



AN HIV/STD SEXUAL RISK REDUCTION GROUP-LEVEL INTERVENTION FOR WOMEN

STARTER KIT

Packaged by:

Nonprofit Consulting Services—a program of Public Health Solutions
and the HIV Center for Clinical and Behavioral Studies
at New York State Psychiatric Institute and Columbia University



ACKNOWLEDGEMENTS

We acknowledge the support provided by the Centers for Disease Control and Prevention (CDC) through cooperative agreement # 5 H62 PS000784-02 for the funding to develop The Future Is Ours (FIO) intervention package and by Dr. Anke A. Ehrhardt for the research on which this product is based. We also acknowledge the intervention package development team at Public Health Solutions: Heidi Arner, Pam Farquhar, Laura Frye, Jeff Natt, Inez Sieben, Imelda Walavalkar, and at Columbia University Medical Center, HIV Center for Clinical and Behavioral Studies: Dr. Susie Hoffman, Dr. Jessica Adams-Skinner, and Dr. Teresa Exner. FIO is one in a series of products sponsored by CDC's Prevention Research Branch-*Replicating Effective Programs (REP)*. The FIO project was funded 100% by the CDC.

Other CDC-funded REP products can be found at: http://www.cdc.gov/hiv/topics/prev_prog/rep

The original implementation research was done by the HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute and Columbia University, New York and was supported by the National Institute of Mental Health Grant 5P50 MH-43520.

The research outcomes are published in: A.A. Ehrhardt, T.M. Exner, S. Hoffman, I. Silberman, C-S. Leu, S. Miller, & B. Levin (2002). A gender-specific HIV/STD risk reduction intervention for women in a health care setting: short- and long-term results of a randomized clinical trial. *AIDS Care* 14(2): 147-161.

Special thanks to CDC Project Officer and other staff:

Alyce Vyann Howell
Patricia Jones
Winifred King
Arlene Edwards
Harnecya Hooper
LaShonda Roberson

Special thanks to the case study agencies for testing The Future Is Ours (FIO) intervention package:

Wyckoff Heights Medical Center (Brooklyn, N.Y.)
United Community Centers (Brooklyn, N.Y.)

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INTRODUCTION TO THE STARTER KIT

Purpose of the Starter Kit

This document provides an introduction to the Future Is Ours (FIO, pronounced fee-oh). Within these pages are the tools agencies will need to decide if FIO is right for their agency, and if they are funded, to get started with preparations for implementation. Often agencies are waiting for an upcoming Training of Facilitators (TOF) but would like to get started preparing for the intervention. This kit will provide the worksheets, timelines, and information you need to do so.

OVERVIEW OF FIO

FIO Basics

The Future is Ours (FIO) is an eight-session evidence-based HIV prevention intervention that is delivered in interactive group sessions over an eight-week period.

Appropriate Audience

FIO is a gender-specific HIV/STD risk-reduction intervention designed for heterosexually active, at-risk women of diverse ethnicities (African American/Black, Caribbean, Latina, White), ages 18 to 30. Women are considered at-risk for HIV and other STDs if they are having unprotected sex with male partners whose past or current sexual and/or drug use risk behaviors place them at risk of infection. The intervention is designed for women who are not injection drug users, who are HIV-negative or of unknown status, are not pregnant or trying to become pregnant, and who live in communities where rates of HIV and other STDs are high.

In these communities, women often do not recognize that unprotected sexual intercourse in ongoing relationships with men potentially places them at risk for HIV and other STD infections. Many of these women may be disempowered within their intimate relationships due to economic dependence on men, traditional gender role expectations, and limited control over how sexual activity occurs. Even though they, themselves, may be monogamous, their sexual partner's past or current sexual behavior and/or drug use may place them at risk for infection^{1,2,3}. Additionally, they may not have the knowledge, self-efficacy, and skills to use a range of protection strategies, including negotiating for male condoms, using the female condom, and refusing unsafe sex.

FIO Goals

The overall goal of FIO is to empower women to reduce unsafe sexual encounters (unprotected vaginal or anal sex contacts) by increasing the use of male and female condoms and alternate protection strategies. These alternate protection strategies include engaging in “outercourse” (sex without penetration), getting tested for HIV jointly with a partner (followed by mutual monogamy and a safety agreement), deciding to be celibate, and refusing unsafe sex or deciding to not get involved with a partner who will not use condoms.

For an extensive description of behavioral determinants, activities, and outcomes see Appendix A: FIO Behavior Change Logic Model.

1 Exner, T. M., Dworkin, S. L., Hoffman, S., & Ehrhardt, A. A. (2003). Beyond the male condom: The evolution of gender-specific HIV interventions for women. *Annual Review of Sex Research*, 14, 114-136.

2 Ehrhardt, A. A., Exner, T. M., Hoffman, S., Silberman, I., Leu, C-S., Miller, S., & Levin, B. (2002). A gender-specific HIV/STD risk reduction intervention for women in a health care setting: short- and long-term results of a randomized clinical trial. *AIDS Care*, 14(2), 147-161.

3 Seage, G. R., Holte, S. E., Metzger, D., Koblin, B. A., Gross, M., Celum, C., Marmor, M., Woody, G., Mayer, K. H., Stevens, C., Judson, F. N., McKirnan, D., Sheon, A., Self, S. & Buchbinder, S. P. (2001). Are US populations appropriate for trials of human immunodeficiency virus vaccine? The HIVNET Vaccine Preparedness Study. *American Journal of Epidemiology*, 153(7), 619-627.

FIO Description

FIO is a small-group, gender-specific, cognitive behavioral intervention that consists of eight two-hour interactive sessions. Sessions should contain eight to twelve women. These sessions are facilitated by two women, at least one of whom should match the ethnic background of the majority of participants. It allows women to connect with each other by sharing their feelings about relationships with men, values and personal vulnerability. It also teaches them to understand and personalize their risk for HIV and other STDs, identify gender-based barriers to safer sex, and gain practical knowledge about a range of risk-reduction strategies. Additionally, women build skills necessary to communicate and negotiate safer sex with their partners (including how to identify and respond to abuse in relationships), and how to solve problems to avoid setbacks. The group sessions (outlined below) incorporate a variety of techniques including demonstrations, exercises, goal setting, group discussions, lectures, review of printed materials, role-plays, skill practice, and a video. A key emphasis of FIO is that women consistently make choices regarding their sexual behavior which are often influenced by gender norms that are supported by society. Participants are made aware of these choices and their consequences and are taught how to make better choices that result in safer sex behaviors.

Session One: Why should I care about getting STDs and HIV?

Session Two: How do I avoid partners who don't care?

Session Three: What's the best way to protect myself?

Session Four: How can I find out if we are infected?

Session Five: How do I ask my partner to use protection?

Session Six: How do I influence my partner to use protection?

Session Seven: How do I refuse sex or unprotected sex?

Session Eight: How do I continue protecting myself and others?

Ideal Agencies to Implement FIO

FIO can be used by any community- or clinic-based organization or health department where a confidential setting can be provided for the small group sessions to meet. Agencies adopting FIO are expected to have access to large numbers of women who are at risk due to their sexual relationships with men. Some examples are shelters and public housing, drop-in centers, STD and other public health clinics, colleges and universities, and family planning clinics.

Benefits to Women

Women who complete the FIO intervention benefit in numerous ways, including increases in:

- ⇒ Perception of personal risk for HIV and STDs and prioritization of HIV/STD prevention
- ⇒ Knowledge of own and partners' pasts and current HIV/STD risk behaviors
- ⇒ Knowledge of risky sexual acts, symptoms and effects of STDs, and various birth control methods
- ⇒ Knowledge of how to select and influence partners and deal with their negative reactions
- ⇒ Awareness of various strategies for how to protect themselves from HIV (male and female condoms, Mutual Testing, "outercourse," refusal of unsafe sex, and abstinence)

-
- ⇒ Understanding of how gender norms in relationship are barriers to safer sex
 - ⇒ Positive attitudes toward male and female condoms and women's sexual pleasure
 - ⇒ Self-efficacy to use male and female condoms and eroticize safer sex
 - ⇒ Self-efficacy to affirm their sexual and relationship rights, negotiate with partners for condom use and testing, refuse unsafe sex, and deal with negative reactions from partners
 - ⇒ Self-efficacy to ask partners about their past risk behaviors and assess their attitudes toward safer sex
 - ⇒ Self-efficacy to help other women protect themselves
 - ⇒ Self-efficacy to "problem solve" when safer sex is not maintained
 - ⇒ Intention to reduce occasions of unprotected sex
 - ⇒ Communication and negotiation skills
 - ⇒ Condom-use skills

Benefits to Your Agency

If you choose to adopt FIO, you would be one of the first agencies to offer a gender-specific intervention scientifically proven to reduce sexual risks among sexually-active African-American, Latina, and Caucasian women. Case study agencies that implemented FIO reported that after completing FIO, the participants were better able to recognize patterns in their relationships with men that lead to unsafe sex. Women also reported using the tools and information they received in the FIO intervention in their lives between sessions.

SCIENCE BEHIND FIO

To better understand FIO and how it works, it is important to understand the underlying theories upon which FIO was developed, the scientific research findings related to FIO, the critical components required for FIO's success, and how FIO is designed to address certain determinants that result in the intended outcomes. The following sections describe these aspects of FIO.

Original Research and Findings for FIO

The original study that evaluated FIO (The Future Is Ours) was conducted among 360 women aged 18 to 30 years, who were recruited from a family planning clinic in Brooklyn, N.Y. between 1994 and 1997⁴. Seventy percent of the women were Black/African-American, 17% were Latina, and the remainder were White or of other ethnicities. In terms of risk, 64% of women reported having at least one of the following: an STD in the past year, two or more current partners, or six or more lifetime partners. Further, 53% of women reported their main partner had at least one risk, such as not having been tested for HIV or possibly having had outside partners, and 33% reported that their main partner had two or more risk characteristics.

Women were randomly assigned to an eight-session intervention, a four-session intervention, or a control group, which consisted only of regular interviews and referral services if necessary. Outcomes for the three groups were then compared. The study demonstrated that the eight-session FIO was effective in reducing unprotected vaginal and anal intercourse in both the short-term (one month after the intervention) and long-term (12 months after the intervention). This included both increasing use of male and female condoms and reducing the number of sexual contacts. Women in the eight-session FIO intervention were also more likely to use an alternative protection strategy that they had not used previously. Alternative protection strategies included refusing sex if a partner would not use a condom, having non-penetrative sex, engaging in mutual HIV/STD testing with a partner, or deciding not to have sex.

Theoretical Foundation

FIO is guided by three major theories, the **Modified AIDS Risk Reduction Model (M-ARRM)**, **Gender Script Theory**, and **Social Learning Theory**. The activities throughout FIO are based on these theories.

M-ARRM

The M-ARRM⁵ is an adaptation of the AIDS Risk Reduction Model (ARRM)⁶. The developers of FIO used formative, qualitative research with women from the target population to make the ARRM specific to women—thus the M-ARRM (Modified AIDS RISK Reduction Model). The M-ARRM incorporates aspects of gender script theory⁷ to explain why heterosexually active women are at risk for HIV and other STDs.

4 Ehrhardt, A. A., Exner, T. M., Hoffman, S., Silberman, I., Leu, C-S., Miller, S., & Levin, B. (2002). A gender-specific HIV/STD risk reduction intervention for women in a health care setting: short- and long-term results of a randomized clinical trial. *AIDS Care*, 14 (2), 147-161.

5 Miller, S., Exner, T. M., Williams, S. P., & Ehrhardt, A. A. (2000). A gender-specific intervention for at-risk women in the USA. *AIDS Care*, 12(5), 603-612.

6 Catania, Kegeles, and Coates (1990). Towards an understanding of risk behaviors: An AIDS risk reduction model (ARRM). *Health Education Quarterly*, 17, 53-72.

The M-ARRM states that in order to increase their safer sex behaviors, women need to (1) label themselves as at risk due to their relationships with men (**Susceptibility**); (2) make safer sex a priority (**Prioritization**); (3) make a commitment to change risky behaviors (**Intention**); (4) seek and implement solutions to change (**Enactment**); and (5) maintain safer behaviors (**Maintenance**). See Appendix A for an illustration.

Gender Script Theory

Gender Script Theory tells us that our expectations for how women and men should act in relationships (or, what are called “gender scripts”) can make women vulnerable to HIV and STDs. Gender scripts are cultural expectations or messages that we all learn growing up⁷. One example is “a woman should play ‘hard to get’ with a man.” Even when we might disagree with them, gender scripts often influence our behaviors. Here are some key “gender scripts” that make it difficult for women to be safe.

“A woman is nothing without a man.” This is the idea that if we don’t have a boyfriend, a partner, a special guy, or a husband, we are not really worth very much as women. Think about movies, novels, TV shows, what our parents or grandparents say. Most of us grow up with this message in one way or another. If women have this message playing in the back of their minds, it will be harder for them to insist that their partner use a condom, to talk to their partners about past behaviors, and to refuse sex. FIO challenges this idea by getting women to think about their sexual and relationship rights and recognizing that they can choose partners who care about their health.

“Loving, intimate relationships are safe relationships.” This is the idea that “If I love my partner and he loves me, he’s not going to put me at risk.” This sexual script relates to sexual risk—women may be unwilling to acknowledge that there might be risk in their relationships. They may think that if they themselves are monogamous, they are safe, and they may not want to address the fact that their partner’s past or current behaviors might be putting them at risk. A related idea is that condoms do not belong in these close relationships because condoms imply that “trust” and intimacy is not there. FIO helps women understand that even the men we love can put us at risk and that condoms can be part of a loving, intimate relationship.

Understanding women’s gender scripts helped the developers modify the ARRM so that it was relevant to women’s risk in their relationships with men. Gender Script Theory is woven throughout the intervention.

Social Learning Theory

While the first three components of the M-ARRM (Susceptibility, Prioritization, and Intention) tell us WHAT beliefs and values need to be changed in order for women to be able to make their behaviors safer, the last two components (Enactment and Maintenance) refer specifically to adopting and maintaining new behaviors.

Social Learning Theory^{8,9} is relevant here, as it emphasizes the importance of learning new skills in a supportive social setting. Social Learning Theory describes HOW to change behavior (i.e., the types of ACTIVITIES that help people adopt new behaviors). It says that people are enabled to change a behavior by engaging in activities that:

7 Simon, W., & Gagnon, J.H. (1986). Sexual scripts: Permanence and change./ Archives of Sexual Behavior, 15, 97-120..

8 Rotter, J. B. (1967). Beliefs, social attitudes and behavior: A social learning analysis. In R. Jessor & S. Feshbach (Eds.), *Cognition, personality, and clinical psychology*. San Francisco: Jossey-Bass..

9 Bandura, A. (1986). Social foundations of thought and Action: A social-cognitive theory. Englewood Cliffs: Prentice Hall.

- ⇒ Alter old beliefs about the new behavior (e.g., if I refuse unsafe sex, my partner will leave me) through exploring the benefits associated with the new behavior (e.g., if I refuse unsafe sex, my partner will see that I am serious about my health);
- ⇒ Enable them to gain skills through watching someone model the behavior, practicing it, getting feedback, and teaching it to others;
- ⇒ Promote confidence that they can perform the new behavior (self-efficacy);
- ⇒ Provide incentives and social support for change (adopting new behaviors).

Based on this theory, FIO includes interactive activities that encourage women to alter old beliefs (e.g., recognize how gender scripts guide their choices) and explore the benefits of new behaviors. FIO activities help women gain new skills and confidence to use those skills. As they observe facilitators model the skills, practice themselves, and teach them to others they become more confident in their ability to use the skills. Support from the group is emphasized by the giving and receiving of “Thanks” Chips as a sign of appreciation for other individual’s contributions and changes.

What Are Women’s HIV/STD Prevention Needs?

In the early days of the epidemic, only sex workers and women who injected drugs were considered to be at risk for HIV. Even today, some heterosexually active women do not realize the extent of their risk. Yet HIV and STD transmission is occurring increasingly among heterosexually active women. For example, at the time of this writing (2009), women accounted for 26% of new adult cases of HIV/AIDS infection in 2007⁸. High-risk heterosexual contact was the source of 80% of these newly diagnosed infections⁹. Women living in urban areas, especially minority women, are at increased risk for HIV infection. Of all women diagnosed with AIDS in 2005, 80% were Black or Latina¹⁰.

For other sexually transmitted diseases (STDs), including chlamydia, trichomoniasis, and gonorrhea, younger women, in particular, are at increased risk. The CDC estimates that 19 million new STD infections occur each year, almost half of them among young people ages 15 to 24¹¹.

To prevent HIV/STD infection, women need strategies that recognize:

- ⇒ a woman may be monogamous herself, but her partner may be placing her at risk through his high-risk behaviors.
- ⇒ women often have little control over the circumstances of sex, or whether or not they even have sex. Many women report that they have at some point been coerced to have sex.
- ⇒ because many women are economically dependent on men, they don’t feel that they have the option to refuse sex or insist on condom use
- ⇒ when women are advised to use condoms, it often is not recognized that women don’t “use” condoms; rather, men use condoms.
- ⇒ there is at present only one method that women have some direct control over – and that is the female condom.

10 CDC Cases of HIV Infection and AIDS in the United States and Dependent Areas, 2007. HIV/AIDS Surveillance Report, Volume 19.

11 CDC MMWR: Sexual and Reproductive Health of Persons Aged 10–24 Years—United States, 2002–2007. July 17, 2009 / 58 (SS06);1-58.

Core Elements

Core Elements are the components that are the most essential features of FIO and are considered to be responsible for its efficacy. They are the parts of an intervention that must be present and cannot be changed¹². In other words, Core Elements must be implemented with fidelity. Fidelity is the practice of staying within the guidance of the approved intervention process; it is keeping the heart of the intervention unchanged so as to reproduce its effectiveness in the field with another population or in a different setting. Below is a listing of FIO's Core Elements and further information on their importance:



Core Element #1

Enable women to personalize their risk for HIV and other STDs and identify gender-related barriers to safer sex.

FIO does this by:

- Discussing how women's vulnerability is related to their relationships with men;
- Sharing of personal stories about relationships;
- Identifying traditional gender behaviors (or "gender scripts") in role-plays; and
- Evaluating their own risk and the risk of their partners.

Rationale: One of the greatest challenges to seeing themselves at risk for HIV and other STDs is for women to understand how their relationships with men, even relationships that are trusting and committed, can place them at risk. Traditional roles and expectations for how women and men should act in intimate relationships make it difficult to raise issues related to both partners' past and current sexual behaviors, and for women to insist that partners undertake behaviors to stay safe. This Core Element links to the M-ARRM component called **Susceptibility**.



Core Element #2

Encourage women to prioritize safer sex.

FIO does this by:

- Linking the need for protection to women's longer-term life goals; and
- Relating "helping themselves" to helping others protect themselves—women in the group, partners, friends, family, and the wider community.

¹² AIDS Education and Prevention: Turning HIV Prevention Research Into Practice (2000), 12 (Suppl A), 145.

Rationale: Linking actions taken to protect oneself against HIV and STDs to women’s longer-term life goals and projects provides a rationale for making difficult behavioral changes. Relating self protection to helping others draws on altruistic values and builds cohesiveness within the group. This Core Element links to the M-ARRM components called **Prioritization** and **Intention**.



Core Element #3

Reinforce women’s sexual and relationship rights.

FIO does this by:

- Teaching skills for selecting partners who care about safer sex through demonstration, practice, and role-plays;
- Teaching skills for asking partners to get tested for HIV and other STDs;
- Sharing of personal experiences about relationships;
- Letter writing to partners; and
- Developing a Sexual Bill of Rights.

Rationale: Social and economic pressure to “have a partner” may hinder women from acknowledging that they have the right to relationships in which a partner respects them and their needs. Being able to ask partners to get tested for HIV and other STDs is an important part of determining whether a partner’s past behaviors may put a woman at risk for disease. This Core Element links to the M-ARRM components called **Susceptibility**, **Intention**, **Enactment** and **Maintenance**.



Core Element #4

Affirm a positive view of women’s sexuality and safer sex.

FIO does this by:

- Modeling frank and non-judgmental discussion of the range of sexual behaviors;
- Eliciting participants’ preferences for sexual terminology;
- Developing a Sexual Bill of Rights;
- Doing a body-mapping exercise;
- Role-plays discussing sexual pleasure; and
- Brainstorming ways to eroticize safer sex and make sex more playful.

Rationale: Giving women permission to speak frankly about sex and affirming the importance of their own sexual pleasure empowers them to place value on what they want from sexual relationships. Research shows that neither men nor women like to use protection methods that decrease their sexual pleasure. Exploring ways to eroticize safer sex and to engage in sexual activity that does not entail intercourse broadens women’s available choices for enjoyable, safe sexual encounters, reinforces the idea of choice, and increases the likelihood of long-term behavior change. This Core Element relates to the M-ARRM components called **Intention, Enactment** and **Maintenance**.



Core Element #5

Emphasize that women have choices in how to protect themselves.

FIO does this by:

Presenting options for safer sex and helping women consider which options will work for them and their partners. Options include:

- Male and/or female condoms;
- Undertaking mutual HIV and STD testing with a monogamous partner;
- Engaging in non-penetrative sex (“outercourse”);
- Refusing unsafe sex; and
- Remaining abstinent.

Rationale: Making choices is a theme that runs throughout the intervention. Understanding that they have a range of options to protect themselves and that some of these are more under their control than male condoms helps women acknowledge their own ability and act to protect themselves. Some women also have limited knowledge about what options exist to prevent unintended pregnancy, disease, or both and that many methods that prevent pregnancy have no impact on disease prevention. This Core Element relates to the M-ARRM components called **Intention, Enactment** and **Maintenance**.



Core Element #6

Provide accurate information about HIV/STD risk and testing.

FIO does this by:

- Discussing STD effects if untreated;

- Covering Steps for Mutual Testing with a monogamous partner;
- Discussing HIV/STD testing, emphasizing that testing only tells about the past, not about future risk; and
- Going over methods of contraception that also protect against disease and those that do not.

Rationale: Many women are unaware of several facts related to STDs. For instance, many women do not know that most women and many men who are infected with an STD are asymptomatic—they have few, if any, signs or symptoms. Many are also unaware that some STDs are relatively common, and that, untreated, they can cause additional problems, including infertility and risks for the fetus. Knowing what tests are available for HIV, and that any test can only tell about the past and does not prevent HIV or other STDs helps in decision-making about getting oneself tested, asking a partner to get tested, and getting tested together with a partner. This Core Element relates to the M-ARRM components called **Susceptibility, Prioritization, and Intention.**



Core Element #7

Build skills for safer sex.

FIO does this by:

Demonstration, practice, role-plays, teaching others, and goal setting related to:

- Using male and female condoms;
- Negotiating with partners for male and female condom use;
- Negotiating with partners for mutual HIV/STD testing;
- Selecting partners who care about safer sex;
- Helping other women protect themselves;
- Eroticizing safer sex;
- Refusing unsafe sex; and
- Maintaining safer sex over the long term.

Rationale: Besides having an intention to change, people need to have the skills to change. Social Learning Theory says that these skills can be taught and reinforced through describing the behavior, modeling it, gaining practice, teaching it to someone else, and getting and giving positive feedback for reinforcement of one's efforts. Making one's sexual relationships safer is not a one-time behavior. Often, the barriers to safer sex increase over time; for example, partners in long-term relationships may want to stop using condoms. Women are given tools to deal with "slips" and maintaining safety over the long term. This Core Element relates to the M-ARRM components called **Enactment and Maintenance.**



Core Element #8

Teach women how to address negative reactions and resistance to safer sex, as well as to recognize and deal with relationship violence and other forms of abuse.

Rationale: Since negative reactions and resistance to safer sex are expected from some men, women need to be prepared to deal with resistance and not to “cave” when men object to male or female condom use or getting tested for HIV. Many women have already experienced abuse in their current or past relationships and may reasonably fear that raising issues related to testing or condom use could lead to abuse. All women need to know the signs of abuse and what to do if they are in an abusive situation. This Core Element relates to the M-ARRM components called **Enactment** and **Maintenance**.

Key Characteristics

Key Characteristics are the crucial activities and delivery methods for FIO. These may be adapted for specific agency and population needs but none of the Key Characteristics can be eliminated. Below is a summary of the Key Characteristics.

1. Target Audience:

- Young women (18-30 years)
- Ethnically diverse women
- At-risk women who have sex with men
- Women living in communities where rates of HIV and other STDs are high

2. Session Structure and Logistics:

- Bring together groups of eight-to-twelve women to build group cohesion and support.
- Conduct sessions in an enclosed space that is conducive to confidentiality, but large enough to allow the participants to move around.
- Conduct sessions once a week to allow women time to practice the material.

3. Techniques and Tools:

- Use a variety of tools for skill-building including demonstration, practice, discussions, role-play and goal setting.
- Use a variety of techniques to help women change their thoughts including sharing of personal experiences, letter writing, the Feeling Thermometer and relaxation.
- Build group cohesion through “Thanks” Chips which allow participants to get and give positive reinforcement.
- Use multi-cultural role-plays to stimulate discussion.

Session Structure

The following table lists the major tools used in FIO and explains their purpose, procedures, the core elements to which they link, and the connection to the theories upon which FIO is based. This table is a great way to see how all the tools and techniques in FIO connect to the broader theoretical underpinnings. This table also provides concrete examples of how the three theories that guide FIO are expressed within the intervention.

FIO SESSION STRUCTURE				
TOOL	PURPOSE	PROCEDURES	CORE ELEMENTS	Theory
Positive Introductions	Every session begins with women introducing themselves and stating a positive aspect of themselves. This activity is designed to improve self-esteem and develop relationships between the women.	Facilitators should introduce the go-round by participating, but be very selective in disclosing (e.g., you may want to only disclose something neutral and/or not too revealing).	Not Applicable (N/A)	<p>M-ARRM: N/A</p> <p>Social Learning Theory: Positive Introductions help to create an accepting and supportive environment. This helps the women feel comfortable trying out new behaviors.</p> <p>Gender Script Theory: During Positive Introductions women may present themselves in a way that differs from what is socially accepted for women (speaking positively about oneself in public).</p>
Lottery	The lottery should be conducted at the beginning of each session in order to encourage women to attend each session and arrive on time.	<p>During the beginning of Exercise 1 of each session, distribute and collect lottery tickets and ask for a participant volunteer to select winner.</p> <p>Tickets may also be distributed before the session begins to minimize the amount of time taken from the session.</p>	N/A	<p>M-ARRM: N/A</p> <p>Social Learning Theory: The lottery reinforces the new behavior of attending FIO regularly and on-time.</p> <p>Gender Script Theory: N/A</p>

FIO SESSION STRUCTURE				
TOOL	PURPOSE	PROCEDURES	CORE ELEMENTS	Theory
Goal-Setting	Goal-setting is designed to have women take steps to apply the information they are learning within the intervention into their daily lives to reduce their risk of HIV/STD transmission. The following session then begins with a check-in on each woman's progress in meeting her between-session goals.	When women are setting their goals, it is important to make sure that the goals are challenging but doable within the time frame between sessions (usually a week). The purpose is to build self-confidence in their abilities to protect themselves. We want women to experience success in achieving their between-session goals in order to reinforce their abilities to make more substantial changes in their lives.	<p>#2-Encourage women to prioritize safer sex</p> <p>#4-Affirm a positive view of women's sexuality and safer sex</p> <p>#7-Build skills for safer sex</p>	<p>M-ARRM: Prioritization Intention Enactment</p> <p>Social Learning Theory: Participants demonstrate the desired behavior and are rewarded through group support. This increases participants' sense of their personal ability to make behavioral changes (also called self-efficacy).</p> <p>Gender Script Theory: N/A</p>
Present New Information	To introduce or review HIV-related risk information or risk-reduction options. This section of the session provides content for the skills-building and goal-setting.	Varies by session. May include risk assessment, presentation of information related to HIV/STDs, contraceptives and HIV/STD protection methods, information on HIV/STD testing, communication tips, etc.	<p>#1-Enable women to personalize their risk for HIV and other STDs and identify gender-related barriers to safer sex</p> <p>#6-Provide accurate information about risk and testing</p>	<p>M-ARRM: Susceptibility Prioritization Intention Enactment Maintenance</p> <p>Social Learning Theory: For participants to perform new behaviors, such as using female and male condoms, they must first develop the necessary skills. Skills can be learned by direct teaching, by watching others perform the behaviors, and by practicing.</p> <p>Gender Script Theory: N/A</p>

FIO SESSION STRUCTURE				
TOOL	PURPOSE	PROCEDURES	CORE ELEMENTS	Theory
Scripted Role-Plays	To enable participants to observe the demonstration of a particular skill. For the “actors,” scripted role-plays begin the process of behavioral rehearsal.	Two participants read out a prepared script. Other participants discuss how the characters handled a particular situation, noting whether they followed the guidelines for the skill. For role-plays related to “gender scripts,” participants discuss how the characters reflect common beliefs about how women and men should act in relationships or why women do not feel at risk.	#3-Reinforce women’s sexual and relationship rights #4-Affirm a positive view of women’s sexuality and safer sex #8-Teach women how to address negative reactions and resistance to safer sex, as well as to recognize and deal with relationship violence and other forms of abuse #7-Build skills for safer sex	M-ARRM: Susceptibility Prioritization Intention Enactment Maintenance Social Learning Theory: Women build and practice new skills, which increases their abilities to change their behaviors. Gender Script Theory: Women are able to explore how traditional gender roles that hinder their abilities to protect themselves may be able to be addressed through use of effective communication skills. Women are able to express and discuss with each other socially acceptable and expected behaviors.
Unscripted Role-Plays	To provide participants with an opportunity to practice skills presented in session.	Varies by session. To process these role-plays, the facilitators should ask the individual who was in the role practicing the skills, “What did you like about what you did?” “What would you have done differently?” The facilitator should then ask the other person in the role play, “What did you like about what she did?” “What would you have done differently if you were in the role?” Observers should monitor how the volunteers implemented the skills using these two processing questions.	#3-Reinforce women’s sexual and relationship rights #4-Affirm a positive view of women’s sexuality and safer sex #8-Teach women how to address negative reactions and resistance to safer sex, as well as to recognize and deal with relationship violence and other forms of abuse #7-Build skills for safer sex	M-ARRM: Susceptibility Prioritization Intention Enactment Maintenance Social Learning Theory: Women build and practice new skills, which increases their abilities to change their behaviors. Gender Script Theory: Women are able to explore how traditional gender roles that hinder their abilities to protect themselves may be able to be addressed through use of effective communication skills. Women are able to express and discuss with each other socially acceptable and expected behaviors.

FIO SESSION STRUCTURE				
TOOL	PURPOSE	PROCEDURES	CORE ELEMENTS	Theory
Letter Writing	Letter writing offers women an opportunity to apply the information they have learned and to think through how their decisions impact their lives.	Varies by session. Facilitators should ask for volunteers to read their letters as scripted. As with all FIO activities, do not force participants to participate.	<p>#3-Reinforce women’s sexual and relationship rights</p> <p>#5-Emphasize that women have choices in how to protect themselves</p> <p>#8-Teach women how to address negative reactions and resistance to safer sex, as well as to recognize and deal with relationship violence and other forms of abuse</p>	<p>M-ARRM: Susceptibility Intention Enactment Maintenance</p> <p>Social Learning Theory: Letter writing provides an opportunity for skills building and observing others applying the information they have learned within a supportive environment.</p> <p>Gender Script Theory: Focuses on women’s rights to define their own sexual behavior.</p>
Demonstrations Followed by Practice	To enable participants to observe the correct way to perform a particular behavior, such as inserting a female condom, and then to practice the skill themselves.	Facilitators model the correct behavior, step by step. Participants watch (or follow along). Participants then practice the skill themselves.	#7-Build skills for safer sex	<p>M-ARRM: Intention Enactment Maintenance</p> <p>Social Learning Theory: Women build and practice new skills, which increases their abilities to change their behaviors.</p> <p>Gender Script Theory: Women are able to explore how traditional gender roles that hinder their abilities to protect themselves may be able to be addressed through use of effective prevention skills.</p>

Behavior Change Logic Model

The FIO Behavior Change Logic Model is a visual description of how the underlying theory relates to each of the activities performed in the intervention and, in turn, how these activities are related to the intended outcomes. This document can be used as a simple way to conceptualize how all the parts of the intervention fit together. Some agencies find the Logic Model useful as a tool to help explain the intervention to key stakeholders, new staff, or potential funding sources.

FIO Behavior Change Logic Model

Problem Statement

Target Population: The Future Is Ours (Project FIO) is a gender-specific HIV/STD risk-reduction intervention designed for heterosexually active at-risk women of diverse ethnicities (African-American/Black, Caribbean, Latina, White), ages 18 to 30, who are not injecting drug users, are HIV-negative or of unknown status, are not pregnant or trying to become pregnant, and who live in communities with high rates of HIV and other STDs.

Risk Behaviors: This population is at risk for HIV and other STDs due to having unprotected sex with male partners whose past or current sexual and/or drug use risk behaviors place them at risk of infection.

Behavioral Determinants

Corresponds to risk or contextual factors

- Low perception of their own and their partners' risks for HIV and STDs
- Little understanding of gender-related barriers to safer sex
- Safer sex is a low personal priority

Activities*

To address behavioral determinants

- Conduct eight separate interactive two-hour sessions in a small group
- Discuss how women's vulnerability is related to their relationships with men.
- Share personal stories about relationships.
- Evaluate personal risks for HIV and other STDs.
- Evaluate partners' risks for HIV and other STDs.
- Discuss why women deny their risk and read a role-play script about this.
- Role-play helping another woman assess her risk.
- Discuss how gender stereotypes make it difficult for women to ask partners about past and current risk.
- Identify traditional gender behaviors in role-play.
- Identify personal values in order to link the need for protection to women's longer-term life goals.
- Review long-term life goals by sharing with a partner.
- Affirm and support individual and group long term goals to stay healthy by providing peer and social support to each individual's commitments to protect herself and others and the community.
- Develop a list of women's sexual rights.
- Connect group discussions and role-plays to sexual rights list.

Major Risk and Contextual Factors for HIV: Heterosexually active women who live in communities with high rates of HIV and other STDs often do not recognize that they are at risk for these infections. Many women are disempowered within their intimate relationships due to economic dependence on men, traditional gender role expectations, and limited control over the circumstances of sex. Women may not be aware that even though they are monogamous, their current or former partners' past or current sexual and/or drug use behaviors may place them at risk. Additionally, they may not have the knowledge, self-efficacy, and skills to use a range of protection strategies, including negotiating for male condoms, using the female condom, and refusing unsafe sex.

Outcomes

Expected changes as a result of activities targeting behavioral determinants

Immediate Outcomes

Intermediate Outcomes

(at least one month post intervention)

Increases in:

- Perception of personal risk for HIV and STDs
- Knowledge of partners' past and current HIV/STD risk behaviors and HIV status
- Understanding of how gender norms in relationships are barriers to safer sex

- Personal priority placed on HIV/STD prevention

- Self-efficacy to affirm their sexual and relationship rights

- Reduction in unprotected vaginal and anal sex occasions
- Increase in male and female condom protected vaginal and anal sex occasions
- Increase in use of alternative strategies for protection (Mutual HIV Testing, "outercourse", refusal of unsafe sex, leaving a relationship or not starting one because of concerns about safer sex, abstinence)

Behavioral Determinants <i>Corresponds to risk or contextual factors</i>	Activities <i>To address behavioral determinants</i>
<ul style="list-style-type: none"> • Negative attitudes toward male and female condoms • Negative attitudes toward women’s sexuality • Low awareness of choices for how to protect themselves • Little knowledge of : <ul style="list-style-type: none"> • Risky sexual acts • Effects of untreated STDs • Role of HIV and STD testing in prevention • Steps for Mutual HIV Testing with a partner • Methods for protection against disease, pregnancy, and both 	<ul style="list-style-type: none"> • Play casually with male and female condoms to increase comfort levels. • Conduct a role-play of an older woman giving advice to a younger woman on how to make sex pleasurable and discuss how it feels to talk openly about sexual pleasure. • Identify what gives each woman sexual pleasure and ways to make sex more playful by completing a body map, brainstorming ideas in small groups, and writing on a card as a way to increase one’s own sexual pleasure. • Discuss whether being a woman who thinks about her own sexual pleasure and how to make sex more playful conflicts with gender norms. • Explore the use of female condoms if partners refuse male condoms. • Discuss the option of Mutual Testing for those who do not want to use condoms forever or who want to get pregnant. • Introduce “outercourse” and have small groups brainstorm ideas for non-insertive sex. • Discuss refusal of unsafe sex as a strategy for protection. • Discuss issues around abstinence by reviewing a magazine article on the topic and eliciting responses. • Identify risky sexual acts through a group game. • Review information on STD symptoms (and lack thereof), and effects of untreated STDs on women’s health and fertility. • Provide facts about and discuss pros and cons of getting tested for HIV. • Review information on how to engage in HIV testing with a mutually monogamous partner before giving up condom use or trying to get pregnant. • Discuss information on a variety of methods that provide protection against STDs, pregnancy, or both, and reinforce knowledge by answering “Dear Dr. Viola” letters.

Outcomes <i>Expected changes as a result of activities targeting behavioral determinants</i>	
Immediate Outcomes	Intermediate Outcomes (at least one month post intervention)
<ul style="list-style-type: none"> • Positive attitudes toward male and female condoms • Positive attitudes towards women’s sexual pleasure • Intention to reduce unprotected occasions of sex • Awareness of various strategies for how to protect themselves from HIV (male and female condoms, Mutual Testing, “outercourse,” refusal of unsafe sex, and abstinence) • Knowledge of risky sexual acts • Knowledge that STDs often cause no symptoms and knowledge of the effects of untreated STDs • Recognition that HIV testing is not a prevention strategy • Knowledge of the steps in Mutual HIV Testing • Knowledge that male and female condoms offer protection against both disease and pregnancy • Knowledge that hormonal methods do not protect against disease 	

Behavioral Determinants <i>Corresponds to risk or contextual factors</i>	Activities <i>To address behavioral determinants</i>
<ul style="list-style-type: none"> • Few skills to : <ul style="list-style-type: none"> • Use male and female condoms • Negotiate with partners for male and female condom use • Eroticize safer sex • Refuse unsafe sex • Negotiate with partners for Mutual HIV/STD Testing • Select partners who care about safer sex • Help other women protect themselves • Maintain safer sex over the long term • Experience with negative reactions from partners, including verbal or physical abuse 	<ul style="list-style-type: none"> • View demonstration of correct use of male and female condoms and practice use on anatomical models. • Review guidelines for influencing a partner to use a condom or accept a female condom, read a script, and practice through role-plays. • Practice assertive responses to men’s reasons for not wanting to practice safer sex. • Explore strategies to make using condoms erotic. • Review guidelines on refusing unsafe sex, demonstrate through a script, and role-play refusal. • Develop and practice skills for asking partners to be tested for HIV and STDs through role-playing and letter writing. • Practice problem-solving skills in relation to testing issues in small groups. • Identify characteristics of past partners that prevented practicing safer sex and consider how to select partners who care about safer sex. • Practice helping a younger woman consider a partner’s risk. • Present guidelines for handling “slips” and practice problem-solving strategies in small groups. • Through reading a script, discuss how asking a partner to use a condom might change a relationship or conflict with gender norms. • Identify possible partner reactions to being asked to use protection and review guidelines for responding • Using the Feeling Thermometer and letter writing, explore what it means to the relationship if a partner is unwilling to have protected sex. • Present examples of verbal, sexual, and physical abuse, read role-play scripts related to this, present guidelines for dealing with abuse, and give out list of local resources for abused women

Outcomes	
<i>Expected changes as a result of activities targeting behavioral determinants</i>	
Immediate Outcomes	Intermediate Outcomes (at least one month post intervention)
<ul style="list-style-type: none"> • Self-efficacy to use male and female condoms • Knowledge of the steps in influencing new/casual and steady partners to use condoms or accept the female condom • Self-efficacy to influence and negotiate with new/casual and steady partners to use male and female condoms • Self-efficacy to eroticize safer sex • Self-efficacy to refuse unsafe sex or not start a relationship if partner is unwilling to practice safer sex • Self-efficacy to ask partners to get tested • Knowledge of factors to consider in selecting a potential partner • Self-efficacy to ask partners about their past risk behaviors and assess their attitudes toward safer sex • Self-efficacy to help other women protect themselves • Self-efficacy to “problem solve” when safer sex is not maintained • Knowledge of strategies for dealing with negative reactions • Self-efficacy to deal with negative reactions from partners, including verbal or physical abuse 	

*Some activities are used throughout the intervention that do not relate specifically to a Core Element but are linked to the theoretical basis of FIO. These important activities include:

- ⇒ As weekly homework, women set small achievable goals that are steps toward safer sex and review achievement of them the following week.
- ⇒ Use of the Feeling Thermometer to process emotional reactions to various situations.
- ⇒ Use of “Thanks” Chips to give and receive positive affirmation from other group members and build group cohesion.

HOW TO GET STARTED

Purpose Of This Section

This section will help prepare your agency to put FIO into action. There are many important steps in this process including assessing agency readiness, securing support through stakeholder buy-in, finding and training the right staff, obtaining all necessary materials, budgeting, determining where you will conduct FIO sessions, writing appropriate agency policies, and recruiting and retaining participants.

In the following pages are tools that will help agencies work through all of the pre-implementation steps.

If a CDC directly funded agency has trouble developing capacity in any of these areas (e.g. developing a budget), consult with your CDC Project Officer concerning your agency's capacity building assistance (CBA) needs, and then submit a request on the CDC Capacity Building Assistance Request Information System (CRIS) website at <http://www.cdc.gov/hiv/cba>. If an agency is indirectly funded through their state or local health department, consult your health department on your CBA needs and the health department will submit a CRIS request.

Agency Readiness Checklist

After gaining an initial understanding of the requirements for implementing FIO, your agency can use the following checklist to conduct a brief self-assessment to determine your current capacity and areas that you may need to develop. Read each item and then place a check mark (✓) in only one response option.

Capacities and Resources Needed for FIO	Yes, we have this capacity	We do not presently have this capacity, but can build it	We do not have this capacity and would need CBA to build it
Access to women who meet the specified criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agency commitment to implement and sustain the entire eight-session FIO program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support or “buy-in” from other individuals and agencies (e.g. Board of Directors, your community, partner agencies, funding sources)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Two female staff members who are skilled facilitators/trainers with experience in HIV/STD prevention, sexual and reproductive health, and working with women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Commitment to and completion of five days of intensive training on FIO intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meeting space to conduct confidential FIO sessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to TV/VCR or DVD player, easel, newsprint for use on easel, markers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to purchase/obtain a variety of male and female condoms, male penile models and female pelvic models for demonstration and skill building during program sessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to recruit and retain members of target population (eight to ten women) for eight two-hour sessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resources available to purchase/obtain small incentives to encourage participation, and one small prize for a lottery conducted at each session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Intervention Checklist

The purpose of this checklist is to stimulate thinking and engage key people in dialogue, so that they might ask each other the right questions to determine if they wish to adopt The Future Is Ours. This checklist is not exhaustive.

YES	NO	QUESTION
<input type="checkbox"/>	<input type="checkbox"/>	Are intervention goals appropriate for your organization?
<input type="checkbox"/>	<input type="checkbox"/>	Are intervention goals appropriate for your target population?
<input type="checkbox"/>	<input type="checkbox"/>	Are intervention objectives appropriate for your organization?
<input type="checkbox"/>	<input type="checkbox"/>	Are intervention objectives appropriate for your target population?
<input type="checkbox"/>	<input type="checkbox"/>	Does your organization have the capacity to implement each core element?
<input type="checkbox"/>	<input type="checkbox"/>	Does the organization have a management commitment to implement each core element with fidelity?
<input type="checkbox"/>	<input type="checkbox"/>	Does the organization have staff commitment to implement each core element with fidelity?
<input type="checkbox"/>	<input type="checkbox"/>	Does the organization have sufficient resources to implement each core element with fidelity?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have the capacity to recruit members of the target population for this intervention?
<input type="checkbox"/>	<input type="checkbox"/>	Does this intervention address or have the capacity to address risk factors within your target population?
<input type="checkbox"/>	<input type="checkbox"/>	Does your agency have the resources necessary for the program?
<input type="checkbox"/>	<input type="checkbox"/>	Does FIO meet the needs of the population you serve?
<input type="checkbox"/>	<input type="checkbox"/>	Does your agency have enough staff available to implement the program?
<input type="checkbox"/>	<input type="checkbox"/>	Does your agency have staff available with the skills needed to implement the program?
<input type="checkbox"/>	<input type="checkbox"/>	Will implementing FIO change your agency's organizational practices, including relationships with other prevention or service agencies?
<input type="checkbox"/>	<input type="checkbox"/>	Does your agency have experience serving multi-ethnic heterosexually active women between the ages of 18 and 30?
<input type="checkbox"/>	<input type="checkbox"/>	Does your target population engage in sexual risk behaviors that are addressed by FIO?
<input type="checkbox"/>	<input type="checkbox"/>	Does FIO fit into your current prevention services?

Steps to Secure Support for Your Program

Securing support or buy-in from your agency, other agencies, and other stakeholders is crucial to ensuring the success of your programs. This support may include your Board of Directors/Executive Board, individuals in your community, partner agencies, staff and volunteers at your agency, and your funding sources.

There are three main components to securing support, but many agencies and individuals will be part of more than one of these categories:

- ⇒ Getting buy-in from key stakeholders, i.e., individuals or groups that have a stake in the successful implementation of an intervention
- ⇒ Building a network of agencies to recruit clients from and refer clients to
- ⇒ Establishing a Community Advisory Board

The following checklist details the steps needed to secure support to implement FIO. This section will also provide information about establishing Community Advisory Boards.

Checklist: Steps for Securing Support for Your Program

Although most agencies already have established stakeholders and agency networks, this checklist can be used to build upon these relationships. It can be used by your agency's promoters, an individual or group of people within or connected to your agency, to mobilize support for implementing FIO.

Step 1: Identify your stakeholders, network agencies, and potential Community Advisory Board members.

You should have at least one agency or individual from each of the following categories:

- Your agency's Board of Directors/Executive Board
- Staff members from your agency who will have a role in implementing FIO
 - Administrators who will obtain support
 - Supervisors who will monitor the intervention
 - Staff who will interact with participants throughout the intervention
- Local agencies from which you can recruit participants, facilities, or both
 - Agencies offering support or services to your target population of heterosexually active women who are at high risk for STDs/HIV
 - Health care providers and mental health professionals serving women who are part of the target population
 - Community and social service organizations (e.g., day care centers; clinic waiting rooms; work, WIC or income assistance programs)
 - Social- and entertainment-focused venues where members of your target population frequent (e.g., hair salons, shopping centers, clubs)
- Organizations which could provide assistance or other resources
 - Merchants for incentives, such as refreshments, cosmetics and toiletries, movie passes, clothes, transportation, etc.
 - Agencies, newspapers and newsletters, merchants, social venues, printers, sororities, publishers, broadcasters, and others that can advertise the intervention
 - Clinics, community centers, churches and other agencies that can provide a venue for the intervention
 - Agencies that can provide childcare
 - Agencies that can provide transportation
 - Advisory board to help adapt the intervention
 - Agencies for referring members of the target population for additional service needs (e.g., intimate partner violence, mental health services, drug treatment)
- Agencies with which your agency needs to maintain good community or professional relations:
 - Local health department
 - Local medical and mental health associations
 - Community and social service organizations
 - Your funding source(s)
 - Political or community leaders

Step 2: Decide what specific roles you would like each individual/agency to play.

This means finding the right people to:

- Provide financial support
- Refer relevant women to the intervention
- Serve as an intervention facilitator
- Be a resource to which you can refer participants
- Join your Community Advisory Board
- Help adapt the intervention for your specific target population
- Assist in advertising the intervention
- Provide space in which the intervention sessions can take place
- Supply refreshments for participants
- Donate small incentives or lottery prizes for participants
- Spread the word about FIO by speaking supportively about it in conversations with people they are connected to

 Step 3: Send letters that inform the chosen individuals/agencies.

- Describe FIO.
- Explain why FIO is important to your agency.
- Outline the specific role(s) you believe chosen individual/agencies can play in ensuring the success of the intervention.
- Offer an opportunity for them to learn more.

 Step 4: Make follow-up calls after two weeks to assess interest.

If they are interested, schedule a time to meet (e.g., lunch-and-learn at your agency with a group of other stakeholders, presentation at their agency for several of their staff or association members).

 Step 5: Hold a meeting or speak with each person/agency individually to enlist their support.

- Show FIO marketing materials if the setting and time allow.
- Describe several specific roles they could play and what these would entail (e.g. referring clients).
- Highlight to them the benefits of their involvement to their agency, the community, and the population of interest.
- Answer any questions they may have.
- Invite them to commit to supporting FIO by taking on one or several roles.
- Keep track of commitments.

Step 6: Get them involved.

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. Ask them to contact you if they would like to get involved or if they have any questions. Keep the letter on file in case they reconsider later.

If an individual or agency committed to a role that is important to pre-implementation, get them involved as quickly as possible.

If an individual or agency commits to a role that involves them later in the process, send brief updates and be sure that they understand you will be calling on them for future support.

Step 7: Maintain stakeholders' interest and commitment to FIO.

Hold periodic celebratory meetings for supporters to demonstrate your appreciation for and the value of their contributions, keep them updated on the intervention's progress, and keep them engaged in the process.

Identifying the Right Program Staff

In order for FIO to run smoothly and effectively, your program will need one Program Manager and two trained female facilitators. Additionally, certain sessions of FIO may elicit strong emotional reactions from participants. These sessions include Sessions 2, 4, and 7. It is recommended that a mental health provider be on call when these sessions are being conducted.

Program Manager

The following is a list of the program manager's most fundamental responsibilities in implementing FIO. While these are all crucial, the manager's duties are not limited to these.

- Preparing the agency for the intervention
- Determining whether and with which organizations to collaborate
- Hiring and managing the appropriate facilitators and administrative staff
- Overseeing the intervention and the intervention team
- Ensuring all the necessary intervention materials are available, up-to-date and in good condition
- Setting up training and technical assistance
- Managing adaptation of FIO for your specific target population
- Establishing and overseeing an evaluation plan
- Conducting group supervision sessions
- Creating and following a program budget
- Developing recruitment and retention strategies
- Quality assurance
- Monitoring fidelity of the intervention
- Managing funding requirements (e.g., writing annual reports, ensuring funders requirements around monitoring and evaluation and quality assurance are met, etc.)

Facilitators

FIO should be implemented with two female facilitators. It is recommended that they have training in HIV 101, strong self-help group facilitation skills and experience working with women. Past experience in delivering the intervention has demonstrated that women feel more comfortable and safe discussing issues of sex and sexuality with women facilitators. For women who have been victims of domestic violence or any crimes against women, the presence of a female facilitator will help to create a safe and supportive environment. Additionally, it is recommended that at least one facilitator match the ethnicity of the majority of participants.

Facilitators should be non-judgmental and preferably have group facilitation training experience. It is important to note that the facilitators for FIO will operate in a role that is somewhere between a teacher and a group facilitator. They need to understand that although FIO is a scripted behavioral intervention, a good facilitator knows how to respond to the issues that participants present and can confidently handle the discussions and personalities that emerge in the group. Effective facilitators of FIO should have both knowledge of teaching strategies and group facilitation skills.

Teaching Skills	Group Facilitating Skills
<ul style="list-style-type: none"> • Modeling skills taught in curriculum • Engaging all participants in activities • Speaking to larger groups (e.g., projecting their voice so that they are heard) • Ensuring that participants grasp the structure and goals of exercises 	<ul style="list-style-type: none"> • Group management • Responsiveness to participants' feelings • Good listening skills • Skill for paraphrasing participants' comments effectively • A non-judgmental attitude • Ability to respond positively to group dynamics

Recommended Facilitation Skills and Characteristics

Finding and maintaining effective facilitators can prove a challenge for an agency. The list below will help you develop job descriptions and select the most appropriate facilitators.

Group Facilitation Skills

Good facilitation skills can be learned. Some of those skills include, but are not limited to:

- Modeling skills for participant to practice
- Giving constructive feedback on role-plays
- Establishing trust
- Helping participants create bonds
- Keeping discussions on track and on time
- Keeping participants involved in the discussions
- Maintaining an open climate
- Maintaining a safe environment
- Maintaining respect among participants
- Managing different personality types
- Creating a sense of shared ownership in their input

Characteristics of Effective Facilitators

Other aspects of facilitators are more inherent. When evaluating potential facilitators, ensure that they are:

- Trustworthy
- Flexible
- Active listeners
- Able to promote communication
- Able to maintain eye contact
- Able to adapt to changing dynamics in the group
- Understanding and non-judgmental
- Able to manage and control problems

- Dynamic and friendly
- Respectful of confidentiality
- Patient
- Culturally competent
- Good observers
- Authentic
- Empathetic and supportive
- Able to use humor effectively and appropriately
- Interested in working with groups
- Able to create a warm and welcoming environment
- Respectful of others and their opinions
- Able to build rapport
- Willing to learn from the group
- Aware of their own comfort level, skills and limit

Once you have found potential facilitators, provide them with the basic information about FIO and what their specific roles and responsibilities will be. Both facilitators will be required to attend a FIO Training of Facilitators (TOF). You can use sections of this manual including *Overview of FIO* and *FIO Fact Sheet*, and the *FIO Facilitator Guide* to orient facilitators around the goals and objectives of the intervention, and accordingly, what their jobs will involve. It is also recommended that facilitators have or obtain introductory HIV knowledge and skills (HIV 101) prior to attending a FIO TOF course in addition to having the skill sets listed above. Facilitation skill building is also available through capacity building assistance (CBA) requests.

Mental Health Provider

FIO presents information and draws out discussions on sensitive topics including women's history of being in relationships with men who do not support them, HIV and STD testing, and domestic violence. During the original research, some of the material elicited strong emotional responses in some participants. Because facilitators are not expected to have mental health backgrounds to properly counsel women in acute need, mental health providers should be available to provide services during Sessions Two, Four and Seven. Mental health providers include mental health counselors, licensed clinical social workers, psychologists, and psychiatrists. These sessions are thought to be the most potentially provoking; however, a mental health provider should be available if problems arise during the other sessions. Therefore, it is necessary to have strong internal and external referral networks to provide the additional needs participants may have during FIO implementation. It is not required that a mental health provider be on staff but rather that one is available as a collaborative partner for referrals.

Materials Needed to Conduct FIO

Below is a checklist of materials you will need for FIO. Your agency should maintain a steady supply of these materials. For information on specific quantities please see the cost worksheet.

✓	Material
	Access to television
	Access to DVD player
	Access to laptop computer
	Access to LCD projector
	Easel
	Colored and white paper
	Easel paper
	Post-it notes
	Index cards
	Masking tape
	Pens/Pencils
	Markers
	Name tags
	Male penis models
	Female pelvic models
	Male condoms
	Female condoms
	Lubricant
	Sex toys—(external ones e.g., vibrators)
	Telephone
	Baby wipes
	Jar of honey
	Scarf
	Non-oil based massage cream
	Erotic book
	Lottery prizes
	Lottery tickets (roll)
	Bag for lottery tickets
	Clock

Recommended Sources

Listed are some recommended sources for models and condoms. Your community advisory board may be able to help you find cost-effective sources as well.

Penis models: Condomerie (www.condomerie.com)

Health Information Projects (www.superiormedical.com)

MOI Inc. (www.moiinc.com)

Total Access Group (www.totalaccessgroup.com)

Pelvic Models: Health Information Projects (www.superiormedical.com)

Ortho-McNeil Pharmaceuticals (www.ortho-mcneil.com)

Mentone Educational Centre (www.mentone-educational.com)

Total Access Group (www.totalaccessgroup.com)

Female Condoms: Many state and local health departments offer the female condom free of charge and/or at a deeply discounted rate. Contact your local department of health for information about obtaining female condoms for educational demonstrations.

Additionally, The Female Health Company (www.femalehealth.com) provides information about distributors throughout the United States and contact information for bulk orders.

Unlubricated Female Condoms: Total Access Group (www.totalaccessgroup.com)

Male Condoms: Male condoms can often be obtained from local health departments or family planning clinics at deeply discounted rates. Contact your local health department or family planning clinic for information about obtaining male condoms for educational programming.

Several Websites also offer discount rates on bulk orders:

www.condomhall.com

www.undercovercondoms.com

www.1stopcondomshop.com

www.condomdepot.com

Note on Lambskin vs. Latex Condoms: While lambskin condoms are effective at preventing pregnancy, they do not prevent the transmission of HIV and other STDs. Only condoms made of latex or polyurethane are effective at preventing the transmission of HIV. Individuals with latex allergies should use polyurethane condoms instead of lambskin condoms to help prevent HIV transmission.

Budget Narrative

Although an adequate budget for staffing and supplies is essential for successful implementation of FIO, it is also necessary to ensure adequate existing infrastructure.

At a minimum, FIO should be implemented with 1.4 Full-Time Equivalents (FTEs), though this will vary based on the number and spacing of cycles. These staff members will be responsible for recruiting participants, marketing the program, facilitating sessions, and conducting evaluation activities. The following staff breakdown is recommended for an agency implementing one cycle per quarter:

1 Program Manager (20% during Pre-Implementation; 30% during Implementation)

2 Facilitators (40% each)

1 Administrative Assistant (10%)

Program Manager

The Program Manager provides oversight of FIO including preparing the agency for FIO, developing collaborative relationships with other agencies, assisting with client recruitment and retention, securing materials and resources for FIO, supervising the facilitators, ensuring all FIO materials are up-to-date and in good condition, conducting monitoring and evaluation activities, conducting quality assurance, and managing funding requirements.

Facilitators

These staff members are primarily responsible for recruitment of participants, delivery of the FIO intervention, participant retention and data collection. Facilitators must attend the Training of Facilitators (TOF) and should begin recruitment activities at least one month but preferably three months before the target FIO start date. Facilitators should provide services or ongoing contact to interested women prior to the actual start of the FIO intervention cycle in order to maintain interest in the intervention. In addition to the delivery of FIO, facilitators spend a significant amount of time helping to retain participants in FIO. This includes making repeat reminder phone calls and sending letters. Facilitators must also complete FIO monitoring and evaluation documentation and attend supervision and quality assurance meetings.

Administrative Assistant

This staff person is primarily available to assist the Program Manager and Facilitators in preparing FIO materials such as ordering supplies and printing and assembling the Participant Workbooks. The Administrative Assistant may also be responsible for data entry, confirming potential participants, and providing follow-up on referrals.

This staffing pattern is the minimal number needed to implement FIO effectively. With these staff members in place, agencies can offer one cycle of FIO at a time. Thus, over a 12-month period, a maximum of six cycles could be completed.

If your agency plans to serve a large number of clients and your budget allows for additional staffing, you may consider allocating more time to the Program Manager and Facilitators. This would allow the Facilitators to conduct more recruitment, retention and marketing activities and deliver additional cycles of FIO. This would also allow the Program Manager to conduct more oversight and evaluation activities.

NOTE: Administrative Assistant duties could be added to the Facilitator job descriptions, which would eliminate the need for this staff person but would add time to the facilitators line.

Estimating the Budget for Implementing FIO

Budgets vary from organization to organization. Here are general categories that an agency should consider when estimating their budget.

Personnel: Personnel are often the most expensive component of a program's budget. This component includes staff salaries. As shown above, FIO requires four staff members.

Facilities: This category includes rent, utilities, insurance, and maintenance. FIO requires access to a room large enough to comfortably seat eight-to-twelve participants plus two facilitators and to allow flexible seating arrangements. In addition, an office is needed for staff to have ongoing contact with participants. If an agency's own facility does not offer this space, additional space will need to be rented or borrowed from another agency.

Equipment: Standard office equipment is needed to print/duplicate program forms and Participant Workbooks, look up current information about resources related to HIV and STD prevention, and enter/store client and evaluation data. Additionally, in one FIO session, a DVD player and TV are required. Other recommended equipment includes a laptop computer, a desktop computer, easels, service contracts for equipment maintenance and Internet access.

Supplies: Standard office supplies (e.g., newsprint pads, markers), postage and mailing, and copying and printing costs are needed to be budgeted for FIO. Additional supplies should include incentives for participants during group sessions and intervention materials (i.e., condoms, safer sex kits, anatomical models, FIO novelties, travel reimbursement, refreshments).

Recruitment: In order to recruit participants, agencies will need to develop flyers and advertisements that can be widely disseminated throughout the community. This category also includes the costs associated with advertising in newspapers or other media. In addition, agencies may choose to distribute giveaways such as food (food must be calculated per person and be of reasonable cost), t-shirts, condoms or other risk reduction materials during recruitment.

Travel: Some agencies may require a budget for travel both for conducting FIO sessions off-site and to attend supervision or other program meetings (mileage, parking, gas, public transportation, etc.). Another travel expense is attending the CDC facilitator training. For more information, please visit www.effectiveinterventions.org.

Consultancy: Agencies are encouraged to seek technical assistance for evaluation, staff training, or for any areas that need to be enhanced. Additionally, a mental health provider should be accessible to provide support during three of the FIO sessions as discussed earlier.

Sample Cost Work Sheet

The following worksheet is a guide to assist your agency in determining the budget needed to implement the FIO intervention. Your agency may already have some of the itemized resources already in place.

Categories	Pre-Implementation (Start-up)		Implementation (Intervention Delivery)	
	# staff	% FTE	# staff	% FTE
Personnel (30%)				
Salaried:				
Program Manager	1	20%	1	30%
Facilitator	2	80%	2	80%
Administrative Assistant	1	10%	1	10%
Fringe Benefits		25%		25%
TOTAL	4	135%	4	145%
Facility (25%) (% of time used for the intervention)				
	Cost Methodology		Cost Methodology	
Rent (office)	\$	x % = \$	\$	x % = \$
Rent (group meeting space)	\$	x % = \$	\$	x % = \$
Utilities	\$	x % = \$	\$	x % = \$
Telephone/Fax	\$	x % = \$	\$	x % = \$
Maintenance (office)	\$	x % = \$	\$	x % = \$
Insurance (property, liability, etc.)	\$	x % = \$	\$	x % = \$
TOTAL	\$		\$	
Equipment (10%) (% of time used for intervention at depreciated value)				
Television	\$	x % = \$	\$	x % = \$
DVD player	\$	x % = \$	\$	x % = \$
Laptop	\$	x % = \$	\$	x % = \$
LCD projector	\$	x % = \$	\$	x % = \$
Easel (2)	\$	x % = \$	\$	x % = \$
Equipment maintenance (i.e. service contracts)	\$	x % = \$	\$	x % = \$
Internet service provider	\$	x % = \$	\$	x % = \$
TOTAL	\$		\$	

Categories	Pre-Implementation (Start-up)	Implementation (Intervention Delivery)
Supplies (15%)		
Postage and mailing	\$	\$
Copying and printing	\$	\$
Office Supplies:		
Paper (colored and white)	# @ \$ /ream = \$	# @ \$ /ream = \$
Easel newsprint paper (16 pads)	# @ \$ /pad= \$	# @ \$ /pad= \$
Post-It notes (16 pads)	# @ \$ /pad = \$	# @ \$ /pad = \$
Index cards (2 packs)	# @ \$ /pack = \$	# @ \$ /pack = \$
Name Tags (2 packs)	# @ \$ /pack = \$	# @ \$ /pack = \$
Masking tape (2 rolls)	# @ \$ /roll = \$	# @ \$ /roll = \$
Pens/Pencils (4 boxes)	# @ \$ /box= \$	# @ \$ /box= \$
Markers (2 packs)	# @ \$ /pack = \$	# @ \$ /pack = \$
Program Supplies:		
Male penis models (10)	# x \$ /each = \$	# x \$ /each = \$
Female pelvic models (5)	# x \$ /each = \$	# x \$ /each = \$
Male condoms (1 gross)	# gross x \$ /gross = \$	# gross x \$ /gross = \$
Female condoms (1 gross)	# gross x \$ /gross = \$	# gross x \$ /gross = \$
Lubricant (1 box)	# @ \$ /box = \$	# @ \$ /box = \$
Sex toys (2 different types of external toys e.g., vibrators)	# x \$ /each = \$	# x \$ /each = \$
Lottery prizes (8, one per session)	# x \$ /each = \$	# x \$ /each = \$
Miscellaneous (bag, clock, telephone, baby wipes, jar of honey, scarf, massage cream, erotic book)	\$	\$
Refreshments (must be used only for participants in the sessions, not for staff meetings)	\$ x number of participants = \$	\$ x number of participants = \$
TOTAL	\$	\$

Categories	Pre-Implementation (Start-up)	Implementation (Intervention Delivery)
Recruitment (10%)		
Advertising:		
Staff	\$	\$
Clients	\$	\$
Printed materials/Promotional giveaways:		
Flyers/Brochures	\$	\$
Posters	\$	\$
Incentives (t-shirts, pens, bags, bus tokens, gift certificates)	\$	\$
TOTAL	\$	\$
Travel (5%)		
Local: (Attend meetings or deliver intervention off-site)		
Work or personal vehicle	# miles x \$ /mile = \$	# miles x \$ /mile = \$
Public transportation [round trips (RT)]	# RT x \$ /RT = \$	# RT x \$ /RT = \$
Out-of-Town: (training, conferences)		
Airfare	# staff x \$ /fare = \$	# staff x \$ /fare = \$
Hotel	# staff x \$ /night x # nights = \$	# staff x \$ /night x # nights = \$
Per diem	# staff @ \$ /day x # days = \$	# staff @ \$ /day x # days = \$
TOTAL	\$	\$
Consultancy (5%)		
Evaluation Consultant	# hours @ \$ /hour = \$	# hours @ \$ /hour = \$
Mental Health Provider	# hours @ \$ /hour = \$	# hours @ \$ /hour = \$
TOTAL	\$	\$
GRAND TOTAL	\$	\$

NOTE: If undergoing adaptation, additional costs will arise including personnel and facilities for an estimated extra six weeks.

Appropriate Venues to Implement FIO

FIO should take place in an enclosed space that is conducive to confidentiality, but large enough to allow the participants to move around. The following are some suggestions for location selection and room logistics:

Facility

- Centrally located and as close as possible to all major transit routes so it is easy for participants to access
- Open at flexible dates/hours to make the intervention as accessible as possible
- Allow for TV, DVD player and easel charts to be set up in advance

Room

- Big enough to seat 10-12 individuals (8-10 participants, 2 facilitators) comfortably in a circle
- Chairs should be easy to move around. Sofas are not recommended since they are not easy to move into a circle
- Tables for food and beverages
- Allows enough privacy so that participants are not distracted or interrupted by people in the nearby area

Policies and Standards Needed to Implement FIO

Before an agency attempts to implement FIO, the following policies and standards should be in place to protect clients and the agency:

Confidentiality and Informed Consent

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, a signed informed consent form from the client must be obtained. This consent form should carefully and clearly explain (in appropriate language) the responsibility of the agency and the rights of the client. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Cultural Competency

Agencies must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. They should hire, promote, and train all staff to be representative of and sensitive to these different cultures. Facilitators, in particular, should be aware of cultural differences within the group as well as between themselves and the group members. Facilitators should understand these differences and the potential implications and be prepared to address any resulting issues. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. Agencies should also facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, (<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>) which should be used as a guide for ensuring cultural competence in programs and services.

Legal and Ethical Policies

Agencies also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

Agencies must be prepared to refer participants as needed. In order to best serve the HIV-related service needs of clients, providers must know about appropriate referral sources for additional prevention services and clinical needs, such as partner services, STD clinics, and other health department and CBO prevention programs, as well as domestic violence, physical abuse and drug treatment programs. It is highly recommended that agencies create a detailed referral list of available resources and services for women, and to develop a tracking system for follow-up of referral completions. Specifics for the list may be created based on observations and findings during the intake process of FIO participants.

Data and Record Storage

Agencies need to have a policy on accessing and storing electronic and/or hardcopy records of potential intervention participants including the lists used for recruitment, the assessments and interviews done prior to the selection process, etc.

Recruitment and Retention of FIO Participants

If your agency does not have a systematic way to collect client information to help your staff recruit, retain, and follow-up with clients, your agency will need to develop a client recruitment and retention plan. This section will provide information about what questions to consider and possible methods to use. For additional guidance and practical information on how other agencies have responded to recruitment and retention issues, please consult the Technical Assistance Guide (TA Guide).

 It is important to note that recruiting enough women who meet the eligibility criteria for FIO may require significant planning. It is advised to start recruitment well in advance (e.g., three months prior to first session) of the targeted implementation date and screen women as your staff recruits them into FIO as a means of maximizing your staff's time and efforts.

Recruitment of Participants

It is important to develop a recruitment plan detailing the following:

- ⇒ How and where will you recruit participants?
- ⇒ What are appropriate areas and times to recruit?
- ⇒ What kind of participants will you recruit? To be eligible, participants must be heterosexually active women between the ages of 18 and 30 who are not injection drug users, who are HIV-negative or of unknown status, are not pregnant or trying to become pregnant, and who live in communities where rates of HIV and other STDs are high.
- ⇒ What are recruitment strategies for your target population?
- ⇒ What kinds of marketing/recruitment materials will be used?
- ⇒ How many participants will you recruit? How often?
- ⇒ Who will be responsible for each of the associated activities?

As mentioned earlier, your Community Advisory Board (CAB) can help you answer these questions. They can inform your agency on the most appropriate locations to find your target population, specific strategies that have been found to be effective in the past, and may even connect you with free or low cost resources to help with these activities. Refer to the FIO TA Guide for specific information on recruitment gathered from the piloting of the intervention with two case study agencies.

Methods Used to Recruit Participants

There are a number of methods that can be used to recruit clients, including posting flyers in areas your target population spends time, placing advertisements in community newsletters, and mobilizing agency representatives to do street outreach and agency in-reach at relevant times/locations.

Tapping into social networks is another low-cost, effective strategy for reaching large numbers of potential participants. Any agency in your network that has a specific and organized connection to your target population will be invaluable to your recruitment efforts. They can identify relevant participants and may even

serve as a hosting site for sessions. This is particularly true for agencies that have a pre-existing group that meets regularly, such as programs where participants are required to attend in order to meet legal or educational obligations. Aside from helping recruit the most appropriate individuals for FIO, agencies in your network can also be useful in making announcements at relevant events or informally spreading the word through existing social networks (e.g., you may designate several individuals to send out e-mails or post flyers in their agencies). Developing Memoranda of Agreement (MOA) with agencies may assist in assuring cooperation and collaboration with agencies in your network. See Appendix J for the FIO marketing brochure for use with service providers and Appendix K for an example of a marketing flyer.

Designate Recruiters

Anyone familiar with the goals of the program or connected to your target population can be useful for client recruitment. This may include designated staff such as your facilitators, in addition to specific members of the community such as religious leaders, hairdressers, and social event organizers. Also, members of your Community Advisory Board, community gatekeepers, and previous clients of the agency or intervention can either serve as recruiters themselves or connect you to other individuals willing and able to recruit. While not necessary, if a formal designated recruiter is identified outside of existing staff and volunteers then subsequent adjustments to the cost worksheet and job descriptions should be made. Refer to the FIO TA Guide for more guidance.

Locations to Find Clients

In order to maximize the effectiveness of your recruitment plan, your agency should first identify geographical regions within your area that are of higher HIV/STD risk due to having higher rates of HIV and/or STD infection, then identify locations within those areas in which to recruit. Organizations, agencies, and social venues where members of your target population receive services or spend time are ideal for recruitment. These can include other programs at your own agency, clinics or social service agencies such as Planned Parenthood or WIC centers, hair salons and laundromats, day care centers or more entertainment-focused venues including clubs, community centers, and neighborhood hang-out spots. Also consider public housing, apartment complexes, group homes and drop-in centers.

Sufficient Recruitment Time

Schedule plenty of time before you intend to begin FIO for recruiting participants. Through experience implementing FIO, it is recommended that recruitment begin at least one month prior to the start of each FIO cycle. Develop a plan to engage and retain those women who express interest while you continue to recruit for the group. This might include offering supportive group sessions, individualized services, and periodic phone/email/instant messages. Refer to the FIO TA Guide for specific information.

Sufficient Numbers to Recruit

When recruiting potential participants, ensure that you obtain commitments from approximately three times the total number of women who you want to complete the cycle. For example, if you want eight participants to complete the eight-session cycle of FIO, recruit 24 women. Implementation of multi-session interventions have shown that many women will commit to participation, but do not begin the intervention. Similarly, there is a certain percentage of participants who will not be retained in the intervention. In order for FIO sessions to be interactive and productive, having at least eight to ten participants for each cycle is important. Refer to the TA Guide for more information.

Retention of Participants

Below are a number of factors to think about when considering a plan to ensure clients attend all eight FIO sessions. High retention rates will help maximize the effectiveness of the intervention. Refer to the FIO TA Guide for specific information.

Scheduling FIO Sessions

A number of factors need to be considered when choosing the days, times, and location for your sessions. Surveying potential participants regarding available times and support needs will help determine the most appropriate times and locations for holding the group sessions. Some issues to consider include childcare responsibilities/accessibility, job and/or school commitments, and accessibility of the intervention location. Additionally, your staff may be able to address some of the factors that may help or hinder your target population's participation.

Location of Intervention Site

The location where the eight FIO sessions are being held can greatly influence retention rates. A location that your target population can access easily (and access in safety and comfort) can encourage regular attendance. Be flexible and creative and hold the intervention in various communities. Sessions do not have to be held at the agency's facility.

Incentives for Participants

Incentives are useful in both motivating participants to attend FIO for the first time, and ensuring they return on a consistent basis. Incentives can be both practical (e.g., transportation vouchers and food coupons), or more fun-focused (e.g., lottery prizes, gift baskets with miscellaneous travel-size items like liquid body wash, lotion, toothpaste, etc., make-up, clothing, or movie passes). Offering incentives, such as having an introductory open house breakfast, graduation ceremonies, or small tokens of appreciation given out at the end of each session can be a useful tool in bringing women in to introduce them to FIO as well as to keep them coming back. It is important to set aside time and resources for appropriate incentives. Your agency should research what their most cost-effective incentives are, and can use the guidance of selected members of the target population.

FIO Session Atmosphere

The pace, flow, and interest level of the sessions can have a great impact on the willingness of participants to return to later sessions. Facilitators thus have a large responsibility for supporting participant retention. Session contact should be exciting and presented in an innovative and fun way to encourage participants to return to later sessions.

Participants who feel alienated or disconnected are less likely to return to future sessions than those who feel welcomed, safe, and supported. Facilitators should ensure participants contribute to discussions, participate in role-plays, and feel supported when expressing themselves. Positive reinforcement (e.g., through the use of "Thanks" Chips) can be helpful to promote retention. Personal "thank-yous" for attendance from facilitators after the session is completed can serve as additional positive reinforcement tools—particularly if coupled with appreciation for specific contributions made by the participant during the session.

Keeping in Touch with Participants Between Sessions

Administrative actions such as regular session reminders can improve participant retention. Keeping in touch with participants can help support their commitment to the program and reinforce group support and cohesion. If possible, obtain contact information that is as extensive as possible, including information on friends and family who may be able to assist you in contacting participants. Successful retention may require staying in very consistent contact with participants. This may include sending meeting reminders, phone calls, post cards, email or text messages just prior to the next session, or as a thank-you for attending the previous session. Making multiple reminder calls to each participant every week is highly recommended. These concepts are of key importance given the social and cultural aspects of women's lives and the number of FIO sessions that are conducted.

Pre-Implementation Worksheet

This worksheet is a comprehensive guide to help your agency work through the details of each step in the pre-implementation process.

Securing Support

Remember to identify potential stakeholders, network agencies, and Community Advisory Board members from each of the following categories:

- Your agency’s Board of Directors/Executive Board.
- Staff at your agency who will be involved with FIO.
- Local agencies from which you can recruit participants, facilities or both.
- Organizations which could provide assistance or other resources.
- Agencies with which you need to maintain good community/professional relations.

Name of Agency/ Individual:				
Contact Information				
Proposed Role				
Date Letter Sent				
Date of Follow-Up Call(s)				
Agreed to Role	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Plans for Getting Them Involved or Follow-Up:				

Name of Agency/ Individual:				
Contact Information				
Proposed Role				
Date Letter Sent				
Date of Follow-Up Call(s)				
Agreed to Role	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Plans for Getting Them Involved or Follow-Up:				

Name of Agency/ Individual:				
Contact Information				
Proposed Role				
Date Letter Sent				
Date of Follow-Up Call(s)				
Agreed to Role	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Plans for Getting Them Involved or Follow-Up:				

Identifying the Right Staff

Name of Program Manager: _____

- Internal Training Complete
- Attended FIO Training of Facilitators

Notes: _____

Name of Facilitator: _____

- Internal Training Complete
- Attended FIO Training of Facilitators

Notes: _____

Name of Facilitator: _____

- Internal Training Complete
- Attended FIO Training of Facilitators

Notes: _____

Additional FIO Team Members:

Name: _____ Role: _____

FIO Materials

Potential Resources:

Type of Material: _____ Name of Resource: _____
Resource Contact Information: _____

Type of Material: _____ Name of Resource: _____
Resource Contact Information: _____

Type of Material: _____ Name of Resource: _____
Resource Contact Information: _____

Type of Material: _____ Name of Resource: _____
Resource Contact Information: _____

Type of Material: _____ Name of Resource: _____
Resource Contact Information: _____

Type of Material: _____ Name of Resource: _____
Resource Contact Information: _____

Type of Material: _____ Name of Resource: _____
Resource Contact Information: _____

Type of Material: _____ Name of Resource: _____
Resource Contact Information: _____

Notes: _____

Developing a Budget

Completed Cost Worksheet

Finding Appropriate Venues

Potential Venues:

Name of Location:	Contact Information:	Facility			Room			Use As FIO Venue
		Centrally Located	Flexible Times/Days	Allow for Advance Setup	Room is Large Enough	Chairs Can Be Moved	Tables for Food/Drink	
		<input type="checkbox"/> Yes <input type="checkbox"/> No						
		<input type="checkbox"/> Yes <input type="checkbox"/> No						
		<input type="checkbox"/> Yes <input type="checkbox"/> No						
		<input type="checkbox"/> Yes <input type="checkbox"/> No						
		<input type="checkbox"/> Yes <input type="checkbox"/> No						
		<input type="checkbox"/> Yes <input type="checkbox"/> No						

Pre-Implementation Timeline

This timeline indicates the suggested timeframe and responsible staff for all the tasks associated with pre-implementation of FIO. It can be used as a tool to create a schedule for staff and to develop a work plan.

Tasks	Staff Responsible	Weeks																
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Organizational Structure & Capacity																		
Complete FIO Agency Readiness Assessment (see page 32)	Executive Director/ Program Manager	X																
Assess agency's capacity for implementing FIO (convene meetings with senior management staff including the Executive Director, Program Director, Accountant, and other relevant staff)	Executive Director/ Program Manager/ Accountant	X	X															
Conduct community review to identify target population, potential venues, etc.	Executive Director/ Program Manager			X	X	X												
Update or create job descriptions for the Program Manager and two Facilitator positions	Executive Director/ Program Manager			X	X													
Identify additional staff to support coordination and delivery of the intervention (e.g., administrative staff)	Program Manager			X														
Identify mental health provider to provide on-call services during three of FIO sessions	Program Manager			X														
Advertise position vacancies in local newspapers, Internet employment sites, among agencies' network of affiliates and collaborating partners, etc.	Program Manager				X	X	X											
Interview and select candidates who meet the requirements of the vacant positions (see page 38)	Executive Director/ Program Manager					X	X	X	X									

Pre-Implementation Timeline (continued)

Tasks	Staff Responsible	Weeks																
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Support of Stakeholders (See page 35)																		
Identify key stakeholders, network agencies, and individuals as potential Community Advisory Board (CAB) members.	Executive Director/ Program Manager/ Facilitators		X	X	X													
Develop a “Roles and Responsibilities” document that delineates the role of the CAB, key stakeholders and promoters.	Executive Director/ Program Manager/ CAB			X	X	X												
Secure stakeholders’ and promoters’ buy-in. Representatives should sign a memorandum of understanding (MOU).				X	X	X												
Implement the CAB, holding regular meetings	Executive Director/ Program Manager/ CAB				X	X	X	X		X		X		X		X		
Creating a Budget (see page 43)																		
Program, fiscal and senior management staff convene meetings to review resources needed to implement the program including staffing, supplies, equipment, etc.	Executive Director/ Program Manager/ Accountant					X	X											
Develop a two-year budget that reflects costs that include the pre-implementation phase of the program through delivery of intervention to the target population.	Executive Director/ Program Manager/ Accountant					X	X											

Pre-Implementation Timeline (continued)

Tasks	Staff Responsible	Weeks															
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Identify venues where the target population congregates, receives services, etc. in order to promote the program to them	Program Manager/ Facilitators/ Outreach Workers/ Community Advisory Board									X	X	X					
Select venue to implement the intervention (see page 48)	Program Manager/ Facilitators/ Outreach Workers											X	X				
Building Staff Capacity																	
Orient staff about FIO program and contract deliverables	Program Director										X	X	X				
Arrange for staff to participate in a FIO training of facilitators (TOF). Training is also recommended for the Program Manager.	Program Manager				X	X	X	X	X								
Staff participate in TOF	Facilitators/ Program Manager											X	X	X			
Client Recruitment (see page 50)																	
Develop recruitment plan.	Program Manager/ Facilitators	X	X	X													
Develop and/or tailor marketing materials including brochures and flyers to distribute during outreach activities, network meetings, as part of mailings, etc.	Program Manager/ Facilitators			X	X	X	X										
Begin marketing the program and advertising availability of FIO services in the community including where the target population congregates	Facilitators/ Outreach Workers/ CAB				X	X	X	X	X	X	X	X	X	X			

Pre-Implementation Timeline (continued)

Tasks	Staff Responsible	Weeks															
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Quality Assurance (QA)																	
Develop the program's monitoring and evaluation framework	Program Manager/ Evaluation Consultant									X	X	X	X				
Develop an Evaluation Plan and adapt as necessary FIO data collection instruments to assess if program process objectives and outcome objectives were met	Evaluation Consultant							X	X	X	X	X					
Develop a quality assurance plan which will be utilized by both the Program Manager and facilitators	Program Manager/ Evaluation Consultant								X	X	X						
Orient and train staff on the program's QA plan, data collection instruments, evaluation system, etc.	Evaluation Consultant												X	X			
Logistics																	
Confirm location/site to deliver the intervention	Program Manager														X	X	
Schedule sessions	Program Manager/ Facilitators														X	X	
Screen lists/files of potential participants based on agency's criteria	Program Manager/ Facilitators														X	X	
Research and assemble resource and referral lists for distribution to participants and develop follow-up protocol	Program Manager/ Facilitators														X	X	
Schedule meetings to practice facilitation of intervention prior to first cycle	Program Manager/ Facilitators														X	X	

Pre-Implementation Timeline (continued)

Tasks	Staff Responsible	Weeks															
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Preparation																	
Administer pre-assessment questionnaire to capture basic demographic data and risk factors of potential participants	Facilitators															X	X
Select participants	Program Manager/ Facilitators															X	X
Purchase necessary intervention supplies (see page 41)	Program Manager/ Facilitators															X	X
Prepare intervention materials including copies of handouts, resource lists and participant workbooks	Facilitators															X	X
Practice and prepare Cycle One materials—Program Manager will serve as an observer	Program Manager/ Facilitators																X

IMPLEMENTATION AND MAINTENANCE

Purpose of this Section

This section provides tools to ensure the smooth implementation of FIO and to help your organization maintain Future Is Ours. It includes a summary of the implementation process as well as timelines for implementation and for maintenance.

Implementation Summary

This chart will help agencies prepare for the implementation of FIO by listing what inputs need to be gathered, what activities need to be conducted, and what outputs will be expected.

INPUTS <i>Resources needed to implement and conduct intervention activities</i>	ACTIVITIES <i>Actions required to prepare for and conduct the intervention</i>	OUTPUTS <i>Deliverables or products that result from implementation activities</i>
<ul style="list-style-type: none"> • Agency capacity to conduct The Future Is Ours (FIO) • A least two skilled female facilitators with experience in leading personal discussions with other women who are sexually intimate with a male partner • Program Manager who will assist with pre-implementation activities and conduct quality assurance activities • Clinically trained worker who can provide on-call support for select FIO sessions • Confidential and safe meeting space to conduct all FIO sessions without interruptions • Agency, staff, and other stakeholder (local agencies with target client population, organizations that can provide material support) buy-in and involvement in assisting agency to implement FIO • Network of agencies to recruit clients from and refer clients to • Establishment of Community Advisory Board • Access to local Materials Review Board • Commitment to and completion of five days of intensive training on FIO intervention. • Ability to recruit and retain target population over eight-week period • Local/state public health officials' support for FIO implementation • Community and consumer support for FIO implementation • Input of agency staff, consumers, and community stakeholders into planning and implementation • External technical assistance 	<ul style="list-style-type: none"> • Closely review FIO curriculum/ intervention and understand theory and science behind it • Assess agency capacity to conduct FIO and identify technical assistance needs • Request technical assistance from Project Officer, CBA Coordinator • Introduce and orient staff to FIO • Assess need for adaptation of intervention and contact Project Officer for further assistance • Obtain and utilize consumer, community stakeholder input on FIO intervention • Inform local/state public health officials about FIO to gain their support • Prepare implementation plan with measurable goals and process and outcome objectives • Prepare evaluation plan including tools, data collection, data analyses, interpretation and reporting • Develop program monitoring plan to improve program and for quality assurance • Identify logistics for FIO (e.g., times, days, space) • Train and build skills of FIO facilitators and recruitment staff • Plan and implement process/procedures to integrate FIO into flow of agency services and programs • Design participant recruitment process including who recruits and how • Gain access to TV and DVD player, easel, newsprint pads for use on easel, markers • Purchase/obtain a variety of male and female condoms, male penis models and female pelvic models for demonstration and skill building during program sessions • Purchase/obtain small incentives to encourage participation, and one small prize for a lottery conducted at each session • Prepare participant workbooks • Conduct FIO intervention 	<ul style="list-style-type: none"> • Implementation plan, tailored to target population including measurable goals and process and outcome objectives • Written process/procedures to integrate FIO into flow of agency services and programs • Written FIO recruitment process • Evaluation plan including tools, evaluation data, data analysis, and summary reports with interpretation • Documentation of regular program monitoring and program improvement in accordance with monitoring plan • % of planned # of participants recruited/approached for FIO in [timeframe] • % of planned # of FIO sessions held in [timeframe] • % of planned # of participants in each FIO session in [timeframe] • % of planned # of participants in [timeframe] • % of planned # of FIO participants who satisfy target population characteristics in [timeframe]

Implementation Timeline

This timeline offers a suggested schedule for completing all the FIO activities associated with implementation over the course of one intervention cycle.

Tasks	Staff Responsible	Weeks													
		14	15	16	17	18	19	20	21	22	23	24	25	26	
Confirm participants and provide information on schedule and time	Program Manager/ Facilitators			X	X	X	X	X	X	X	X	X	X	X	
Arrange snacks and obtain incentives	Program Manager/ Facilitators			X	X	X	X	X	X	X	X	X	X	X	
Conduct pre-test	Facilitators			X											
Conduct Session One	Facilitators			X											
Debrief Session One including review of participant feedback forms	Program Manager/ Facilitators			X											
Conduct ongoing supervision meetings following each session conducted (group and 1:1 meetings, as necessary)	Program Manager/ Facilitators			X	X	X	X	X	X	X	X	X	X	X	
Conduct ongoing quality assurance measures to monitor implementation of FIO	Program Manager/ Evaluation Consultant			X	X	X	X	X	X	X	X	X	X	X	
Practice and prepare Session Two materials—Program Manager will serve as an observer	Program Manager/ Facilitators				X										
Conduct Session Two	Facilitators				X										
Debrief Session Two including review of participant feedback forms	Program Manager/ Facilitators				X										
Practice and prepare Session Three materials—Program Manager will serve as an observer	Program Manager/ Facilitators					X									

Tasks	Staff Responsible	Weeks													
		14	15	16	17	18	19	20	21	22	23	24	25	26	
Conduct Session Three	Facilitators					X									
Debrief Session Three including review of participant feedback forms	Program Manager Facilitators					X									
Practice and prepare Session Four materials—Program Manager will serve as an observer	Facilitators						X								
Conduct Session Four	Facilitators						X								
Debrief Session Four including review of participant feedback forms	Program Manager Facilitators						X								
Practice and prepare Session Five materials—Program Manager will serve as an observer	Program Manager Facilitators							X							
Conduct Session Five	Facilitators							X							
Debrief Session Five including review of participant feedback forms	Program Manager Facilitators							X							
Begin recruiting participants for next cycle	Facilitators Outreach Workers Community Advisory Board							X							
Practice and prepare Session Six materials—Program Manager will serve as an observer	Program Manager Facilitators								X						

Tasks	Staff Responsible	Weeks													
		14	15	16	17	18	19	20	21	22	23	24	25	26	
Conduct Session Six	Facilitators									X					
Debrief Session Six including review of participant feedback forms	Program Manager Facilitators									X					
Administer pre-assessment questionnaire to capture basic demographic data and risk factors of potential participants for next cycle	Facilitators									X	X				
Practice and prepare Session Seven materials—Program Manager will serve as an observer	Program Manager Facilitators										X				
Conduct Session Seven	Facilitators										X				
Debrief Session Seven including review of participant feedback forms	Program Manager Facilitators										X				
Select participants for following cycle	Facilitators										X				
Schedule and conduct interviews with participants to complete baseline assessment	Facilitators											X	X		
Practice and prepare Session Eight materials- Program Manager will serve as an observer	Program Manager Facilitators											X			
Conduct Session Eight	Facilitators											X			
Conduct post-test	Facilitators											X			
Debrief Session Eight including review of participant feedback forms	Program Manager Facilitators											X			

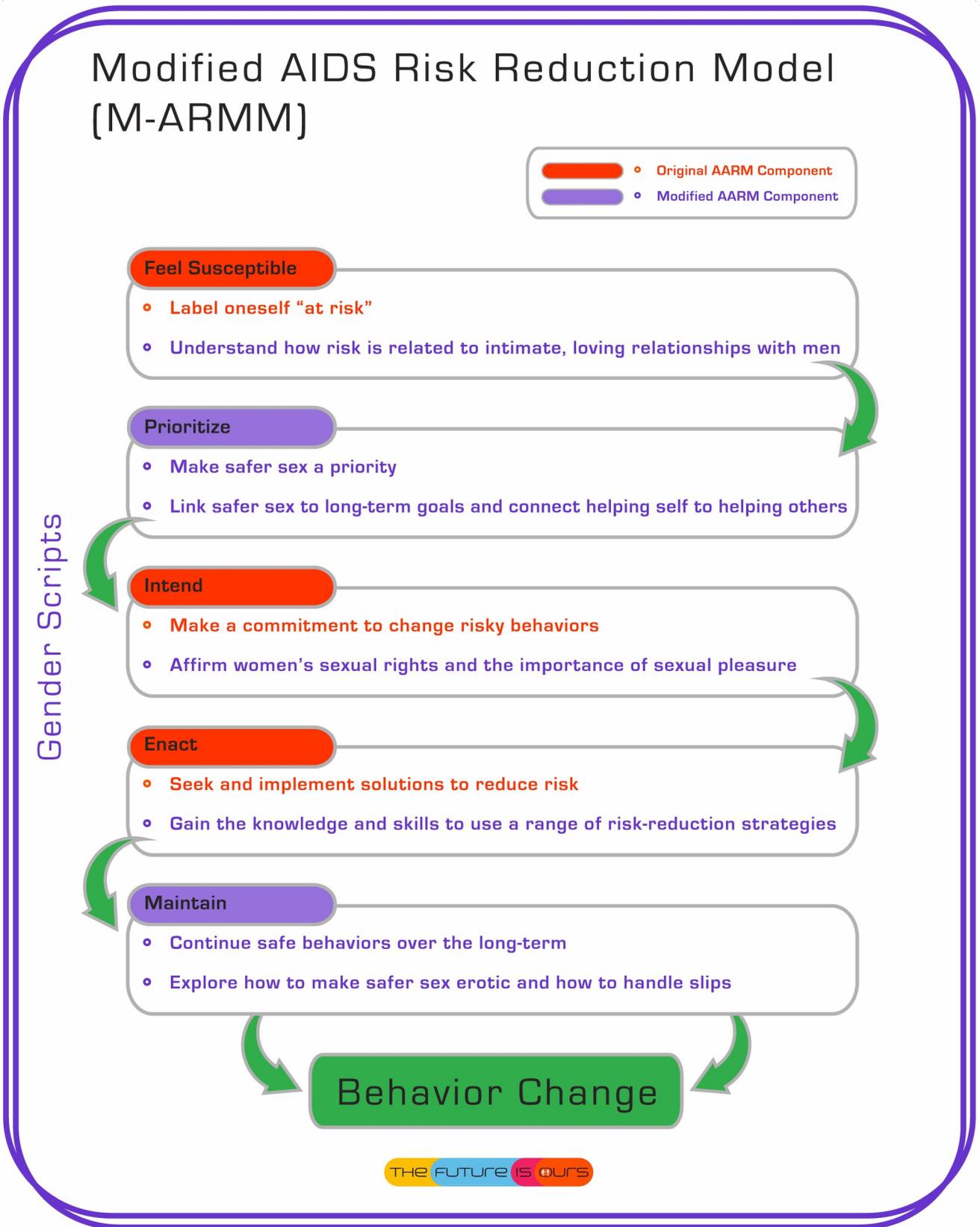
Maintenance Timeline

Tasks	Staff Responsible	Weeks													
		14	15	16	17	18	19	20	21	22	23	24	25	26	
Review all Quality Assurance instruments utilized by participants and FIO staff	Program Manager Evaluation Consultant Facilitators												X	X	
Assess if program process objectives and outcome objectives were met at the end of the intervention	Program Manager Evaluation Consultant Facilitators												X	X	
Revisit recruitment and retention strategy. Correct if process objectives are not met.	Program Manager Facilitators		X	X	X	X	X	X	X	X	X	X	X	X	X
Confirm participants for second cycle and inform them of venue, frequency of meetings, time, etc.	Facilitators													X	X

APPENDICES

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APPENDIX A: M-ARRM DIAGRAM



APPENDIX B:

CONTENT OF AIDS-RELATED WRITTEN MATERIALS, PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS

Interim Revisions June 1992

1. Basic Principles

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

- a. Written materials (e.g., pamphlets, brochures, fliers), audio visual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.
- b. 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

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 con

ducted 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.

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.

- a. 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.

b. 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.

c. When a cooperative agreement/grant is awarded, the recipient will:

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

APPENDIX C: CDC STATEMENT ON THE ABC'S OF SMART BEHAVIOR



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.

APPENDIX D: CDC STATEMENT ON NONOXYNOL-9 SPERMICIDE



May 10, 2002/51(18);389-392

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.

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

Editorial Note:

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

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

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a non-representative 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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TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contraception, by Title X Family Planning Region — United States, 1999

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

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

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

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

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods				
		Condoms with N-9	Condoms without N-9	Gel	Vaginal			Foam
					Film	Insert	Jelly	
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.

APPENDIX E: CDC STATEMENT ON STUDY RESULTS OF PRODUCTS CONTAINING NONOXYNOL-9

The logo for MMWR Weekly, featuring the letters "MMWR" in a large, bold, white font on a blue rectangular background, with the word "Weekly" in a smaller, italicized, white font to its right.

August 11, 2000/49(31);717-8

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

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

APPENDIX F: FACT SHEET FOR PUBLIC HEALTH PERSONNEL: MALE LATEX CONDOMS AND SEXUALLY TRANSMITTED DISEASES



For more information:
 CDC's National Prevention Information Network
 (800) 458-5231 or www.cdcnpin.org
 CDC National STD/HIV Hotline
 (800) 227-8922 or (800) 342-2437
 En Espanol (800) 344-7432
www.cdc.gov/std

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% effective, and condom use cannot guarantee absolute protection against any STD. Furthermore, condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV and other STDs. In order to achieve the protective effect of condoms, they must be used correctly and consistently.

Incorrect use can lead to condom slippage or breakage, thus diminishing their protective effect. Inconsistent use, e.g., failure to use condoms with every act of intercourse, can lead to STD transmission because transmission can occur with a single act of intercourse.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer.

Sexually Transmitted Diseases, Including HIV

Sexually transmitted diseases, including HIV

Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases (STDs), including discharge and genital ulcer diseases.

While the effect of condoms in preventing human papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

There are two primary ways that STDs can be transmitted. Human immunodeficiency virus (HIV), as well as gonorrhea, Chlamydia, and trichomoniasis – the discharge diseases – are transmitted when infected semen or vaginal fluids contact mucosal surfaces (e.g., the male urethra, the vagina or cervix). In contrast, genital ulcer diseases – genital herpes, syphilis, and chancroid – and human papillomavirus are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Condoms can be expected to provide different levels of protection for various sexually transmitted diseases, depending on differences in how the diseases are transmitted. Because condoms block the discharge of semen or protect the male urethra against exposure to vaginal secretions, a greater level of protection is provided for the discharge diseases. A lesser degree of protection is provided for the genital ulcer diseases or HPV because these infections may be transmitted by exposure to areas, e.g., infected skin or mucosal surfaces, that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing rates of STDs between condom users and nonusers in real-life settings. Developing such measures of condom effectiveness is challenging. Because these studies involve private behaviors that investigators cannot observe directly, it is difficult to determine accurately whether an individual is a condom user or whether condoms are used consistently and correctly. Likewise, it can be difficult to determine the level of exposure to STDs among study participants. These problems are often compounded in studies that employ a “retrospective” design, e.g., studies that measure behaviors and risks in the past.

As a result, observed measures of condom effectiveness may be inaccurate. Most epidemiologic studies of STDs, other than HIV, are characterized by these methodological limitations, and thus, the results across them vary widely—ranging from demonstrating no protection to demonstrating substantial protection associated with condom use. This inconclusiveness of epidemiologic data about condom effectiveness indicates that more research is needed—not that latex condoms do not work. For HIV infection, unlike other STDs, a number of carefully conducted studies, employing more rigorous methods and measures, have demonstrated that consistent condom use is a highly effective means of preventing HIV transmission.

Another type of epidemiologic study involves examination of STD rates in populations rather than individuals. Such studies have demonstrated that when condom use increases within population groups, rates of STDs decline in these groups. Other studies have examined the relationship between condom use and the complications of sexually transmitted infections. For example, condom use has been associated with a decreased risk of cervical cancer—an HPV associated disease.

The following includes specific information for HIV, discharge diseases, genital ulcer diseases and human papillomavirus, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV/AIDS

HIV, the virus that causes AIDS

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS.

AIDS is, by far, the most deadly sexually transmitted disease, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual transmission of HIV is both comprehensive and conclusive. In fact, the ability of latex condoms to prevent transmission of HIV has been scientifically established in “real-life” studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as semen and vaginal fluids, blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate conclusively that the consistent use of latex condoms provides a high degree of protection.

Discharge Diseases, Including Gonorrhea, Chlamydia, and Trichomoniasis

Discharge diseases, other than HIV

Latex condoms, when used consistently and correctly, can reduce the risk of transmission of gonorrhea, Chlamydia, and trichomoniasis.

Gonorrhea, Chlamydia, and trichomoniasis are termed discharge diseases because they are sexually transmitted by genital secretions, such as semen or vaginal fluids. HIV is also transmitted by genital secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against discharge diseases such as gonorrhea, Chlamydia, and trichomoniasis, by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of Chlamydia, gonorrhea and trichomoniasis. However, some other epidemiologic studies show little or no protection against these infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the discharge diseases. More research is needed to assess the degree of protection latex condoms provide for discharge diseases, other than HIV.

Genital Ulcer Diseases and Human Papillomavirus

Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male or female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Correct and consistent use of latex condoms can reduce the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. While the effect of condoms in preventing human papillomavirus infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through “skin-to-skin” contact from sores/ulcers or infected skin that looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/fluids. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are, or are not, covered (protected by the condom).

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of syphilis and genital herpes. However, some other epidemiologic studies show little or no protection. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the genital ulcer diseases. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers in settings where chancroid is a leading cause of genital ulcers. More research is needed to assess the degree of protection latex condoms provide for the genital ulcer diseases.

While some epidemiologic studies have demonstrated lower rates of HPV infection among condom users, most have not. It is particularly difficult to study the relationship between condom use and HPV infection because HPV infection is often intermittently detectable and because it is difficult to assess the frequency of either existing or new infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against HPV infection.

A number of studies, however, do show an association between condom use and a reduced risk of HPV-associated diseases, including genital warts, cervical dysplasia and cervical cancer. The reason for lower rates of cervical cancer among condom users observed in some studies is unknown. HPV infection is believed to be required, but not by itself sufficient, for cervical cancer to occur. Co-infections with other STDs may be a factor in increasing the likelihood that HPV infection will lead to cervical cancer. More research is needed to assess the degree of protection latex condoms provide for both HPV infection and HPV-associated disease, such as cervical cancer.

Department of Health and Human Services

For additional information on condom effectiveness, contact
CDC's National Prevention Information Network
 (800) 458-5231 or www.cdcnpin.org

APPENDIX G: GLOSSARY OF TERMS

Adaptation: Modification of the key characteristics of an intervention so as to deliver it to a different population, in a different venue, with a different message, or in a different manner than the one in which efficacy was originally demonstrated; altering the “who” or “where” of the intervention (e.g., FIO was originally tested with women 18 to 30, but has since been adapted to be used with women 30 to 40). While adaptation can ensure that the intervention is culturally-relevant to the target population, it must not change the program by diverging from the goals of the intervention or eliminating any Core Elements (see below).

Altruism: A selfless concern for the welfare of others.

Chlamydia: Any of several common, often asymptomatic, sexually transmitted diseases caused by the microorganism *Chlamydia trachomatis*.

Clitoris: A small elongated erectile organ at the front part of the vulva, similar in function to the penis.

Core Elements: Those parts of an intervention that must be present and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based and are thought to be responsible for the intervention’s effectiveness. Core Elements are essential and cannot be ignored, added to, or changed.

Fidelity: The practice of staying within the parameters of the approved adaptation process; it is keeping the heart of the intervention unchanged so as to reproduce its effectiveness with another population or in a different setting.

Formative Evaluation: A series of activities undertaken to furnish information that will guide the FIO program adaptation and development process so as to be appropriate for heterosexually active women from different populations in different settings than the original intervention.

Gender Norms (Session Five): Appropriate behaviors, beliefs, and attitudes for males and females, as directed by a society.

Gender Script Theory: This theory tells us how our expectations for how women and men should act in relationships (or, what are called “gender scripts”) can make women vulnerable to HIV and STDs. Gender scripts are cultural expectations or messages for how women and men should act in relationships that we all learn growing up. One example is “a woman should play ‘hard to get’ with a man.” Even when we might disagree with them, gender scripts often influence our behaviors.

Gender Stereotypes (Refer to Session Two): Commonly accepted views of how men and women should behave.

Gonorrhea: A sexually transmitted infection caused by *gonococcal* bacteria that affects the mucous membrane chiefly of the genital and urinary tracts and is characterized by an acute purulent discharge and painful or difficult urination, though women often have no symptoms.

Intention: A course of action that one intends to follow.

Key Characteristics: Crucial activities and delivery methods for conducting an intervention that may be adapted for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. Key Characteristics cannot be eliminated, but they can be adapted to different types of youth and agencies.

Modified AIDS Risk Reduction Model (M-ARRM): Model that provides an overview of how women make changes to increase their safer sex behaviors. This model states that women need to (1) label themselves as at risk due to their relationships with men (**Susceptibility**); (2) make safer sex a priority (**Prioritization**); (3) make a commitment to change risky behaviors (**Intention**); (4) seek and implement solutions to change (**Enactment**); and (5) maintain safer behaviors (**Maintenance**).

Microbicides (Session Three): Substances (like gels or creams) that could be inserted into the vagina or rectum prior to sex in order to prevent the transmission of HIV (and possibly other STDs). They are currently under development, but as of this writing, none have yet been found effective.

Outcome Monitoring: Activity of collecting and analyzing data about participants' knowledge, attitudes and behaviors before and after participating in an intervention.

Peer Norms: A perception of the standard, model, or pattern regarded as typical among one's equals.

Post-Exposure Prophylaxis (PEP): A high dose of HAART (anti-HIV drugs), given for 28 days. Treatment must be started within 72 hours (three days) of exposure to HIV to be effective.

Process Evaluation: Activity of collecting and analyzing data related to actual intervention implementation compared to how the intervention was designed to work. Process evaluation is a review of the fidelity to the intervention's core elements and key characteristics as well as the extent that it reached its intended audience.

Process Monitoring: Activity of collecting and analyzing data to determine the characteristics of FIO participants (e.g, demographics), the provided services, and resources used to deliver those services.

Reinvention: A modification of an intervention that changes (adds to, deletes, or alters) any part of an intervention's Core Elements. The CDC recommends that any program undergoing reinvention be renamed and be evaluated with an experimental design.

Self-Efficacy: A person's belief in his or her ability to carry out and accomplish a specific task (e.g., using condoms during every sexual encounter, continuing to remain HIV negative).

Self-Esteem: A realistic respect for or favorable impression of oneself; self-respect.

Self-Protection (Session One): Denial of risk is often serving a purpose related to maintaining a positive self-view or maintaining the fulfillment of needs met in the relationship. This means that for many women admitting they are at risk means admitting things they do not want to admit about their relationship. Accordingly, admission of risk is seen as a threat.

Sexually Transmitted Disease (STD): A condition caused by one of over 25 bacteria or viruses, usually spread by sexual intercourse but potentially through oral sex or other routes such as infected needles; the most common STDs include herpes, human papillomavirus (HPV), gonorrhea, syphilis, and Chlamydia.

SMART Objectives: An objective that is Specific, Measureable, Achievable, Relevant, and Time-Bound.

Social Learning Theory: A theory describing an interpersonal process through which skills are acquired, strengthened and maintained. New skills are acquired when individuals see and model new behaviors, receive feedback on their own performance of the new behavior, and receive positive social—and self-reinforcement for exhibiting the new behavior. By practicing skills in a supportive social environment, individuals increase their motivation and self-efficacy in their ability to use these skills in a variety of contexts.

Syphilis: A sexually transmitted disease caused by the spirochete *Treponema pallidum* that is characterized in its primary stage by genital sores. If untreated, skin ulcers develop in the next stage, *secondary syphilis*. As the disease progresses to potentially fatal *tertiary syphilis*, neurologic involvement with weakness and skeletal or cardiovascular damage can occur.

Target Population: Any high-risk population in which there are established social networks, such as young women of a particular ethnic or racial background, Native American reservation women, etc.

APPENDIX H: RESOURCES FOR PRE-IMPLEMENTATION AND EVALUATION

Capacity Building Assistance (CBA)

The CDC's Capacity Building Assistance program is designed to assist organizations in their ability to implement and sustain science-based and culturally-proficient HIV prevention behavioral interventions and HIV prevention strategies. Any CBA requests should be initiated with the grantee's Project Officer, if directly funded by the CDC, or Program Officer, if indirectly funded through a state health department. Agencies that are eligible for CBA support must receive funding either indirectly or directly through the CDC.

A CBA provider may be able to assist your organization in the development of logic models, evaluation tools, and other program needs to implement FIO effectively.

The following Websites may be of assistance in determining whether CBA's contributions could aid your organization's implementation process and will guide you through the registration process for CBA:

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

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

<http://www.cdc.gov/hiv/topics/cba/cpp.htm>

Behavior Change Logic Model Development Resources

The following Websites may be helpful in providing assistance in the development of both theoretical and implementation logic models, regardless of whether or not your organization chooses to seek CBA.

<http://www.cdc.gov/eval/resources.htm>

<http://www.insites.org/documents/logmod.pdf>

(Everything You Wanted to Know About Logic Models But Were Afraid to Ask, by InSites and Professional Evaluation Services)

<http://www.unitedwayatlanta.org/docs/ci/OM101.ppt>

(United Way's Guide to Developing Logic Models)

Additional Resources

www.effectiveinterventions.org

(DEBI site)

<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>)

(Cultural competence; pre-implementation activities)

<http://foundationcenter.org/>

(Information on philanthropic funding sources)

www.grants.gov

(Information on government grants)

HIV AND FEMALE HEALTH WEBSITES

The following Websites provide information on HIV and female health that may be of interest to you or your participants:

www.aids-ed.org

www.amfar.org

www.thebody.com

www.cdc.gov/hiv/

www.cdc.gov/ncbddd/pregnancy_gateway/default.htm

www.cdc.gov/women/

www.goaskalice.com

www.guttmacher.org

www.plannedparenthood.org/

www.siecus.org

APPENDIX I: BIBLIOGRAPHY

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APPENDIX J: MARKETING BROCHURE

How effective is FIO?

The original research demonstrated that FIO was effective in reducing unprotected vaginal and anal intercourse in both the short-term (one month after the intervention) and long-term (12 months after the intervention). This reduction was due both to increasing use of male and female condoms and decreasing the total number of sexual contacts. Women in the FIO intervention were also more likely to use an alternative protection strategy that they had not previously used.

What experiences have agencies had with FIO?

"I have seen participants truly blossom over the course of the 8 weeks. It is such a pleasure to facilitate a curriculum that speaks directly to the needs of our clients."

Program Manager
Women's Prison Association
New York, NY

"The whole eight weeks was a learning experience that I can take back to my community and family."

FIO Participant

For more information contact:

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Future Is Ours (FIO)

(pronounced fee-oh)

An HIV/STD Sexual Risk Reduction Group-Level
Intervention for Women at Risk from Sex with Men.

What is FIO about?

FIO is a small group intervention that helps women address their thoughts, opinions, and feelings about men, sex, and relationships, and gives them an array of skills to help make those relationships safer. FIO emphasizes that women make choices and that these choices are often influenced by gender norms (expectations for how women and men should act in these relationships). These gender norms often make it difficult for women to be empowered for safer sex in their relationships.

FIO teaches women to:

- understand and personalize their risk for HIV and other STDs
- identify gender-based barriers to safer sex
- link self-help to helping others – women in the group, family, and the wider community
- gain practical knowledge and skills to use a range of risk-reduction strategies
- recognize women’s sexual rights and the importance of sexual pleasure for women
- build skills necessary to communicate and negotiate safer sex with their partners
- solve problems to avoid setbacks and maintain safer sex over the long term

Who is FIO for?

FIO is a gender-specific HIV/STD risk reduction intervention designed for heterosexually active, at-risk women of diverse ethnicities (African-American/Black, Caribbean, Latina, White), ages 18 to 30, who live in communities where rates of HIV and other STDs are high.

How is FIO implemented?

FIO intervention uses:

- eight two-hour group sessions
- small groups of 8-12 high-risk heterosexually active women
- interactive and fun demonstrations, exercises, goal-setting, group discussions, role-plays, and video

What are the goals of FIO?

The overall goal of FIO is to empower women to reduce unsafe sexual encounters. Women are encouraged to increase their use of male and female condoms as well as use alternative protection strategies. These alternative protection strategies include:

- engaging in outercourse (sex without penetration)
- getting tested for HIV jointly with a partner followed by mutual monogamy and a safety agreement
- deciding to be celibate
- refusing unsafe sex
- deciding not to get involved with a partner who will not use condoms

APPENDIX K: SAMPLE MARKETING FLYER



Hello Ladies!

Come learn ways to keep yourself and your community healthy
in:

THE FUTURE IS OURS (FIO)



FIO is an 8-session program for women 18—30 years old.

[incentive information including lotteries]

Come learn, share, and win!

