occurred among MSM (New York City Department of Health and Mental Hygiene [NYCDOHMH] 2008a); and for MSM under age 30, 77% occurred among Blacks and Latinos (NYCDOHMH 2008b). Moreover, surveillance data on sexually transmitted infections (STIs) in New York city during 2006

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indicate that Black men and MSM accounted for more diagnoses of primary and secondary syphilis and anorectal gonorrhea than any other group (NYCDOHMH 2007). Taken together, these data demonstrate the severe and disproportionate impact of the HIV/AIDS epidemic and STIs on Black MSM in the US (Wilton 2009).

HIV behavioral research has shown that unprotected anal intercourse (UAI) results in the greatest risk of acquiring and transmitting HIV among MSM (Vittinghoff et al. 1999). Biomedical research has indicated that the presence of STIs (i.e., gonorrhea, syphilis) facilitates HIV acquisition and transmission (Wasserheit 1992). In recent years, a growing number of research studies have sought to identify factors associated with the high rates of HIV infection among Black MSM (Mays et al. 2004). A critical review of these studies has identified high rates of STIs, infrequent HIV testing, and late diagnosis of HIV infection as key factors associated with increased HIV risk (Millett et al. 2006). A subsequent meta-analysis showed that, compared to White MSM, Black MSM report less illicit substance use, fewer sexual partners, and less frequent disclosure of same-gender sexual behaviors; and no significant racial differences were noted in the frequency of sexual risk behaviors, history of commercial sex work, HIV testing patterns, or sexual contacts with HIV-positive partners (Millett et al. 2007). Some researchers have posited that Black MSM are at disproportionate risk of HIV infection due to a higher prevalence of HIV and STIs among members of their sexual networks, are more likely to have sex with Black men than with men of other races and ethnicities, are less likely to disclose their same-sex behaviors to medical providers, and are subject to a myriad of barriers to health care (Aral et al. 2008; Bernstein et al. 2008; Berry et al. 2007; Malebranche et al. 2004). All of these findings indicate a need for HIV/STI prevention programs for Black MSM to emphasize more frequent HIV and STI testing in addition to reducing UAI.

Several HIV prevention interventions for MSM have been shown to be efficacious in reducing HIV sexual risk behaviors such as UAI and the number of sexual partners, and increasing protective sexual behaviors, such as condom use (Herbst et al. 2007; Johnson et al. 2008). To date, however, only one behavioral intervention developed specifically for Black MSM has been evaluated in a randomized controlled trial (Peterson et al. 1996). In that trial, Black MSM participating in a three-session intervention condition reported greater reductions in risky sexual behavior than participants in a single-session intervention; however, neither intervention condition differed significantly from the control condition. Research is currently underway to develop new interventions for Black MSM (Koblin et al. 2008; Williams et al. 2008), and a recent evaluation of an efficacious community-level

intervention originally developed for White MSM and adapted for Black MSM reported favorable results (Jones et al. 2008). However, there is an urgent need for innovative approaches to address the paucity of efficacious and culturally appropriate HIV/STI prevention interventions that are available for Black MSM (Black Gay Research Group 2007; Mays et al. 2004; Wheeler et al. 2008; Wilton 2009). One such approach consists of identifying and supporting rigorous evaluations of interventions that have been developed by community-based organizations (CBOs) for Black MSM with considerable input from served communities (CDC 2004). This grassroots approach to intervention development is not only culturally relevant, but can also enhance community ownership and empowerment through the participation of served communities in the development of intervention programs (Minkler and Wallerstein 2003).

Beginning in 1997, two CBOs that serve Black MSM—Men of Color Health Awareness (MOCHA) in Rochester and Buffalo, NY, and People of Color in Crisis (POCC) in Brooklyn, NY—collaborated with an HIV/STI prevention and training program (Center for Health and Behavioral Training) at the University of Rochester to develop a culturally tailored behavioral intervention for Black MSM that integrated HIV and STI prevention. The group-level, peer-led intervention, *Many Men, Many Voices (3MV)*, was developed based on a review of published studies of HIV and STI risks among Black MSM, and extensive ethnographic formative research in Black MSM communities (Coury-Doniger et al. 1998). The intervention was originally based on two evidence-based interventions for MSM (Kelly et al. 1989; Peterson et al. 1996); however, focus groups, key informant interviews, and pilot tests revealed a need to address the unique prevention needs of Black MSM. New intervention components were developed to address the dual identity struggle of Black MSM as men who are Black and gay; the relationship between STIs and HIV infection; the effects of familial, cultural, and religious norms; the effects of racism and homophobia on HIV risk behaviors; and sexual relationship dynamics common to Black MSM.

The 3MV intervention has been delivered by various CBOs since 1997, and because of an urgent need for interventions for Black MSM, CDC included 3MV in its Diffusion of Effective Behavioral Interventions (DEBI) program beginning in 2004 (Academy for Educational Development 2008). However, the efficacy of the intervention had never been rigorously evaluated in a randomized controlled trial. The purpose of this study is to report the results of an outcome evaluation of the 3MV intervention as delivered to Black MSM by POCC, a Brooklyn-based CBO that had been providing HIV prevention services to Black MSM in New York city since

1988. In delivering *3MV*, POCC sought to lower HIV and STI transmission risks among Black MSM by reducing unprotected insertive and receptive anal intercourse with main and casual sex partners and the number of sex partners, and by increasing protective behaviors including consistent condom use during anal intercourse and testing for HIV and other STIs. The evaluation of *3MV* was supported by the Innovative Interventions project of the CDC that aimed to support CBO efforts to rigorously evaluate their locally-developed HIV prevention interventions for high-risk minority populations (CDC 2004).

Methods

Participants

From August 2005 through November 2006, POCC evaluation project staff recruited potential participants from venues throughout New York City. Contacts with potential participants were established through active recruitment methods that included street outreach, displays at New York City Black gay pride festivals, referrals from friends of participants, community-based gatekeepers and POCC clients, and distribution of palm cards in nightclubs and other venues frequented by Black MSM. Passive recruitment methods were also used, including advertisements in gay newspapers or magazines. All potential participants were screened twice to determine eligibility. Initial eligibility was determined by telephone screening. Individuals who called POCC, or who were called by POCC staff based on the contact information they provided, were required to self-identify as a Black MSM (i.e., self-identify as gay, bisexual or same gender-loving, or as being sexually active with other men, or sexually or emotionally attracted to other men), be 18 years of age or older, willing to attend and participate in an HIV/STI prevention intervention retreat delivered outside New York City, and could not have previously participated in the *3MV* intervention. Of the 720 potential participants who were contacted during the initial screening process, 601 (83.5%) were eligible and were invited to visit the POCC offices in Brooklyn, NY for a second, in-person screening interview.

During the second screening session, project staff met with potential participants to verify the information provided during the initial telephone screening and to further assess their eligibility. Eligible participants were required to report their HIV serostatus as HIV-negative or unknown, be willing to attend an intervention retreat without their primary partner or boyfriend, be willing to discuss male-to-male sexual behavior in a group setting, reside in New York City, and have no plans to relocate within 6 months. Of the 490 individuals who completed the second

screening, 338 (69%) met all of the eligibility criteria and were enrolled in the evaluation (see Fig. 1). Participants who were ineligible because of their HIV-positive serostatus or for other reasons were referred to appropriate primary care, social services, or other HIV prevention programs offered at POCC or elsewhere in the community.

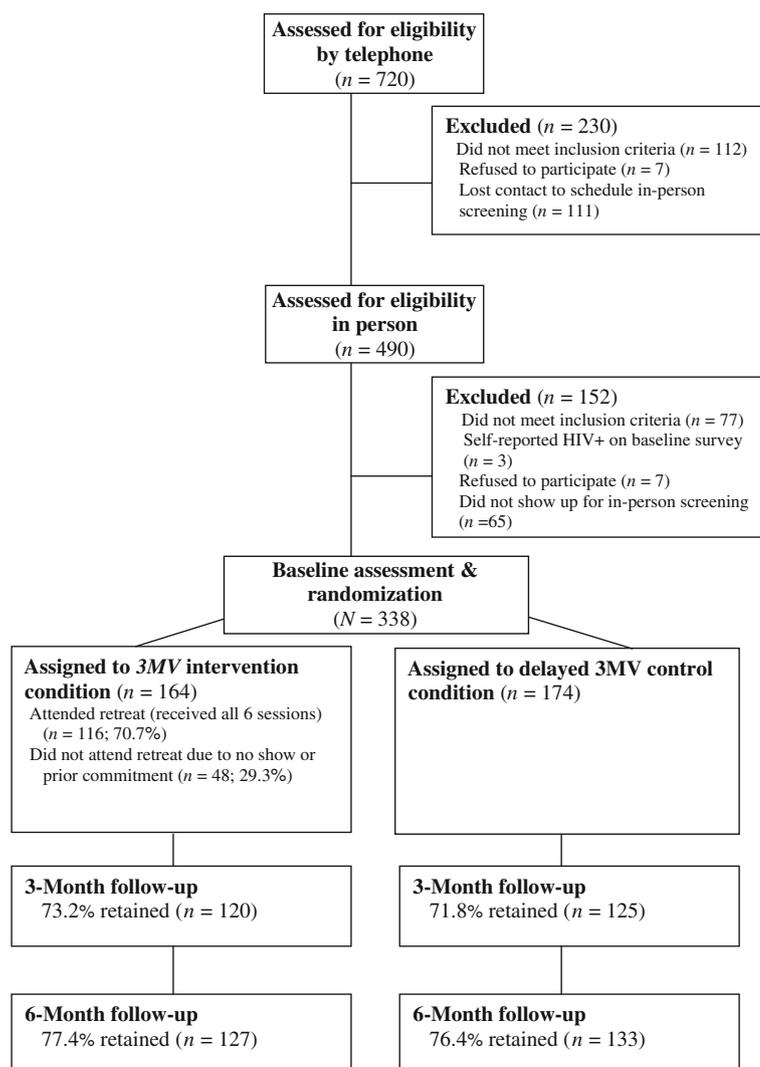
Study Procedures

The evaluation design was a randomized controlled trial, and the evaluation protocol was approved by the Human Subjects Research Review Committee at Binghamton University. All eligible participants completed a baseline assessment using audio computer-assisted self-interview (ACASI) technology. Participants were then randomly assigned to the *3MV* intervention condition ($n = 164$) or the wait-list comparison condition ($n = 174$) using a computer software program developed for the project. Those individuals who were assigned to the intervention condition were given dates for the weekend intervention retreats they would attend (comprising half-day Friday and all day Saturday and Sunday) at temporarily rented facilities in upstate New York. Individuals who were assigned to the comparison condition were scheduled to receive the *3MV* intervention 6 months following completion of their baseline assessment.

Prior to attending the intervention retreat, participants were requested to attend an orientation meeting at POCC to obtain information about the logistics and format of the retreat, and to establish ground rules for appropriate behavior. The groups of participants met at POCC offices on Friday before their retreat, and were transported by bus to the retreat venue. Once participants arrived at the retreat location, they received the *3MV* intervention during six consecutive 2- to 3-h sessions. All facilitators delivered the intervention in accordance to the *3MV* curriculum.

Two trained Black MSM peers co-facilitated the sessions. During each retreat, two quality assurance experts rated the facilitators' skills using a standardized assessment instrument. The ratings demonstrated that the facilitators delivered the intervention components with fidelity to the *3MV* curriculum. Participants were not compensated for their participation in the intervention. However, they were provided with roundtrip bus transportation to the retreat location, lodging and meals, and were remunerated for completing follow-up assessments after receiving the intervention (see details below). Participants were invited to return to POCC 2 weeks following the retreat to receive information about services for Black MSM in the community, including HIV/STI testing and treatment, mental health and substance use treatment, and access to health care; however, this was not an intrinsic part of the *3MV* intervention.

Fig. 1 Flow diagram of study participant recruitment, allocation, and retention, New York City, 2005–2007



Intervention Methods

3MV is a small group intervention that addresses behavioral and social determinants and other factors influencing the HIV/STI risk and protective behaviors of Black MSM. These other factors include cultural, social and religious norms, identity of Black MSM and their degree of connectedness to Black and gay communities, HIV/STI interactions, sexual relationship dynamics, and the social influences of racism and homophobia. Behavior change theories and models guiding the development of 3MV included social cognitive theory (Bandura 1977), the behavioral skills acquisition model (Kelly 1995), the transtheoretical model of behavior change (Prochaska et al. 1992), and the decisional balance model (Janis and Mann 1977). A unique component of 3MV is the development of menus of behavior change options for HIV/STI prevention rather than a singular emphasis on condom use that is common in other HIV prevention interventions for MSM

(Coury-Doniger et al. 2001). Session 1 (*The Culture of Black MSM*) helped participants recognize how racism and homophobia are related to sexual and substance use risk behaviors. Session 2 (*STI/HIV Prevention for Black MSM*) described the roles of “Tops” and “Bottoms” as they relate to sexual relationship dynamics and the risk of STI and HIV transmission. Session 3 (*STI/HIV Risk Assessment and Prevention Options*) helped participants personalize their own risk by building a menu of behavioral options (e.g., abstinence, mutual monogamy between two HIV seronegative partners, consistent condom use) to reduce HIV/STI transmission risk. Session 4 (*Intentions to Act & Capacity for Change*) enhanced participants’ intentions to change their own risky behaviors, and guided them toward safer sex behaviors. During Session 5 (*Relationship issues: Partner selection, Communication & Negotiation*), participants recognized power and control dynamics in their relationships, and were encouraged to select and implement a relationship-focused risk reduction behavior change

option with their partner(s). Session 6 (*Social Support & Problem Solving to Maintain Change*) involved participants role-playing communication and negotiation strategies, provided peer support to promote problem solving, and identified effective risk-reduction strategies if relapse should occur. Information about the 3MV intervention is available from the Center for Health and Behavioral Training (<http://www.urmc.rochester.edu/chbt/>).

Data Collection

Evaluation data were collected from all participants at baseline, at 3 and 6 months following the intervention retreat for 3MV participants, and at 3 and 6 months after collection of baseline data for comparison participants. At each assessment, participants completed behavioral risk interviews using ACASI that assessed demographics, drug use, and sexual risk behaviors. Participants received no remuneration for the baseline assessment, \$50 for the 3-month assessment, and \$75 for the 6-month assessment.

Outcome Measures

Based on the 3MV menu of options, several outcomes were used to assess the efficacy of the intervention in reducing sexual risk behaviors, increasing protective behaviors, and increasing HIV and STI testing. Because these measures were based on self-reports, steps were taken to enhance the validity of participants' responses: ACASI was used to minimize interviewer bias and socially desirable responses (Metzger et al. 2000); 3-month recall periods were used to optimize recall of behaviors; and facilitators who delivered the intervention were not involved in baseline and follow-up assessment activities.

Sexual Risk Behavior Outcomes

Items regarding sexual risk behaviors were adapted from a previous study (Wolitski et al. 2005). Participants were asked to report the number of anal intercourse acts occurring during the past 3 months with their main and casual male sex partners. Questions were further stratified according to respondents' insertive or receptive role during anal sex, with and without ejaculation, and with and without condoms. Questions about unprotected and protected anal intercourse acts with casual partners were asked separately according to partners' HIV serostatus. Allowable responses to these sex behavior questions ranged from 0 to 999 acts. To reduce the effects of responses with extreme values and possible overestimates, responses that reported 100–999 acts for any item were Winsorized or recoded to the highest value for that item that was <100 (Lix and Keselman 1998). When a small proportion of

values are extreme, substituting the next largest observation yields a more stable variance and an optimum estimate of the mean (Dixon 1960). The largest number of responses affected on any one item by these adjustments was four, representing 1.2% of the 338 participants.

Sexual risk behavior outcomes during the past 3 months were computed by adding responses to summarize the number of episodes of unprotected insertive anal intercourse (UIAI) and unprotected receptive anal intercourse (URAI) with main partners, and UIAI and URAI with casual partners. Dichotomous variables were also constructed to represent whether participants reported any UAI, UIAI, and URAI with main or casual male partners. Following Wolitski et al. (2005), condom use during anal intercourse was categorized as having used condoms always (100% of acts), sometimes (1–99% of acts), or never (0% of acts) among respondents who reported anal intercourse with main and casual partners in the past 3 months.

Additional self-reported sexual risk behaviors during the past 3 months included the total number of male sex partners and the number of episodes of unprotected and protected vaginal and anal sex with women. However, too few participants (9%; $n = 31$) reported having sex with a woman to perform statistical tests on these sex outcomes.

HIV and STI Testing Outcomes

Participants were asked if they had been tested for HIV, and if tested, if they had received their test results. The baseline assessment included lifetime HIV testing history and HIV testing during the past 3 months. Those participants who reported that they had received their test results were asked to describe their HIV serostatus. Identical questions were asked about testing for STIs, including gonorrhea, syphilis, and Chlamydia. HIV and STI testing questions at the 3- and 6-month follow-ups used a 3-month recall period.

Statistical Analyses

The evaluation outcomes were assessed using a rigorous intention-to-treat approach where participants were included in the analysis as originally assigned, regardless of whether they actually attended the intervention retreat (Lyles et al. 2006). Sub-analyses of intervention participants who did attend the intervention were also conducted. The results of the as-treated analyses were similar to the results of the intention-to-treat analyses although slightly more favorable. Baseline descriptive statistics were calculated to summarize sociodemographic variables, drug and sexual behaviors, and HIV and STI testing among men in the two evaluation conditions. Differences between

conditions were assessed using Student *t* tests for continuous variables and chi-square analyses for categorical variables. An alpha level of 0.05 was used for all statistical tests.

All analyses of results at the 3- and 6-month assessments included the baseline measure for the corresponding outcome as a covariate. These analyses used logistic regression to compute the adjusted odds ratio (OR) and 95% confidence interval (CI) for dichotomous outcomes (HIV and STI testing) and logistic regression with the assumption of proportional odds for the three-level ordinal outcome (condom use). Count outcomes (number of UAI acts) were modeled using SAS Proc GENMOD (SAS Institute, Cary, NC) to compute a negative binomial fit with a log link function. The results were used to calculate rate ratios (RR) and 95% CI. To clarify whether the use of negative binomial models were adequate for our outcome analysis, analyses were also conducted that modeled each count outcome (episodes of unprotected sex or number of sex partners) as a zero-inflated negative binomial distribution (Rose et al. 2006). The results were very similar to those described below for the negative binomial model, and are not presented here.

Intervention efficacy was also analyzed over the entire study period (from baseline to the 6-month assessment). To assess intervention effects for the entire follow-up period, logistic and linear generalized estimating equation (GEE) regression models were constructed to control for repeated within-subject measurements (Liang and Zeger 1986). These models included a time-independent variable (study condition) and time-dependent variables (covariates and outcomes). Fitted GEE parameters represent log odds ratios in logistic models of dichotomous outcomes and log rate ratios in negative binomial models of count outcomes over the entire 6-month period for an “average” participant. The 95% CI around the adjusted odds ratios or rate ratios and the corresponding *P* value were also computed.

Results

Sample Characteristics

The characteristics of the 338 participants who completed a baseline assessment and enrolled in the study are shown in Table 1. There were no statistically significant differences between the two study conditions on baseline sociodemographic characteristics, drug use, and sexual risk behaviors. The majority of the sample identified themselves as male (99.1%; *n* = 335) and three participants self-identified as transgender (0.9%). Participants had a mean age of 29.6 years (SD = 9.3; range 18–72). Two-thirds of participants (67.6%; *n* = 228) reported their race/ethnicity as

African American, while the remaining participants reported their race/ethnicity as Caribbean/West Indian (16.7%; *n* = 56), Afro-Latino (11.3%; *n* = 38), African (1.5%, *n* = 5), or mixed ancestry (3.0%; *n* = 11). The majority of participants had attended college (41.7%; *n* = 141) or had a college degree (29.9%; *n* = 101), whereas 21.6% (*n* = 73) had only a high school degree or general educational development certificate (GED) and 6.8% (*n* = 23) had dropped out of high school.

The majority of participants (78.1%; *n* = 264) identified as gay or homosexual, 18.3% (*n* = 62) bisexual, 1.2% (*n* = 4) heterosexual or straight, and 2.4% (*n* = 8) were unsure of their sexual orientation. About half of the participants (51.2%; *n* = 173) reported assuming both insertive and receptive sex roles during anal intercourse, 26.3% (*n* = 89) took the insertive role only, and 17.1% (*n* = 58) the receptive role only. At baseline, about one-third (34.0%; *n* = 115) of the participants reported that they were in a relationship with a main male partner. Among these men, 59.1% (*n* = 68) had been in that relationship more than 6 months. Nearly three-quarters of the respondents (*n* = 240) reported having had anal intercourse with a non-main or casual male sex partner; and 66 (19.5% of the total sample) reported that they had had sex with both main and casual male partners during the 3 months prior to the baseline assessment.

Analysis of Attrition

Overall, 299 participants (88.5%) returned for at least one follow-up assessment and were included in the main outcome analyses; 245 (72.5%) were retained at 3 months and 260 (76.9%) at 6 months (Fig. 1). Retention rates were >70% for both the intervention and comparison groups at each of the two follow-up assessments. Compared to the 299 participants returning for at least one follow-up, the 39 lost to follow-up were less likely to self-identify as gay or homosexual ($\chi^2[1, N = 338] = 7.08, P = 0.008$) or report having a main male sex partner ($\chi^2[1, N = 338] = 5.08, P = 0.024$), and more likely to report having sex with a woman ($\chi^2[1, N = 338] = 5.64, P = 0.018$). No differences in attrition were observed between study conditions at the 3- or 6-month assessments (*P*'s equal 0.78 and 0.83, respectively). Participants in the 3MV intervention who were lost to follow-up were less likely to report having a main male sex partner ($\chi^2[1, N = 164] = 8.81, P = 0.003$) and were more likely to report having been tested for an STI ($\chi^2[1, N = 164] = 5.76, P = 0.016$). Among participants in the comparison condition, those who were lost to follow-up were less likely to identify as gay or homosexual ($\chi^2[1, N = 174] = 4.21, P = 0.04$) and more likely to report having sex with a woman ($\chi^2[1, N = 142] = 5.76, P = 0.016$).

Table 1 Baseline comparability of the *Many Men, Many Voices (3MV)* intervention and wait list comparison groups of Black MSM, New York city, 2005–2007

Characteristic	3MV intervention (N = 164)		Wait list comparison (N = 174)		t-test/ χ^2 (P value) ^a
	Mean (SD)	N (%)	Mean (SD)	N (%)	
<i>Sociodemographics</i>					
Age at baseline visit (years)	29.5 (9.1)		29.7 (9.5)		0.15 (0.88)
Latino ethnicity		17 (10.4)		21 (12.2)	0.28 (0.59)
Born outside United States		19 (11.6)		23 (13.2)	0.46 (0.65)
Self-identified gay or homosexual		131 (79.9)		133 (76.4)	0.59 (0.44)
High school graduate		40 (24.4)		56 (32.2)	2.52 (0.11)
Income <\$20,000 per year		81 (50.0)		76 (44.2)	1.13 (0.29)
Unemployed		38 (23.2)		41 (23.6)	0.01 (0.93)
Attended prior HIV workshop		28 (17.3)		44 (25.6)	3.40 (0.07)
<i>Drug use behaviors (past 3 months)</i>					
Had 5 or more alcoholic drinks at single occasion		88 (62.9)		83 (53.0)	0.69 (0.41)
Any use of marijuana		140 (85.9)		143 (83.1)	0.48 (0.49)
Any use of crack or cocaine		19 (11.7)		14 (8.1)	1.21 (0.27)
Any use of crystal methamphetamine		4 (2.5)		2 (1.2)	0.81 (0.37)
Any use of ecstasy		15 (9.3)		22 (12.8)	1.06 (0.30)
Any use of ketamine		2 (1.2)		4 (2.3)	0.56 (0.45)
Any use of other street drugs		13 (8.0)		12 (7.0)	0.13 (0.72)
Any injection drug use		1 (0.6)		3 (1.7)	0.90 (0.34)
<i>Sex behaviors (past 3 months)</i>					
Number of male sex partners	3.0 (3.7)		3.3 (5.6)		0.46 (0.64)
Have main male sex partner		52 (31.7)		63 (36.2)	0.76 (0.38)
Have casual male sex partner(s)		121 (73.8)		119 (68.4)	1.19 (0.28)
UAI with sex worker		30 (18.3)		37 (21.3)	0.47 (0.49)
UAI while using drugs		28 (17.1)		28 (16.1)	0.06 (0.81)
UAI while using alcohol		38 (23.3)		35 (20.6)	0.36 (0.55)
Attended sex party for men		18 (11.0)		27 (15.5)	0.10 (0.22)
Any vaginal sex with a woman		16 (11.6)		15 (10.6)	0.08 (0.78)
<i>Number episodes UAI with male sex partners (past 3 months)</i>					
Main partner					
Any UAI	4.4 (19.6)		5.9 (18.4)		0.76 (0.47)
Insertive UAI	2.4 (12.4)		4.9 (17.4)		1.50 (0.13)
Receptive UAI	2.0 (9.7)		1.0 (4.1)		-1.24 (0.22)
Casual partners					
Any UAI	4.4 (13.1)		4.7 (20.9)		0.15 (0.88)
Insertive UAI	2.6 (8.1)		2.8 (11.9)		0.16 (0.87)
Receptive UAI	1.7 (7.0)		1.9 (9.5)		0.16 (0.87)
<i>HIV testing^b</i>					
Ever tested		156 (95.1)		169 (97.1)	0.92 (0.34)
Tested past 3 months		63 (38.4)		77 (44.3)	1.19 (0.28)
Received test results ^c		58 (92.1)		74 (96.1)	1.05 (0.31)
<i>STI testing^{b,d}</i>					
Tested past 3 months		54 (32.9)		67 (39.0)	1.32 (0.25)
Received STI diagnosis ^c		5 (3.0)		10 (5.7)	1.45 (0.23)

UAI, unprotected anal intercourse

^a Statistics are t-tests for means and standard deviations, and Chi-square tests for percentages^b Based on self-report^c Among those who tested in past 3 months^d Includes syphilis, gonorrhea and chlamydia

Participation in Intervention Retreats

As indicated in Fig. 1, 116 (70.7%) of the 164 individuals who were assigned to the 3MV intervention condition attended the intervention retreats after providing baseline information. Compared to intervention participants who attended their retreats as scheduled, those who did not attend retreats were more likely to report that they had taken part in a prior HIV prevention group or workshop (27.1 vs. 13.2%; $\chi^2[1, N = 162] = 4.58, P = 0.032$). No other baseline differences were observed between retreat attendees and non-attendees.

Effects of the 3MV Intervention on Unprotected Anal Intercourse

The occurrences of UAI reported during the past 3 months were analyzed separately for participants' main and casual male sex partners (Table 2). There were no significant intervention effects on the number of any, insertive, or receptive UAI episodes with main partners at the 3- or 6-month assessments; however, the direction of all changes was protective and more favorable in the intervention condition. Analyses of reported UAI episodes with casual male sex partners indicated that, relative to comparison participants, 3MV intervention participants reported significantly greater reductions in the total number of UAI episodes at the 6-month assessment (RR = 0.34, 95% CI = 0.14–0.83, $P = 0.012$). There was a significant intervention effect on reductions in insertive UAI episodes

with casual male sex partners at the 6-month assessment (RR = 0.24, 95% CI = 0.09–0.65, $P = 0.005$). Examination of linear trends across the entire study period indicated that 3MV participants reported a 51% greater reduction than comparison participants in the total number of insertive UAI episodes with casual sex partners (RR = 0.49, 95% CI = 0.28–0.87, $P = 0.015$; see Fig. 2). There were no statistically significant intervention effects on receptive UAI with casual male partners, but the effects favored the intervention group at the 6-month assessment and across the entire study period.

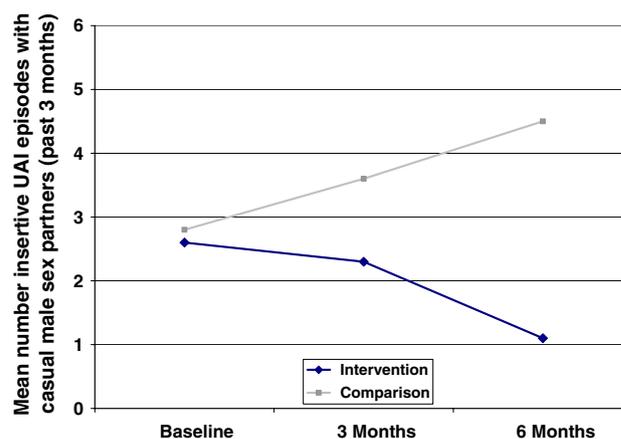


Fig. 2 Effects of the *Many Men, Many Voices (3MV)* intervention on insertive unprotected anal intercourse (UAI) with casual male sex partners, New York city, 2005–2007

Table 2 Effects of the *Many Men, Many Voices (3MV)* intervention on reported unprotected anal intercourse and number of male sex partners among Black MSM, New York city, 2005–2007

Outcome	3-Month assessment			6-Month assessment			GEE model— Baseline to 6 months RR ^a (95% CI)
	3MV M (SD)	Comparison M (SD)	RR ^a (95% CI)	3MV M (SD)	Comparison M (SD)	RR ^a (95% CI)	
<i>Number episodes UAI with male sex partners (past 3 months)</i>							
<i>With main partner</i>							
Any UAI	3.9 (16.5)	6.5 (23.0)	0.55 (0.20, 1.48)	2.1 (11.1)	4.7 (20.1)	0.40 (0.13, 1.25)	0.72 (0.38, 1.35)
Insertive UAI	2.5 (14.2)	5.2 (20.4)	0.48 (0.14, 1.68)	1.6 (10.1)	4.2 (19.7)	0.37 (0.10, 1.35)	0.85 (0.41, 1.74)
Receptive UAI	1.3 (6.0)	1.3 (6.4)	0.56 (0.16, 1.98)	0.5 (2.9)	0.5 (2.1)	0.65 (0.23, 1.86)	0.58 (0.30, 1.10)
<i>With casual partners</i>							
Any UAI	3.5 (14.7)	5.1 (20.6)	1.10 (0.41, 2.99)	2.0 (5.6)	6.2 (22.7)	0.34 (0.14, 0.83)*	0.58 (0.33, 1.01)
Insertive UAI	2.3 (12.0)	3.6 (14.6)	0.99 (0.33, 3.00)	1.1 (3.4)	4.5 (18.6)	0.24 (0.09, 0.65)**	0.49 (0.28, 0.87)*
Receptive UAI	1.2 (3.7)	1.5 (8.5)	1.51 (0.62, 3.69)	0.9 (3.3)	1.7 (6.8)	0.58 (0.20, 1.67)	0.80 (0.42, 1.53)
<i>Number male sex partners (past 3 months)</i>	2.2 (3.3)	3.2 (5.8)	0.75 (0.57, 0.98)*	2.0 (3.0)	2.6 (4.9)	0.81 (0.58, 1.12)	0.95 (0.80, 1.13)

CI confidence interval; RR rate ratio; UAI unprotected anal intercourse

^a Estimates result from negative binomial regression models that include the baseline value as a covariate and consider the wait list comparison condition as the referent

* $P < 0.05$; ** $P < 0.01$

When the outcome variables were dichotomized into any reduction versus no reduction in insertive or receptive UAI with main or casual partners, no statistically significant intervention effects were observed (results not shown). However, changes across time were generally protective and more favorable in the intervention condition.

Effects of the 3MV Intervention on Number of Male Sex Partners

At the 3-month assessment, 3MV participants reported a 25% greater reduction in the number of main or casual male sex partners during the past 3 months than comparison participants (RR = 0.75, 95% CI = 0.57–0.98, $P = 0.04$; see Table 2). Changes in number of male sex partners at the 6-month assessment and across the entire study period also favored the intervention group but were not statistically significant.

Effects of the 3MV Intervention on Condom Use During Anal Intercourse

Condom use categorized as always, sometimes, or never during insertive or receptive anal intercourse was evaluated for participants who engaged in this behavior at the 3- and 6-month assessments. Analyses of change in the percentage of condom-protected insertive or receptive anal intercourse acts with main sex partners indicated greater consistent condom use among 3MV participants at both follow-up assessments, but these findings were not statistically significant. The percentage of condom-protected insertive and receptive anal intercourse acts with casual male partners also did not differ between 3MV and comparison participants at the 3- and 6-month assessments. However, 3MV participants reported a trend for greater consistent condom use during receptive anal intercourse with casual partners

across the entire study period than comparison participants (OR = 1.55, 95% CI = 0.99–2.43, $P = 0.056$).

Effects of the 3MV Intervention on Testing for HIV and STIs

There were no statistically significant intervention effects on self-reported HIV testing at the 3-month follow-up; however, at the 6-month follow-up 3MV participants had an 81% greater odds of testing for HIV than comparison participants (OR = 1.81, 95% CI = 1.08–3.01, $P = 0.023$; Table 3). Four participants in each of the study conditions reported that they were HIV-positive at the 6-month assessment. Examination of linear trends across the entire study period indicated that 3MV participants had a 33% greater odds of testing for HIV than comparison participants (OR = 1.33, 95% CI = 1.05–1.68, $P = 0.016$). There were no statistically significant intervention effects on testing for STIs at the 3- or 6-month follow-up assessments, but the direction of changes was protective and favored the intervention group at all assessments (Table 3).

Discussion

This study evaluated the efficacy of an innovative HIV/STI prevention intervention for Black MSM that had been developed by two CBOs and a university-based HIV/STI prevention and training program with substantial involvement of the Black MSM community. Relative to comparison participants, those in the 3MV intervention reported a 25% greater reduction in number of male sex partners at the 3-month assessment, and a 66% greater reduction in any UAI and a 51% greater reduction in insertive UAI with casual male partners at the 6-month assessment. Over the entire study period, 3MV participants

Table 3 Effects of the *Many Men, Many Voices (3MV)* intervention on self-reported testing for HIV and other STIs among Black MSM, New York city, 2005–2007

Outcome ^b	3-Month assessment			6-Month assessment			GEE model—Baseline to 6 months OR ^a (95% CI)
	3MV % (no.)	Comparison % (no.)	OR ^a (95% CI)	3MV % (no.)	Comparison % (no.)	OR ^a (95% CI)	
HIV testing	52.0 (64/123)	46.3 (56/121)	1.41 (0.83, 2.39)	54.8 (69/126)	43.3 (58/134)	1.81 (1.08, 3.01)*	1.33 (1.05, 1.68)*
STI testing ^c	42.5 (51/120)	35.5 (44/124)	1.47 (0.86, 2.51)	33.9 (43/127)	32.3 (43/133)	1.17 (0.69, 1.98)	1.16 (0.90, 1.49)

CI confidence interval; OR odds ratio

^a All ORs adjusted for baseline level and wait list comparison condition as the referent. Generalized estimating equation (GEE) models include all three assessments

^b Recall period is past 3 months

^c Includes testing for chlamydia, gonorrhea, or syphilis

* $P < 0.05$

reported a nearly significant trend for greater consistent condom use during receptive anal intercourse with casual partners, the behavior that confers the greatest risk of HIV infection for seronegative MSM (Vittinghoff et al. 1999). Moreover, intervention participants were 81% more likely to report being tested for HIV than comparison participants at the 6-month assessment. The magnitude of intervention effects for the aforementioned sex risk behaviors exceed those reported in meta-analyses of behavioral interventions for MSM (Herbst et al. 2007; Johnson et al. 2008). Additional reductions were observed for insertive and receptive UAI with main partners at 3 and 6 months, with point estimates ranging from 35 to 68%, and for receptive UAI with casual partners at 6 months, with a point estimate of 42%. Although these results were not statistically significant, they exceeded the average reduction of 30% reported from a meta-analysis of 18 small group interventions for MSM (Johnson et al. 2008). Thus, compared to the state of the science in HIV prevention research for MSM, these are strong intervention effects.

The significant findings may be attributed in part to the intervention's unique feature of engaging participants in the development of menus of options for HIV/STI risk reduction. The *3MV* menus, based on known determinants of communicable disease transmission (Cohen 2005), include options for reducing risky sexual and increasing protective health behaviors for men and their partners (Coury-Doniger et al. 1998). Throughout the intervention, participants were encouraged to select and implement at least two strategies that were most relevant for their personal situation and most likely to succeed. This approach differs from other HIV prevention interventions for MSM that primarily emphasize consistent condom use with all sex partners. By encouraging participants to choose an individualized strategy, the group-level *3MV* intervention became tailored to each participant's unique circumstances thereby increasing the likelihood of behavior change (CDC 2001).

The *3MV* intervention had a protective, but not statistically significant, effect on UAI and condom use outcomes among participants with main sex partners. It is possible that we were unable to detect statistically significant intervention effects on these outcomes because too few men enrolled in the study had long-term primary partners. Indeed, only one-third of enrolled participants reported having a main male sex partner at baseline, and of these, only 59% (68 participants) had been in that relationship longer than 6 months. It may also be the case that men in a primary relationship chose to be mutually monogamous and obtain HIV testing for themselves and their partner to ensure mutual knowledge of their HIV-negative serostatus. If that was the case, those men would not necessarily choose to reduce UAI with their uninfected partner.

Nonetheless, the overall pattern of intervention effects in reducing risky sex behaviors with main partners was in the protective direction, and these findings are promising, considering the many challenges that MSM face when negotiating sexual safety with their intimate primary sex partners (Guzman et al. 2005).

Studies have shown that compared to White MSM, Black MSM have higher rates of unrecognized HIV infection, lower rates of routine HIV testing, and more frequently delay HIV testing, thereby increasing the likelihood of an AIDS diagnosis when first tested (Hall et al. 2007). The *3MV* intervention demonstrated a statistically significant effect on self-reported HIV testing behaviors at the 6-month follow-up at which point intervention participants reported an 81% greater odds of testing for HIV compared to comparison participants. This suggests that *3MV* can increase HIV testing and the chances of early diagnosis for Black MSM.

In contrast, there were no statistically significant intervention effects for increased STI testing. This difference may reflect barriers that many Black MSM face when accessing testing for STIs. Although HIV testing is readily available free of charge in a variety of CBO settings, STI testing requires a clinical visit during which fees may be charged. Nearly one-fourth of the Black MSM in this study were unemployed, and nearly half reported having an income of <\$20,000 per year, which may have been a barrier to accessing STI testing. The need to disclose one's male-to-male sexual behavior to a medical provider may also be a barrier to STI testing. In an analysis of MSM residing in New York city, 39% did not disclose their MSM status to their medical provider, and Black MSM were much less likely to disclose than White MSM (60 and 19%, respectively; Bernstein et al. 2008). Lack of disclosure to a medical provider may result in lack of identification and treatment of STIs since MSM need to disclose their same sex behavior before STI testing of the throat and rectum could occur. In a recent study of MSM, one-third of the total number of gonorrhea infections detected would have remained undiagnosed and untreated if only urethral specimens were obtained (Gunn et al. 2008). Lastly, while prevention efforts have contributed to reducing the stigma of HIV, STIs are still associated with high levels of stigma and shame, providing another barrier to STI testing (Eng and Butler 1997).

Findings of our study should be viewed within the context of several limitations. According to the *3MV* curriculum, the intervention sessions can be delivered over the course of 6 weekly sessions or during a single weekend-long retreat. In this study, we chose to evaluate *3MV* as a 3-day weekend retreat. The benefits of the retreat format include ensuring that participants receive the full dose of the intervention, and can focus their attention on the

intervention activities by reducing the distractions of everyday life. A limitation of the retreat format as evaluated is the cost associated with renting facilities and providing meals and transportation. However, many CBOs have devised more economical ways to deliver interventions using a weekend retreat format in or near their agency (Knights et al. 2008). We recommend that 3MV should also be rigorously evaluated when delivered over 6 weekly sessions. An additional limitation involves the use of a wait list comparison condition to evaluate the intervention. While time-matched attention controls provide greater scientific rigor for addressing potential changes caused by factors other than the intervention, use of a wait list comparison receiving no attention at all may introduce a bias toward finding significant results (Johnson et al. 2008).

This evaluation of 3MV has revealed several areas that require future investigation. First, more formative or operational research should be conducted to inform changes to the 3MV intervention that will result in greater reductions in sex risk behaviors, particularly receptive UAI, and increased STI testing. For example, the extent to which the intervention focuses on the reduction of receptive UAI could be revisited and receive greater emphasis, and access to STI testing after the intervention could be facilitated through a collaboration with a clinical provider. Second, given the high HIV prevalence among Black MSM, future studies should adapt 3MV and rigorously evaluate its efficacy in reducing HIV transmission risk behaviors among HIV-positive Black MSM. Third, future 3MV evaluations should include biological markers of incident HIV and STIs. Fourth, POCC staff noted that some participants that had attended a 3MV retreat together continued to meet on their own accord for ongoing support. Future studies should examine the degree to which 3MV facilitates a sense of community among Black MSM, and whether these social networks help reinforce HIV/STI risk reduction. Finally, the effectiveness and generalizability of 3MV should be evaluated among diverse Black MSM populations, and in diverse delivery settings and geographic areas.

This study is the first to demonstrate the efficacy of an integrated HIV/STI prevention intervention developed with and for Black MSM. The findings of this study support the continued diffusion of 3MV to prevention programs serving Black MSM in the US. There is also an urgent need to increase the number of evidence-based interventions for Black MSM, like 3MV, that focus on the role of STIs in acquiring and transmitting HIV infection (Aral et al. 2008). Moreover, given that disparities in STIs have been cited as a reason for the disproportionately high rates of HIV among Black MSM (Millett et al. 2006), greater resources are needed for more effective STI testing and treatment programs. The highest priority should be afforded to

funding innovative models of HIV/STI prevention for Black MSM that involves collaboration between CBOs and experts in behavioral interventions and STI prevention.

Acknowledgments Funding for this evaluation study was provided by the Centers for Disease Control and Prevention (CDC) to People of Color in Crisis (POCC), Inc. under cooperative agreements U65/CCU224517 and U65/CCU223830. This study was registered on ClinicalTrials.gov (NCT00137631). The authors would like to acknowledge other members of the 3MV Evaluation Team who helped make this study possible: LaRon E. Nelson (Center for Health and Behavioral Training, University of Rochester Medical Center) and project staff at POCC. At the time of this study, Gary English was the Executive Director of POCC and Michael Roberson and Basil Lucus were staff members of POCC. The authors would also like to thank the following individuals for their many contributions to this study: Peter McGrath (Center for Health and Behavioral Training, University of Rochester Medical Center), Duane Moody (Northrop Grumman Mission Systems), Sima Rama (Manila Consulting), Sekhar R. Thadiparthi (Satyam Computer Services Limited), and Kenneth Jones, April Bankston, Cynthia M. Lyles, the late Ida M. Onorato, David Purcell, Pilgrim Spikes, Ron Stall, and Richard J. Wolitski (CDC).

Disclaimer The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the US Centers for Disease Control and Prevention.

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3MV IMPLEMENTATION SUMMARY

Inputs →

Are the resources needed to implement and conduct intervention activities.

- Agency capacity to conduct the intervention (e.g., time, funding, resources)
- Knowledge of skills and content related to the intervention, including group facilitation, program planning, prevention theory and science, sexually transmitted diseases (STDs), and the target population
- Two highly skillful, culturally competent, small-group facilitators who possess sufficient knowledge of the risk behaviors and social practices of black gay men; at least one facilitator should be a member of the intervention's target population
- A supervisor or program manager who is charged with administrating the intervention and overseeing the facilitators
- Organizational policies and procedures that govern human relations, employee conduct, finance, and administration
- Comfortable, accessible, and safe space to conduct the intervention, including all appropriate training equipment
- Training on the implementation of 3MV, including any Web-based or distance learning requirements to build background knowledge
- Materials to conduct, monitor, promote, and evaluate the intervention, including the 3MV Intervention Kit, the 3MV Evaluation Field Guide, and the Implementation Planning Tool
- Stakeholder support for implementation of the intervention
- Access to and positive relations with gay, bisexual, and other black MSM who constitute the target population
- Technical assistance related to planning, adaptation, or evaluation

3MV IMPLEMENTATION SUMMARY (CONTINUED)

Activities → Are the actions required to prepare for and conduct the intervention. There are two sets of activities—(1) those needed to get the intervention started and (2) those needed to implement, conduct, and sustain intervention activities. Monitoring and Evaluation (M&E) activities are a subset of the latter.	Outputs Are the deliverables or products that result from implementation activities. Outputs provide evidence of service delivery.
Preimplementation	Preimplementation
<ul style="list-style-type: none"> • Closely review the intervention and training materials and understand the theory and science behind Many Men, Many Voices (3MV), as well as how the session activities are linked together • Assess agency capacity to conduct the intervention and solicit technical assistance for areas of need • Develop implementation plan with specific timelines, M&E quality assurance plans, and agency policies and procedures specific to 3MV, including how clients will be recruited and retained • Identify and prioritize target population within the broader category of black men who have sex with men (MSM); develop and implement recruitment plan, including the identification of recruitment venues and strategies; develop a retention plan if 3MV is to be provided in 7 weekly sessions • Plan for and establish a Community Advisory Board or Community Review Panel • Market the intervention to key stakeholders; enlist community support and involvement from gatekeepers • Identify qualified, culturally competent, and interested staff to coordinate and facilitate the intervention and recruit for it • Identify experienced supervisor or manager to ensure plans are followed and to conduct M&E activities • Train and build skills of agency staff, including attending a Centers for Disease Control and Prevention (CDC)-sponsored 3MV training of facilitators (TOF) • Identify logistics for implementation of the intervention (e.g., times, days, space) • Assess the need to adapt materials and activities from 3MV, ensuring that core elements are retained • Obtain or produce intervention materials • Have staff practice facilitating 3MV with mock clients • Recruit clients from identified target population 	<ul style="list-style-type: none"> • Written policies, procedures, and implementation and M&E plans tailored to your agency and target population • Community Advisory Board or Community Review Panel established for reviewing intervention materials and implementation activities • Intervention marketing and recruitment materials developed and produced • Trained staff who can effectively implement and facilitate the intervention sessions • Intervention materials produced or acquired • Intervention participants recruited

3MV IMPLEMENTATION SUMMARY (CONTINUED)

Activities → Are the actions required to prepare for and conduct the intervention. There are two sets of activities—(1) those needed to get the intervention started and (2) those needed to implement, conduct, and sustain intervention activities. Monitoring and Evaluation (M&E) activities are a subset of the latter.	Outputs Are the deliverables or products that result from implementation activities. Outputs provide evidence of service delivery.
Implementation and Maintenance	Implementation and Maintenance
<ul style="list-style-type: none"> • Continue recruitment of participants • Conduct intervention sessions, using either a weekly format or a 3-day weekend retreat • Use a sign-in sheet to identify clients and update contact information at each session • Call clients after each weekly session to process reactions and promote retention; assist with problem solving of barriers to attending all sessions • Continue to provide access to trainings for facilitators to update knowledge of STD and HIV prevention and black MSM behavioral risk • Train other agency staff as 3MV facilitators to ensure agency capacity even with staff turnover • Revise and refine implementation of 3MV based on analysis of program monitoring and process evaluation 	<ul style="list-style-type: none"> • Implementation of planned number of 3MV cycles • Staff received ongoing training • Intervention activities adapted as needed
Monitoring and Evaluation	Monitoring and Evaluation
<ul style="list-style-type: none"> • Develop system for collecting, storing, and analyzing intervention and participant data • Develop a tracking tool to assess retention • Revise or develop data collection instruments • Collect and analyze data on implementation of 3MV, including participant satisfaction and immediate outcomes as well as intervention delivery • Report findings to staff and relevant stakeholders • Report required data to funder • Use results from evaluation to improve program delivery 	<ul style="list-style-type: none"> • Monitoring data collected and summary reports developed • Quality assurance activities conducted • Quality improvement plans developed related to facilitator skills, recruitment, and retention for future 3MV interventions • Intervention findings reported to staff and stakeholder • Required data reported to funder

BEHAVIOR CHANGE LOGIC MODEL

Problem Statement: Black gay men and other black men who have sex with men (MSM) are at risk for HIV infection because of HIV risk behaviors (e.g., engaging in unprotected anal sex); low levels of health-promoting behaviors (e.g., getting tested for HIV and other sexually transmitted diseases [STDs]; getting treated for HIV and other STDs); and the high background prevalence of HIV and STDs among black MSM. A combination of social, cultural, and personal factors influences these behaviors. Many black gay men struggle with issues of identity and self-value, which may stem from discrimination such as homophobia and racism, as well as from isolation from their communities, families, and religious organizations. The lack of STD and HIV knowledge; low perception of risk for HIV and STDs; and lack of skills and low self-efficacy for condom use, negotiation, and partner communication also affect these behaviors.

Behavioral Determinants Correspond to HIV risk behaviors in this population	Activities To address behavioral determinants	Outcomes Expected changes as a result of activities targeting behavioral determinants Immediate	Outcomes Expected changes as a result of activities targeting behavioral determinants Intermediate
<ol style="list-style-type: none"> 1. Negative attitudes, beliefs, values, and low self-standards that stem from or relate to discrimination (e.g., racism and homophobia) and oppressive cultural and religious practices. These elements reflect an unhealthy or conflicted identity. 2. Lack of knowledge of STDs and the interrelations among STDs and HIV. 3. Lack of knowledge of risk-reduction options and protective behaviors (e.g., reducing number of sexual partners; getting tested and treated for STDs). 4. Lack of intentions to use condoms during anal sex. 5. Low self-efficacy to communicate with sexual partner and to negotiate condom use with sexual partner. 	<p>During weekly, small-group meetings or during one 3-day-long weekend retreat, participants will discuss, process, and engage one another in seven distinct sessions. The sessions include, but are not limited to, the following activities:</p> <ol style="list-style-type: none"> 1. Discuss factors that affect black gay men, such as dual identity, racism, homophobia, and cultural and religious norms. (BD-1) 2. Discuss the roles and risks for tops, bottoms, and versatiles. (BD-2, 9) 3. Discuss and role-play STD and HIV interactions. (BD-2, 3, 9) 4. Discuss prevention and harm-reduction options for HIV and STDs. (BD-3, 4, 5, 6, 8) 	<ol style="list-style-type: none"> 1. Improved values, self-standards, attitudes, beliefs, and identity as a black gay man. (A-1) 2. Increase in perception of personal susceptibility to HIV and STDs. (A-2, 3) 3. Increased knowledge of STDs and the interaction between STDs and HIV. (A-2, 3) 	<p>Favorable, and significant, results demonstrated in the efficacy trial:</p> <ol style="list-style-type: none"> 1. Reduced frequency of unprotected anal sex. (IO-1-7) 2. Reduced number of male sex partners. (IO-1- 7) 3. Increased HIV testing. (IO-1-7)

BEHAVIOR CHANGE LOGIC MODEL (CONTINUED)

Behavioral Determinants Correspond to HIV risk behaviors in this population	Activities To address behavioral determinants	Outcomes Expected changes as a result of activities targeting behavioral determinants Immediate	Outcomes Expected changes as a result of activities targeting behavioral determinants Intermediate
<ul style="list-style-type: none"> 6. Lack of HIV risk-reduction behavioral skills (e.g., technical skills related to condom use; self-management skills related to addressing other issues in one’s life that influence HIV risk behavior). 7. Lack of peer and social support for behavior change. 8. Lack of self-efficacy to engage in safer behaviors (e.g., consistent condom use with main and casual partners). 9. Low perception of risk for acquiring STDs and HIV. 10. Lack of knowledge about the process of and steps involved in purposeful behavior change. 	<ul style="list-style-type: none"> 5. Discuss intentions and readiness to practice risk-reduction options (e.g., reducing number of sexual partners; getting tested and treated for STDs) and health-promotion behaviors. (BD-4, 5, 6, 8, 10) 6. Practice skills (e.g., partner communication; condom negotiation). (BD-5, 6, 8) 7. Practice decision making and problem solving. (BD-5, 6, 7, 8) 8. Present and practice use of the stages of change approach to behavior change, including normalization of and preparation for obstacles, challenges, and relapse. (BD-10) 	<ul style="list-style-type: none"> 4. Increased knowledge of risk-reduction and health-promotion behaviors. (A-4) 5. Increased knowledge of HIV risk-reduction behavior skills. (A-4, 5, 6, 7) 6. Increased skills and self-efficacy related to consistent condom use, condom negotiation, and partner communication. (A- 6, 7) 7. Increased intentions to adopt a risk-reduction or health-promotion behavior. (A-2, 3, 4, 5, 6, 7) 	<p>Favorable, but not significant, results demonstrated in the efficacy trial:</p> <ul style="list-style-type: none"> 1. Increased condom use for anal sex. (IO-1-7) 2. Increased STD testing. (IO-1-7)

SAMPLE CONFIDENTIALITY AGREEMENT FOR 3MV STAFF MEMBERS

To protect the confidentiality of people who participate in the 3MV intervention and to foster an atmosphere of respect for all participants, all persons involved in 3MV must agree to the following:

Staff members should not discuss the identity of participants.

Staff members should not discuss what was said by the participants with others who are not part of the 3MV staff.

Staff members should not discuss intervention participants outside the context of 3MV.

Staff members should encourage intervention participants to refrain from discussing or sharing the personal information of other participants.

In a case where a staff member knows a participant, the staff member should refrain from discussing that person with other staff members or sharing any additional information about the participant.

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

Signature: _____

Date: _____ / _____ / _____

SAMPLE 3MV IMPLEMENTATION PLANNING TOOL

The sample 3MV Implementation Planning Tool is divided into steps. Table 1 presents the preparation steps, Table 2 provides the implementation steps, Table 3 provides the maintenance steps, and Table 4 outlines the evaluation steps.

Table 1. Planning and Preliminary Steps

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Identify population of black men who have sex with men (MSM) to target	Knowledge of black MSM population; support from stakeholders; skills to conduct formative evaluation	Program staff	Month 1	
Begin developing relevant community relationships	Knowledge of local HIV programs, gatekeepers from black MSM community	Project coordinator	Month 1	
Estimate number of black MSM you can target with 3MV on the basis of available resources	Resources, funding, staff to target specific network size	Project coordinator	Month 1	
Recruit, hire, and train facilitators and other program staff, as needed	Knowledge of staff requirements, recruitment resources	Project coordinator	Month 1	
Develop an implementation plan and program objectives that are consistent with overall 3MV intervention; develop objectives that are SMART	Knowledge of SMART objectives, 3MV intervention activities, core elements	Program staff	Month 2	
Develop policy and procedures for your agency	Knowledge of local and national guidelines, laws; funder requirements; 3MV activities	Project coordinator	Month 2	
Develop a monitoring and evaluation (M&E) plan	Knowledge of M&E, 3MV activities	Program staff	Month 2	

Implementation Manual

Table 1. Planning and Preliminary Steps (continued)

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Ensure facilitators are trained and have practiced facilitating intervention sessions	Knowledge of and training on 3MV intervention, group facilitation; STD overview for nonclinicians	Project coordinator; intervention facilitators	Month 2	
Identify potential venues for delivering intervention activities	Knowledge of appropriate venues in local area; intervention space requirements	Program staff	Month 3	
Select appropriate venue	Information on available venues; intervention space requirements	Project coordinator	2 months before implementation phase	
Develop 3MV marketing materials	Knowledge of target black MSM community and their interests, language, terminology; ability to conduct focus groups	Project coordinator	2 months before first cycle of 3MV intervention	
Develop plan and schedule for intervention sessions	Knowledge of number of intervention cycles to conduct; knowledge of convenient times, locations, availability of venues	Project coordinator	1 month before implementation phase	
Identify and secure intervention space	Knowledge of 3MV intervention space requirements; maximum number of participants per session; convenient times, locations for participants; funding	Project coordinator	1 month before implementation phase	
Adapt 3MV intervention materials, as needed	Data collected from any preimplementation assessment activities on target population of black MSM; intervention intent; internal logic	Program staff	3 to 6 months before implementation phase	

Implementation Manual

Table 2. Implementation Steps

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Conduct 3MV intervention sessions	Knowledge of 3MV intervention sessions; trained facilitators; space, staff, intervention materials	Intervention facilitators	After completion of preimplementation phase	

Table 3. Maintenance Steps

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Recruit successive cycles of participants	Knowledge of potential participants, number of participants needed; recruitment skills	Program staff	After completion of first cycle of 3MV intervention	

Implementation Manual

Table 4. Evaluation Steps

Step	Capacity and Knowledge Needed	Person(s) Responsible	Timeline	Notes
Determine which level of M&E you can conduct (formative evaluation, process monitoring, process evaluation, outcome monitoring)	Knowledge of agency resources, time; knowledge of M&E concepts; knowledge of evaluation forms required by funding agency, desired by implementing agency; knowledge of purposes of evaluation process	Project coordinator	As you develop your M&E plan	
Conduct process M&E; collect data	Knowledge of process M&E methods, process evaluation forms, 3MV core elements	Program staff	During preimplementation, implementation, maintenance phases	
Conduct quality assurance assessment of intervention sessions; collect data	Knowledge of quality assurance methods, facilitator fidelity/process form	Project coordinator	After every four opinion leader trainings	
If resources allow, conduct outcome monitoring of 3MV; collect data	Knowledge of outcome monitoring methods, data collection forms	Program staff	At least 6 months after all opinion leaders have been trained	
Analyze collected data	Knowledge of analysis techniques	Program staff	Quarterly	
Review evaluation data and identify intervention areas and activities for improvement	Knowledge of intervention objectives, core elements	Program staff	Quarterly	
Report findings to stakeholders, staff, and funders	Skills to summarize, report data	Project coordinator	At least once every 6 months	

Why use 3MV for black gay men?

3MV is designed to address the unique social, cultural, and personal factors that influence the risk behaviors of black gay men. Among black gay men, 3MV has also been shown to be effective in:

- Reducing rates of unprotected sex
- Increasing consistent condom use
- Reducing numbers of sex partners
- Increasing HIV testing rates

How is 3MV implemented?

3MV is a seven-session intervention delivered to 6–12 participants. Sessions last from 2 to 3.5 hours and build on the discussion and exercises of prior sessions. Sessions are delivered by two culturally appropriate facilitators, one of whom needs to be a black gay man. 3MV can be delivered over a 7-week period or as a weekend retreat. Sessions use role-play activities, group exercises, facilitated discussions, and skills-building activities. Participants are encouraged to share personal experiences, attitudes, beliefs, and feelings. 3MV should be implemented in a private setting where participant feel safe.

How do I find out more about 3MV?

www.effectiveinterventions.org



DRAFT

I deserve to be
Happy



I deserve to be
Healthy



What is Many Men, Many Voices?

Many Men, Many Voices (3MV) is a small, group-level behavioral intervention that decreases the HIV and STD risk behaviors and increases health promotion behaviors (e.g., HIV testing, STD screening) among black gay men. 3MV helps black gay men better understand the social and behavioral factors that put them at increased risk for HIV and other STDs. Through 3MV, participants:

- Learn about the unique factors (racism, homophobia) that put them at risk for STDs/HIV
- Learn about how to prevent and reduce their risk
- Discuss their intentions to change risk behaviors
- Practice behavioral skills that focus on risk prevention and reduction
- Learn basic information about the transmission, signs, symptoms, and treatment of HIV and STDs
- Provide and receive positive support for making healthy behavior changes

Who is 3MV for?

3MV is designed for black gay men. This includes men who have sex with men (MSM) who identify as gay and those who do not, but have sexual and/or emotional attractions to other men. 3MV is not appropriate for MSM who do not have sexual and/or emotional attractions for other men (e.g., inmates who have “situational sex,” men who trade sex for money or drugs). 3MV was not specifically designed for other racial/ethnic minority groups, but could be adapted for these populations.

What is needed to implement 3MV?

To implement 3MV, agencies will need:

- Culturally appropriate facilitators and program administrative staff
- 3MV implementation materials (e.g., manuals, handouts, slides, monitoring tools, recruitment/marketing posters, and flyers)
- Easily accessible meeting space to fit 15 people
- Supplies and equipment (e.g., masking tape, markers, easel charts, newsprint, LCD projector, and laptop)

What are the benefits of 3MV?

Benefits to Participants

- Establishes and builds supportive relationships with other black gay men who are also working to change their HIV/STD risk behaviors

Benefits to Your Agency

- Establishes positive relationships with black gay men
- Increases support among black men within LGBT communities
- Enhances reputation among black gay men
- Increases opportunities to be involved in other prevention activities targeting black gay men

Benefits to Communities

- May reduce HIV and STD incidence and prevalence among its most vulnerable members
- Raises awareness about the importance of STD and HIV prevention, testing, and treatment among those at risk



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I Deserve to Be Healthy

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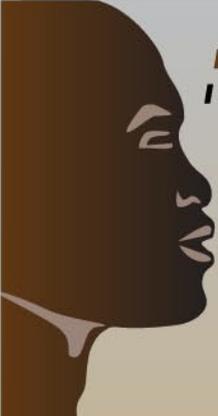


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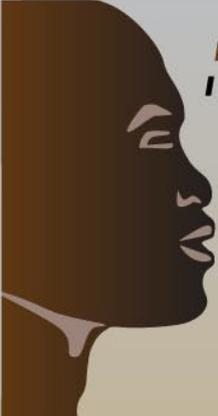


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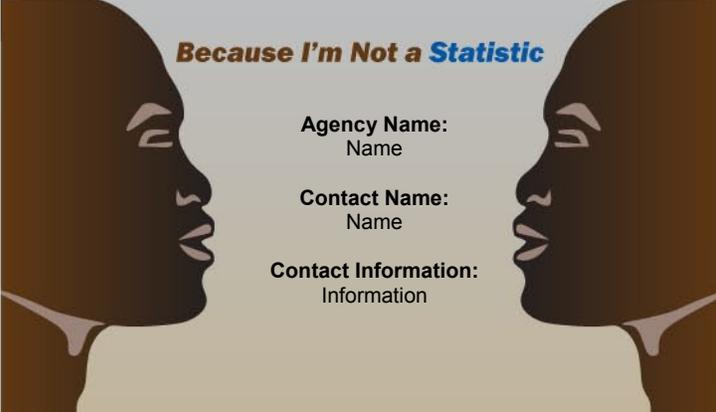
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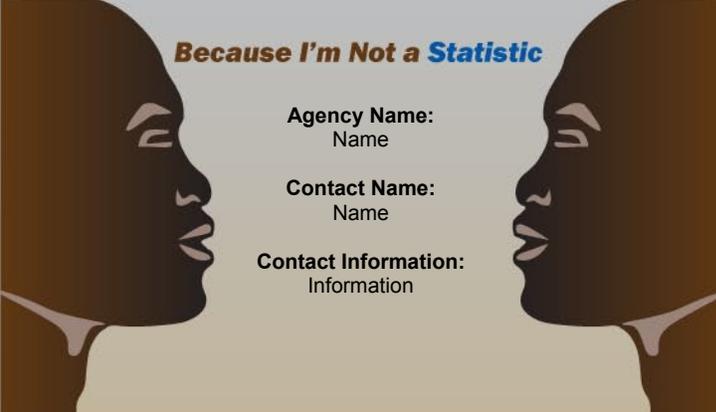


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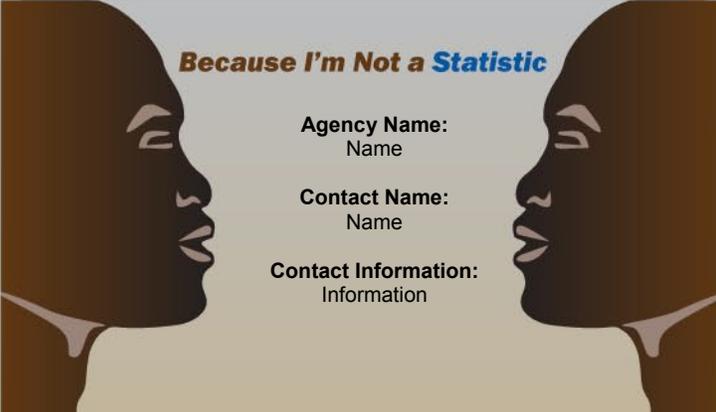


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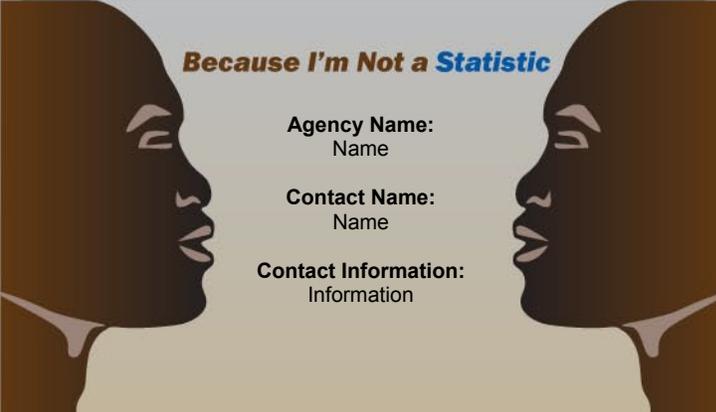


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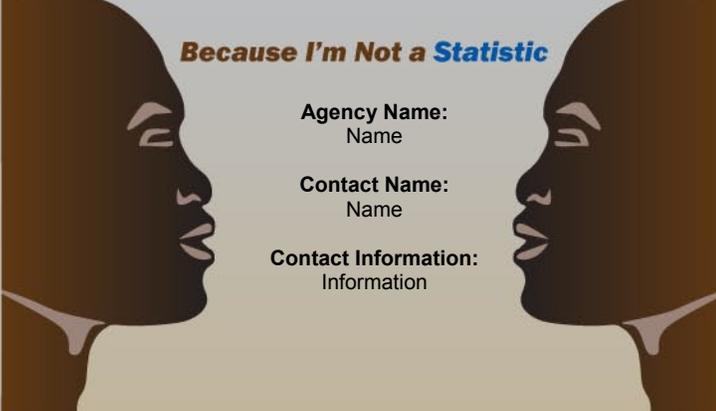


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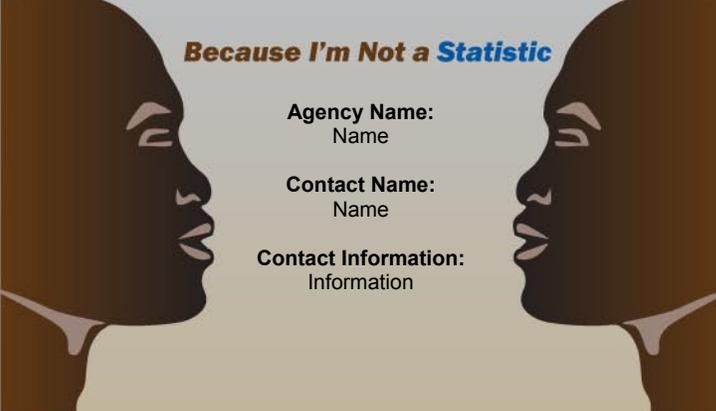


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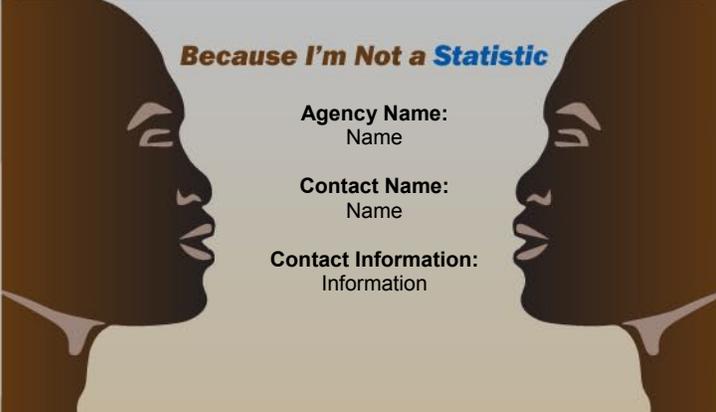


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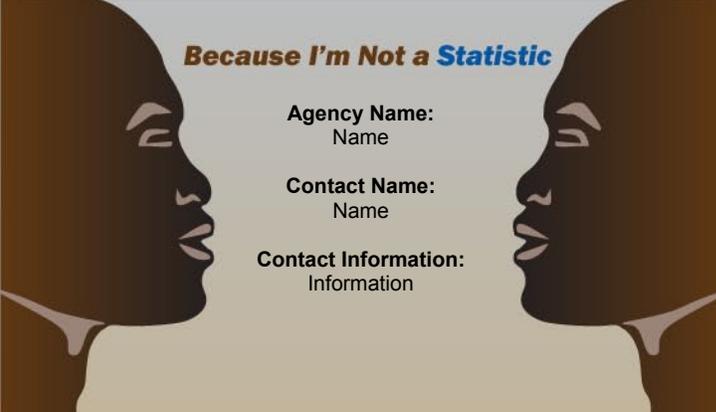


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KEEPING SEXY BLACK



How do I find out more about 3MV?

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E-mail: 12346666@ertyuawerihhoihuuu.com

Phone: 222-222-2222

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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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August 11, 2000

Notices to Readers — Continued

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

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

Reference

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



MMWRTM

Morbidity and Mortality Weekly Report

Weekly

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

Nonoxynol-9 Spermicide Contraception Use — United States, 1999

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

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

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

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

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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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The ABCs of Smart Behavior

To avoid or reduce the risk for HIV

A stands for abstinence.

B stands for being faithful to a single sexual partner.

C stands for using condoms consistently and correctly.



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



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

Interim Revisions June 1992

1. Basic Principles

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

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

"SEC. 2500. USE OF FUNDS.

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

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

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

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

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

2. Program Review Panel

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

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

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

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

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

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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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