



**A Couples-level Intervention for Relationships Living with  
or At Risk for HIV/STIs**

**STARTER KIT**

**Revised Version  
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We acknowledge the support provided by the Centers for Disease Control and Prevention (CDC) through an agreement with DANYA International Inc., and cooperative agreement #U65/PS000239 for the development of the original product and by Dr. Nabila El-Bassel for the research on which this product is based. The original design and implementation research was done by the Social Intervention Group, at the Columbia University School of Social Work (New York, NY) and was supported by the National Institutes of Mental Health Grant MH57145. Subsequent adaptations on which this revision is based were supported by: Multimedia **Connect** implementation study NIMH Multimedia **Connect** implementation study was funded by NIMH MH080659 (PI Witte); Packaging study #U65 funded by CDC (PI Witte);

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## Important Information for Users

This HIV/STI risk-reduction intervention is intended for use by persons who are at high risk for acquiring or transmitting HIV/STI and who are voluntarily participating in the intervention. The materials in this intervention package are not intended for general audiences.

The intervention package includes implementation manuals, training and technical assistance materials, and other items used in intervention delivery. Also included in the packages are: 1) the Centers for Disease Control and Prevention (CDC) factsheet 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,” 4) the ABCs of Smart Behavior, and 5) the 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 conducting 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, program manager(s), and program evaluator(s) when preparing for implementation, monitoring, and evaluating the intervention.



## Getting Started

### What is Connect?

**Connect** is a three-session, relationship-based intervention, provided to couples together with their main sex partners. The couple then attends three sessions together. The first goal of the intervention is to teach couples communication techniques and HIV/STI risk reduction knowledge and skills. The second goal is to explore with the couple the gender and power dynamics in their relationship that may be barriers to safer sex behaviors. **Connect** is based on two theories, the AIDS Risk Reduction Model (ARRM)<sup>1</sup> and the Ecological Perspective<sup>2</sup>. **Connect** is strongly influenced by Family Therapy and counseling techniques, specifically those used at and recommended by the Ackerman Institute for the Family.

**Connect** addresses couples' HIV/STI risk behaviors, knowledge, relationship communication, gender and power dynamics, and safer sex negotiation skills. Sessions involve the introduction of modeling, review and practice of communication (Speaker/Listener Technique) and risk reduction skills, and goal setting. Risk reduction skills include male and female condom use, identifying alternatives to high- or moderate-risk behaviors, trigger identification, problem solving, social support, and types of support mapping. Participants explore existing behaviors, see new behaviors modeled for them, practice those skills, receive feedback, and reevaluate their behaviors. The goal of the intervention's relationship-based approach is to reframe safer sex not as individual "protection," but rather as a way to preserve relationship and community, as an act of love, commitment, and intimacy. It emphasizes the importance of communication, negotiation, and problem-solving skills, and highlights how relationship dynamics may be affected by gender roles and expectations. The session content emphasizes the contribution each participant and their partner makes to enhancing the future health of their partnership, family, and community. Consistent with the U.S. National HIV Prevention Plan, the intervention also can be used with individuals and couples living with HIV without changing its core elements. However, minor adjustments to the language used in some of the sessions would need to be made. For example, the intervention emphasizes reducing risk for any new STIs, including HIV, for HIV-infected individuals, **Connect** highlights newer, drug-resistant strains of HIV and

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<sup>1</sup> Catania, J.A.; Kegeles, S.M.; Coates, T. J. Towards an understanding of risk behavior: An AIDS Risk Reduction Model (ARRM). *Health Education Quarterly*, 1990;17:53-72.

<sup>2</sup> Bronfenbrenner, U. The ecology of human development. *American Psychologist*, 1979;32:513-531.

how STIs can do harm to an HIV-positive person's immune system. Also, **Connect** addresses the misperception that an HIV-positive person whose viral load is undetectable poses no transmission risk.

Between 1997 and 2001, **Connect** was developed and tested by the investigative team at the Social Intervention Group at the Columbia University School of Social Work<sup>3</sup>. **Connect** was the first relationship-based HIV/STI prevention intervention for couples. **Connect** comprised six weekly sessions lasting 120 minutes each and conducted by one facilitator. The intervention focused couples who had been in a relationship for at least 6 months and were committed to remaining in the relationship for the next year. The couples also met additional criteria for being at high risk for sexual transmission of HIV due to their own or their partner's suspected risk behaviors (e.g., sex outside of the relationship, or injecting drug use). The study was based in a New York City primary care health services facility in a community with high HIV prevalence and mainly lower income African-American and Latina/o clients.

In the original **Connect** intervention, 217 couples were recruited and randomly assigned to (1) six sessions of the relationship-based intervention provided to couples together, (2) the same intervention provided to the woman alone, or (3) a one-session control condition provided to the woman alone. At both three months<sup>4</sup> and 12 months<sup>5</sup> post-intervention, the intervention demonstrated efficacy in reducing the proportion of unprotected sexual acts and increasing the proportion of protected sexual acts. No significant differences in effects were observed between couples receiving the intervention together and those in which the woman received it alone. While both the protocols for couples and women alone were shown to be effective, this package is the protocol used for couples and not women alone. **For readers who want more details on the intervention study, copies of articles can be found in Appendix VI.**

Supporting a HIV discordant couples treatment adherence is critical to HIV viral suppression, health outcomes and reduction of HIV transmission. **Connect** sessions provide a context to learn about HIV, treatment and transmission risks while practicing communication and problem-solving skills to address triggers to risky behaviors, relapse

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<sup>3</sup> El-Bassel, N., Witte, S., Gilbert, L., Sormanti, M., Moreno, C., Pereira, L., Elam, E. & Steinglass, P. (2001). HIV prevention for intimate couples: A relationship-based model. *Families, Systems, and Health*, 19 (4), 379-395.

<sup>4</sup> El-Bassel, N., Witte, S.S., Gilbert, L., Wu, E., Chang, M., Hill, J. & Steinglass, P. (2003). The efficacy of a relationship-based HIV/STD prevention program for heterosexual couples. *American Journal of Public Health*, 93, 963-969.

<sup>5</sup> El-Bassel, N., Witte, S.S., Gilbert, L., Wu, E., Chang, M., Hill, J. & Steinglass, P. (2005). Long-term effects of an HIV/STI sexual risk reduction intervention for heterosexual couples. *AIDS and Behavior*, 9 (1), 1-13.

and challenges to treatment adherence. Skills are directed toward any barrier or trigger, as identified by the couple, that may inhibit sustained safer behaviors and compliance with medical intervention. While the primary outcomes for **Connect** were proportion of unprotected sexual acts and increased condom use, subsequent adaptations of **Connect** (**Connect** II, EBAN and Renaissance) with shared core components have demonstrated efficacy in increasing condom use, reducing unprotected sexual acts, improving treatment access, reducing substance use and effective reversal of an opioid overdose. EBAN is an 8 session intervention for African-American HIV-serodiscordant couples of which 4 sessions are in couples groups and 4 are in individual couple sessions. **Connect** II is a 4 session adaptation of **Connect** in which the target population focuses on couples engaged in substance use related risk. **Connect** II, now under the revised name Protect and **Connect** (PACT), has been tailored for men under community supervision and their female partners and is being tested for effectiveness in probation and community court settings. It includes a case management and service linkage component. Renaissance is a 5 session adaptation for couples where at least one partner is an injection drug user. Three sessions are conducted in same gender groups while 2 sessions are conducted with individual couples. Opioid overdose prevention and response was integrated into this HIV/STI prevention intervention.

**Connect** sessions are not classes or lectures. They are interactive sessions that can be both educational and entertaining. They create a context through which people can:

- ♥ Examine their risks and analyze their existing interpersonal behaviors with their main partner;
- ♥ Develop skills to reduce their risks; improve communication, negotiation skills, and relationship quality; and
- ♥ Enhance dialogue in their relationship and remove barriers to relationship change.
- ♥ Navigate couples to real resources of support in a continuum of care such as: HIV testing and treatment or prevention services, referrals for other health care

### Benefits of HIV/STI prevention with couples

Providing HIV/STI risk-reduction interventions to couples together encourages collaboration to address mutual needs, which may be more effective for some people than reaching that person alone. In **Connect**, the relationship, and not just the individual, is the focus for change. The emphasis is on the fact that it takes two people, not just one, for shared behaviors to change. Having both partners engaged in the process allows

the facilitator to address stumbling blocks or barriers in the relationship. Both partners are invited to share their perspectives and are encouraged to develop understanding of each other and a sense of unity. There is value in strengthening couple-level support, satisfaction, and unity to reduce distress and increase individual feelings of well-being. It is also important to help couples increase their sexual satisfaction within the relationship without incurring increased risk for transmission of HIV and other STIs. Sex is an intimate behavior that can influence and be influenced by other modes of emotional intimacy within a relationship.

The couple-based counseling literature suggests that relationship-based interventions can be provided either to one partner alone or to the couple together, but that interventions delivered to the couple together may be more effective for several reasons. First, individuals acting alone to introduce safer sex practices may face negative reactions from their partners including isolation, threats to end the relationship, or physical or emotional violence. Second, the expectation that individuals can teach new knowledge and skills to their partners assumes that they have the necessary communication skills. Third, the supportive environment of a couple-based intervention may enable intimate partners to feel safer disclosing highly personal information (e.g., sex outside of the relationships, or STI histories) to their partners that will enable them to gain a more realistic sense of their risks for HIV/STI as a couple.

### The science behind Connect

The **Connect** intervention is based on **AIDS Risk Reduction Model (ARRM)**, which was developed as a conceptual framework to organize HIV risk reduction behavior change information and skills. This model joins pieces from a number of cognitive and behaviorally-based health behavior change theories, including **Social Cognitive Theory**<sup>6</sup>. The ARRM has three stages. The first is recognizing and labeling one's sexual behaviors as high-risk for contracting HIV. The second stage is making a commitment to reduce high-risk sexual behaviors and increase low-risk activities. The third stage is seeking and carrying out strategies to reach these goals, such as talking with one's sex partner about change, starting condom use, and seeking help from one's network of family, friends, and community for changing risk behaviors. Although separated for conceptual purposes, these stages may occur at the same time.

For **Connect**, we modified the ARRM by adding an additional stage: "maintenance" of behavioral change. While ARRM focuses on changing individual behavior, in combination

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<sup>6</sup> Bandura, A. (1994). Social cognitive theory and control over HIV. In R.J. DiClemente & J.L. Peterson (Eds.), *Preventing AIDS: Theories and methods of behavioral intentions*. (pp. 25-59).

with Family Therapy techniques and a couple-based format, the emphasis on improving communication and negotiation skills for behavior change may best occur with partners together in relationship-based sessions.

According to the AIDS Risk Reduction Model, these stages can be achieved by:

- ♥ Identifying ones' own risk behaviors and situations that may lead to unsafe sex
- ♥ Discussing and negotiating strategies with one's partner to avoid situations leading to risky behavior
- ♥ Identifying positive reasons to stay healthy and to practice safer sex
- ♥ Stating a commitment to keep ones' relationship safer and healthy
- ♥ Anticipating having sex so that one is prepared to use condoms
- ♥ Observing healthy communication and safer behaviors being modeled
- ♥ Having guided practice or rehearsal of new behaviors and skills
- ♥ Receiving corrective feedback on one's performance of the behavior or skill
- ♥ Gaining personal experience with new behaviors and skills
- ♥ Developing and maintaining relationships that support safer sex behaviors.

Structured, skill-based, experience-based strategies enable individuals to anticipate problem or high-risk situations and to develop specific behavioral skills in solving problems, overcoming challenges, or avoiding risks. Skills training includes introduction and definition, modeling, and behavior rehearsal with coaching and feedback. Goal-setting helps apply skills to other areas of life. Positive reinforcement and social support make "trying out" new behaviors easier and help maintain commitment to change over time.

Many factors affect a person's ability to change. The ARRM considers that behaviors, environment, attitudes, and beliefs influence and depend on each other. Therefore, in order for persons to successfully change their behavior, they need:

- ♥ Information—Such as awareness of risk and knowledge of techniques for reducing risk and communicating with one's partner
- ♥ Self-efficacy—Belief in one's ability to control one's own motivations, thoughts, emotions, and specific behaviors, particularly when communicating with a sex partner

- ♥ Outcome expectations—Belief that good things will happen as a result of new relationship behaviors
- ♥ Outcome expectancies—Belief that the results of new relationship behaviors are valuable and important
- ♥ Social skills within interpersonal relationships—Such as the ability to communicate effectively, to negotiate, and to resist pressures from others
- ♥ Self-regulating skills—Such as the ability to communicate, negotiate, and solve problems successfully with one’s partner
- ♥ Reinforcement—“Rewards” received and experienced by oneself and by the relationship as a result of successfully performing and maintaining new behaviors

In **Connect**, all of the above information and skills are nested within an **Ecological Perspective**, which means that the intervention addresses multiple levels (biological, psychological, and social) which influence risky and safer behaviors. This approach combines some context and relationship issues that have been shown to be significant barriers to HIV risk reduction for individuals. Examples include imbalances in gender and power and perceived negative reactions from partners, including rejection, mistrust, or conflict. **Connect** activities address:

- ♥ Personal factors and experiences which may help or hinder HIV risk reduction, such as trauma, self-efficacy, or communication skills
- ♥ Relationship factors, such as power imbalances, intimacy, trust, and communication among partners
- ♥ Family and peer group factors, such as identifying and developing social supports for safe and healthy relationship behaviors
- ♥ Awareness of community factors, such as pressures or norms, including gender and sexual stereotypes that challenge risk reduction behavior change

**Connect** intervention components were designed to address mainly the relationship and family-based factors described above.

The implementation of **Connect** is heavily influenced by techniques and strategies used in the practice of **Family Therapy**, particularly those developed with the Ackerman Institute for the Family, based in New York City. Ackerman Family Therapy is a form of psychotherapy that brings families together to solve their shared problems. Problems are lessened by allowing couples to harness their strengths and resources, and to work together. The activities in **Connect** guide facilitators to focus on the couple’s relationship as

the focus of change, and work with the couple (family) to readapt themselves in response to an external event or circumstance (here, HIV/STI risk) in a safer and healthier way by communicating and working together.

Examples of Family Therapy facilitation methods include:

- ♥ Joining with the couple, and focusing on their relationship as the focus of change
- ♥ Externalizing (Identifying) HIV and other STIs as outside threats to the health and safety of the relationship
- ♥ Emphasizing the importance of good communication, including teaching the Speaker/Listener Technique, to improve the relationship and the relationship change process
- ♥ Pointing out observed positive interactions between partners to increase couple unity and ability to change risk behaviors
- ♥ Maintaining a neutral “observer stance,” presenting information or skills, and coaching when appropriate, but emphasizing the couple as experts in their own relationship
- ♥ Allowing time and space for the couple to talk, listen, and learn from each other

The goal of the **Connect** intervention is to change risky sexual behavior among couples affected or infected by HIV or other STIs by enhancing the quality of their relationship and communication, and their shared commitment to safety and health. The AIDS Risk Reduction Model predicts that enhancing self-efficacy for communicating with ones’ partner and for engaging in behaviors that reduce risk, and that building commitment and social support for maintaining safer behaviors leads to effective maintenance of safer behavior. Achieving lower risk involves using behavioral skills and practicing safer sex behaviors. Enhancing communication and negotiation skills between partners is effective in increasing safer behaviors. The Ecological Perspective keeps the focus larger than the individual, with an eye to the relationship and family-level contexts in which risk and safety occur. The Family Therapy techniques create an atmosphere and environment supportive to couples as they explore and learn new relationship techniques and safer behaviors.

### Core elements and key characteristics

Evidence-based interventions, such as **Connect**, have components that should be included without alteration (*Unless* the latest scientific evidence requires that they be changed due to immediate or long-term harm-physical, mental, or social, or where changes will yield greater benefits to the focus population) to ensure the intervention’s effectiveness. These

components are called Core Elements. Core Elements are required components that represent the theory and internal logic of the intervention and most likely produce the intervention's main effects. Researchers identify Core Elements through research and practice. Core Elements define an intervention and must be implemented with fidelity to increase the likelihood that prevention providers will have program outcomes that are similar to those in the original research. **Connect**'s six Core Elements are as follows:

- ♥ Working with sexual partners together in structured, facilitated sessions emphasizing the relationship as the focus of change.
- ♥ Creating a prevention and/or risk reduction strategy customized to the partners' relationship history, characteristics and agreements.
- ♥ Identifying how gendered expectations, stereotypes, stigma and power imbalances influence decisions regarding biobehavioral and biomedical prevention approaches.
- ♥ Using modeling, practice, and goal setting to promote mastery in communication, negotiation, problem-solving and social support enhancement within partnerships to reduce risks.
- ♥ Enhancing skills to navigate family, community and structural-level barriers that impact risk reduction and access to care.
- ♥ Facilitating linkage to care and other needed services to address co-occurring issues.

These six Core Elements must be maintained without alteration to ensure *fidelity* to the intervention and its effectiveness. *Fidelity* is conducting and continuing an intervention by following the Core Elements, protocols, procedures, and content set by the research study that determined its effectiveness. While the Core Elements should not be altered, unless the latest scientific evidence requires that they be changed due to immediate or long-term harm-physical, mental, or social, or where changes will yield greater benefits to the focus population, implementing agencies can adapt Key Characteristics. Key Characteristics are activities and delivery methods for conducting an intervention that, while considered of great value to the intervention, can be adjusted without changing the outcome of the intervention. These activities and delivery methods can be adapted for different agencies and at-risk populations. *Adaptation* describes the process of customizing delivery of interventions to agency circumstances and ensuring that messages are appropriate for focus populations without altering, deleting, or adding to the intervention's Core Elements.

Remember, Key Characteristics are important aspects of an intervention that can be adapted to be more appropriate for your community. Some Key Characteristics identified from the original research for **Connect** are:

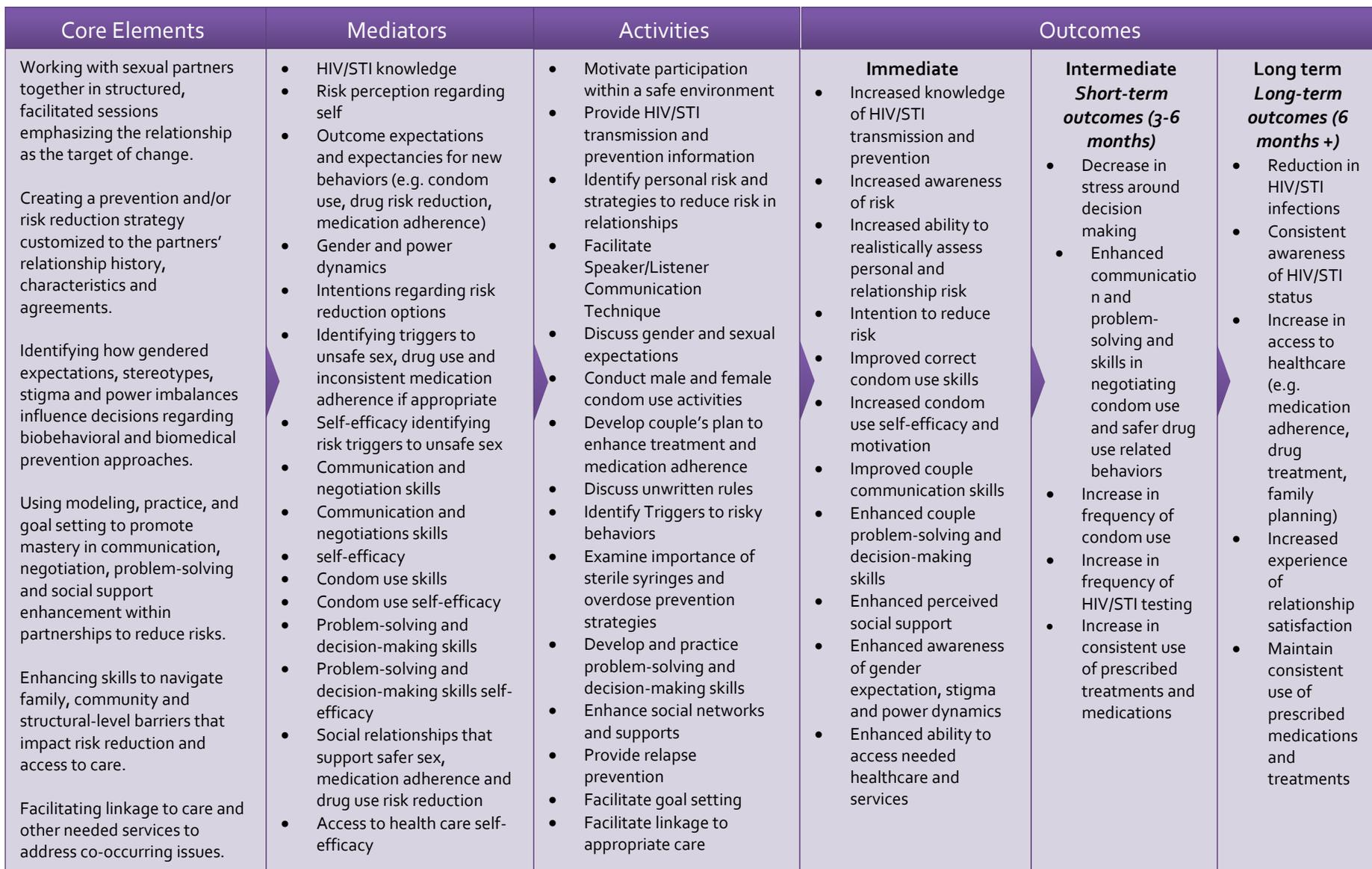
- ♥ Partners meet in facilitated sessions lasting up to 90 minutes.
- ♥ Sessions are held three to five days apart so that participants can meet their goals and practice skills to build self-efficacy.
- ♥ The facilitators should be knowledgeable in HIV and other STIs. Specialized training in couples/partnership work and issues with special populations is strongly suggested (e.g. drug using couples, MSM, criminal justice involvement, stigma and cultural competence).
- ♥ The individual violence screening is conducted by a person not facilitating sessions one to three.
- ♥ The same facilitator conducts sessions one through three with the same couple.
- ♥ Implementers should have a strong working knowledge of local resources for successful referrals and linkage to care.
- ♥ At each session couples receive a take-home condom packet with assorted condoms and lubricants. (Contents may be locally adapted).
- ♥ The facilitator asks partners for the terms they use for their partnership, sexual behaviors, agreements and how to refer to each other, and uses these terms and contracts in the sessions, as appropriate.

## The Behavioral Change Logic Model

The **Connect** Behavioral Logic Model is presented on the next page. Logic models are systematic and visual ways to present the internal logic of an intervention, which begins with its theoretical foundation. The model shows the relationships among:

- ♥ The intent of **Connect** (what behavioral problem is to be changed)
- ♥ The risk context of factors from behavioral theory that impact at risk behavior (*behavioral determinants*).
- ♥ The intervention activities of **Connect** that are meant to act on those behavioral determinants.
- ♥ The expected outcomes, or changes in behavioral risk, that are a result of the activities focusing behavioral determinants.

Connect Behavioral Change Logic Model



Analysis and reporting.

## Organizational assessment activities

Agency needs assessment, agency capacity-building, and developing the budget are three central Getting Started activities. It is important to note that these activities do not happen strictly in the order they appear in this manual—they may happen at the same time. These activities appear in this order in the manual because they build on one another.

### Getting started: Agency needs assessment

The Needs Assessment focuses on whether or not providing the **Connect** intervention makes sense and is consistent with your agency's strategic vision and mission.

- ♥ Is providing **Connect** a good fit for your agency?
- ♥ Does your agency serve couples as one of your focus populations?
- ♥ Does providing couple-level HIV/STI education and prevention programming fit with the mission and vision for the agency?
- ♥ Does your agency have the administrative and staff support and capacity to provide the **Connect** intervention?
- ♥ Does your agency have the resources necessary for intervention?
- ♥ Will implementing **Connect** change your agency's relationship with prevention or service agencies?
- ♥ Does your agency have strong agreement with HIV testing and treatment providers?

Some of these questions may be answered by incorporating questions regarding **Connect** into a mechanism that you currently use to conduct an agency needs assessment. It is important to gain support from administration and staff, but more importantly, from your agency's client base and the local community, as noted in the next section. It is best to know what your community needs and wants, otherwise great intentions based solely on assumptions can fail.

Once you have determined that there is a need to fill, that is, your current client or community base feels that the **Connect** intervention would be beneficial, then the next step is capacity-building.

## Getting started: Agency capacity issues

The first Getting Started activity is addressing the capacity issues. Capacity issues are focused on securing the “buy-in” of stakeholders in the agency.

### *Buy-In*

Securing “buy-in” is crucial because it assures the support of agency administration and allows for agency resources to be utilized for intervention implementation. Obtaining “buy-in” is most effectively accomplished by identifying at least one agency administrator or staff person to “champion” the intervention, that is, to advocate for its integration into existing service provision at the agency. A **Connect** *champion* could be an individual or a group of people. The *champion* should be selected by an agency administrator. Regardless of the number of *champions*, the central issue is convincing the agency that implementing **Connect** would enhance the quality of its prevention services and that the agency is capable of implementing **Connect**. A *champion* is someone within the agency who is a mid-to-upper level administrator who generally serves as a link between administration and staff. The *champion* needs to be adept at answering questions and mediating any changes in organizational structure; they can serve as a negotiator of any necessary trade-offs or compromises. The *champion* becomes the intervention’s spokesperson, anticipating the reservations of staff, answering questions about the intervention’s needs and resources. The *champion* must have an excellent knowledge of the intervention including its, Core Elements, Key Characteristics, and costs. In addition, the *champion* can use the marketing materials available in the intervention package. The *champion* can use the information presented in this manual and the rest of the package to further field any questions or concerns about **Connect**.

Your agency’s intervention *champion* can use the following stakeholder’s checklist to obtain support for implementing **Connect**. The stakeholders are those people on your Board of Directors/Executive Board, in your community, agency, your staff, or your funding source who have a stake in the successful implementation of an intervention. The stakeholder’s checklist contains those items the *champion* can use to convince the stakeholders that **Connect** is an intervention that your agency can and should implement because it meets the needs of the community your agency serves.

## Stakeholder's Checklist

1. Assess the community to determine whether they will support the Core Elements of **Connect**
2. Identify your stakeholders
  - a. Your agency's Board of Directors/Executive Board
  - b. Staff members from your agency who will have a role in the operation of the intervention
    - i. Administrators who will obtain support
    - ii. Supervisors who will monitor the intervention
    - iii. Staff who will interact with participants at any level
  - c. Local agencies from which you could recruit participants, facilitators, or both
    - i. Agencies offering education and prevention services for people affected or infected by HIV and other STIs, including public health, STI, or infectious disease clinics
    - ii. Health care providers and mental health professionals serving people affected or infected by HIV or other STIs
    - iii. Social service agencies reaching people affected or infected by HIV or other STIs
    - iv. Organizations of people living with HIV/AIDS and organizations which may have members who are living with HIV/AIDS
  - d. Organizations that could provide assistance or other resources
    - i. Merchants for incentives, refreshments
    - ii. Agencies, merchants, printers, publishers, broadcasters, and others that can advertise the intervention
    - iii. Agencies that can provide space to provide the intervention
    - iv. Agencies that can provide child care
    - v. Agencies that can provide transportation
    - vi. Other collaborating agencies to provide information for the Resource Manual

- e. Agencies with which your agency maintains good community or professional relations
  - i. Local health department
  - ii. Local medical and mental health associations
  - iii. Your funding source(s)
  - iv. Others
3. Getting stakeholders informed, supportive, and involved
  - a. Getting them informed about the intervention
    - i. Decide in advance what specific roles you want each stakeholder to play. Who will you ask to:
      - (a) provide financial support?
      - (b) refer couples at risk of HIV/STI infection to the intervention?
      - (c) serve as an intervention facilitator?
      - (d) be a resource to which you can refer participants?
      - (e) assist in advertising the intervention?
      - (f) provide a room in which the sessions can be held?
      - (g) supply refreshments for participants?
      - (h) donate small incentives or prizes for participants?
      - (i) speak supportively about **Connect** in conversations with their associates?
    - ii. Send letters that tell stakeholders about **Connect**, its importance, when your agency will be making the intervention available, what specific role(s) you think that they might play in the success of the intervention. Offer an opportunity for them to learn more.
    - iii. Call in two weeks and assess their interest. If they are interested, schedule a time to meet (e.g., one-on-one, lunch-and-learn at your agency with a group of other stakeholders, or a presentation at their agency for several of their staff or association members).

- iv. Hold the meeting, show **Connect** marketing materials if the setting and time allow, answer questions.
- b. Getting them supportive
    - i. Describe several specific roles they could play.
    - ii. Emphasize the benefits of their involvement to themselves, their agency, the community, and persons living with or at risk for HIV/AIDS and answer questions.
    - iii. Invite them to commit to supporting **Connect** by taking on one or more roles. Keep track of commitments.
  - c. Getting them involved
    - i. Soon after meeting, send a thank you letter that specifies the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later.
    - ii. For persons who committed to a role that is important to pre-implementation, put them to work as soon as possible.
    - iii. For person who committed to involvement later in the process, send them brief progress updates and an idea of when you will be calling on their support.
    - iv. 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.

### Getting started: Budget

The final Getting Started activity is developing the budget.

The budget is meant to be an example of possible costs associated with implementing **Connect**. Depending on the number of times you implement the intervention or your specific agency needs, these figures will vary from organization to organization. This is meant only as a guide.

Beside the trained facilitators, the time needed to train in the intervention, and supervision of the intervention, the costs of the intervention are minimal. To conduct **Connect**, and agency will need one or two, 100 or 50 percent Full Time Equivalent (FTE) paid, experienced facilitator(s), counselor(s), mental health professional(s) (MHP), social worker, or nurse, ideally one male and one female, and one 25 percent FTE program

coordinator for supervision, evaluation, and quality assurance. We estimate that each facilitator will need to attend 2 days of face-to-face training in **Connect**, with up to an additional review of training materials from the Training of Facilitators (TOF) CD-ROM or website, or with the printed TOF manual. The original intervention study provided participants with a \$20 incentive per session, per person. However, if **Connect** is integrated as part of ongoing client services or HIV/STI prevention or educational services, only token incentives for the intervention may be necessary or allowable. If not able to access materials via website, an agency will need to acquire, laptop with DVD player or a DVD player with remote control. The intervention also involves the use of an easel, easel paper, and markers. **Connect** is not a high maintenance intervention and can be made feasible for most agencies.

### *Cost Sheet*

To conduct **Connect**, an agency will ideally have a 100 percent FTE paid, experienced counselor to serve as a facilitator (or two 50 percent FTE, one male and one female). The cost sheet assumes that your agency already has access to intervention participants. If this is not the case, you will need to add recruitment costs. The cost sheet provides estimates for providing the **Connect** intervention at your agency assuming there are no donations or in-kind contributions.

Categories for Provider Costs to Implement the Connect Intervention<sup>7</sup>

| Categories                                | Pre-Implementation |                                    | Implementation <sup>8</sup>    |                                    |
|---|--------------------|------------------------------------|--------------------------------|------------------------------------|
|   | <i>(start-up)</i>  |                                    | <i>(intervention delivery)</i> |                                    |
| Personnel                                 | # staff            | % time/wk                          | # staff                        | % time or # hrs/wk                 |
|   |                    | (% FTE time spent on intervention) |                                | (% FTE time spent on intervention) |
| Salaried:                                 |                    |                                    |                                |                                    |
| Program Coor.                             | 1                  | 25%                                | 1                              | 25%                                |
| Admin. Asst.                              | 1                  | 20%                                | 1                              | 10%                                |
| Facilitator, MHP <sup>9</sup>             | 1                  | 100%                               | 1                              | 25%                                |
| Fringe benefits                           |                    | 25%                                |                                | 25%                                |
| Facility(ies)                             |                    |                                    |                                |                                    |
|   |                    | (% time used for intervention)     |                                | (% time used for intervention)     |
| Rent: Office                              | \$ x               | % =                                | \$ x                           | % =                                |
| Small meeting space                       | \$ x               | 20% =                              | \$ x                           | 3 sessions =                       |
| Utilities                                 | \$ x               | % =                                | \$ x                           | % =                                |
| Telephone/fax                             | \$ x               | % =                                | \$ x                           | % =                                |
| Maintenance                               | \$ x               | % =                                | \$ x                           | % =                                |
| Insurance                                 | \$ x               | % =                                | \$ x                           | % =                                |
| Equipment                                 |                    |                                    |                                |                                    |
|   |                    | (% time used for intervention)     |                                | (% time used for intervention)     |
| Online access/downloads may replace these | \$ x               | % =                                | \$ x                           | % =                                |
| One laptop                                | \$ x               | % =                                | \$ x                           | % =                                |
| Copier                                    | \$ x               | % =                                | \$ x                           | % =                                |
| Easel                                     | \$ x               | % =                                | \$ x                           | % =                                |
| Equipment maintenance                     | \$ x               | % =                                | \$ x                           | % =                                |
| Internet service provider                 | \$ x               | % =                                | \$ x                           | % =                                |
| Supplies                                  |                    |                                    |                                |                                    |

<sup>7</sup> To get your actual costs, multiply the totals you calculate from the cost sheet according to the number of couples you will serve. For example, if you will serve 50 couples, multiply the totals by 10.

| Categories                          | Pre-Implementation |            | Implementation <sup>8</sup>             |             |
|-------------------------------------|--------------------|------------|---|-------------|
| Postage & mailing                   | \$                 |            | \$                                      |             |
| Copying & printing                  | \$                 |            | \$                                      |             |
| Office supplies:                    |                    |            |   |             |
| Paper (white)                       | 1 ream x           | \$ /ream = | 1 ream x                                | \$ /ream =  |
| Paper (colored)                     | 0                  |            | 1 ream x                                | \$ /ream =  |
| Certificate paper                   | 0                  |            | 1 pkg. x                                | \$ /pkg. =  |
| Pens                                | 1 dozen x          | \$ /doz. = | 2 dozen x                               | \$ /doz. =  |
| Easel paper                         | 0                  |            | 2 pads x                                | \$ /pad =   |
| Markers                             | 0                  |            | 1 pkg. x                                | \$ /pkg. =  |
| Push pins                           | 0                  |            | 1 box x                                 | \$ /box =   |
| Masking tape                        | 0                  |            | 1 roll x                                | \$ /roll =  |
| Stickers                            | 0                  |            | 1 box x                                 | \$ / box =  |
| Business cards                      | 0                  |            | 1 box x                                 | \$ / box =  |
| Condoms:                            |                    |            |   |             |
| Male                                | 0                  |            | 1 dozen x                               | \$ /doz. =  |
| Female                              | 0                  |            | 1 dozen x                               | \$ /doz. =  |
| Take Home Condom Packet             | 0                  |            | 1 packet per session (5 x 3 = 25 total) | \$          |
| Lubricant                           | 0                  |            | 1 dozen                                 | \$ /doz. =  |
| Latex barriers                      | 0                  |            | 1-5 x                                   | \$ /doz. =  |
| Printed materials:                  |                    |            |   |             |
| Initial Assessments                 | 0                  |            | 10 x                                    | \$ /each =  |
| Session monitoring                  | 0                  |            | 5 x                                     | \$ /each =  |
| Participant Feedback                | 0                  |            | 10 x                                    | \$ /each =  |
| Information sheets/ flyers          | 100 x              | \$ /grs. = | 5 x                                     |             |
| Other materials:                    |                    |            |   |             |
| Key chains or other incentives      | 0                  |            | 5 couples x 3 sessions=25 x             | \$ /each =  |
| Catering/refreshments/ snacks       |                    |            | 3 sessions x 10 people = 50 x           | \$ /pers. = |
| <b>Recruitment</b>                  |                    |            |   |             |
| (of staff/volunteers)               |                    |            |   |             |
| Advertising                         | 10 column inches x | \$ /inch = | 10 column inches x                      | \$ /inch =  |
| <b>Travel</b>                       |                    |            |   |             |
| Miles to/from intervention location | # miles x          | ¢/mile =   | # miles x                               | ¢/mile =    |

| Categories                         | Pre-Implementation | Implementation <sup>8</sup> |
|------------------------------------|--------------------|-----------------------------|
| (if other than regular work place) |                    |                             |

<sup>8</sup> Intervention delivery costs are based on 10 participants (five couples) for three sessions. The sessions are figured as follows: three **Connect** sessions provided to the couple together. Numbers of printed and other materials are calculated as follows: for the complete intervention you will need two **Connect** Risk Behavior and Skills Assessments (RBSA), three **Connect** Supervision Checklists, two participant feedback forms and 6 novelty/incentives (three each for each participant). One incentive is provided to each participant at each session. For each session you also will need two refreshments or snacks per couple.

<sup>9</sup> The facilitator, a skilled counselor, will need to be paid for their time spent interviewing participants, training (four days), and practicing during pre-implementation. Intervention delivery time includes review before each session, travel to the sessions, session time, and debriefing time and assumes weekly sessions for three weeks, plus a week for preparation and wrap-up.

<sup>10</sup> This budget lists a laptop with DVD player. If DVDs are to be used, you may substitute a DVD player, or plan to show videos available from a web-based source. By the time you read this intervention, technology may have changed. Please refer to the online resources, web links provided.



## Pre-Implementation

### What is pre-implementation?

Pre-Implementation prepares the implementing agency to perform the intervention. It is during this period that your agency can make any necessary organizational changes, assess resource needs, and develop marketing and evaluation plans. Pre-Implementation is also the time to explore the needs for adapting **Connect**. For **Connect**, Pre-Implementation activities are focused on the following:

- ♥ Staffing requirements
- ♥ Securing the Intervention resources
- ♥ Adapting the Intervention
- ♥ Program Review Board
- ♥ Developing an evaluation plan
- ♥ Planning for any legal and ethical issues
- ♥ Marketing **Connect** and recruiting participants

### Staffing requirements

In order for **Connect** to run smoothly you will need a Program Coordinator; And least one, but preferably two, trained facilitator(s), one male and one female, who are (ideally) mental health professionals.

#### Program Coordinator

The list of items below contains some of the Program Coordinator's primary responsibilities. The Program Coordinator may be responsible for additional tasks during the course of the intervention.

*The Program Coordinator is primarily responsible for the following tasks:*

- ♥ Preparing the agency for the intervention
- ♥ Collaborating with other agencies
- ♥ Securing the intervention needs
- ♥ Preparing intervention materials
- ♥ Hiring and managing the intervention team
- ♥ Setting up training and technical assistance

- ♥ Recruiting participants
- ♥ Establishing and overseeing the evaluation plan
- ♥ Overseeing the intervention and facilitators
- ♥ Conducting supervision sessions
- ♥ Managing the budget
- ♥ Assuring quality
- ♥ Monitoring fidelity

## Facilitators

### *Roles and responsibilities of Facilitator:*

- ♥ Prepare for sessions
- ♥ Balance the needs of the participants and the structure of the sessions
- ♥ Facilitate discussion between participants while following the session's curriculum
- ♥ Practice and review materials
- ♥ Build couple unity
- ♥ Inform participants of the duty to warn, confidentiality, and other relevant laws
- ♥ Guide the couple sessions
- ♥ Handle emotional issues
- ♥ Balance attention to both partners in the couple
- ♥ Emphasize the relationship as the unit of change
- ♥ Create safe, welcoming, and non-judgmental environment for couples (e.g., session agreements)
- ♥ Affirm past experiences while communicating an expectation for safer, healthier future experiences
- ♥ Create a Resource Manual which provides information about other local and accessible services offered to couples at risk for HIV/STIs
- ♥ Deal with inappropriate behavior problems
- ♥ Allow couple dialogue to occur
- ♥ Provide for clarity and understanding

Facilitation practice is not required, but it is highly recommended prior to Facilitators beginning **Connect** sessions. Participants for these sessions can be recruited from staff or agency volunteers; however, if volunteers participate, it is important to make sure they understand their role and the goals of the practice sessions. One of the goals of the practice is to give the facilitators an opportunity to spend time learning to use the implementation

section, which includes all sessions, and the intervention forms before the intervention begins. Facilitators may want to practice a whole session, or an activity that is either specific to a session (e.g., identifying triggers to sexual risk behavior) or happens in all sessions (e.g., goal-setting). In addition, the practice will give the facilitators a feel for the basic logistics of **Connect**.

During facilitation practice, facilitators can develop a better understanding of complicated relational dynamics that may influence **Connect** implementation, and develop strategies for dealing with them. Many of these are highlighted and illustrated using video vignettes in the Training of Facilitators Curriculum/CD-ROM or online resource. Facilitators can actively practice managing conflict and providing referrals to meet the participant's needs. The practice sessions will increase facilitators' comfort-level with the couple facilitation process and promote flexibility in adjusting the **Connect** session agenda to the needs of the participants. In addition, facilitation practice will help facilitators assess strengths and weaknesses of their facilitation skills. Program Coordinators and relevant staff members may want to observe the practice sessions and provide facilitators with feedback as needed. Some potential self-evaluation questions are:

- ♥ How did the session facilitation go?
- ♥ What went well? Why did it go well?
- ♥ What did not go well? Why did it not go well?
- ♥ How can I address issues that did not go well?
- ♥ What should I make sure to cover or raise in the next session?

Additionally, practice will provide the facilitators an opportunity to assess and evaluate their knowledge of the intervention content. Some sample evaluation questions are:

- ♥ Does the couple understand the session's goals and activities?
- ♥ What did the participants learn? What should they have learned?

Facilitation practice should promote learning, improve facilitation skills, and develop strategies for dealing with difficult situations and adhering to session content while providing good quality facilitation to the couple.

### *Where to find effective Facilitators*

This section contains some suggestions on how to find effective facilitators. You can use the characteristics and skills of effective facilitators on page 21 of this Implementation Manual to help you choose the right facilitators. Once you identify potential facilitators, provide

them with basic information about **Connect** and their expected roles and responsibilities. Examples of these roles and responsibilities are listed on page 19 of this Implementation Manual. Facilitators will be required to attend training on the intervention. You can use the information in this manual to help facilitator candidates understand what the intervention is, what their job will involve, and what skills and experience you are looking for in the facilitators.

### Where can you find Facilitators?

- ♥ Social work programs at local colleges and universities
- ♥ Network within your own organization or other similar organizations for recommendations
- ♥ Couples counseling or family therapy programs

A wide range of credentials can allow for a large pool of staff complimentary to the implementation setting. Training and on-going supervision serve to build and maintain intervention capacity within agencies.

### *Characteristics of Facilitators*

The following are lists of the characteristics to look for and the characteristics to avoid when selecting facilitators for **Connect**. The facilitators will direct the intervention sessions guiding the participants through the content of **Connect**. As you will see, many are also applicable when choosing any facilitator for a behavioral-based intervention.

### Facilitators SHOULD HAVE the following characteristics:

- ♥ Trustworthy
- ♥ Flexible
- ♥ Active listener
- ♥ Follows up on identified needs
- ♥ Good knowledge of group process
- ♥ Ability to promote communication
- ♥ Maintains eye contact
- ♥ Understanding of couple dynamics
- ♥ Understanding and non-judgmental
- ♥ Ability to manage and control problems
- ♥ Dynamic and friendly
- ♥ Respect for confidentiality
- ♥ Patient
- ♥ Knowledge of HIV/AIDS
- ♥ Culturally competent

- ♥ Good observer
- ♥ Authentic
- ♥ Empathetic and supportive
- ♥ Uses humor effectively and appropriately
- ♥ Ability to make appropriate referrals to services
- ♥ Interested in working with couples
- ♥ Creates warm and welcoming environment
- ♥ Respectful of others and their opinions
- ♥ Ability to build rapport
- ♥ Willingness to learn from participants
- ♥ Ability to adjust agenda times to meet needs of the couple
- ♥ Focuses on couple's needs instead of own persona agenda
- ♥ Aware of own comfort level, skills, and limits
- ♥ Ability to work with people where they are/client centered
- ♥ Shares and discloses personal information appropriately

**Facilitators SHOULD NOT have the following characteristics:**

- ♥ Anxious with individuals/ couples
- ♥ Acts superior to participants
- ♥ Dominates discussion
- ♥ Withdraws physically or emotionally from individuals or couples
- ♥ Lacks sensitivity to the needs of others
- ♥ Needs to be the center of attention
- ♥ Inflexible and non-adaptive
- ♥ Places their own personal needs before the needs of the couple
- ♥ Oriented towards an individual than the couple
- ♥ Pushes personal agenda
- ♥ Presents erroneous information as fact

***Skills of Facilitators***

The selection of a skilled counselor, Social Worker, mental health professional (MHP), counselor, nurse or case manager as a facilitator is an important part of **Connect**. The facilitator for **Connect** can be someone with a bachelor's level training in counseling/mental health work, a psychologist, a social worker, a Licensed Practicing Counselor, or a Licensed Chemical Dependency Counselor. A wide range of credentials can

allow for a large pool of staff complimentary to the implementation setting. Training and on-going supervision serve to build and maintain intervention capacity within agencies.

In addition to the general facilitator characteristics just listed, the MHP should have experience working with individuals, couples, or groups of people either at risk for HIV/STIs or living with HIV/AIDS. Participants in **Connect** may have issues that require special attention. As with any behavioral intervention or service to an individual, the facilitator may have to deal with participants who are having suicidal or homicidal thoughts. Facilitators may have to talk briefly after sessions with participants if something is bothering them, and to assist in referring them to an agency or other professional who may help them. It is necessary for the successful facilitation of the sessions to allow time for the couple to talk about how they are feeling after some activities. The intervention (at any point or all the way through) may be emotionally moving or life changing for some participants. Facilitators need to be aware of couple or individual participant issues, make good use of their supervision time to deal with concerns, and to know where to get assistance when needed.

The **Connect** intervention includes discussions about personal behaviors such as sexual practices, drug or alcohol use, other triggers for risk behaviors, and intimate partner and relationship issues. Topics of intimate, physical, emotional, and sexual coercion may arise. It is not unusual that some participants may feel uneasy talking about these topics. It is important for facilitators to be able to distinguish between normal discomfort and an unexpected, negative reaction that may have been brought on by the **Connect** intervention. These reactions must be taken seriously and handled in a consistent manner based on agency protocol. If a negative reaction occurs, facilitators should follow the agency's protocol. Agencies implementing **Connect** should develop a plan for addressing participants who may experience suicidal or homicidal thoughts, violent outbursts or disclosures, or other negative reactions. This plan will assist the facilitator in knowing where and how to refer participants for either additional assessment or treatment services.

### HIV status and attendance

**Connect** can be implemented with HIV-negative, HIV-positive, or HIV--discordant couples. HIV discordant couples will find the intervention sessions an opportunity to use the skills to address treatment decisions and to develop a plan to support consistent follow-through. As in any program involving immune-compromised participants, during the course of **Connect**, participants may be absent as a result of health events such as doctor's visits or any other issue related to their disease. These side effects can impact the physical, emotional, and mental well-being of participants. Your agency should establish attendance policies to deal with absences or the cancellation of sessions.

**Connect** sessions should be provided to both partners together, so if one partner cannot make it to a session, the session should be rescheduled for a time when both partners can attend.

## Resources needed

### Supplies

In order to implement **Connect**, in addition to specific supporting materials for each session, your agency will need to ensure that it has the following list of supplies. The following items are not included in the package. An agency will need to get them before implementing **Connect**, along with the supplies listed in the budget.

- ♥ Web resources, Laptop or DVD player with remote control
- ♥ Computer with printer (for ease of adapting intervention materials, printing non-adapted forms, and the Intervention Manual) and monitor
- ♥ Video monitor
- ♥ Food/snacks (optional)
- ♥ Participant incentives (optional)
- ♥ Male and female anatomical models for condom demonstration
- ♥ Condoms (male and female)
- ♥ Latex barriers (for male to female oral sex)
- ♥ Lubricant (lube)
- ♥ Push pins
- ♥ Poster putty and/or masking tape
- ♥ Resource Manual
- ♥ Pencils/pens

### Location, room logistics, and time

**Connect** should take place in a private and secure location. The following are some suggestions for location selection and room logistics:

- ♥ Central location along major transit routes so participants without transportation can easily and readily access the location
- ♥ Space for audio/visual equipment and easel (which need to be set-up near the facilitators)

- ♥ Intervention room accessible at a variety of times for flexible scheduling
- ♥ Child care available on the premises

Accommodating couples for sessions can be challenging. Often both participants work, they may or may not live together, either or both may have children. Sessions should be offered at flexible times: during the week day, some evenings, and ideally sometimes on weekend days. The availability of the facilitators and the room also needs to be considered.

### Intervention videos

The **Connect** intervention includes # videos to view with participants.

### Incentives

In the original research, incentives were given to encourage intervention participants to arrive on time. Incentives also can be used to keep participants engaged during sessions. Good food is a great way to hold participants' attention. Incentives are not a Core Element or Key Characteristic of **Connect**, so your agency is not required to provide incentives. We encourage your agency to consider using incentives for the same reasons they were used in the original research. Suggestions are fast food coupons, discount store gift cards, and movie rental cards.

We also encourage your agency to be creative with using and delivering the incentives. If your agency does not have the financial capabilities to purchase gift cards and gift certificates, it may be possible to solicit donations from the community and offer those donations as incentives.

### Other intervention materials

Other resources needed for the intervention are in the **Connect** intervention package. These materials are:

- ♥ Implementation Manual
  - › Session scripts
  - › Risk Behavior and Skills Assessment (RBSA)
  - › Evaluation materials
- ♥ Supporting print materials (goal cards, posters, fact cards, handouts)
- ♥ Marketing material

- ♥ Video vignettes on one master video, or web-based storage:
  - › STIs
  - › Modeling of the Speaker/Listener Technique
  - › Female condom video demonstration
  - › Triggers
  - › Problem-solving
  - › Anti-retroviral Treatment adherence
  - › Decisions about PREP
- ♥ Disk containing electronic version of forms and handouts

## Overview of implementation plan

### Planning

Your agency/organization must have infrastructure, capacity qualified staff, and training to implement **Connect** and coordinate services for participants, adapt **Connect** with scientific rigor, and have an advisory board for program oversight.

### Implementation

Recruit couples. Screen participants for risk behaviors and skills. Schedule sessions. Conduct Sessions with recruited couples who meet criteria for being at risk. Ensure fidelity of the intervention's core elements using the supervision check lists.

### Monitoring/evaluation

Establish data collection and analysis system. Administer pre- and post-assessments. Maintain an evaluation database, analyze the data, and produce the reports. If funded by CDC, coordinate and administer Program Evaluation Monitoring System (PEMS) tools. Coordinate PEMS data system and transfer data to CDC.

## Planning and Preliminary Steps

| Step   | Capacity and Knowledge Needed   | Person(s) Responsible                                 | Timeline                          | Notes |
|--|---|---|-----------------------------------|-------|
| Assess agency capacity for implementing <b>Connect</b>   | <ul style="list-style-type: none"> <li>◆ commitment to working with couples</li> <li>◆ access to couples and adequate private space for sessions</li> <li>◆ required material resources</li> <li>◆ time for all required sessions</li> </ul>  | Agency administrator                                  | 52-49 weeks before implementation |       |
| Secure agency “buy-in”   | <ul style="list-style-type: none"> <li>◆ determine <b>Connect</b> is a good fit with current agency services</li> <li>◆ determine the intervention is acceptable to focus audience</li> </ul>   | Agency administrator, Agency staff                    | 48-36 weeks before implementation |       |
| Establish infrastructural Support  | <ul style="list-style-type: none"> <li>◆ form a diverse community advisory board (CAB)</li> <li>◆ develop a budget and support mechanisms</li> <li>◆ develop plan to prepare for staff attrition</li> <li>◆ identify social services for referrals</li> <li>◆ select intervention “champion”</li> </ul> | Agency administrator, CAB                             | 35-28 weeks before implementation |       |
| Network with other agencies and community organizations to determine their support for <b>Connect</b>                                  | <ul style="list-style-type: none"> <li>◆ knowledge of intervention</li> <li>◆ marketing skills</li> <li>◆ ability to answer questions</li> <li>◆ knowledge of community and agencies working with couples</li> </ul>  | Agency administrator, Agency partners                 | 27-15 weeks before implementation |       |
| Identify and involve stakeholders  | <ul style="list-style-type: none"> <li>◆ knowledge of intervention</li> <li>◆ marketing skills</li> <li>◆ organizational skills</li> <li>◆ ability to answer questions</li> </ul>   | Agency administrator, Agency staff, stakeholders      | 18-15 weeks before implementation |       |
| Create Community Advisory Board (CAB) and hold meetings of CAB to obtain information on recruitment, venues, incentives, and marketing | <ul style="list-style-type: none"> <li>◆ knowledge of intervention</li> <li>◆ marketing skills</li> <li>◆ ability to answer questions</li> <li>◆ ability to establish connections with community persons</li> </ul>   | Agency administrator, Agency Staff, CAB, stakeholders | 14-9 weeks before implementation  |       |

| Step   | Capacity and Knowledge Needed  | Person(s) Responsible              | Timeline                         | Notes |
|--|--|------------------------------------|----------------------------------|-------|
| Identify possible venues for sessions  | <ul style="list-style-type: none"> <li>◆ knowledge of locations frequented by focus population</li> <li>◆ ability to access possible venues</li> <li>◆ ability to establish trust with people</li> </ul>   | Agency staff, CAB                  | 14-9 weeks before implementation |       |
| Identify members of the <b>Connect</b> intervention team (Program Manager, admin. Staff)               | <ul style="list-style-type: none"> <li>◆ knowledge of internal staff capacity and skills</li> <li>◆ knowledge of staff person's interest in taking leadership with <b>Connect</b> program</li> </ul>   | Agency administrator, Agency staff | 7-8 weeks before implementation  |       |
| Recruit and hire at least two facilitators   | <ul style="list-style-type: none"> <li>◆ knowledge of HIV/STI intervention and/or experience with couple-based facilitation skills</li> <li>◆ knowledge of special needs of partners at risk for or living with STIs, including HIV/AIDS</li> </ul>        | Agency administrator               | 7-8 weeks before implementation  |       |
| Assemble Resource manual and create referral system  | <ul style="list-style-type: none"> <li>◆ knowledge of focus population needs</li> <li>◆ knowledge of agency resources</li> <li>◆ knowledge of and familiarity with local resources, including personal contacts</li> </ul>                                 | Agency staff                       | 5-6 weeks before implementation  |       |
| Develop marketing plan, adapt marketing information sheet, identify recruitment sites, begin marketing | <ul style="list-style-type: none"> <li>◆ knowledge of focus population, places to recruit participants, focus populations members' preferences</li> <li>◆ ability to design a marketing plan</li> </ul>  | Agency staff, CAB                  | 5-6 weeks before implementation  |       |
| Send all facilitators to <b>Connect</b> training   | <ul style="list-style-type: none"> <li>◆ knowledge of tasks and skills required to implement <b>Connect</b></li> <li>◆ trained on background to <b>Connect</b> intervention, couple facilitation skills, adaptation, and facilitating the three</li> </ul> | Agency administrator, Facilitators | 5-6 weeks before implementation  |       |

| Step   | Capacity and Knowledge Needed  | Person(s) Responsible      | Timeline                                 | Notes |
|--|--|----------------------------|--|-------|
|  | sessions   |                            |  |       |
| Obtain intervention resources                              | <ul style="list-style-type: none"> <li>◆ knowledge of the intervention and required materials</li> <li>◆ knowledge of existing local and agency resources</li> </ul>   | Agency administrator       | 5-6 weeks before implementation          |       |
| Conduct facilitation practice                              | <ul style="list-style-type: none"> <li>◆ knowledge of the intervention materials and Implementation Manual</li> </ul>  | Supervisor, Facilitators   | 3-6 weeks before implementation          |       |
| Recruit potential participants                             | <ul style="list-style-type: none"> <li>◆ knowledge of intervention, focus population, and places/methods to recruit participants</li> <li>◆ skills to explain the program</li> <li>◆ ability to interact with strangers</li> <li>◆ ability to create trust and elicit information</li> </ul> | Agency staff, Facilitators | Begin<br>3-4 weeks before implementation |       |
| Adapt intervention materials                               | <ul style="list-style-type: none"> <li>◆ knowledge of intervention, focus population members' preferences</li> </ul>   | Agency staff, Facilitators | 3-4 weeks before implementation          |       |
| Select, secure, and schedule venue for conducting sessions | <ul style="list-style-type: none"> <li>◆ ability to access location frequented by focus population</li> </ul>  | Agency staff stakeholders  | 3-4 weeks before implementation          |       |

| Step   | Capacity and Knowledge Needed  | Person(s) Responsible                  | Timeline                        | Notes |
|--|--|--|---------------------------------|-------|
| Develop an evaluation plan   | <ul style="list-style-type: none"> <li>◆ knowledge of the evaluation forms required by a funding agency and those desired by the implementing agency</li> <li>◆ knowledge of the purposes of the evaluation process</li> </ul> | Agency administrator, Agency staff     | 3-4 weeks before implementation |       |
| Schedule sessions  | <ul style="list-style-type: none"> <li>◆ ability to communicate with potential participants</li> <li>◆ Mastery of the sessions' content and purpose</li> </ul>   | Agency staff, Supervisor, Facilitators | 1-2 weeks before implementation |       |
| Schedule debriefing/ supervision sessions for facilitators with Program Supervisor | <ul style="list-style-type: none"> <li>◆ knowledge of facilitator session implementation schedule</li> <li>◆ coordination of schedules to identify consistent meeting time</li> </ul>  | Supervisor, Facilitators               | 1-2 weeks before implementation |       |
| Obtain incentives and refreshments   | <ul style="list-style-type: none"> <li>◆ knowledge of local resources and focus population preferences</li> </ul>  | Agency staff                           | 1-2 weeks before implementation |       |
| Confirm participants and inform them of venue and time                             | <ul style="list-style-type: none"> <li>◆ ability to communicate with potential participants</li> </ul>   | Agency staff, Facilitators             | 1-2 weeks before implementation |       |

## Implementation Steps

| Step   | Capacity and Knowledge Needed  | Person(s) Responsible     | Timeline                    | Notes |
|--|--|---------------------------|-----------------------------|-------|
| Practice, prepare, and conduct Session One     | <ul style="list-style-type: none"> <li>◆ knowledge of session content and materials needed</li> <li>◆ training on <b>Connect</b> intervention facilitation</li> <li>◆ high level of facilitation skills knowledge of session content and materials needed</li> <li>◆ ability to provide supervision</li> <li>◆ discussion</li> </ul> | Facilitators, Supervisors | Weeks 1-2 of implementation |       |
| Debrief and receive supervision on Session One | <ul style="list-style-type: none"> <li>◆ knowledge of session content and materials needed</li> <li>◆ ability to provide supervision</li> <li>◆ discussion knowledge of session content and materials needed</li> <li>◆ training on <b>Connect</b> intervention facilitation</li> <li>◆ high level of facilitation skills</li> </ul> | Facilitators, Supervisors | Weeks 1-2 of implementation |       |
| Practice, prepare, and conduct Session Two     | <ul style="list-style-type: none"> <li>◆ knowledge of session content and materials needed</li> <li>◆ training on <b>Connect</b> intervention facilitation</li> <li>◆ high level of facilitation skills knowledge of session content and materials needed</li> <li>◆ ability to provide supervision</li> <li>◆ discussion</li> </ul> | Facilitators, Supervisors | Weeks 3-4 of implementation |       |
| Debrief and receive supervision on Session Two | <ul style="list-style-type: none"> <li>◆ knowledge of session content and materials needed</li> <li>◆ ability to provide supervision</li> <li>◆ discussion knowledge of session content and materials needed</li> <li>◆ training on <b>Connect</b> intervention facilitation</li> <li>◆ high level of facilitation skills</li> </ul> | Facilitators, Supervisors | Weeks 3-4 of implementation |       |
| Practice, prepare, and conduct Session Three   | <ul style="list-style-type: none"> <li>◆ knowledge of session content and materials needed</li> <li>◆ training on <b>Connect</b> intervention facilitation</li> <li>◆ high level of facilitation skills knowledge of session content and materials needed</li> <li>◆ ability to provide supervision</li> </ul>                       | Facilitators, Supervisors | Weeks 3-4 of implementation |       |

| Step   | Capacity and Knowledge Needed  | Person(s) Responsible     | Timeline                 | Notes |
|--|--|---------------------------|--------------------------|-------|
|  | <ul style="list-style-type: none"> <li>◆ discussion</li> </ul>   |                           |                          |       |
| Debrief and receive supervision on Session Three | <ul style="list-style-type: none"> <li>◆ knowledge of session content and materials needed</li> <li>◆ ability to provide supervision discussion</li> </ul> | Facilitators, Supervisors | Week 3 of implementation |       |

| Step                                       | Capacity and Knowledge Needed  | Person(s) Responsible              | Timeline   | Notes |
|--|--|------------------------------------|--|-------|
| Generate database for data to be collected | <ul style="list-style-type: none"> <li>◆ knowledge of data management techniques and software (e.g., Microsoft Access, Microsoft Excel, SPSS, SAS)</li> </ul>  | Agency staff                       | 1-2 weeks before implementation                            |       |
| Collect necessary evaluation forms         | <ul style="list-style-type: none"> <li>◆ knowledge of <b>Connect</b> evaluation forms, purpose, intent, and usage</li> <li>◆ instrument design experience</li> <li>◆ ability to motivate staff to complete forms</li> <li>◆ ability to communicate need for evaluation to staff</li> </ul> | Agency staff, Agency administrator | Begin 1-2 weeks before implementation, continue throughout |       |
| Manage database                            | <ul style="list-style-type: none"> <li>◆ knowledge of data management techniques and software (e.g., Microsoft Access, Microsoft Excel, SPSS, SAS)</li> </ul>  | Agency staff                       | Begin 1-2 weeks before implementation, continue throughout |       |
| Summarize data from evaluation forms       | <ul style="list-style-type: none"> <li>◆ ability to use basic commands for aggregating and reporting data</li> </ul>   | Agency staff                       | Weeks 1-end of implementation, repeat quarterly            |       |

Analyze and report collected data

- ◆ knowledge of analysis techniques
- ◆ knowledge about how organization and funding agency defines success

Agency staff

Weeks 1-end of implementation, used to promote best practices/ lessons learned

## Implementation summary

The Implementation Summary on the next page is a framework to visually present a summary of how **Connect** is put into practice. The summary shows the relationship among:

- ♥ The inputs (resources) used by **Connect**'s implementation activities.
- ♥ The implementation activities of **Connect**.
- ♥ The outputs (programmatic deliverables or products) that result when the implementation activities are conducted.

### Connect Implementation Summary

| Inputs   | Implementation Activities   | Outputs  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Facilitator training and training materials</li> <li>• Recruitment strategies and materials</li> <li>• <b>Connect</b> intervention package and design</li> <li>• Agency capacity, including space and staff</li> <li>• Funding</li> <li>• External technical assistance</li> <li>• Support from external "authorities" on HIV prevention</li> </ul> | <ul style="list-style-type: none"> <li>• Train facilitators</li> <li>• Recruit participants (optional testing offered)</li> <li>• Motivate participation within safe environment</li> <li>• Provide HIV/STI transmission and prevention information</li> <li>• Identify personal risk and strategies to reduce risk in long-term relationship</li> <li>• Facilitate Speaker/Listener Technique</li> <li>• Discuss gender, roles, sexual differences and unwritten rules</li> <li>• Identify triggers to risky behaviors</li> <li>• Develop and practice problem-solving and decision-making skills</li> <li>• Enhance social networks and supports</li> <li>• Discuss ways to support HIV treatment adherence</li> <li>• Facilitate goal setting</li> <li>• Provide relapse prevention</li> <li>• Facilitate goal setting</li> <li>• Link to appropriate care services</li> </ul> | <ul style="list-style-type: none"> <li>• Participants recruited</li> <li>• 3 sessions facilitated for each couple</li> <li>• Follow-up provided as needed</li> </ul> |

## Appendix I—CDC Guidelines



## 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.



*For more information:*  
CDC's National Prevention Information Network  
(800) 458-5231 or [www.cdcnpin.org](http://www.cdcnpin.org)

CDC National STD/HIV Hotline  
(800) 227-8922 or (800) 342-2467  
En Español (800) 344-7432  
[www.dcd.gov/std](http://www.dcd.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.**



**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.

1. 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 description 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.

## 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 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.

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## **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 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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3. Kreiss J, Ngugi E, Holmes K, et al. Efficacy of nonoxynol-9 contraceptive sponge use in preventing heterosexual acquisition of HIV in Nairobi prostitutes. *JAMA* 1992;268:477--82.
4. Van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9--14, 2000, Durban, South Africa.
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**Table 1**

**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 <sup>a</sup> | No. of women served | Male condoms   |             | N-9 products <sup>b</sup> |            |
|---------------------|---------------------|----------------|-------------|---------------------------|------------|
|                     |                     | 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)        |
| <b>Total</b>        | <b>4,315,040</b>    | <b>527,248</b> | <b>(12)</b> | <b>92,997</b>             | <b>(2)</b> |

<sup>a</sup> 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.

<sup>b</sup> 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

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.

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## 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 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

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\* Use of trade names and commercial sources is for identification only and does not constitute endorsement by CDC or the U.S. Department of Health and Human Services.

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## Appendix II—Recruitment Poster

- ℳ Are you in a relationship with a partner of the opposite sex?
- ℳ Do you want to learn how to protect yourself and your partner against HIV and other STIs?



## **Join the CONNECT program!**

**Connect is a 3-session program designed for couples to talk about, learn about, and practice safer sex, communication, and healthy behavior techniques together.**

Each session lasts approximately 90 minutes and can be scheduled twice a week or weekly. You and your partner will:

- ℳ Learn about how to keep each other healthy and safe.
- ℳ Learn communication and healthy behavior techniques to strengthen your relationship.

**Interested? Call us at:**