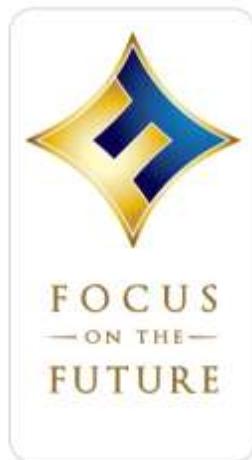


FOCUS ON THE FUTURE

A brief, single-session intervention with
young African American males
who have sex with women,
who report symptoms of an STD and/or
have been diagnosed with an STD



Implementation Manual



2012

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This package has been developed by Cicitelli Associates Inc. (CAI) based on the recognized methodology "Focus on the Future", an individual-level, clinic-based, single-session intervention designed by Dr. Richard Crosby and Dr. Ralph DiClemente to address the common errors made and the multiple problems experienced by young African American heterosexual men when using condoms.

CAI grants permission to the CDC to maintain the intervention's geographic relevance and accuracy over time. All portions of the publication and materials related may be amended from the 2012 version packaged by CAI as determined by the CDC.

Important Information for Users

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

The intervention package includes the Starter Kit, the Implementation Manual with Facilitator's Guide and Staff Presentation, the Technical Assistance Guide, the Training of Facilitators Curriculum with accompanying Participant Handbook and Training Presentation, the Fact Sheet, marketing brochures, promotional posters, information cards, branded ditty bags, and training DVD.

Before conducting this intervention in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved, the intervention package materials are to be used by trained facilitators when implementing the intervention.

How to Use the Implementation Manual

The Focus on the Future Implementation Manual (IM) was developed as a resource for agency administrators and facilitators. The information in this IM provides an overview of **Focus on the Future (FOF)**. The IM should be used to guide the implementation process.

This manual is divided into the following sections: Overview of the Intervention, Science Behind the Intervention, Pre-Implementation, Implementation, Maintenance, Monitoring and Evaluation, and Appendices. The following is a brief overview of the sections of the manual and how to use it.

Overview of the Invention

The overview section addresses the primary concerns your agency has when becoming familiar with a new intervention. In the overview section of the manual you will find an overview of the intervention, the 5 principles, the target population, venues for delivery, and benefits of the intervention to the agency and client.

The Science Behind the Intervention

The science behind the intervention section outlines the social and behavioral science used in **FOF**, a review and explanation of the *core elements* and *key characteristics* of **FOF**, the behavior change logic model, and modifications to the intervention during packaging.

Pre-Implementation

The pre-implementation section addresses 3 *getting started* activities (Assessing Fit, Capacity Issues, and Budget Development), staffing requirements, and the issues that arise when preparing for implementation. This section also contains various tools, checklists, and helpful reminders your agency can use during the pre-implementation phase.

Implementation

The implementation section addresses the issues that your agency will focus on while implementing **FOF**. The implementation section contains the **Peer Health Advisor Facilitator's Guide** which is necessary in order to facilitate the **FOF** session. This section also has ideas on recruitment and a list and explanation of the forms used in **FOF**.

Maintenance

The maintenance section contains items and ideas that will help your agency institutionalize **FOF** into the prevention services your agency offers.

Monitoring and Evaluation

In this section are program evaluation tools your agency may want to use to evaluate the success of **FOF** and ideas about how to improve your next delivery of the sessions.

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Overview of the Focus on the Future (FOF) Intervention

What is FOF?

FOF is a 45 to 60 minute, individual-level, single-session, behavioral intervention for African American men who have sex with women (MSW) ages 18-29, who report STD symptoms and/or are newly diagnosed with an STD, who reported their HIV status as negative or unknown, and who inconsistently and/or incorrectly use male condoms during vaginal sex with female partners in the last 3 months. The intervention is provided in an STD clinic to clients newly diagnosed with an STD and/or who report symptoms of an STD. The intervention focuses on building the clients' knowledge, skills and attitudes to reduce subsequent STD diagnoses, increase condom and lubricant use, decrease the frequency of unprotected sex, reduce the number of female sexual partners, and increase condom use and condom negotiation self-efficacy.

During this single-session intervention, the trained Peer Health Advisor (PHA) provides information, motivation and skills directly relevant to addressing the multiple barriers to condom use that men may face. Emphasis is placed on the correct and consistent use of condoms and lubricant as a way to increase sexual pleasure and taking responsibility and an active role in reducing HIV and STDs. At the end of the intervention, men are given a small nylon bag ("ditty bag") to fill with packets of lubricant and condoms to use and to find products that have the right fit and feel. The large selection of condoms and packets of lubricant that men choose from include high-end and popular brands that are appealing to young African American men (e.g., Trojan Magnum).

Clients observe the PHA demonstrate the correct application of a condom on a model and the client practices those skills until he expresses a sense of mastery. Throughout the session, men are encouraged to feel good about using condoms and lubricant, to experience condoms as being compatible with sexual pleasure, and to actively protect themselves from future STD infection. From the conversation with the PHA, the clients learn that the high-risk behaviors that lead to the acquisition of STDs are similar to those that would put them at-risk for HIV. Clients are motivated to personally respond to the HIV epidemic through the use of a large poster illustrating the disproportionate HIV/AIDS burden experienced by African Americans in the US.

Key to the intervention is the ability of the PHA to establish rapport, a trusting relationship, and an environment that focuses on the client's future and his community's future. This is most effective when a member of the target population is chosen as the PHA to implement the intervention. Establishing a respectful and non-judgmental environment that focuses on the client's future will motivate men to fully engage in the intervention. It is also crucial that the tone of the intervention is "sex-positive" (e.g. a healthy, non-judgmental attitude towards the man's sexuality and lifestyle).

FOF is a one-time intervention, which means that clients are only eligible to participate once, even if they screen eligible to participate multiple times. It is most effective if it is integrated as a standard of care at clinics. This is because clients are more likely to participate if they view **FOF** as a part of the services that have been arranged for them during their clinic visit.

FOF at a Glance

The table below provides a brief overview of the goal, activities, and time for each of the six components of **FOF**.

Component	Goals	Overview	Time
<p>Component 1 Establish a constructive rapport and show the client respect.</p>	<p>Create a positive and comfortable environment so clients will fully engage in the following teaching/learning process;</p> <p>Establish the upcoming session as a chance to improve existing condom use skills.</p>	<p>The PHA meets the client and uses different strategies (e.g., discuss sports or music, “caring brother” or “being real” approach, etc.) to build rapport and establish a non-judgmental climate. The PHA casually inquires about how often the client uses condoms and describes the goal of the intervention, which is to help the client resolve any problems he may have with using condoms.</p>	<p>5 minutes</p>
<p>Component 2 Fill gaps in the client’s understanding of correct condom use based on a review of the Short Condom Use Survey (SCUS).</p>	<p>Understand the errors that the client has made when using condoms;</p> <p>Address errors and rectify misconceptions the client may have about correct condom use.</p>	<p>The PHA gives the client a few minutes to complete the survey. The PHA reviews the survey and gives the client positive feedback about things he is doing well and addresses errors he has made when using condoms in the past.</p>	<p>10 minutes</p>
<p>Component 3 Inquire about clients' past condom use experiences, discuss condom negotiation strategies, and increase motivation to use condoms by showing HIV rates poster.</p>	<p>Rectify issues with condom use;</p> <p>Discuss condom negotiation skills and help the client determine ones that will work for him;</p> <p>Increase client motivation to improve upon existing condom use skills by showing disproportionate HIV rates among African American males.</p>	<p>The PHA asks the client about how often he uses condoms and gives him positive reinforcement. The PHA and client have an informal discussion about experiences that the client has with condoms (e.g., tight fit, girlfriend will suspect him of cheating, etc.). The PHA presents options of how the client can introduce condoms into relationships. The client looks at the poster on the wall that illustrates how African Americans are disproportionately affected by HIV. The PHA addresses the client’s reaction to the poster in a way that will further motivate him to take action on behalf of his community.</p>	<p>10 minutes</p>

Component	Goal	Overview	Time
<p>Component 4 Provide guided practice in the correct application and use of condoms and water-based lubricant.</p>	<p>Increase clients' self-efficacy for condom and lubricant use;</p> <p>Show that oil-based lubricants do not work;</p> <p>Develop an understanding of how to introduce condoms into current and future relationships.</p>	<p>The PHA blows up a condom, ties it tightly, and rubs baby oil on it. It breaks. This is used as a jumping off point for a discussion about why the client should never use oil-based lubricants. The PHA gives the client a card with correct condom use instructions and demonstrates how to properly use a condom and lube using the penile model, delivering key health promotion messages throughout the process. The client then practices putting the condom and lube on the penile model until he has done it correctly three or four times. The PHA delivers important messages about condom use throughout the practice.</p>	<p>10 minutes</p>
<p>Component 5 Address erection and access problems.</p>	<p>Get clients to "shop ahead" for condoms and lubricant;</p> <p>Normalize the loss of an erection thereby helping clients to get beyond this problem without taking off the condom.</p>	<p>The PHA engages the client in a discussion about how erection loss is normal and strategies to overcome it. The discussion also focuses on the importance of having a supply of good fitting condoms on hand before sex occurs.</p>	<p>5 minutes</p>
<p>Component 6 Help clients achieve a satisfactory fit and feel.</p>	<p>Provide information, motivation, and skills to clients that will increase their quality of condom and lubricant use and thereby decrease the odds of condom failure;</p> <p>Close the session.</p>	<p>The client spends some time exploring the different condoms and lubricants by opening them up and feeling them. The PHA describes features that help him find a few with the best feel and fit. The client fills a small bag with any condoms/lubricant he chooses (25+ of each). The client is asked what he will remember about the conversation and then to share the information with a friend or family member.</p>	<p>10 minutes</p>
<p>Total Time</p>			<p>~50 minutes</p>

FOF is based on 5 principles. The 5 principles were chosen by the original researchers.

1. **Unconditional respect for men**

- This principle permeates the entire intervention. PHAs must show clients unconditional respect regardless of whether the past decisions they have made are compatible with the PHAs' values. This also means that the PHA needs to be respected by clients and clinic staff.
- This principle is one of the most recognized principles of sexual education. It comes from the Sexuality Information and Education Council of the United States (SIECUS) *Guidelines for Comprehensive Sexuality Education* (<http://www.siecus.org>).

2. **Options and know how**

- Key to the intervention is teaching men how to correctly use a condom and giving them a wide option of high-end and popular condoms to try at home in order to find one with the right fit and feel. They will also be given water-based lubricant to take home and try.
- This principle comes from *If the Condom Fits, Wear It: A Qualitative Study of Young African American Men* by Dr. Richard Crosby published in 2004 in the Journal of Sexual Transmitted Infections (**Appendix B**).

3. **Practice is good**

- It is important that clients get to practice putting a condom on a penile model until they have done it properly 3 or 4 times and that they get to practice this skill at their own pace.
- Clients are encouraged to practice with the 25+ condoms and 25+ packets of water-based lubricant after the session ends.
- This principle also comes from *If the Condom Fits, Wear It: A Qualitative Study of Young African American Men*.

4. **Condoms can feel better**

- The PHA needs to sexualize condoms, conveying that they are compatible with sexual pleasure and can make sex feel better. This is done by adding moisture, studding, and ribbing, as well as giving people the peace of mind that they are protecting themselves from STDs and HIV.
- This principle also comes from *If the condom fits, wear it: a qualitative study of young African American men*. In this study, Dr. Crosby found that the more men use condoms, the less likely they are to report condoms interfering with sexual pleasure.

5. **Protect our future**

- This principle relates to clients protecting their own futures and the future of their communities. Some clients may feel defeated and that they do not have valuable futures. It is important that the PHA conveys that the clients have futures ahead of them and they can ensure they are healthy by making positive and knowledgeable decisions. PHAs can do this by not challenging the wisdom of the clients' past choices—the focus should be on the future and never on the past. **FOF** also places an emphasis on the high rates of HIV amongst the African American community and the importance of the client protecting his community's future.
- This principle was developed by the original developer and researcher, Dr. Crosby. He believes that men do not want to talk about condoms and disease, however they are interested in talking about themselves and how to protect their futures.

The **FOF** intervention is not a lecture, but a sex-positive, structured conversation that uses positive reinforcement, culturally appropriate terms, and a focus on the client's future. This intervention creates a context in which participants can

- Rectify misconceptions about correct condom use,
- Recall problematic events when using condoms,
- Identify and rectify common problems with condom use,
- Illustrate scenarios that involve condom negotiation,
- Consider outcomes of consistent and correct condom use in attainment of future goals,
- Ask questions about various types of condoms and lubricant,
- Practice correctly applying different types of condoms and lubricant on a penile model,
- Find a condom with the right fit and feel.

Target Population

Who is it for?

The target population for **FOF** is African American men ages 18-29, who have sex with women (MSW), who report STD symptoms and/or are newly diagnosed with an STD, who reported their HIV status as negative or unknown, and who inconsistently and/or incorrectly use condoms during vaginal sex with female partners in the last 3 months. This population is in a demographic group highly impacted by HIV whose risk is due to the lack of consistent and correct use of condoms and lubricant as a means of protection.

FOF is most effective in geographic areas with high STD rates and a high proportion of clients who are young African American males who have sex with women.

Who else can **FOF** be adapted for?

A man who has sex with men (MSM) in addition to having sex with women should not be excluded from **FOF**. The client is eligible as long as he self-identifies as someone who has sex with women and has used a condom during vaginal sex within the last 3 months. The focus of the intervention is to address issues with consistent and correct use of condoms and lubricants, and therefore men who have sex with men in addition to women can participate. The PHA establishes a non-judgmental rapport with clients. However, the main focus of their conversation is on condom use while having sex with women. MSM who exclusively have sex with men are not eligible to participate.

Venues and Setting for the Delivery of **FOF**

In the original research, **FOF** was delivered in a private room in an STD clinic. It is important that **FOF** is delivered in a private room to ensure client confidentiality. The room should have at least two comfortable seats and a table, and have a positive climate that encourages openness and trust. This could include the use of music, identifiable pictures and posters, and brochures. The room must be available to the PHA for at least 60 minutes for an uninterrupted session with each client.

Appropriate Settings to Implement FOF

FOF is intended to be implemented in STD clinic settings that can provide testing, diagnosis, and treatment for most commonly occurring STDs. During the original research, **FOF** was conducted in a public STD clinic in Louisville, Kentucky. **FOF** materials were pilot tested in four STD clinics, two in the North East and two in the South East U.S. All of these clinics had experience serving a high proportion of young African American men who have sex with women.

FOF can also be adapted for Community-Based Organizations (CBOs) that serve men who meet the eligibility criteria and that are able to diagnose and treat STDs.

Benefits to Clinic and Care Services

FOF has many benefits to the implementing clinic, including

- Complementing, expanding and enhancing the quality of existing prevention services by providing a brief, evidence-based program;
- Supporting the clinic's mission;
- Closing gaps in needed services for young African American men;
- Integrating a new prevention service that does not require a great amount of resources or effort;
- Impacting the norms and culture of the community regarding the way members think about sex (i.e.,,, move towards a “sex-positive” model whereby condom use and lubricants are eroticized);
- Enhancing the image of the STD clinics/CBOs as
 - Attractive sites for funders to invest in;
 - Creative, innovative, and proactive sites in addressing HIV/STDs in African American males.
- Reducing the transmission of HIV/STDs in the community.

Benefits to Clients in Care

FOF is beneficial to clients receiving the intervention in the following ways

- Enhancing their quality of life by providing them with the skills to prevent infecting or re-infecting themselves with an STD or HIV and infecting their partners;
- Providing them with a wide variety of high-end lubricants and condoms to identify those that have the right fit and feel;
- Providing them with an opportunity to connect with a caring and knowledgeable peer who is interested and believes in their futures;
- Providing them with a safe environment to practice properly applying condoms and lubricant and talk through any potential barriers to consistent use;
- Reducing worry and concern when having sex, making it a more enjoyable experience;
- Allowing them to maintain their current lifestyle with regard to sex;
- Empowering them to be a part of the collective action to reverse the high HIV/STD prevalence in their demographic group;
- Alleviating the burden of HIV/STDs in the community amongst African American males;

- Providing positive ripple effects in cases where clients represent a “hub” of transmission through extensive social networks;¹
- Impacting the norms and culture of the community regarding the way they think about sex (i.e., move towards a “sex-positive” model whereby condom use and lubricants are eroticized).

¹ Guttmacher Policy Review, Spring 2009, Volume 12, Number 2. For Some Sexually Transmitted Infections, Secondary Prevention May Be Primary by Adam Sonfield.

The Science Behind the FOF Intervention

Original Research Findings

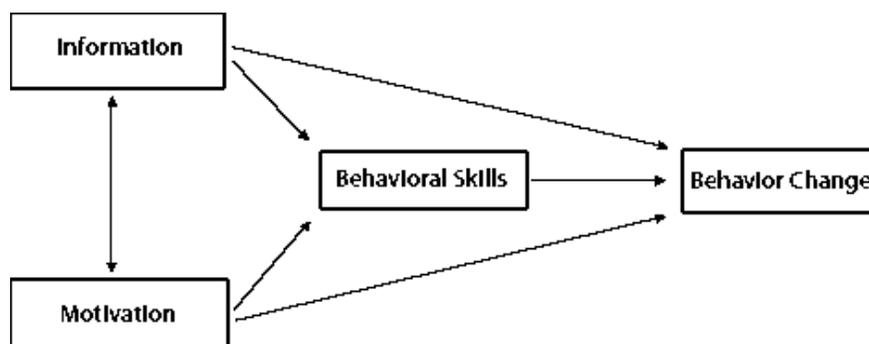
To design and test the efficacy of the intervention, Crosby et al. originated a two-year randomized control study in a public STD clinic in Louisville, KY. Results from this study showed various positive effects on the behaviors of the intervention clients.² When clients completed a three month follow-up assessment, individuals who received the **FOF** intervention were significantly less likely to have acquired a subsequent STD. A significant number reported having fewer sexual partners, significantly fewer acts of unprotected sex, and were significantly more likely to report using condoms during their last episode of sexual intercourse with a woman. They also had significantly improved proficiency scores for condom application skills. The results also suggest a substantial protective benefit for men’s female sexual partners against HIV or other STD acquisition. **FOF** was shown to be effective when clients received it one time, and there is no evidence that suggests it would continue to be effective when given to the same client multiple times.

How it is Different from Other HIV Prevention Interventions

FOF fills a critical gap in evidence-based HIV prevention interventions currently available for young African American men who have sex with women (MSW), because it is designed to meet their needs and address their concerns regarding consistent condom use. **FOF** is one of only a few evidence-based interventions recognized by the CDC for use in STD clinic settings.

Theories and Models Used

The **FOF** intervention is based on the Information, Motivation, and Behavioral Skills Model (IMB).³ This theory asserts that HIV-related information, motivation, and behavioral skills are the fundamental determinants of HIV/STD prevention. If an individual is well-informed, motivated to act, and possesses the skills and confidence to take effective action, he or she is more likely to initiate and maintain patterns of HIV/STD preventive behavior.



The “**information**” aspect of the model addresses the cognitive domain and refers to the provision of knowledge to support the change in behavior. The “**motivation**” component targets the affective

² Crosby R, DiClemente R, et al. A brief, clinic-based, safer sex intervention for heterosexual African American men newly diagnosed with an STD: A randomized controlled trial. *Research and Practice*. 2009; 99: 1-8.

³ Fisher J, Fisher W. The information-motivation-behavioral skills model. In: DiClemente RJ, Crosby RA, Kegler M, eds. *Emerging Theories in Health Promotion Practice and Research*. San Francisco, CA: Jossey-Bass; 2002: 40-70.

domain and encourages the development of a favorable attitude towards the positive health behavior and capitalizes on existing social support systems to enhance motivation. Identifying barriers and strategies to overcome them is another way to enhance motivation. The “**behavior**” aspect of the model focuses on the psychomotor domain. Through instruction, repeated demonstrations and practice, individuals acquire the practical skills necessary to maintain the behavior change.

According to IMB, health interventions should be focused on

1. Communicating effective health information that is appropriate for the target health behavior and specific to a population,
2. Increasing personal motivation and social support, and
3. Skill-training to increase self-efficacy for performing a health behavior.

During the **FOF** intervention, information directly relevant to the quality of condom use is provided. Men also learn, by demonstration, that oil-based lubricants can quickly erode latex condoms.

Increasing motivation to use condoms is a central component of **FOF**. Throughout the session, men are encouraged to feel good about using condoms, to consider condoms as being compatible with sexual pleasure, and to actively protect themselves from future STD infection. Clients are also motivated to personally respond to the AIDS epidemic through the use of large posters illustrating the disproportionate HIV/AIDS burden experienced by African American men in the United States.

Skill acquisition is another essential component of **FOF**. Correct condom and lubrication use are demonstrated and practiced by the men until they exhibit a sense of mastery.⁴

FOF also draws from Albert Bandura’s Social Learning Theory⁵. This theory states that people learn new behavior through observational learning, imitation, and modeling. If people observe positive, desired outcomes in the observed behavior, then they are more likely to model, imitate, and adopt the behavior themselves. **FOF** utilizes a Peer Health Advisor (PHA) to model correct condom and lubricant use skills. With the PHA’s guidance, the clients then imitate those skills to build their self-efficacy for correct and consistent condom use.

Although it is not a formal theory, an important feature of **FOF** is that it can be customized to the needs of each client. Customizing is a process that matches messages and approaches with the needs and values of the client.⁶ The one-on-one interaction of **FOF** (in the context of a trusting relationship) allows the PHA to “listen and respond” to the needs of the client. The content of the program is used much like a checklist of competencies, whereby, once competency is established for a component, the PHA is able to move on to the next component. This form of customizing allows for the vast differences in learning that inevitably exist, even in highly homogenous populations. This on-the-spot customizing provides men with the skills they lack rather than leading them through a program that is customized for a group of people. Evidence clearly suggests that customized HIV prevention interventions are likely to be superior to “canned programs.”^{7,8}

⁴ Crosby R, DiClemente R, et al. A brief, clinic-based, safer sex intervention for heterosexual African American men newly diagnosed with an STD: A randomized controlled trial. *Research and Practice*. 2009; 99: 1-8.

⁵ Bandura A. Self-efficacy: Toward a unifying theory of behavior change. *Psych Rev* 1977; 84:191-215.

⁶ Petty RE, Barden J, Wheeler SC. The elaboration likelihood model of persuasion: Health promotions that yield sustained behavior change. In DiClemente, R. J., Crosby, R. A., & Kegler, M. (eds.) (pp. 71 – 99) *Emerging Theories in Health Promotion Practice and Research*. San Francisco, CA: Jossey-Bass Wiley. 2002.

⁷ Coates TJ, Aggleton P, Gutwiller F, et al. HIV prevention in developed countries. *Lancet* 1996; 348:1143-1148.

Core Elements and Key Characteristics

Core Elements are defined as “elements that embody the theory and internal logic of the intervention and most likely produce interventions’ main effects.”⁹

*Core elements are critical features of an intervention’s intent and design and are thought to be responsible for its effectiveness. Consequently, core elements should be maintained without alteration to ensure program effectiveness.*¹⁰

FOF Core Elements

Content

1. A trained PHA teaches correct condom use skills for clients. (IMB Components: Information, Behavior).
 - The PHA will foster positive attitudes and norms towards correct and consistent condom use by providing adequate opportunity for clients to practice proper application of condoms during the session. This will improve the clients’ condom use behaviors and self-efficacy.
2. The PHA and clients discuss condom negotiation skills. (IMB Components: Behavior.)
 - The PHA addresses issues with using condoms in the clients’ lives and discusses condom negotiation strategies that they can use with partners. Being able to negotiate condom use with his partners impacts the clients’ condom use behaviors.
3. The PHA provides clients with 25+ packets of water-based lubricants and 25+ condoms of their choice from a broad selection of high-end and popular brands. (IMB Components: Motivation, Behavior.)
 - After determining which condoms might have the right fit and feel for the clients, the clients select 25+ condoms and 25+ packets of lubricant from a large variety of high-end and popular brands. Clients are also provided with a bag to carry their condoms and packets of lubricant. Having condoms with the right fit and feel, packets of lubricant, and a trendy bag with which to carry them motivates men to use condoms, thereby increasing their condom use behaviors.
4. The PHA clearly communicates the importance of the client protecting his and his community’s futures by using condoms correctly and consistently with his partner(s). (IMB Components: Behavior.)
 - The PHA equates condom use with an investment in the clients’ futures, lowering their chances of contracting or transmitting future STDs and slowing the spread of HIV/AIDS in their communities.

⁸ DiClemente RJ. Development of programmes for enhancing sexual health. Lancet 2001; 358:1828-1829.

⁹ Glossary. AIDS Education and Prevention, 12, Supplement A, 145-146, 2000.

¹⁰ Glossary. AIDS Education and Prevention, 12, Supplement A, 145-146, 2000.

Pedagogy

1. The PHA establishes rapport and a trusting relationship with the client at the beginning of the session. (IMB Components: Motivation.)
 - The relationship with the PHA motivates clients to fully engage in the forthcoming teaching/learning session and establishes an effective means of relating prevention messages to them.
2. The PHA shows unconditional respect for men and maintains a non-judgmental environment for the client concerning any risk behaviors disclosed. (IMB Components: Information, Motivation.)
 - The PHA maintains a “sex-positive” attitude, which is a healthy, non-judgmental attitude towards the client’s sexuality and lifestyle choices. By remaining non-judgmental, the client is motivated to fully engage in the session and feel comfortable disclosing information about his risk behaviors. In turn, the PHA can provide information about condom use issues that is customized to the client with positive reinforcement.

Implementation

1. The intervention is delivered at a point when the client is feeling vulnerable and is highly concerned about his STD infection status. This may be while he is in the clinic waiting, after a presumptive diagnosis, or after a confirmed lab result. (IMB Components: Motivation.)
 - The time when a client believes that he may be infected with an STD or after he receives a positive diagnosis is a critical period in which to address prevention with clients. It is a moment of great motivation for clients to improve their safe sex practices. Thus, the intervention should be delivered at a location that can test and diagnosis clients with STDs.
2. The PHA conducts a customized one-to-one counseling session with the client for 45-60 minutes. (IMB Components: Information.)
 - The interactive nature of the program allows the PHA to proceed at a pace and level that is developmentally appropriate for each client. Depending on the needs of the client, the duration of the intervention is a minimum of 45 minutes. Depending on the client, up to 60 minutes may be required to ensure that the appropriate information is covered during the session.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations.¹¹

*Key Characteristics are less essential to effectiveness, but essential to adaptations an agency may consider making. Key Characteristics can be altered so that an intervention can be customized to the specific needs of the at-risk community receiving the intervention and the capabilities of the organization implementing the intervention.*¹²

¹¹ Glossary. AIDS Education and Prevention, 12, Supplement A, 145-146, 2000.

¹² Glossary. AIDS Education and Prevention, 12, Supplement A, 145-146, 2000.

FOF Key Characteristics

1. A survey is completed by the client to inform the PHA of his problems with using condoms.
 - This short survey allows the PHA to customize the intervention so that it addresses the client's specific needs and concerns.
 - Tailoring Options: The client may be asked to verbally answer the questions on the survey or communicate his issues with condom use so that the PHA can address his specific concerns.
2. A visual aid (i.e., poster) hanging in the room that displays HIV prevalence among African American males in the US is used to increase men's motivation to change behaviors associated with condom use.
 - This poster helps to create a personal motivation for the client to improve his safe sex practices.
 - Tailoring Options: If hanging the poster on the wall is not an option, the poster can be shown to the clients at the appropriate time during the intervention.
3. The PHA needs to have similar everyday experiences and communication styles.
 - Identifying with the PHA is important because it increases the value of the intervention's messages.
 - Tailoring Options: A PHA who can communicate clearly and effectively should be prioritized over one who might communicate in a common way with the client, though these are related concepts.
4. The PHAs are men who come from the community for which the intervention is intended.
 - This goes beyond the concept of "matching" by race, age, and gender,
 - Tailoring Options: The PHA can be recruited from another nearby community with a similar socio-economic-cultural environment.
5. Both the PHA and the client should be seated in a private and comfortable environment.
 - The space should feel comfortable and safe so that the client feels able to communicate freely and openly about his experiences and concerns.
 - Tailoring Options: As space is often limited, a multi-purpose space may be used as long as it is private during the intervention.

While every attempt should be made to maintain fidelity to the original intervention, Key Characteristics may be adapted to accommodate the capabilities of the implementing organization. This is different from the Core Elements, which cannot be modified.

Focus on the Future (FOF) Behavior Change Logic Model

Statement of the Problem

FOF is designed for African American men who have sex with women (MSW) ages 18-29, who are newly diagnosed with an STD and/or report symptoms of an STD, who report their HIV status as negative or unknown, and have used a male condom during vaginal sex at least once in the past 3 months.

Major risk factors for HIV include: membership in a demographic group highly impacted by HIV and STDs, lack of consistent condom use as a means of protection, incorrect use of condoms, and incorrect/lack of use of water-based lubricant.

Specific Behavior Change Logic

Determinants <i>To address risk behavior/factors</i>	Activities <i>To address behavioral determinants</i>	Outcomes <i>Expected changes as a result of activities targeting behavioral risk determinants</i>	
<ul style="list-style-type: none"> • Incorrect or lack of condom use skills • Low self-efficacy related to condom use • Lack of skills using lubricant • Low self-efficacy related to the use of lubricant • Negative attitudes toward condom use • Lack of self-efficacy toward negotiating condom use • Inability to identify triggers of unsafe sex • Lack of knowledge of HIV/AIDS prevalence • Low or no risk perception regarding self • Lack of perceptions regarding risk reduction options (e.g., planning for sex, finding a condom with the right fit and feel, using lubricant, etc.) 	<p>45-60 minute individual-level, single-session behavioral intervention, delivered by a trained Peer Health Advisor.</p> <ul style="list-style-type: none"> • Recall any problematic events when using condoms • Rectify misconceptions about correct condom use • Illustrate proper condom use • Consider outcomes of consistent and correct condom use in attainment of future goals • Ask questions about various types of condoms • Practice correctly applying different types of condoms on a penile model • Illustrate scenarios that involve condom negotiation • Discuss how to overcome barriers • Understand the importance of being prepared by having 2 to 3 condoms on hand when having sex • Experiment with different types of condoms and lubricant until they find a brand and size that best serves their needs • Know where to locate condoms in the community (including types and price) 	<p>Immediate Outcomes</p> <ul style="list-style-type: none"> • Increase knowledge regarding correct condom use • Increase risk perception as it relates to unprotected sex • Increase motivation to use condoms consistently and correctly • Increase decision-making • Decrease negative attitudes towards condoms and increase positive attitudes • Improve condom use skills • Improve lubricant use skills • Increase self-efficacy related to safer sex skills (e.g. use of lubricant, planning ahead, etc.) 	<p>Intermediate Outcomes</p> <ul style="list-style-type: none"> • Reduction in subsequent diagnosis of an STD • Reduction in the number of sexual partners • Increased condom use and decreased unprotected vaginal and anal intercourse • Increased communication with partners about HIV/STI risks and condom use • Increased communication with peers about HIV/STI risks and condom use • Improved management of risky sexual situations, e.g., <ul style="list-style-type: none"> ○ Planned ahead to practice safer sex ○ Increased condom carrying • Correct and consistent condom use (less slippage, breakage, etc.) • Increased/improved condom negotiation skills • Improved planning for accessibility of condoms when needed

Pre-Implementation Section

Purpose

Pre-implementation prepares the implementing agency to perform the **FOF** intervention. It is during this period that your agency can make any necessary organizational changes, conduct an assessment, and develop program integration and monitoring and evaluation plans. Pre-implementation is also the time to explore the need for tailoring **FOF**. For this intervention, pre-implementation activities are focused on

- Determining agency need and capacity for **FOF**,
- Budgeting,
- Securing support through stakeholder “buy-in,”
- Hiring and training the necessary staff,
- Developing practices for patient eligibility screening and recruitment,
- Determining how to fit **FOF** into clinic flow,
- Determining a location for the intervention to take place,
- Obtaining and sustaining intervention supplies.

In the following pages are tools that will help your agency work through all of the pre-implementation processes.

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 Office concerning your agency’s capacity building assistance (CBA) needs and then submit a request to 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 point of contact will submit a CRIS request.

Target Population Appropriate for FOF

FOF is designed for African American men ages 18-29 who have sex with women (MSW) and newly diagnosed with an STD or report symptoms of an STD. Participants should also have used a male condom during vaginal sex at least once during the past three months, and should report their HIV status as either negative or unknown. This population is also at risk of transmitting or acquiring HIV due to having unprotected sex with female partners. Major risk factors include

- Membership in a demographic group highly impacted by STD/HIV,
- Lack of consistent condom use as a means of protection,
- Incorrect use of condoms and/or lubricant.

Other groups of young men in your community may also be highly impacted by STD/HIV such as young Hispanic men, Caucasian Men who have sex with Men (MSM) or MSM of color. **FOF** may be adapted for use with other communities who are highly impacted by STD/HIV; however, due to the specific type of information relevant for people living with HIV, **FOF** is not recommended to be delivered to men who know they are HIV-positive. For more information about adaptation, please refer to the “Adaptation” section.

Agency Fit and Capacity

Your agency should have the capacity to successfully implement **FOF**. Capacity is concerned with issues that relate to the agency as a whole, not only the capacity to carry out the specific intervention. It needs to be determined whether or not **FOF** will be of value to your agency and appropriate for clients, and whether or not your agency has the capacity to implement such an intervention. Use the checklist below to keep track of what steps still need to be taken before your agency is ready to implement the intervention. If other parties need to be involved to accomplish these goals you can use this checklist to keep track of their progress as well. (See **Appendix C**.)

Statement	Agree	Disagree
FOF meets the purpose, goals, and objectives of my agency.		
FOF meets the needs of the target population that my agency serves.		
My agency can secure adequate funding to successfully provide the intervention to clients.		
My agency has a history of working with the target population and has access to the target population from our existing services. (See Appendix K for a tool to determine the approximate number of eligible clients your clinic sees each day.)		
My agency is ready to implement the intervention (See “Agency Readiness to Implement the Intervention.”)		
My agency is able to secure “buy-in” for the intervention from key staff in my agency and supporting agencies in the community, as well as from other relevant stakeholders.		
My agency has organizational support to develop and sustain FOF .		
My agency has the policies and procedures in place to support this intervention.		

Stakeholder "Buy-in"

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

Stakeholder checklist

1. Identify your stakeholders

- Your agency's Board of Directors/Executive Board (if applicable)
- Staff members from your agency who will have a role in the operation of the intervention
 - i. Administrators who will obtain support
 - ii. Supervisors who will monitor the intervention
 - iii. Staff who will interact with participants at any level
- Local agencies from which you could recruit PHAs
 - iv. Agencies offering support groups for African American men ages 18-29 who have sex with women
 - v. Health care providers and mental health professionals serving African American men ages 18-29 who have sex with women
 - vi. Social service agencies reaching African American men ages 18-29 who have sex with women
 - vii. Organizations of African American men ages 18-29 who have sex with women and organizations that may have members who are African American men ages 18-29 who have sex with women
- Organizations which could provide assistance or other resources
 - viii. Merchants for incentives, refreshments
 - ix. Agencies that can provide a venue for the intervention
 - x. Agencies that can provide transportation
 - xi. Advisory board to help tailor intervention
 - xii. Other collaborating agencies to provide information for resource packets
- Agencies with which your agency needs to maintain good community or professional relations
 - xiii. State and local health department
 - xiv. Local medical and mental health associations
 - xv. Sexually transmitted disease (STD) clinics and services
 - xvi. Community-based organizations
 - xvii. Your funding source(s)

- xviii. Others
- 2. Getting stakeholders informed, supportive, and involved
 - Getting them informed about the intervention
 - i. Decide in advance what specific roles you want each stakeholder to play.
 - Who will you ask to
 1. provide financial support,
 2. refer African American men ages 18-29 who have sex with women to the intervention,
 3. assist with implementation of the intervention,
 4. be a resource to which you can refer participants,
 5. help tailor the intervention for your target population,
 6. provide a room in which the sessions can be held,
 7. supply refreshments for participants,
 8. donate small incentives or prizes for participants,
 9. speak supportively about **FOF** in conversations with their associates?
 - ii. Send letters that tell stakeholders about **FOF** and its importance, that your agency is/will be making the intervention available, and, what specific role(s) you think that they might play in the success of the intervention, and offer an opportunity for them to learn more.
 - iii. Call in 2 weeks and assess their interest. If they are interested, schedule a time to meet (e.g., one-on-one, lunch-and-learn at your agency with a group of other stakeholders, presentation at their agency for several of their staff or association members).
 - iv. Hold the meeting, to describe **FOF** and answer questions.
 - Getting their support
 - v. Describe several specific roles they could play.
 - vi. Emphasize the benefits of their involvement to themselves, their agency, the community, and answer questions.
 - vii. Invite them to commit to supporting **FOF** by taking on one or more roles. Keep track of commitments.
 - Getting them involved
 - viii. Soon after meeting, send a thank you letter that specifies the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later.
 - ix. For persons who committed to a role that is important to pre-implementation, put them to work as soon as possible.
 - x. For persons who committed to involvement later in the process, send them brief progress updates and an idea of when you will be calling on their support.

- xi. Hold periodic celebratory meetings for supporters to acknowledge your appreciation for and the value of their contributions; update them on the intervention's progress, and keep them engaged.

Staff "Buy-in"

Key to successful implementation of **FOF** is to secure "buy-in" from staff before implementation begins. Because this is an intervention that requires the involvement of a number of staff members (for screening and recruitment purposes) it is important that staff are involved, engaged, and encouraged to provide timely and direct feedback during the planning and implementation processes. Staff "buy-in" means that all staff members have the answers they need to understand why the intervention is a valuable service to offer clients, how it will be implemented, when it will be implemented, and that their direct and timely feedback is essential to the success of the intervention. When staff "buys-in" to the intervention, they become a force for driving the intervention's success.

In order to make sure that the intervention is successful, upper-management "buy-in" must be sought at the beginning of the pre-implementation process. Upper-management must be made aware of both the importance and resources/staff required for **FOF** so that they will support the intervention and resource/staff allocation throughout implementation. Upper-management also supports the implementation process by championing the intervention throughout the agency by putting their weight behind it so that the intervention is seen to have great value. These 2 types of support are essential to the ongoing viability of the intervention.

Once upper-management is behind the intervention, a meeting should be held to introduce staff to the intervention and generate enthusiasm for the new service that will be provided to clients. It is recommended that agencies

- Set a date for "buy-in" meeting (at least 1 month prior to implementation),
- Invite all staff, including upper-management and the PHA if he has been hired,
- Prepare a presentation on FOF (see example PowerPoint presentation included in this package).
- Conduct the meeting
 - Review the PowerPoint presentation;
 - Show clips of or the entire FOF video so staff have an understanding of exactly what the PHA will be discussing with clients;
 - Review parts of the Implementation Manual;
 - Provide answers to questions and concerns about adopting the intervention at the agency.

Once initial “buy-in” has been secured from all staff, “buy-in” will need to continually be built upon and addressed throughout the course of implementation. To promote on-going “buy-in” from staff, you can

- During staff meetings
 - Ask the PHA to provide an update about the successes and challenges associated with implementing FOF;
 - Clarify roles and responsibilities of staff involved in the intervention;
 - Ask staff to brainstorm solutions to challenges with implementation;
 - Ask staff for feedback about implementation;
 - Refresh staff’s knowledge about the intervention by showing the FOF video.
- Ask the clinic director or manager to send out a memo to staff that describes the successes of the intervention, clarifies roles and responsibilities, and provides other relevant updates.
- Provide additional training to staff on effective recruitment messages, how to screen for eligibility, etc.
- Publish FOF successes and updates in the agency newsletter.

Program Review Panel

If CDC will be funding all or part of your agency’s implementation of **FOF**, your agency must follow the Requirements for Contents of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs. You also must submit the program’s modules, content, information collection forms, participant handouts, videos and other program materials you plan to use for approval by a local Program Review Board (PRB). The PRB’s assessment will follow the CDC Basic Principles found in 57 Federal Register 26742. If all of your funding for **FOF** is coming from another source, check with that source for their policy on PRB approvals.

We recommend that you first find out what the local PRB’s procedures are from your state health department and work within them. It may be helpful to your PRB to provide an overview or executive summary of the intervention with other relevant materials. Also providing a copy of the research article may be useful for PRB members who are interested in the scientific evidence supporting the intervention.

Emphasize the activities that are Core Elements of the intervention. Emphasize that these elements are required in order to get results similar to those of the original research. Be prepared to answer questions, to make things clear, or refer PRB members to sections of the package materials for information.

If all of your funding for **FOF** is from another source, check with that source for their policy on approvals.

Identifying Appropriate Staff

To implement **FOF** your agency will need to involve a number of existing staff, as well as integrate the new staff member hired specifically for the intervention, the PHA. Specifically, **FOF** requires the participation of each of the following individuals.

- *Clinic Director*: Preparing the agency for **FOF**, securing funds and “buy-in,” hiring a PHA, organizing training for all necessary staff, quality assurance, budget management, establishing and executing the evaluation plan, and communicating with the agency manager, etc.
- *Clinic Manager*: Supervises the PHA or the PHA’s supervisor, helps to evaluate agency policies and procedures as they apply to **FOF**, obtains supplies for the intervention, determines space to be used for the intervention, evaluates agency readiness for implementation, debriefs weekly with the PHA and PHA’s supervisor on intervention successes and challenges, etc.
- *PHA’s Supervisor*: Receives training on **FOF**, supervises the PHA, debriefs weekly with the PHA, reviews the PHA’s performance, supports the PHA, etc. See the section below for more guidance on providing supervision to the PHA.
- *Clinical, Nursing, Social Work, Disease Investigation Specialist (DIS), and Triage Staff*: These staff understands the clinic’s flow for each day and incorporates the provision of **FOF** by the PHA based on the client’s eligibility. These staff receives orientation on the screening for eligibility and referral processes for **FOF**, screen clients for eligibility, recruit clients, etc.
- *PHA*: Receives training on **FOF**, conducts the **FOF** intervention and serves as a consultant on safe sex practices to clients after intervention. See the section below for more guidance on hiring the PHA.

Hiring the PHA

Recruiting an appropriate PHA is a key component of **FOF**. Filling the position is more complicated than simply finding someone who fits the required profile. The PHA needs to be someone who is non-judgmental, has a sex-positive attitude, able to quickly establish a rapport with each client, and create an environment of trust and respect that encourages open and honest communication during each session. PHAs should have the following characteristics

- African American man who is able to talk honestly and share experiences about heterosexual intercourse
- 21-to-35-years-old (older candidates are preferred as they may have more experience and appear to be more of an authority to clients);
- Comes from and currently resides in the area surrounding the agency;
- Relates to men quickly (i.e.,,, easily builds rapport, has a good sense of humor, etc.);
- Outgoing, friendly and caring personality;
- Non-judgmental of others’ lifestyles and choices;
- Able to look at sexual behaviors non-judgmentally (a sex-positive attitude);
- Comfortable talking about condoms, sex and STDs;

- Motivated to improve his community;
- Openness and receptive to training/learning.
- Because the person hired for the position will be responsible for reading the Facilitator’s Guide on a regular basis, using a survey with clients, and creating a list of stores in the area where clients can purchase condoms and lubricant, the Peer Health Advisor must be literate. In order to address the candidates literacy level during the interview, you can
 - Ask the candidate to read a pamphlet that you have in the clinic out loud,
 - Ask the candidate to write an answer out to one of the questions.

When recruiting the PHA, it is advised that you do not use online or print advertising. It is difficult to target the desired population using these strategies, and you will waste time and effort filtering through an inflated pool of applicants. Instead, agencies should use their own networks to search for candidates. Staff may know of ideal candidates in the community, including previous or current clients at the agency. Agencies may also reach out to other organizations that they partner with to identify candidates.

A Job Description (**Appendix E**), Interview Tool (**Appendix F**), and Sample Hiring Flier (**Appendix G**) have been included in this package.

Supervising the PHA

PHAs require supervisors who will work to successfully integrate them into the clinic team, meet with them to debrief about the intervention, and provide support in other ways. There are several components that make up the foundation of supportive supervision, such as building a trusting relationship between the supervisor and the PHA and allowing the PHA to explore feelings and reactions that emerge from facilitating the intervention. The following outlines the general principles of conducting supportive supervision.

- The supervisor ensures the PHA is integrated into the agency team, which can be done by
 - Taking him around the clinic to meet other staff members, describing his role at the clinic;
 - Introducing him during the pre-implementation “Staff Buy-in” meeting;
 - Letting other staff know how to contact him with questions about the intervention;
 - Having the PHA share the successes of the program during staff meetings;
 - Sharing the program’s successes in agency newsletters.
- The supervisor sets aside time to meet with the PHA weekly.
 - The supervisor recognizes that this supervision time is dedicated to the PHA.
 - The supervisor creates a safe space. There are no interruptions during supervision, if possible, and the PHA is encouraged to share any concerns.
 - The supervisor sets a time that is consistent and convenient for the supervisor and PHA.
 - The focus of the supervision meeting remains on the development needs and concerns of the PHA.

- The supervisor and PHA set the agenda together.
- The supervisor is open to exploring the feelings and reactions of the PHA that can help him reflect on working with clients who are part of their community.
- The supervisor uses open-ended questions to help the PHA share their work with clients.
- The supervisor is responsive and empathic and encourages the PHA to use his or her insight into the community to respond to client issues.
- The supervisor provides guidance and resources.
- The supervisor remains non-judgmental in his or her approach.

During supervision meetings, discussion topics can include

- Sessions
 - Approximately how long is each session taking?
 - What questions do clients ask or what do they say that you struggle responding to?
 - What common stories/problems/scenarios/characteristics are clients presenting you with that often need to be addressed during **FOF**?
 - What impressions are you receiving or comments are you hearing from clients after they complete the intervention?
 - What do you find clients respond well to? How can you build on that?
 - How is your level of supplies? (Sufficient? Getting low?)
 - What referrals are you making (to other staff within the clinic)?
- Clinic Flow
 - How many clients do you see each day?
 - How much down time do you have each day, on average?
 - What do you do during your down time?
 - How do you think we could recruit more men to the intervention or recruit more effectively?
- Training and Intervention Materials
 - How well did the training prepare you to deliver the intervention?
 - What materials that you received during the training have you been referring to (e.g., Facilitator's Guide, video, cheat sheet, etc.)? How often?
 - Are clients calling you to ask questions? If yes, what types of questions?
 - Have clients mentioned anything about how they are being referred to the program? Are clients asking about **FOF** before being told about the program by clinic staff?
- Integration at the Clinic
 - Does everyone at the clinic understand your role and what you do?
 - Have you met everyone at the clinic?
 - Do you feel like a part of the clinic team?
- Review of the 6 Components (see page 68)
 - What strategies do you use to build rapport?

- How do you use the survey that the clients complete to address the client's problems throughout the session?
- How do the clients feel about condom negotiation? What comes up?
- How do clients react to the posters? How do you address their reactions?
- How do clients feel about practicing correct condom use on the penile model? How do you make them feel more comfortable touching the model, condoms and lube?
- How many times do clients put the condom on the model?
- How do clients react to the discussion about erection loss?
- How do clients feel about or react to the list of stores in the area to buy condoms/lube?
- How do clients react to the number of condoms and lube that you show them? How do you ensure that you are not favoring one condom or lube over another?
- What condoms/lubes are popular? What reasons do clients have for their preferences?
- How do you close the session?

Facility Requirements

FOF requires that the intervention take place in a private room with a door at an agency or clinic that provides STD/HIV screenings and is located in a geographic area with a high incidence of STDs among African American men who have sex with women. It does not need to be a large space, but it should have enough room for both the PHA and the client to sit comfortably in chairs at a desk or table. Selecting a space that has a sink for clients and PHAs to wash their hands after practicing correct condom use on the penile model would be ideal.

There should also be a cabinet, closet or room to store the supplies necessary for the intervention. The ditty bags and the high volume and variety of high-end and popular condoms and lubricant that are associated with **FOF** are appealing to both clients and staff. Therefore, it is important to keep supplies locked up in a closet or room that only a known number of staff have access to. It would be ideal if only the PHA and his supervisor have access to the supplies. Consider having the lock to the closet or room where the supplies for the intervention will be kept changed prior to implementing the intervention.

Policies and Procedures

During pre-implementation, your agency should evaluate current policies and procedures in order to determine their capacity to support the needs of **FOF**. Some policies may need to be revised in order to accommodate the intervention, and some new procedures may be required all together. Examples of these include

- Patient confidentiality,
- Integrating **FOF** into clinic flow,
- Screening for eligibility,
- Recruiting clients,
- Referral tracking,

- Managing supplies,
- Ordering supplies,
- Safety and security plan,
- Planning for potential issues,
- PHAs' Clinic Responsibilities.

Clinic Readiness to Implement the Intervention

It is important that your agency assesses its readiness and that the necessary requirements needed in order to implement this intervention with fidelity are in place. At the point of assessing readiness, your agency should be confident that their setting is appropriate for implementation of **FOF**. If you have any concerns about whether or not your agency has an appropriate setting to deliver **FOF**, refer to the “Appropriate Agencies to Implement **FOF**” and “Agency Fit and Capacity” materials found in the “Overview” section.

Clinic Readiness Checklist

After understanding what is required for implementing **FOF**, your agency can use the following checklist to assess if your agency has the capacity to implement the intervention with fidelity. The checklist will also identify what areas may need to be developed or identify what stakeholders are needed to acquire specific resources. Use the checklist to keep track of what steps still need to be taken before your agency is ready to implement the intervention. If other parties need to be involved to accomplish these goals you can use this checklist to keep track of their progress as well. [See **Appendix H**]

Clinic Readiness Checklist

Capacities and Resources Needed for FOF	Yes/No/ Referral
<i>Staffing Requirements</i>	
<ul style="list-style-type: none"> ● Clinic Director <ul style="list-style-type: none"> ○ Do you have a clinic director who is willing to prepare the clinic for FOF, secure funds and “buy-in,” hire a PHA, organize training for all necessary staff, provide quality assurance, manage the budget, establish and execute the evaluation plan, and communicate with the clinic manager? 	
<ul style="list-style-type: none"> ● Clinic Manager <ul style="list-style-type: none"> ○ Do you have a clinic manager who is willing to supervise the PHA or the PHA’s supervisor, help to evaluate clinic policies and procedures as they apply to FOF, obtain supplies for intervention, determine space to be used for the intervention, evaluate clinic readiness for implementation, and debrief weekly with the PHA or PHA’s supervisor on intervention successes and challenges? 	
<ul style="list-style-type: none"> ● PHA’s Supervisor <ul style="list-style-type: none"> ○ Is there someone at the clinic who is willing to receive training on FOF, supervise the PHA, debrief weekly with the PHA, review the PHA’s performance, and support the PHA? 	
<ul style="list-style-type: none"> ● PHA <ul style="list-style-type: none"> ○ Is there someone you know of who meets the criteria to be a successful PHA, is willing to receive training on FOF, conduct FOF, and serve as a consultant on safe sex practices to clients after FOF? 	
<i>Training Requirements</i>	
<ul style="list-style-type: none"> ● Is the PHA able to attend a 3-day training on FOF and the supervisor able to attend a ½-day training? 	
<ul style="list-style-type: none"> ● Is the clinic committed to orient the staff about the FOF intervention, integration of FOF into clinic flow, screening eligible client processes, etc.? 	
<i>Resources Required</i>	
Do you have the following resources?	
<ul style="list-style-type: none"> ● Ability to purchase and securely store 1 realistic penile model, 1-2 less realistic penile models, bottles of baby oil, 600+ condoms (a variety of desirable and/or high-end brands), 600+ 3 to 8 ml. water-based lubricants packets (a variety of desirable and/or high-end brands), paper towels, hand sanitizer, pens/pencils, ditty bags (small draw-string bags for clients to put 25+ condoms and 25+ lubricants of their choosing). 	

Capacities and Resources Needed for FOF	Yes/No/ Referral
<i>Resources Requirements (Continued)</i>	
<ul style="list-style-type: none"> Available private office/room to conduct FOF session uninterrupted for at least 60 minutes at a time. 	
<ul style="list-style-type: none"> Available wall space in the FOF room to hang the color poster that reveals the dramatic difference in AIDS rates for African Americans versus the rest of the population (nationally). 	
<ul style="list-style-type: none"> Ability to print and prepare wallet-sized cards (outlining the 8 steps for correct condom use on one side and contact information of the PHA and clinic on the other). 	
<ul style="list-style-type: none"> Ability to develop a list of stores in the surrounding area that carry a variety of high-end condoms and lubricants with the address, hours, and prices listed. 	
<ul style="list-style-type: none"> Ability to copy the Short Condom Use Survey (SCUS) and list of stores in the area. 	
<ul style="list-style-type: none"> Access to a laptop computer, iPod/speakers or CD player (optional). 	
<ul style="list-style-type: none"> Availability to purchase/obtain refreshments (water, soda, snacks) (optional). 	
<ul style="list-style-type: none"> A sink for the PHA to wash the penile models daily. 	
<i>Policies and Procedures</i>	
Are the following policies and procedures currently in place and able to satisfy the needs of FOF ? (Which need to be amended, and which need to be created?) For example	
<ul style="list-style-type: none"> Patient confidentiality, 	
<ul style="list-style-type: none"> Integrating FOF into clinic flow, 	
<ul style="list-style-type: none"> Screening for eligibility, 	
<ul style="list-style-type: none"> Recruiting clients, 	
<ul style="list-style-type: none"> Referral tracking, 	
<ul style="list-style-type: none"> Managing supplies, 	
<ul style="list-style-type: none"> Ordering supplies, 	
<ul style="list-style-type: none"> Safety and security plan, 	
<ul style="list-style-type: none"> Planning for potential issues, 	
<ul style="list-style-type: none"> PHAs' Clinic Responsibilities. 	

Integrating FOF into Existing Services

FOF is an intervention for African American men, ages 18-29, not knowingly HIV-positive, who have used a condom when having vaginal sex in the past 3 months, who either report contact, signs and/or symptoms of an STD and/or receive a confirmed or presumptive STD diagnosis. This intervention has been shown to significantly decrease subsequent STD acquisition, number of sexual

partners, and acts of unprotected sex. It has also been shown to significantly increase condom use and correct condom application skills, thereby decreasing opportunities to transmit or acquire STDs.

FOF can be delivered at the following times during a client's visit to the clinic

- **Before** seeing the doctor or nurse **only if** he reports contact, signs and/or symptoms of an STD;
- **After** seeing the doctor or nurse **only if** he receives a presumptive or confirmed STD diagnosis.

These men are the target clients for the intervention as they will have a heightened sense of vulnerability and will be more open to learning how to protect themselves from STDs in the future.

Each clinic implementing **FOF** may choose to integrate it into their patient flow in a different way. The process you choose to integrate **FOF** should not disrupt your ability to serve patients quickly and efficiently. An "Integration Checklist" has been included in **Appendix I** and follows the 19 steps outlined in this document. This checklist can be used to note when steps have been accomplished and to record any important notes that pertain to the steps.

Planning the Process

The goal of the process is to integrate the **FOF** intervention into clinic flow in order to decrease repeat STD infections and increase condom use among African American men who have sex with women, ages 18-29, not knowingly HIV-positive, who either report contact, signs and/or symptoms of an STD and/or receive a confirmed or presumptive STD diagnosis.

A "**FOF** System Integration Planning Tool" is included in **Appendix J**. This tool can be used to record plans, persons responsible, and responsibilities.

STEP 1: Determine who from your agency you will involve in the process planning, implementation and feedback process.

It is important to assemble a team of people who are involved with and understand the process of integrating **FOF** into your clinic systems. Teamwork unlocks the performance potential of organizations. It strengthens the performance capability of individuals and creates ownership and "buy-in" into the process.

When integrating **FOF** into your clinic, you should assemble a multi-disciplinary improvement team at the beginning of the planning process. This team will work together to plan, facilitate, and provide feedback about the integration of **FOF** into clinic flow. It is important that this team sets aside time to meet to communicate plans and any changes to processes.

A staff member should be designated as a "Plan Coordinator." The responsibilities of the Plan Coordinator will be to provide oversight for all activities related to implementing **FOF**. The Plan Coordinator may also copy and prepare the tools provided in this document, orient staff to the

integration plan, and problem-solve any questions and/or concerns that may arise related to the plan. Once logistics for completion of the plan have been determined, the Plan Coordinator should provide an orientation to staff on the purpose of integration plan, the different roles and responsibilities. The Plan Coordinator should be available occasionally throughout the day to ensure that the plan is being implemented by staff and that process data is being collected routinely

It is important to ask the following individuals to be members of the multi-disciplinary improvement team

- The Designated “Plan Coordinator,”
- PHA,
- PHA’s supervisor,
- Clinic Manager,
- Staff member(s) responsible for overseeing clinic flow on a daily basis,
- Staff member(s) responsible for recruiting **FOF** clients,
- Staff member(s) responsible for screening clients for **FOF** eligibility,
- Staff member(s) working in different disciplines at the clinic,
- Other staff members who are involved in and understand clinic flow processes.

STEP 2: Determine approximately how many eligible clients your clinic can see each day.

When integrating **FOF** into your clinic flow, it is important to consider how many eligible clients your clinic serves on a daily basis. Using data from your clinic, complete the “Modeling Anticipated Demand for **FOF** Based on a Calendar Year” in **Appendix K** to determine the number of clients from the **FOF** target population that a PHA would be able to see in one day at your agency.

If your clinic does not have this data readily available, a staff member can be designated to collect this information for a set period of time (e.g., 2 weeks, 1 month, etc.). See **Appendix L** for a “SAMPLE Client Eligibility Tracking Log” that can be used to record this data. If this data is unavailable and your clinic is unable to collect it, you may make assumptions or your best guess whenever necessary.

The information gathered from completing the “Modeling Anticipated Demand for **FOF** Based on a Calendar Year” tool will help you think about the demand for **FOF** at your clinic. It is important to keep that number in mind when determining how and when eligible clients who enter your clinic will receive the **FOF** intervention.

STEP 3: Set FOF targets.

You should use quantitative measures to determine if your integration plan leads to your target numbers for intervention implementation. If you are planning on using the number of clients served each day as a measure, based on the responsibilities of the PHA and length of the intervention, it is recommended a minimum of 5 clients per day receive **FOF**.

Example targets

- A minimum of 5 clients per day receive **FOF**,
- Clients wait no longer than 20 minutes to see the PHA,
- Observed decrease in STD rates amongst the target population,
- Clinic flow remains streamlined.

STEP 4: Determine how to identify clients who are eligible to participate in FOF.

FOF was developed specifically for African American men, ages 18-29, who are not knowingly HIV-positive, have sex with women, have used a male condom in the last 3 months, and either report contact, signs and/or symptoms of an STD and/or receive a confirmed or presumptive STD diagnosis. Therefore, it is very important to effectively screen clients to determine whether they are part of the target population and can be recruited to participate in **FOF**.

Examples of strategies to determine which clients who come into the clinic are eligible to participate in **FOF** are listed below.

- Develop a Form – During registration, ask each male client who registers to complete an extra form that asks the following eligibility questions. If he answers “yes” or “I don’t know” to the first 5 questions and “yes” to at least one of the symptom questions, he is eligible.
 - Do you identify as African American? Yes No
 - Are you between the ages of 18 and 29? Yes No
 - Do you have sex with women? Yes No
 - If yes, have you used a male condom when having sex with a woman in the last 3 months? Yes No
 - Are you HIV-positive? Yes No I Don’t Know
 - Are you experiencing any of the following symptoms?
 - Pain or burning when urinating Yes No
 - Lower abdominal pain Yes No
 - Discharge from the penis Yes No
 - Testicular pain Yes No
 - Frequent urination Yes No
 - Pain during sexual intercourse Yes No
 - Bumps or sores in the genital area Yes No
- Adapt an Existing Form – Adapt a registration form that is currently in use to include the questions listed above.
- Clinician Directed Screen – The nurse or doctor who diagnoses and treats clients orally asks the questions listed above to male clients who have just been diagnosed and treated for an STD (excluding the symptom questions).

- Search and Flag Records. A search is conducted through medical records and those who meet the eligibility criteria to participate are flagged.

The clinic staff member(s) who screen for eligibility can keep a record of the number of eligible clients who enter the clinic each day. This information can be used for data collection activities, which are described later in this document. A data collection form called “SAMPLE Client Eligibility Tracking Log” in **Appendix L** can be used to record this data.

The clinic staff member(s) designated to screen clients for **FOF** should understand their role and responsibilities. For more about roles and responsibilities, see “FOF System Integration Planning Tool” (**Appendix J**).

STEP 5: Once screened for eligibility, determine how eligible clients will be identified by staff that are responsible for recruitment.

Once a client is screened and determined as eligible to participate in **FOF**, staff members who are responsible for recruiting clients need to have a clear indication of who is eligible to participate so they can be recruited (Steps 8 and 9 discuss recruitment).

Will you

- Ask the clinic staff members responsible for screening clients for eligibility to place a green sticker on the client’s chart to indicate that he is eligible?

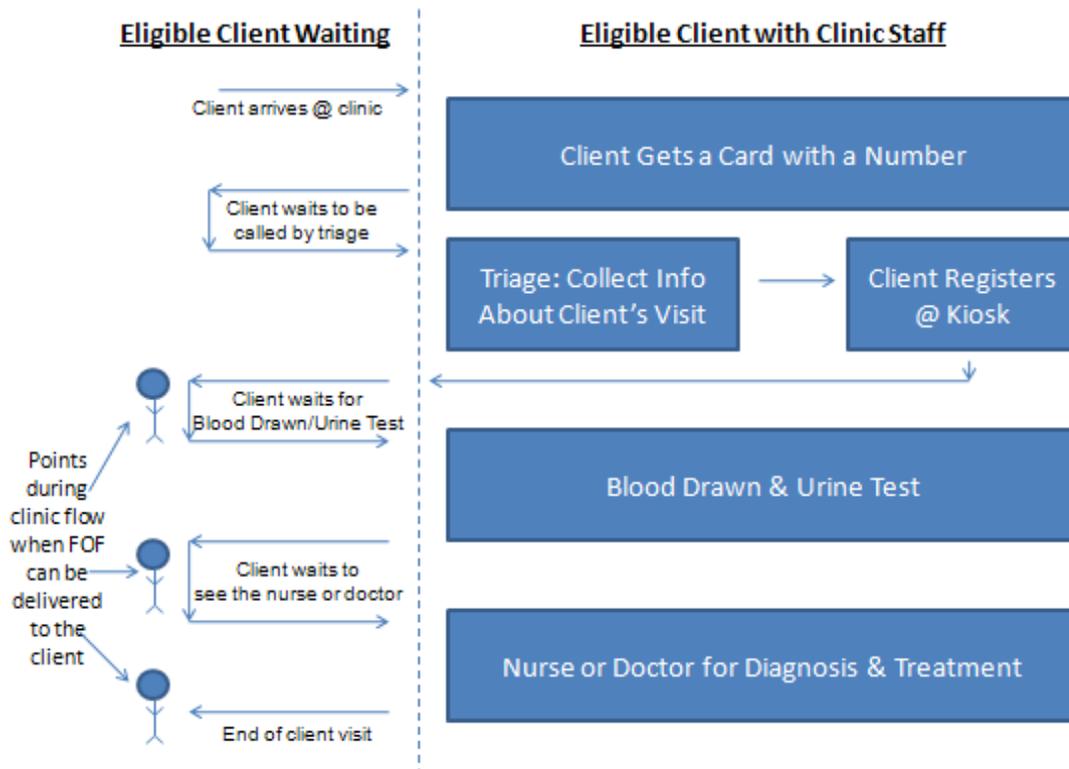
STEP 6: Based on the number of eligible clients your clinic sees each day (from STEP 2), determine when during clinic flow you will recruit eligible clients to participate in FOF.

FOF can be delivered to the following clients at the following times during clinic flow

- **Before** seeing the doctor or nurse **only if** he reports contact, signs and/or symptoms of an STD;
- **After** seeing the doctor or nurse **only if** he receives a presumptive or confirmed STD diagnosis.

The first step is to visualize the patient flow at your clinic and determine all of the points when eligible clients could receive the intervention. An example of all of the points that **FOF** could be integrated into Clinic XYZ’s flow is included below.

Clinic XYZ



Once you have determined all the points when **FOF** can be integrated into flow, you should choose the specific points when **FOF** will be delivered.

Will you

- Allow only clients who have received a presumptive or confirmed diagnosis participate in **FOF**?
- Allow only clients who report contact, signs, and/or symptoms who are waiting to see the doctor or nurse participate in **FOF**?
- Allow a combination of clients who have and have not seen the doctor or nurse to receive the intervention?

After determining the best points during clinic flow to integrate **FOF**, the plan should be communicated to all clinic staff so they have an understanding of when this new service will be delivered to eligible clients.

STEP 7: Determine what time the PHA will start and end his work day.

Once you have decided where **FOF** will fit into your clinic's flow, you should think about the optimal time for the PHA to start his work day.

For example,

- If eligible clients will only receive the intervention after receiving a presumptive or confirmed diagnosis, a start time of 30 minutes to 1 hour after the clinic opens may be the optimal start time for the PHA.
- If eligible clients will receive the intervention before seeing the doctor or nurse, when the clinic opens may be the optimal start time.
- If eligible clients typically don't come into the clinic until the afternoon, a later start time may be optimal.

STEP 8: Determine who will recruit eligible clients to participate in FOF.

It is important that certain clinic staff members are designated to recruit eligible clients to participate in **FOF**. It is also important that those staff members understand their roles and responsibilities. For more about roles and responsibilities, see “FOF System Integration Planning Tool” (**Appendix J**).

Will you

- Designate the doctors and nurses at your clinic to be the only staff recruiting eligible clients after clients have received a presumptive or confirmed STD diagnosis?
- Designate the triage staff to ask eligible clients if they are interested in participating in the intervention before seeing the doctor or nurse?

Marketing materials have been included in the package to strengthen recruitment efforts. These materials include

- A client brochure that can be handed out to clients who screen eligible for the intervention;
- Posters to hang in the waiting room and PHA's room. Agencies should ensure that they print enough posters.

It is useful for all staff to know the eligibility criteria for **FOF** clients, so if clients are missed they can be recruited at different points in the clinic flow. When first beginning to integrate **FOF**, the eligibility criteria for the intervention can be posted in a place where all staff who will be recruiting clients can be reminded and refreshed on what defines a client as eligible.

STEP 9: Determine recruitment messages that clinic staff will use to recruit eligible clients for the FOF intervention.

Clients who are eligible to participate in **FOF** may be upset about their STD symptoms or diagnosis. They may have waited a long time to see the doctor or nurse and may not be interested in staying for an hour after their visit. It is important that staff members who are responsible for recruiting clients are able to quickly build rapport with clients and offer the intervention as a positive and worthwhile experience, stressing the incentives (e.g., free condoms and lube, a one-on-one

discussion, learn how to protect oneself from future STDs, etc.). It is best to present **FOF** as a standard of care at the clinic, which means it is not presented as an option. This is because clients are more likely to participate if they view **FOF** as a part of the services that have been arranged for them during their clinic visit.

- Sample message for all clients
 - Now we'd like you to meet with our PHA as part of the services that we've arranged for you today. He's a guy, just like you, who will talk with you about how to protect yourself from getting another STD and then he'll give you over \$50 worth of really good condoms and lube.
 - If you'd like, you can meet with our PHA. He has 45 minute to 1 hour conversations with men about using condoms. He will give you a whole bunch of free high-end condoms and lube. You'll also get a little bag to put them all in. He's not interested in talking to you about your past, it's all about focusing on your future and making sure you're protected from STDs from now on.
- Sample message for clients who report contact, signs, and/or symptoms and have not seen the doctor or nurse
 - You can get out of the crowded waiting room while you're waiting to see the doctor. We have a young man who works here who talks to guys about using condoms. He'll let you pick out a bag full of free high-end condoms and lube.

If word is getting around in the community that there is someone at the clinic who is giving out free high-end condoms and water-based lubricants, clients may need to be told that they must participate in the entire 45-60 minute intervention in order to receive the complimentary supplies. However, if this is not the case, staff who recruit eligible clients for the intervention may be more successful if they do not tell the clients about the length of the intervention, which can sound like a long time.

STEP 10: Determine who will take clients to the PHA's room and introduce them to the PHA.

Once an eligible client has been recruited for **FOF** and is at the point in the clinic flow when he is ready to receive the intervention, it is important to have staff designated to take the client to the PHA's room. If the PHA is finished working with the previous client, the designated staff member can introduce the client to the PHA. If the PHA is busy working with another client, the designated staff can show the client where to wait and let him know approximately how long his wait will be. (See next step for more information about client wait time.)

Will you

- Designate the doctors and nurses at your clinic to be the only staff escorting clients to the PHA's room and introducing them to the PHA?

- Designate someone from the triage staff to be the only staff escorting clients to the PHA’s room and introducing them to the PHA?

It is important that staff who bring clients to the PHA’s room do not interrupt the PHA in the middle of a session. In order to prevent this from happening, provide training to the staff who are responsible for escorting clients to the PHA’s room. It may be necessary to post a “Do Not Disturb – Session in Progress” sign on the PHA’s door.

STEP 11: Determine how you will know when the PHA will be available to deliver the intervention to a waiting client.

The PHAs should be able to see approximately one client per hour. This means a client should be recruited and ready to meet with the PHA shortly before the PHA has finished with the previous client. It is important for the staff designated to take clients to the PHA’s room to understand how long a client may have to wait before receiving the intervention. This wait time should be communicated to the client so he can decide whether he is willing to stay or not.

Will you

- Place a stop watch outside the PHA’s room and ask him to restart it when he enters the room with each client?
- Ask the PHA to record the time he began delivering the intervention to a client on a log sheet outside of his private room? (See **Appendix M** for a sample “SAMPLE Client Time Log”.)

STEP 12: Determine how you will manage the timing of client recruitment so that the PHA always has someone to deliver the intervention to and so that clients don’t have to wait too long to receive the intervention.

It is important to be thoughtful when planning how and when **FOF** will be integrated into clinic flow. Integration will be a balancing act and may be different from day-to-day depending on how busy your clinic is and how many eligible clients agree to participate.

Referring back to the total number of eligible clients that your clinic sees each day (from “Modeling Anticipated Demand for **FOF** Based on a Calendar Year” in **Appendix K**), think about how you can develop a system whereby clients are recruited in a manner that prevents large numbers of waiting clients. Be aware that on some days, because of the number of eligible clients and clinic flow, some eligible clients may not receive the intervention.

STEP 13: Determine what process data you will collect to determine whether you are meeting your targets.

Collecting and reviewing process data regarding the efficiency and effectiveness of the system of integration you set up is important. Process data refers to information that is collected about the

processes you use to implement **FOF** and the overarching system of care. Data is reviewed after implementing the process for a certain period of time, however, it is important to prepare for how you will collect process data during the planning stage. Process data as it relates to integrating **FOF** into clinic flow is not related to whether the PHA delivers the intervention with fidelity. See the “Monitoring and Evaluation Guide” for more information about how to collect and review outcome data relating to intervention fidelity.

The first step is to determine what type of data you would like to collect. Typically, process data describes the characteristics of the population served, the length of time spent with each client, number of clients seen each day, etc. Once you have determined the process data to collect, it is important to determine how it will be collected. If your clinic does not already collect the information you require, an existing form can be revised or a new form can be created. A clinic staff member should be designated to collect each data set and ensure they understand their role and responsibilities. If that person requires training on data collection, that training should be planned for.

Another tool has been included in this document called the “Router Tool” (see **Appendix N**). This tool can be used to collect information about a client’s eligibility, total time in the clinic, time spent waiting to meet with the PHA, and length of the **FOF** session. The tool can be clipped on or placed within each client’s chart during the registration process. If you plan on using this tool, you should determine when, how and who will place the tool on the client’s chart. You will also need to determine a process to collect the information on the tool and then collect the tools from client charts throughout the day. To protect client confidentiality, please ensure the tool cannot be accessed by the clients. Once logistics for the tool have been determined, a designated staff member (e.g., the “Plan Coordinator”) should provide an orientation to staff on the purpose of the tool and how to complete it.

This data will be used to compare what actually happened during implementation with the targets set in Step 3.

The following table is an example of a plan to collect process data. It includes what data will be collected, how and when it will be collected, who will collect it, and whether the individual collecting the data requires training.

Process Data Collection Planning Chart

Process Data	How (e.g. forms)	Who	When Data is Collected	Training Needed?
Number of eligible clients who receive the intervention everyday	SAMPLE Client Time Log (see Appendix M) or Router Tool (see Appendix N)	PHA	When clients register at clinic	Supervisor will review how to do this with the PHA

Process Data	How (e.g. forms)	Who	When Data is Collected	Training Needed?
Number of eligible clients who <u>do not</u> receive the intervention everyday	Difference between the SAMPLE Client Time Log (see Appendix M) with the SAMPLE Client Eligibility Tracking Log (see Appendix L) or Router Tool (see Appendix N)	Clinic Manager	When clients register at clinic	No
Length of time spent with each client delivering FOF	SAMPLE Client Time Log (see Appendix M) or Router Tool (see Appendix N)	PHA	Record immediately after seeing each client	Supervisor will review how to use form with PHA
Wait time length for each client	SAMPLE Client Time Log (see Appendix M) or Router Tool (see Appendix N)	Doctor/ Nurse & PHA	Doctor/Nurse records the time when the client began to wait PHA records the time when the client entered the room	Supervisor will review how to use form with Doctor/Nurse and PHA
The attitudes/ opinions of staff on the system	FOF Systems: Staff Survey* (see Appendix O)	Clinic Intern	Distribute at the end of the day to staff members	Supervisor will review how to distribute the survey to clients
The attitudes/ opinions of clients on the system	FOF Systems: Client Survey** (see Appendix P)	PHA	Ask client to fill out or read to the client and record answers at the end of the FOF session	Supervisor will review how to use survey with PHA
Total time in clinic for each eligible client	Use current system of tracking time in clinic for each client or Router Tool (see Appendix N)	Clinic Manger	Throughout the client's clinic visit	Router Tool requires staff training

*The Staff Survey is designed to collect feedback about the perceived value of **FOF** and how successfully it has been integrated into clinic flow. This survey should be used within the first week of implementation, and then on a monthly basis thereafter.

The Client Survey is designed to collect feedback about the perceived value and satisfaction with **FOF. It gathers feedback about the PHA's performance. This survey can be completed by every client after every session. The surveys can be directly handed to the PHA or a locked drop box can be set up for the clients to drop the surveys into. Both the PHA and his supervisor should review the surveys daily or at least on a weekly basis.

Implementation of the Process

Once you have a clear plan, carry out the plan, document observations and record process data. Use the following steps to help you implement the integration plan.

Step 14: Determine how long you will try out your plan.

Once you have determined your detailed plan, pick a period for the implementation and evaluation of your system. Typically you will know right away whether the system you designed is successful and whether there are areas for improvement. Therefore, your implementation period should be short so changes can be made to those areas that require adjustments almost immediately.

Will you pilot the integration plan

- For one day?
- For a half-day?
- After the PHA has seen 4 clients?

Step 15: Determine how you will ensure that your plan is being implemented as intended.

It's important to make sure that your plan is implemented as intended and that any deviations are documented and taken into account. Keep track of the data that you have decided to collect, and make note of any parts of the plan that are not implemented as they were intended.

Will you

- Walk through to observe what is happening?
- Hold a staff huddle in the middle of the day to check-in?
- Check in at different points during the day with all staff involved to make sure that they understanding and are performing their roles?

Reviewing the Process

Once you have implemented your plan, review the data and summarize what was learned. Use the following steps to help you review the results of your **FOF** integration plan.

Step 16: Set a review process.

Once you have implemented your plan and collected the data, meet with staff to discuss it.

Will you

- Hold a meeting at the end of the day to review the process data with key staff members?
- Conduct a meeting at a mid-point in the day to review process data?

Step 17: Consider your measures of success.

In this step, compile the process data and compare it to your aims that you set in Step 3. Your review of the data will help you to figure out what actually took place. Compare the data that you collected to your original aims, being sure to fully investigate what the data is telling you. For example, if your original aim was to provide **FOF** to 5 clients per day and on this particular day only 3 clients were served, be sure to look at all the data to get a clear picture of why that may have happened. It may be the case that only 3 clients screened were eligible that day at the clinic.

Step 18: Determine the numbers that represent that the system needs to change.

Once you've compiled your data and compared it to your original aims, you should determine what numbers show that your original system needs to be altered. It is recommended that the system be altered if any of the aims do not meet the minimum target set.

Revising the Process

Finally, determine what changes are to be made and what you want to happen in the next implementation period. Use the following step to help you revise the integration plan.

Step 19: Determine the process of revising the system.

Based on the review your multi-disciplinary improvement team has just completed, you will have gained an understanding of whether or not your system is working well and what changes need to be made. If you have found that your system is running smoothly and meeting your aims, you do not need to do anything at this time; however, it is important to conduct periodic checks to ensure the system continues to run efficiently.

If from your review you have found that your system is not running efficiently, you will want to work with your multidisciplinary improvement team to gather suggestions for improvement. For instance, you may need to rethink when clients receive **FOF** during clinic flow. You also may find that you need to change your recruitment strategies to increase the number of clients who participate in **FOF**.

In order to maximize success, it is important to

- Allow all staff to have input into the changes;
- Communicate the changes to all staff;
- Review roles and responsibilities of staff involved in the intervention;
- Retrain staff.

Pre-Implementation Timeline

The following timeline outlines when the required tasks should take place in order to successfully prepare to implement the **FOF** intervention. The responsible staff and materials are also listed. [See **Appendix Q**]

Task	Person(s) Responsible	Materials	Timeline
<p>Determine Agency Fit and Capacity</p> <ul style="list-style-type: none"> • Agency should meet the following criteria <ul style="list-style-type: none"> ○ Ability to diagnose and treat STDs; ○ Serves a large number of the target population <ul style="list-style-type: none"> ▪ Males, ▪ Ages 18-29, ▪ African American, ▪ Men who have sex with women (MSW), ▪ Newly diagnosed with an STD or report symptoms of an STD, ▪ Uses condoms , ▪ Condom use is incorrect or inconsistent; ○ Has a private space where one-on-one intervention can take place; ○ Has a cupboard, closet or room to securely store supplies for the intervention; ○ Able to secure funding to successfully provide the intervention (this timeline may be ongoing); <ul style="list-style-type: none"> ▪ Able to purchase materials such as high-end/popular condoms and lubricants, small bags, and a penile model; ▪ Able to hire, compensate, and supervise a PHA; ○ Able to promote the program within the community; ○ Has a system in place to track referrals to the program; ○ Management and staff will “buy-in” to the intervention; ○ Follows CDC Standard of Care guidelines (e.g., screening, treating, post-test/risk reduction counseling); ○ Ability to do case study reviews without difficulty for monitoring and evaluation purposes. 	<p>Clinic Director</p> <p>Clinic Manager</p> <p>Clinic Manager</p> <p>Local and State Health Departments</p> <p>Stakeholders</p> <p>Clinic Director</p> <p>Clinic Manager</p>	<p>See Appendix K for a tool to determine the number of eligible clients your clinic sees per day</p> <p>Clinic Floor Plan</p> <p>Funding Opportunity Announcements</p>	<p>Week 1-2</p>

Task	Person(s) Responsible	Materials	Timeline
Develop Budget <ul style="list-style-type: none"> ● Use budget template to plan expenses. <ul style="list-style-type: none"> ○ Staff ○ Facility ○ Equipment ○ Supplies 	Clinic Director, Clinic Manager, Fiscal Managers/ Officers	See Estimated and Blank Cost Sheet	Week 3-4
Obtain Stakeholder “Buy-in” <ul style="list-style-type: none"> ● Engage stakeholders for support and participation in the planning and execution of the intervention ● See Stakeholder Checklist <ul style="list-style-type: none"> ○ List of internal and external partners to reach out to for support in “buy-in,” recruitment, and funding ● Review Program Review Board requirements 	Clinic Director, Clinic Manager, PHA Supervisor	See Appendix D for the Stakeholder Checklist	Week 5
Identify Appropriate Staff to Implement the Intervention <ul style="list-style-type: none"> ● Identify current staff members who will participate in the day to day execution of the intervention. This may include <ul style="list-style-type: none"> ○ Clinic Manager: Oversees the intervention implementation; ○ PHA Supervisor: Oversees the PHA; could be the clinic manager, social worker, nurse, etc.; ○ Clinician, nurses, social workers, DIS, triage staff: Screens and refers clients to the PHA for intervention; ○ New or existing PHA, if applicable. 	Clinic Director, Clinic Manager, PHA’s Supervisor, Clinicians/ Nurses/ Social Workers/ DIS/Triage	Staff Directory	Week 6
Create Data Collection System <ul style="list-style-type: none"> ● If funded by CDC, agencies need to collect data that can be imported into the NHME system. See the Monitoring and Evaluation Section for more details. 	Clinic Director, Clinic Manager	“Monitoring and Evaluation” Section of the IM	Week 7

Task	Person(s) Responsible	Materials	Timeline
Review Policies and Procedures <ul style="list-style-type: none"> • Make sure the current policies and procedures are appropriate for FOF, and make adjustments, if necessary, to accommodate the program. 	Clinic Director, Clinic Manager	See “Policies and Procedures”	Week 8
Set-up a “Buy-in” Meeting at the Agency <ul style="list-style-type: none"> • Conduct a meeting with all staff to introduce and gain support for FOF. 	Clinic Manager	See “Staff Buy-in”	Week 9
Hire a PHA to implement the intervention <ul style="list-style-type: none"> • Revise the Job Description included in the IM. • Develop or adapt the marketing materials included in the IM to advertise the position. • Explore existing networks of appropriate individuals. • Interview candidates using the interview tool in the IM. • Hire a PHA. 	Clinic Director, Clinic Manager, PHA’s Supervisor	Refer to “Identifying Appropriate Staff”	Week 10
Integrate the PHA into Agency Team <ul style="list-style-type: none"> • Introduce the PHA and his role to all staff at the agency. 	Clinic Manager		Week 11
Train the PHA and Supervisor <ul style="list-style-type: none"> • Register the PHA and supervisor for a CDC FOF Training of Facilitators session 3-day training. • Attend Training of Facilitators Program. • Debrief with PHA and supervisor about the Training of Facilitators Program. 	Clinic Manager, PHA’s Supervisor, PHA	CDC Website	Week 12
Train the Clinic Staff <ul style="list-style-type: none"> • Register clinic staff for training on the intervention and how to integrate the PHA into the healthcare team. 	All Clinic Staff	CDC Website	Week 12
Evaluate Agency Readiness to Begin the Intervention. <ul style="list-style-type: none"> • Review the Readiness Checklist <ul style="list-style-type: none"> ○ List of staff involved in intervention (Clinic Manager, staff who will screen and recruit, PHA, etc.); ○ Resources & Materials 	Clinic Manager	See Appendix H for the Readiness Checklist	Week 12

Implementation Overview

The implementation overview addresses two topics: a programmatic timeline and an implementation summary for the intervention.

Programmatic Timeline (1st year only)

The programmatic timeline describes ongoing implementation activities rather than planning and pre-implementation activities.

Activity	Timeline
Distribute and review Client Surveys (Appendix P).	Once every day
PHA meets with Supervisor.	Once every week
Monitoring and evaluation.	Once every week
Monitor levels of supplies (condoms, lubricant, ditty bags, etc.) and purchase supplies as required.	Once every week
Distribute and review Staff Surveys (Appendix O).	Once every month
Address staff “buy-in” (see “Staff Buy-in” in the Pre-Implementation Section of the IM).	Once every month
Provide the PHA with formal feedback based on an observed FOF session with a client (video-taped, tape recorded, male staff member sits in on session to observe, etc.).	Once every month
Review and update “List of stores in the surrounding area that carry a variety of high-end condoms and lubricants with their addresses, hours and prices listed.”	Once every 2 months
Quality assurance staff meets to discuss ways to improve implementation.	Once every 4 months
HIV Rates Pie Chart.	Once a year (or as updated statistics are released by the CDC)

Implementation Summary

This chart will help your agency prepare for the implementation of **FOF** by listing what inputs need to be gathered, what activities need to be conducted, and what outputs will be expected. The inputs section is a summary of the elements your agency should have in place before beginning to implement **FOF**. Once you have these resources, you can begin working on the activities section, which, when executed faithfully, should create the tools in the output section that allow you to offer **FOF** to the target population in your community. [See **Appendix R**]

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 FOF • A PHA who comes from and resides in the community and relates to men positively and quickly • Clinic Manager who will assist with pre-implementation activities and conduct quality assurance activities • Confidential and safe meeting space to conduct all FOF 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 FOF • Commitment to and completion of three days of intensive training on FOF intervention. • Ability to screen for eligibility • Ability to integrate FOF into clinic flow • Local/state public health officials’ support for FOF implementation • Community and consumer support for FOF implementation 	<ul style="list-style-type: none"> • Closely review FOF curriculum/intervention and understand theory and science behind it • Assess agency capacity to conduct FOF and identify technical assistance needs • Request technical assistance from Project Officer, CBA Coordinator • Introduce and orient staff to FOF • Identify appropriate staff to implement the intervention (Assess need for adaptation of intervention and contact Project Officer for further assistance) • Obtain and utilize consumer, community stakeholder input on FOF intervention • Inform local/state public health officials about FOF to gain their support • Prepare implementation plan with measurable goals and process and outcome objectives • Develop program monitoring plan to improve program and for quality assurance • Identify logistics for FOF (e.g., times, days, space) • Train and build skills of FOF PHA, his supervisor, and staff who will refer clients 	<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 FOF into flow of agency services and programs • Written FOF referral 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 referred for FOF in [timeframe] • % of planned # of FOF sessions held in [timeframe] • % of planned # of FOF participants who satisfy target population characteristics in [timeframe]

<p style="text-align: center;">INPUTS</p> <p style="text-align: center;"><i>Resources needed to implement and conduct intervention activities</i></p> <p style="text-align: center;">(continued)</p>	<p style="text-align: center;">ACTIVITIES</p> <p style="text-align: center;"><i>Actions required to prepare for and conduct the intervention</i></p> <p style="text-align: center;">(continued)</p>	<p style="text-align: center;">OUTPUTS</p> <p style="text-align: center;"><i>Deliverables or products that result from implementation activities</i></p> <p style="text-align: center;">(continued)</p>
<ul style="list-style-type: none"> • Input of agency staff, consumers, and community stakeholders into planning and implementation • External technical assistance 	<ul style="list-style-type: none"> • Plan and implement process/procedures to integrate FOF into flow of agency services and programs • Design participant referral process including who refers and how • Purchase/obtain a variety of high-end male condoms, packets of lubricant, male penis models for demonstration and skill building during the session • Purchase/obtain a small bag (e.g., ditty bag) for the client to put condoms and lubricant in at the end of the session • Conduct FOF intervention 	

Budget

Narrative

In order to implement the intervention, personnel, space in the facility, equipment, supplies, and the PHA recruitment need to be included in the budget.

Personnel

A Clinic Director and Clinic Manager will be needed at 5% full time employee (FTE) during pre-implementation and at 2% during the implementation period. Clinicians, nursing, social workers, DIS, and triage staff will be required to spend 1% FTE in order to become familiar with the intervention and screen and recruit eligible clients to **FOF**. A Supervisor needs to be assigned to the PHA. This individual will spend 7% FTE attending the 3-day training and supervising the PHA. Finally, the PHA will be hired from the surrounding community and paid approximately \$10/hour to be trained to carry out the **FOF** intervention. The amount of personnel time may vary depending on agency location.

Facility

FOF requires that the intervention take place in a private room at the agency location. It does not need to be a large space, but it should have enough room for both the PHA and the client to sit comfortably at a table or desk. There should also be cabinet, closet or room to store the supplies necessary for the intervention. The ditty bags and the high volume and variety of high-end and popular condoms and lubricant that are associated with **FOF** are appealing to both clients and staff. Therefore, it is important to keep supplies locked up in a closet or room that only a known number of staff have access to. It would be ideal if only the PHA and his supervisor have access to the supplies. Consider having the lock to the closet or room where the supplies for the intervention will be kept changed prior to implementing the intervention.

Equipment

In terms of equipment, your agency will need a photocopier (to copy the SCUS and list of stores that carry high-end condoms and lubricant) and a computer to print relevant materials. Additionally, the PHA will need to have access to a phone so clients can call him if they encounter issues with condom use. The agency can assign a phone within the facility for the PHA to use, a cell phone can be purchased for the PHA to use, or the PHA can be reimbursed for using his personal phone.

Supplies

A number of supplies need to be purchased for **FOF**. Paper is required to copy the SCUS and list of stores that carry high-end condoms and lubricant. Clients will use pens when filling in the SCUS. Key to the intervention is supplying clients with a variety of high-end/popular condoms and lubricants. Each client will receive 25+ condoms and 25+ packets of lubricant. Additional condoms and packets of lubricant will need to be purchased so the client can practice correctly putting condoms on a penile model and to explore the different features of condoms and lubricant. When

purchased through bulk purchasing sites for the pilot study, this worked out to \$7.30/client for condoms and \$6.55/client for lubricant. Your agency will need to purchase small bags for the clients to put their condom and lubricant samples in. Paper bags can be used, however, it is preferred that agencies use small nylon or velvet bags (“ditty bags”). Providing clients with a higher-end bag to put their samples in makes them feel like a valued and important client of the clinic. A lifelike penile model that accurately represents the anatomy of the target population is required during the skills building component. Having one or two less lifelike models are important to have on hand in the case a client refuses to practice using the lifelike model. Baby oil is needed for the demonstration about the dangers of using oil-based lubricants. A poster with National HIV Rates and PHA contact cards need to be printed in color. Paper towels and hand sanitizer are important to have on hand for clients and the PHA to clean their hands after practicing correct condom use. Finally, if able, your agency can supply the PHA with speakers to play music during the session and with refreshments to offer the clients. Both of these supplies will help the PHA build trust and rapport, which may increase the impact of the intervention.

Two budgets have been included for your consideration. The first is a budget that includes estimated figures and represents the cost of implementing **FOF** for one year (or 1250 clients). The second budget is a blank, user-friendly tool without figures to assist you when developing a budget with your respective figures.

Cost Sheet – Estimated

Categories for Provider Costs to Implement Intervention									
<u>Categories</u>	<u>Pre-Implementation (start-up)</u>			<u>Implementation (intervention delivery)</u>			<u>Cost per Participant</u> N=1250	<u>Total cost</u>	
Personnel (time spent on intervention)									
	<u># Staff Required</u>	<u>% time or # hrs</u>	<u>weeks</u>	<u># Staff Required</u>	<u>% time or # hrs</u>	<u>weeks</u>			
Salaried									
Clinic Director	1	5%	2	1	2%	50	In Kind	In Kind	
Clinic Manager	1	15%	2	1	5%	50	In Kind	In Kind	
Other Clinic Staff	TBD	1%	2	TBD	1%	50	In Kind	In Kind	
Hourly									
Peer Health Advisor	1	40	2	1	40	50			
Compensation	<u>% allocated</u>	<u>\$/hr</u>	<u>weeks</u>	<u>% allocated</u>	<u>\$/hr</u>	<u>weeks</u>			
Peer Health Advisor		\$10.00	2		\$10.00	50	\$16.64	\$20,800.00	
Facilities (time used for intervention)									
	<u># Required</u>	<u># hrs/week</u>	<u>weeks</u>	<u>#</u>	<u># hrs/week</u>	<u>weeks</u>			
Small Private Meeting Space/ Peer Health Advisor Office	1	40	2	1	40	50	In Kind	In Kind	
Equipment (time used for intervention)									
	<u># Required</u>	<u>% time</u>	<u>weeks</u>	<u># Required</u>	<u>% time</u>	<u>weeks</u>			
Copier	1	1%	2	1	1%	50	In Kind	In Kind	
Computer	1	10%	2	1	1%	50	In Kind	In Kind	
	<u># Required</u>	<u>\$ allocated/week</u>	<u>weeks</u>	<u># Required</u>	<u>\$ allocated/month</u>	<u>weeks</u>			
Phone	1	\$6	1	1	\$6.00	50	\$0.24	\$306.00	

<u>Categories</u>	<u>Pre-Implementation (start-up)</u>			<u>Implementation (intervention delivery)</u>			<u>Cost per Participant</u> N=1250	<u>Total cost</u>
Supplies								
	<u>Units</u>	<u>x</u>	<u>Price/unit</u>	<u>Units</u>	<u>x</u>	<u>Price/unit</u>		
Condoms	Client(s)*	1	\$7.30	Client(s)*	1250	\$7.30	\$7.31	\$9,132.30
Lubricants	Client(s)*	1	\$6.55	Client(s)*	1250	\$6.55	\$6.56	\$8,194.05
Penile Model - Rubber	Model(s)	1	\$11.00	Model(s)	0	\$11.00	\$0.01	\$11.00
Penile Model - Wooden	Model(s)	1	\$8.00	Model(s)	0	\$8.00	\$0.01	\$8.00
Penile Model - Plastic Banana	Model(s)	1	\$5.28	Model(s)	0	\$5.28	\$0.00	\$5.28
Ditty Bags	Bag(s)	5	\$1.25	Bag(s)	1250	\$1.25	\$1.26	\$1,568.75
Baby Oil	20oz Bottle(s)	1	\$4.50	20oz Bottle(s)	10	\$4.50	\$0.04	\$49.50
External Audio Speakers	Set(s)	1	\$22.00	Set(s)	0	\$22.00	\$0.02	\$22.00
MP3 Player	Player(s)	1	\$30.00	Player(s)	0	\$30.00	\$0.02	\$30.00
Printer Ink - Black	Cartridge(s)	1	\$122.00	Cartridge(s)	3	\$122.00	\$0.39	\$488.00
Printer Ink - Cyan	Cartridge(s)	1	\$122.00	Cartridge(s)	2	\$122.00	\$0.29	\$366.00
Printer Ink - Magenta	Cartridge(s)	1	\$122.00	Cartridge(s)	2	\$122.00	\$0.29	\$366.00
Printer Ink - Yellow	Cartridge(s)	1	\$122.00	Cartridge(s)	2	\$122.00	\$0.29	\$366.00
Printer Paper	Cartridge(s)	1	\$48.99	Cartridge(s)	3	\$48.99	\$0.16	\$195.96
Posters	Poster(s)	7	\$55.00	Poster(s)	0	\$55.00	\$0.31	\$385.00
Contact cards	Contact card(s)	1250	\$0.22	Contact card(s)	0	\$0.22	\$0.22	\$275.00
Total Cost								
Personnel			\$800.00			\$20,000.00	\$16.64	\$20,800.00
Facilities			In Kind			In Kind	In Kind	In Kind
Equipment			\$6.00			\$300.00	\$0.24	\$306.00
Supplies			\$1,298.87			\$20,164.97	\$17.17	\$21,463.84
Phase Total			\$2,104.87			\$40,464.97	\$34.06	\$42,569.84
Final Total:								\$42,569.84

*Assumes 35 high-end condoms and 35 foils of water-based lube per client (25 of each to take home and 10 of each to open and practice with)

Cost Sheet – Blank

Categories for Provider Costs to Implement Intervention - Template								
<u>Categories</u>	<u>Pre-Implementation (start-up)</u>			<u>Implementation (intervention delivery)</u>			<u>Cost per Participant</u> N=1250	<u>Total cost</u>
Personnel (time spent on intervention)								
	<u># Staff Required</u>	<u>% time or # hrs</u>	<u>weeks</u>	<u># Staff Required</u>	<u>% time or # hrs</u>	<u>weeks</u>		
Salaried								
Clinic Director								
Clinic Manager								
Other Clinic Staff								
Hourly								
Peer Health Advisor								
Compensation	<u>% allocated</u>	<u>\$/hr</u>	<u>weeks</u>	<u>% allocated</u>	<u>\$/hr</u>	<u>weeks</u>		
Peer Health Advisor								
Facilities (time used for intervention)								
	<u># Required</u>	<u># hrs/week</u>	<u>weeks</u>	<u>#</u>	<u># hrs/week</u>	<u>weeks</u>		
Small Private Meeting Space/Peer Health Advisor Office								
Equipment (time used for intervention)								
	<u># Required</u>	<u>% time</u>	<u>weeks</u>	<u># Required</u>	<u>% time</u>	<u>weeks</u>		
Copier								
Computer								
	<u># Required</u>	<u>\$ allocated/week</u>		<u># Required</u>	<u>\$ allocated/month</u>	<u>weeks</u>		
Phone								

<u>Categories</u>	<u>Pre-Implementation (start-up)</u>		<u>Implementation (intervention delivery)</u>		<u>Cost per Participant</u> N=1250	<u>Total cost</u>
Supplies						
	<u>Units</u>	<u>x</u>	<u>Price/unit</u>	<u>Units</u>	<u>x</u>	<u>Price/unit</u>
Condoms	Client(s)*			Client(s)*		
Lubricants	Client(s)*			Client(s)*		
Penile Model - Rubber	Model(s)			Model(s)		
Penile Model - Wooden	Model(s)			Model(s)		
Penile Model - Plastic Banana	Model(s)			Model(s)		
Ditty Bags	Bag(s)			Bag(s)		
Baby Oil	20oz Bottle(s)			20oz Bottle(s)		
External Audio Speakers	Set(s)			Set(s)		
MP3 Player	Player(s)			Player(s)		
Printer Ink - Black	Cartridge(s)			Cartridge(s)		
Printer Ink - Cyan	Cartridge(s)			Cartridge(s)		
Printer Ink - Magenta	Cartridge(s)			Cartridge(s)		
Printer Ink - Yellow	Cartridge(s)			Cartridge(s)		
Printer Paper	Cartridge(s)			Cartridge(s)		
Posters	Poster(s)			Poster(s)		
Contact cards	Contact card(s)			Contact card(s)		
Total Cost						
Personnel						
Facilities						
Equipment						
Supplies						
Phase Total						
Final Total:						

*Assumes 35 high-end condoms and 35 foils of water-based lube per client (25 of each to take home and 10 of each to open and practice with)

Adaptation

Adaptation is the process of modifying an evidence-based intervention to meet a particular population's needs while maintaining fidelity to the intervention's core elements and original intent. Prior to considering adapting an intervention, it is important to consider all available evidence-based interventions to make sure you have selected the intervention that best suits the needs of the target population you want to serve. Matching the HIV-prevention needs of your target population—specifically, risk behaviors and determinants of risk—with an intervention that addresses these problems should be done first. If you determine that there is no existing evidenced-based intervention that can meet your target population's needs, then it may be time to consider adaptation. This means that, for example, you may need to adapt an intervention, originally designed to serve a specific target population, for persons of a different race, ethnicity, or age.

The adaptation process consists of a number of analytical steps ranging from a community assessment which includes an assessment of your target population's HIV prevention needs and determinants of behavior change, to reviewing the existing intervention, community support and norms, to making necessary changes to fit your target population, to pilot testing new materials. A critical component of the process is working with members of your target population and key stakeholders during each step to ensure that your target population's needs are addressed and that the materials are culturally and linguistically competent and age appropriate.

Some things to consider when deciding whether to adapt an existing intervention include: a) how the existing intervention's problem statement and determinants of behavior change, as depicted in the behavior change logic model, fit with your target population's HIV-prevention needs; b) how immediate and intermediate outcomes depicted in the behavior-change logic model fit with the intended behavior change goals for your target population; and, c) whether the existing content, prevention messages, intervention activities, delivery strategies, and materials are suitable and relevant for your target population.

When going through the adaptation process, it is important to keep the original intent of the intervention as depicted in its behavior change logic model. That is, the intervention should continue to address the same needs identified in the problem statement, target the same determinants of behavior change and aim for the same intended outcomes. The specific manner or method by which this is accomplished in the intervention may need to be modified. Understanding the behavior-change logic model and the core elements and key characteristics of the intervention is important so the adaptation process can be done successfully. Core elements cannot be changed. They must be maintained because they are based on the underlying theory or internal logic of the intervention and are believed to be critical to the intervention's success in achieving its outcome objectives, including the behavior changes you want clients to achieve. The intervention's key characteristics can be modified. In general, the intervention content, activities, delivery strategies, and materials can be modified as needed, as long as these changes don't affect the core elements.

It is not recommended that you adapt an intervention for a different risk behavior. For example, an intervention that seeks to change risky sexual behaviors cannot easily be modified to change injection drug use behaviors. To address this problem, selecting a different intervention that better fits your target population and their risk behaviors is strongly recommended. Adaptation is generally not recommended for a population with a different HIV-serostatus or a different gender because of differences in content, prevention messages, and contextual issues.

If you have program evaluation funds, sound management recommends that you conduct process monitoring and process evaluation with the adapted intervention once it is implemented. This will assist you in determining if your target population is being reached as anticipated and if the adapted intervention is being delivered completely, consistently, and with fidelity to your clients.

If your agency is funded by the Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention, you must include your project officer in discussions and decisions about the adaptation process, and your project officer should provide approval for the adapted intervention to be implemented with clients. Your project officer can also discuss capacity-building assistance available from the CDC (<http://www.cdc.gov/hiv/cba>). If you are “indirectly” funded by CDC through your health department, check with health department staff to request assistance on adaptation.

FOCUS ON THE FUTURE

A brief, single-session intervention with
young African American males
who have sex with women,
who report symptoms of an STD and/or
have been diagnosed with an STD



Implementation Guide



2012

Implementation Guide

Introduction

The Implementation Section of this manual is designed to help agencies adopt **FOF** into the services they provide for young African American men who have sex with women. It provides information on the implementation activities, facilitator coordination, and use of the facilitator's guide. The PHA Implementation Guide, which is included in this section, outlines the **FOF** intervention that the PHA will be implementing,

Implementing the **FOF** intervention requires that PHAs prepare materials, set-up the room and practice delivering the intervention. The intervention is comprised of 6 components that the PHA will customize to the needs and concerns of the client. These components focus on addressing client issues and correcting mistaken beliefs by providing information, increasing client motivation to use condoms, and building client skills to use condoms and lubricant. After delivering the intervention to the clients, the PHA will meet regularly with his supervisor and complete required monitoring and evaluation paperwork.

In addition to implementing and delivering **FOF** to the clients, there are a number of programmatic implementation activities that must be accomplished. These activities include pre-implementation activities and maintenance efforts.

Pre-implementation refers to how agencies can prepare to put the intervention into action. This includes steps such as securing support through stakeholder "buy-in," finding and training the appropriate staff, budgeting, determining client eligibility, determining where the intervention will be conducted, and how it will be integrated into clinic flow. More information about pre-implementation activities can be found in the "Pre-Implementation" section.

Maintenance refers to all the factors that agencies should consider in order to sustain the intervention. This includes updating materials, staff training, and quality assurance. More information about maintenance can be found in the "Maintenance" section.

Implementation Activities at a Glance

The following table outlines the activities that need to be completed in order to successfully implement the **FOF** intervention. The suggested person(s) responsible and required materials are also listed. [Appendix U]

Implementation		
Task	Person(s) Responsible	Materials
<p>Organize and set-up supplies for FOF sessions.</p> <ul style="list-style-type: none"> • Pens • 1 color poster with National HIV Rates broken down by race • 1 realistic penile model that accurately represents the anatomy of the target population • 1-2 less realistic penile models (wooden or plastic banana) • Bottles of baby oil • Paper towels • Hand sanitizer • Large number, approximately 35 per participant, and variety of desirable and/or high-end condoms • Large number, approximately 35 per participant, and variety of desirable and/or high-end 3 to 8 ml water-based lubricant packets • Copies of the Short Condom Use Survey (SCUS) • Copies of the list of stores in the surrounding area that carry a variety of high-end condoms and lubricants with the address and hours listed • Wallet-sized contact cards (outlining the 8 steps for correct condom use on one side and contact information of the PHA and clinic on the other) • Small paper or ditty bags (small draw-string bags for clients to put 25+ condoms and 25+ lubricants of their choosing) • Laptop, MP3 player, portable speakers or CD player to play music (optional) • Refreshments, for example, water, coffee, cans of soda (optional) 	<p>Clinic Manager, PHA's Supervisor, Lay Health</p>	<p>See “Facilitator Coordination” for guidance on ordering supplies and preparing materials</p>

Task	Person(s) Responsible	Materials
<p>Develop a Process and Schedule for the PHA to practice implementing FOF.</p> <ul style="list-style-type: none"> • Quality assurance procedures should be developed for practice . 	<p>PHA's Supervisor, PHA</p>	
<p>Set up space for PHA to implement FOF.</p> <ul style="list-style-type: none"> • Make sure the room is private (with a door) and is available for at least 60 minutes per client. • Set up chairs and desk/table. • Hang appropriate posters on the wall. <ul style="list-style-type: none"> ○ Appropriate posters should not detract from the focus of the intervention, which is correct and consistent condom use. ○ For example, the posters that reveal the dramatic difference in AIDS rates for African Americans versus the rest of the population can be hung on the wall. • Set up laptop, MP3 player, portable speakers or CD player to play music (optional). • Make sure there is appropriate space and secure space for supplies. 	<p>Clinic Manager, PHA's Supervisor, PHA</p>	<p>Space for Intervention</p>

Task	Person(s) Responsible	Materials
<p>Develop a plan for PHA down time.</p> <ul style="list-style-type: none"> • Determine what tasks the PHA will be responsible for when not facilitating sessions of FOF with clients. For example <ul style="list-style-type: none"> ○ Review the Facilitator’s Guide and video; ○ Review client satisfaction survey results; ○ Assist with recruitment by greeting clients in the clinic or talking with them in the waiting room; ○ Do an inventory of supplies to ensure there are adequate numbers of condoms, water-based lubricant, handouts, etc.; ○ If clients who received the intervention are back at the clinic for follow-up treatment, meet with them while they are waiting to get feedback about the intervention; ○ Update materials, for example, the “List of Stores”, if necessary; ○ Adapt the intervention by offering it to clients who are 30-35 years old or 16-17 years old; ○ Call clients who participated in the intervention to see if they have any questions and to get feedback about the intervention. 	<p>Clinic Manager, PHA’s Supervisor, PHA</p>	
<p>Conduct FOF.</p> <ul style="list-style-type: none"> • The PHA implements FOF with clients in the clinic. • Client Surveys can be collected from each client to get feedback about FOF and the PHA’s performance. 	<p>PHA</p>	<p>See “Facilitator’s Guide”</p> <p>See Appendix P</p>
<p>Debrief with the PHA on a weekly basis regarding the implementation of the intervention.</p> <ul style="list-style-type: none"> • Discuss successes, concerns or issues with current implementation, devise solutions. 	<p>PHA’s Supervisor, PHA</p>	<p>See “Supervising the PHA”</p>
<p>Follow-up with M&E indicators for measuring continuous and effective implementation of FOF.</p> <ul style="list-style-type: none"> • M&E indicators should be completed and reviewed (e.g., Quarterly) and used to improve the pre-implementation and implementation process. 	<p>Clinic Director, Clinic Manager</p>	<p>See “Monitoring and Evaluation”</p>

Task	Person(s) Responsible	Materials
<p>Monitor levels of supplies and purchase supplies as required on a weekly basis.</p> <ul style="list-style-type: none"> • Ensure there are a sufficient number of supplies and materials for all clients who participate in FOF at the agency. 	<p>Clinic Manager, PHA's Supervisor, PHA</p>	
<p>Distribute and review Staff Surveys on a monthly basis.</p> <ul style="list-style-type: none"> • Ask staff to complete a survey regarding the value of the intervention at the agency and the successes and challenges with the integration of FOF into clinic flow. 	<p>Clinic Manager</p>	<p>See Appendix O</p>
<p>Address staff “buy-in” drift on a monthly basis.</p> <ul style="list-style-type: none"> • Share FOF successes at staff meetings and via newsletters, ask for feedback about FOF from staff, conduct group problem-solving to address challenges with FOF, provide opportunities for retraining and orientation for new staff, etc. 	<p>Clinic Manager, PHA's Supervisor</p>	<p>See “Staff Buy-in”</p>

FOF at a Glance

The table below, which we have reproduced from earlier in this manual so that PHAs will have it as a part of their Facilitator’s Guide, provides a brief overview of the goal, activities, and time for each of the six components of **FOF**.

Component	Goals	Overview	Time
<p>Component 1 Establish a constructive rapport and show the client respect.</p>	<p>Create a positive and comfortable environment so clients will fully engage in the following teaching/learning process;</p> <p>Establish the upcoming session as a chance to improve existing condom use skills.</p>	<p>The PHA meets the client and uses different strategies (e.g., discuss sports or music, “caring brother” or “being real” approach, etc.) to build rapport and establish a non-judgmental climate. The PHA casually inquires about how often the client uses condoms and describes the goal of the intervention, which is to help the client resolve any problems he may have with using condoms.</p>	<p>5 minutes</p>
<p>Component 2 Fill gaps in the client’s understanding of correct condom use based on a review of the Short Condom Use Survey (SCUS).</p>	<p>Understand the errors that the client has made when using condoms;</p> <p>Address errors and rectify misconceptions the client may have about correct condom use.</p>	<p>The PHA gives the client a few minutes to complete the survey. The PHA reviews the survey and gives the client positive feedback about things he is doing well and addresses errors he has made when using condoms in the past.</p>	<p>10 minutes</p>
<p>Component 3 Inquire about clients' past condom use experiences, discuss condom negotiation strategies, and increase motivation to use condoms by showing HIV rates poster.</p>	<p>Rectify issues with condom use;</p> <p>Discuss condom negotiation skills and help the client determine ones that will work for him;</p> <p>Increase client motivation to improve upon existing condom use skills by showing disproportionate HIV rates among African American males.</p>	<p>The PHA asks the client about how often he uses condoms and gives him positive reinforcement. The PHA and client have an informal discussion about experiences that the client has with condoms (e.g., tight fit, girlfriend will suspect him of cheating. etc.). The PHA presents options of how the client can introduce condoms into relationships. The client looks at the poster on the wall that illustrates how African Americans are disproportionately affected by HIV. The PHA addresses the client’s reaction to the poster in a way that will further motivate him to take action on behalf of his community.</p>	<p>10 minutes</p>

Component	Goal	Overview	Time
<p>Component 4 Provide guided practice in the correct application and use of condoms and water-based lubricant.</p>	<p>Increase clients' self-efficacy for condom and lubricant use;</p> <p>Show that oil-based lubricants do not work;</p> <p>Develop an understanding of how to introduce condoms into current and future relationships.</p>	<p>The PHA blows up a condom, ties it tightly, and rubs baby oil on it. It breaks. This is used as a jumping off point for a discussion about why the client should never use oil-based lubricants. The PHA gives the client a card with correct condom use instructions and demonstrates how to properly use a condom and lube using the penile model, delivering key health promotion messages throughout the process. The client then practices putting the condom and lube on the penile model until he has done it correctly three or four times. The PHA delivers important messages about condom use throughout the practice.</p>	<p>10 minutes</p>
<p>Component 5 Address erection and access problems.</p>	<p>Get clients to "shop ahead" for condoms and lubricant;</p> <p>Normalize the loss of an erection thereby helping clients to get beyond this problem without taking off the condom.</p>	<p>The PHA engages the client in a discussion about how erection loss is normal and strategies to overcome it. The discussion also focuses on the importance of having a supply of good fitting condoms on hand before sex occurs.</p>	<p>5 minutes</p>
<p>Component 6 Help clients achieve a satisfactory fit and feel.</p>	<p>Provide information, motivation, and skills to clients that will increase their quality of condom and lubricant use and thereby decrease the odds of condom failure;</p> <p>Close the session.</p>	<p>The client spends some time exploring the different condoms and lubricants by opening them up and feeling them. The PHA describes features that help him find a few with the best feel and fit. The client fills a small bag with any condoms/lubricant he chooses (25+ of each). The client is asked what he will remember about the conversation and then to share the information with a friend or family member.</p>	<p>10 minutes</p>
<p>Total Time</p>			<p>~50 minutes</p>

Facilitator Coordination

This section outlines how the PHA prepares and completes tasks to successfully implement the intervention.

Materials Checklist

The following items are required to implement the **FOF** intervention with each client.

Materials to Prepare Ahead of Time

- Copies of the Short Condom Use Survey (SCUS)
- Laminated color poster with National HIV Rates broken down by race
- Wallet-sized contact cards (outlining the 8 steps to correct condom use on one side and contact information of the PHA and clinic on the other)
- Copies of the list of stores in the surrounding area that carry a variety of high-end condoms and lubricants with the address, hours, and condom and lubricant prices listed

Ordering Supplies

- 1 realistic penile model that accurately represents the anatomy of the target population
- 1-2 less-lifelike penile models (e.g., wooden model, banana, etc.)
- Large number, approximately 35 per participant, and variety of desirable and/or high-end condoms
- Large number, approximately 35 per participant, and variety of desirable and/or high-end 3 to 8 ml water-based lubricants packets
- Ditty bags (a small draw-string bag for clients to put 25+ condoms and 25+ lubricants of their choosing)

Purchasing Supplies

- Pens/pencils
- Bottles of baby oil
- Paper towels
- Hand sanitizer
- Laptop, MP3 player, portable speakers or CD player to play music (optional)
- Refreshments, for example, water, coffee, cans of soda (optional)

Materials to Prepare Ahead of Time

Each of the following items should be prepared in advance of implementing the intervention.

- *Short Condom Use Survey (SCUS):* This survey should be photocopied prior to meeting with clients. (SEE COMPONENT 2).
- *Color Poster:* A poster that demonstrates the disproportionate rate of HIV among African Americans in the country should be printed in color and laminated.(SEE COMPONENT 3).
- *Wallet-Sized Contact Cards:* Wallet-sized cards with the 8 steps to proper condom use on one side and the contact information of the PHA on the other should be printed in color. Agencies should tailor the contact card included in this package and send it to a local

printing business for printing. (See COMPONENT 4 for an example.)

- *List of stores in the surrounding area that carry a variety of high-end condoms and lubricants with the address and hours listed.* This list should be developed and photocopied prior to meeting with clients. It is important to include stores in the area surrounding the clinic where clients can purchase condoms and water-based lubricant in bulk. The purpose of the list is to give clients information about where they can stock up on condoms so they always have an adequate supply before having sex. This means that they will never be in a position where they may have to run to a gas station to buy a condom, be forced to use a condom without the right fit and feel, or choose to simply have sex without using a condom. Consider including large chain drugstores (e.g., CVS, Walgreens) as some clients may not live in the area surrounding the clinic, but may have those stores in their communities. Although the selection and prices may not be the exact same, they will give clients an idea of what brands and condoms the stores generally carry. (See COMPONENT 5 for an example)

Ordering Supplies

It is important to order the supplies for the intervention prior to implementation. Specifically

- 1 realistic penile model that accurately represents the anatomy of the target population;
- 1-2 less-lifelike penile models (e.g., wooden model, banana, etc.);
- Large number, approximately 35 per participant, and variety of desirable and/or high-end condoms.
 - It is important to include condoms that are viewed as high-end and popular in the community where the intervention is being implemented.
 - Note: If your agency plans on offering polyurethane condoms to clients who have been diagnosed with a latex allergy by a physician, you may choose to order less of these. During the pilot process, over 600 clients participated in FOF and although they were available, no polyurethane condoms were distributed.
- Large number, approximately 35 per participant, and variety of desirable and/or high-end 3 to 8 ml water-based lubricants packets.
 - It is important to include water-based lubricants that are viewed as high-end and popular in the community where the intervention is being implemented.
- Ditty bags (a small draw-string bag for clients to put 25+ condoms and 25+ lubricants of their choosing).
 - Ditty bags should be the proper size to fit 25+ condoms and 25+ packets of water-based lubricant.

See **Appendix V** for a list of condoms, water-based lubricant, penile models and suppliers used during the pilot.

Purchasing Supplies

In addition to the materials that need to be prepared and the supplies that need to be ordered, the following supplies need to be purchased (or ordered) for the intervention

- Pens/pencils,
- Bottles of baby oil,
- Paper towels,
- Hand sanitizer ,

- Laptop, MP3 player, portable speakers or CD player to play music (optional),
- Refreshments, for example, water, coffee, cans of soda (optional).

Room Set-up

The room in which the intervention is conducted must be private. This means that there should be a door that can be closed so conversations cannot be heard by people passing by. Rooms created by dividers should not be used, and the room should be available for at least 60 minutes per client.

Before a client enters the intervention room, it is important to set it up so it is inviting to the client. It can be set up in the following way

- Two chairs (one for the PHA and one for the client) are placed face-to-face with a comfortable amount of space in between them;
- The penile model is placed on a table or desk and is visible to the client when he walks into the room;
- A large selection of condoms and lubricant (at least 10 of each variety) are arranged on a table or desk;
- Ditty bags (at least 1) for the client to put his desired condoms and lubricants in sitting on a table or desk;
- Posters hung on the wall (FOF marketing posters, pie charts, and other appropriate posters)
- If the PHA chooses to play music in order to build rapport, a laptop or stereo with the chosen music should be set-up. Note: The music that the PHA plays must be approved by the Clinic Manager.

For example



Practice Time

PHAs require individual practice time. Practice obtained through the Training of Facilitators should be followed up with individual practice. Supervisors should schedule time to meet with the PHA to practice with all materials available. PHAs can practice with supervisor or another individual that

understands the intervention and can give valid feedback. PHAs should practice often to ensure they are not developing habits that compromise fidelity to the intervention's core elements.

Intervention Delivery

FOF, as written, is approximately a 50 minute intervention. Depending on the clients' needs and concerns, the intervention can take as little as 45 minutes and as many as 60 minutes.

Delivery of Components

FOF is comprised of 6 components. It is recommended, but not essential, that the intervention be delivered in the order laid out. The conversational tone allows the intervention to be customized to each client. Therefore, the components may not necessarily flow in the order laid out in the Facilitator's Guide. For example, if a client is immediately curious about the displayed condoms and penile model, the PHA should explore this by completing Component 4 ("provide guided practice in the correct application and use of condoms") before the other components.

Additionally, the amount of time allotted to each component is flexible and should be adapted to reflect the developmental and learning needs of the clients. For example, some clients may require more skills practice whereas others may require more time spent discussing condom use issues.

Restocking Between Clients

In between clients, the PHA will need to restock the supplies he used with the previous client. This includes condoms, lubricants, ditty bags, copies of surveys and posters, and information cards. This can be difficult to do quickly and consistently, especially when a client is waiting to see the PHA. The PHA may find it helpful to create a re-stocking checklist to run through to ensure that he has a full set of supplies for each client that he sees (see **Appendix Z** for an example re-stocking checklist that the PHA can use). The PHA can also use the time when the client is completing the SCUS to restock the table. This will allow the client to have some space while completing the survey and the PHA to ensure there are enough supplies for that client.

Debriefing with the Supervisor

The PHA will meet with his supervisor on a weekly basis. They will meet to discuss client observations and needs, facilitation/implementation successes and challenges, and intervention progress. Policies and procedures related to issues that arise during the intervention should be reviewed at this time. See "Supervising the PHA" in the Pre-Implementation section for more guidance about debriefing.

Policies and Procedures to Address Issues that Arise During FOF

Any issues that arise during the intervention that the PHA cannot address should be addressed with the supervisor immediately or as soon after the intervention as possible.

Issues include when clients

- Ask for advice regarding issues in their relationships not related to condom use;
- Ask to borrow money, ask for home phone numbers, or ask for information about other clients in the clinic;
- Threaten the PHA with violence;
- Ask for information or referrals that the PHA is unsure of;
- Disclose personal issues that must be reported.

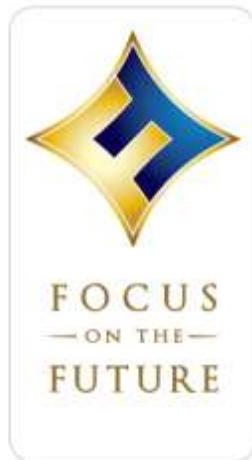
PHA Downtime

On days when an insufficient number of eligible clients are coming into the clinic, it is important that the PHA is using his time at the clinic productively and towards the goals of FOF. The PHA should not be performing duties not related to FOF (e.g., answering phones, filing, etc.). Supervisors should decide the best way for the PHA to use his time when he is not working with clients at the clinic. For example, during downtime, Peer Health Advisors can

- Review the Facilitator's Guide and video;
- Review client satisfaction survey results;
- Assist with recruitment by greeting clients in the clinic or talking with them in the waiting room;
- Do an inventory of supplies to ensure there are an adequate number of condoms, water-based lubricant, handouts, etc.;
- If clients who received the intervention are back at the clinic for follow-up treatment, meet with them while they are waiting to get feedback about the intervention;
- Update materials, for example, the "List of Stores," if necessary;
- Adapt the intervention by offering it to clients who are 30-35 years old or 16-17-years-old;
- Call clients who participated in the intervention to see if they have any questions and to get feedback about the intervention.

FOCUS ON THE FUTURE

A brief, single-session intervention with
young African American males
who have sex with women,
who report symptoms of an STD and/or
have been diagnosed with an STD



Facilitator's Guide



2012

How to Use This Guide

The following provides an overview of how to use the **FOF** PHA Facilitator's Guide.

Components

This guide is divided into the six components of the FOF session. Each component includes the following parts.

- *Goals*: this describes the intent of the component. By understanding the component's goals, PHAs can keep the conversation focused and relevant.
- *Core Elements*: identifies the core element(s) of the intervention that this component covers. The core elements are required elements that represent the theory and internal logic of the intervention and most likely produce the intervention's main effects. Core elements must be implemented with fidelity to increase the likelihood that prevention providers will have program outcomes that are similar to those in the original research.
- *Time*: the approximate amount of time it should take to complete the component.
- *Materials*: lists all items PHAs will need in advance to accomplish the component.
- *Important Considerations for this Component*: contains important background information, common challenges, and effective strategies that PHAs need to be aware for the given component.
- *Procedure*: describes how to accomplish the component with the client. Includes step-by-step instructions that are detailed and directed at the PHA; they are not instructions to be given to the clients. Items in quotes in this section are examples of possible dialogue that can occur between the PHA and the participant, but should not be treated as a script that must be followed. A more natural conversation between the PHA and the client that includes the same points is encouraged.
- *Appendices*: contains various materials relevant to the intervention sessions. These materials include the Short condom use survey (SCUS), the poster, double-sided contact card that lists 8 steps to correct condom use, facilitator forms, resources and **FOF** original research article.
 - **Appendix A**
The original implementation research was done by Dr. Richard Crosby and Dr. Ralph DiClemente. The research outcomes are published in: Crosby R, DiClemente R, et al. A brief, clinic-based, safer sex intervention for heterosexual African American men newly diagnosed with an STD: A randomized controlled trial. American Journal of Public Health. 2009; S96-103.
 - **Appendix B**
If the Condom Fits, Wear It: A Qualitative Study of Young African American Men by Dr. Richard Crosby published in 2004 in the Journal of Sexual Transmitted Infections.

ICONS



Peer Health Advisor Action: The symbol  indicates the **points where the Peer Health Advisor has to take action**. For example, actions include demonstrating the 8 steps to correct condom use.



Peer Health Advisor Question: The symbol  indicates the **points where the Peer Health Advisor asks the client for important information**. For example, questions include asking about past negative experiences with using condoms.



Client Action: The symbol  indicates the **points where the client will take action** to complete a survey or practice new skills with respect to condom and lubricant use.



Key Messages: The symbol  indicates the points where the Peer Health Advisor will deliver key messages to the client regarding condom use.

Peer Health Advisor Facilitator's Guide

The Facilitator's Guide is for PHAs. This guide outlines step-by-step the different components and goals that the PHAs need to achieve with each client. PHAs are encouraged to use the Facilitator's Guide when practicing delivering **FOF**. This Guide can also be used as a reference by the PHA when delivering the intervention to actual clients.

This section provides scripts and step-by-step instructions on how to facilitate **FOF** with the clients.

Component 1: Establish a constructive rapport and show the client respect.

Goals

- Create a positive and comfortable environment so clients fully engage in the following knowledge, skill, and attitude building process;
- Establish the upcoming session as a chance to improve existing condom use skills.

Core Elements

- The PHA establishes rapport and a trusting relationship with the client at the beginning of the session.

Time 5 minutes

Materials

- Laptop, MP3 player, portable speakers or CD player to play music (optional);
- Refreshments, for example, water, coffee, cans of soda (optional).

Important Considerations for this Component

1. One of the keys to having a successful intervention is developing a trusting relationship by establishing a rapport and a non-judgmental climate.
2. The negative experience of being diagnosed with an STD needs to be considered.
 - Clients can enter the clinic with suspicion, stigma, and distrust. They can feel rejected and may often feel betrayed that they were infected with an STD in the

first place. Overall, clients can experience a great deal of negativity in STD clinics.

- In this discouraged state, clients will be more open to receiving help from a caring person that they identify with. Therefore, that negative energy can be used as a stepping stone to build rapport between yourself and the client.
3. Based on the client's characteristics (age, body language, energy, tone, etc.), it is important to establish an effective means of relating prevention messages to him. Different strategies include
- **“Caring Brother” approach** – You can relate to the man with respect but also demonstrate a wisdom that comes with age. Combined with your experiences working with clients at the STD clinic, you can portray yourself as a knowledgeable "brother" who is taking time to protect someone you care about. This type of working relationship is often best suited to men 18 to 21 years of age.
 - **“Being Real” approach** – These clients typically want only the truth and they can quickly detect any subtle attempts to manipulate their behavior. Most of the older (i.e., 21 and above) men attend the nightclub scene on a regular basis. In this type of setting, sexual tension is high and it is imperative that clients learn how to be prepared to practice safer sex, not just be prepared to find sex. These clients also respect explicit direction as long as it does not challenge the wisdom of their past choices—the focus should be on the future and never on the past.
 - These categories are fluid. “Being real” may be the best approach for some younger men and the “caring brother” approach may work best for some older men. You will need to quickly determine which approach to use by observing the client's body language and listening to what he says and his tone.
 - In both cases you can use your own experience as a way to relate to clients regarding the likely hassles they have experienced in using condoms.

- It is important to quickly understand how each client is feeling and adjust your rapport-building strategy to his mood. For example, if a client is energetic, you should demonstrate the same level of energy and enthusiasm. If a client is feeling down, you should show sympathy and understanding.
 - Your rapport-building strategy will change with every client as no two clients are the same.
4. A primary operating component is to show **constant respect for the men** and **keep the focus on their future**.
- Clients want and need to know that others care about their well being and believe in their ability to succeed in the future.
 - Clients may feel hopeless about their futures, so it is important that you emphasize that they have a future.
 - Optimism about the future should permeate every aspect of the intervention session and it should be clear that protecting the future involves protection against STDs and—most importantly—HIV.

Procedure

1. Introductions.

- Welcome the client. For example, “Hey, what’s up?” or “How’s it going?”
- Tell the client your name in a welcoming manner.
- Ask him for his name if he doesn’t share it right away.

2. Establish an initial rapport and get the client in a trusting mood by using “small talk.”

- Several “small talk” options are listed below.
 - These “steps” are not required but are options for PHAs to utilize.
 - Acknowledge the experience the client just had in the clinic, for example
 - “You probably had to wait a long time today. Sorry about that. You can chill here with me though; this will be completely different than what you just got done with.”

- Offer the client a refreshment, for example
 - “You want some water or coffee?”
 - “You want a can of soda?” (if possible)
 - Start a conversation about something the client is wearing (e.g., his shoes, logo on his baseball cap, etc.), for example
 - “Nice sneakers man. Where did you get those? I’ve been looking for ones like those everywhere.”
 - “So you’re a Miami Heat fan? Do you think they will win the title this year?”
 - Start a conversation about pop culture or current events, for example
 - “What kind of music do you like?”
 - “What do you think about the latest NBA trade?”
 - “Did you see the football game on Sunday?”
 - “What do you think about the upcoming elections?”
 - When the client comes in, have some popular music playing at a low volume in the background. If he comments on the music, turn it up and use it to start a conversation.
 - “This new track is amazing. Have you heard any of his other stuff?”
 - “I like this album better than his old stuff. You?”
- The topic is less important than the intent. The intent is to have a conversation that takes the client's mind out of the negative context just described.

3. Get to know the client.

- Ask the client what he does (school, work, etc.), what he likes to do in his spare time, what he wants out of life, etc.
- If the client mentions something that he wants out of life, follow it up with a positive statement about his future, such as
 - “That’s great that you want that. I can help you protect yourself and stay healthy so you can get what you want out of life.”



4. Casually inquire about the client’s frequency of condom use and give affirmations.

- Because only clients who have used condoms in the past 3 months will be enrolled, casually ask clients how often they use condoms, for example
 - “How often would you say that you use condoms?”

- If clients say "sometimes or almost always" build on this with an affirmation, for example
 - "You seem like you care about your health."
- Asking about the client's current condom use during this Component brings condoms into the discussion. This gives the client a general idea of what the intervention will be about.

5. Describe the goal of the session, reinforcing that this is a non-judgmental environment.

- Let clients know the goal of the session by saying
 - "In this session I'm not going to talk about why you're here at the clinic or about your lifestyle. I just want to show you how condoms can make sex better and how to use them in a way that will help you avoid getting another STD."
 - "This session is going to help you resolve any problems you may have with using condoms, including problems with like making sure condoms don't break."
 - "We're not going to talk about your past; we're going to focus on your future."

Component 2: Fill gaps in the client's understanding of correct condom use based on a review of the Short Condom Use Survey (SCUS).

Goals

- Understand the errors that the client has made when using condoms;
- Address errors and rectify mistaken beliefs that the client may have about correct condom use.

Core Elements

- The PHA shows unconditional respect for men and maintains a non-judgmental environment for the client concerning any risk behaviors disclosed;
- The PHA clearly communicates the importance of the client protecting his future by using condoms correctly and consistently with his partner(s).

Time 10 minutes

Materials

- Short condom use survey (SCUS) (see the end of this component)
- Pen or Pencil

Important Considerations for this Component

1. In this component, the client will discuss some problems that he has had in the past with condom use in a general manner. In the next component (Component 3), the client will share more information about specific condom use experiences.
2. Questions that clients answer “No” to on the SCUS can be used to give them affirmations about what they are doing correctly when it comes to using condoms. All questions that the client answers “Yes” to on the SCUS should be addressed and misconceptions should be rectified.
3. It is very important to destroy the survey at the end of the session. The survey should not be kept for any purpose.

Procedure

1. Introduce the Short Condom Use Survey (SCUS) to the client.

- Tell the client that you would like him to complete a survey that will give you more information about how you can help him improve his condom use.
- Use a statement such as
 - “Condoms can be difficult to use. I’m going to ask you to fill out this short survey that will let me know how I can help you in making sure that every time you wear a condom it will be effective at protecting you from getting an STD.”

2. Ask client to complete the SCUS.

- The 15 question “yes or no” survey should take clients approximately 3 minutes to complete.
- If the client prefers, you can read the questions to him and he can tell you his answers.

3. Review SCUS.

- Take 1 or 2 minutes to independently go through the SCUS instrument, taking mental note of successes, errors, and problems with condom use.



4. Based on SCUS, give the client positive feedback about things he is doing well regarding condom use.

- Give clients affirmations on any questions that a client answers “No” to.
- Positive experiences will become the starting point for the subsequent learning exercise. They will also be used to show clients that they clearly care about their futures enough to have taken protective actions in the past.
- Use statements such as
 - “I see you haven’t had a condom break in the past three months—good for you!”
 - “I see you’re careful about not using dry condoms—your partner probably appreciates that!”



5. Based on SCUS, discuss client errors and problems with condom use.

- Ask clients to discuss any items that they answered “Yes” to and may have been problematic events for them when using condoms.
- Some common issues raised by clients and ways to correct misunderstandings are outlined below.

Question Number	Issue	How to Correct Issue
1, 2, 3, 4, 5	Mechanical errors, for example, letting it touch sharp jewelry, putting it on before erect, putting it on the wrong side up, unrolling the condom before putting it on, holding the tip.	Stress to the client the importance of putting the condom on correctly. You can use the model to show the client how to put a condom on correctly at this point if necessary, e.g., how to open a condom package, not unrolling it before putting it on, pinching the tip, etc.
6	Using dry condoms	“By applying water-based lube to your condom, you can make sex much more exciting and enjoyable for yourself and your partner. Lube will also decrease the chances of the condom breaking.”

Question Number	Issue	How to Correct Issue
7, 8	Losing their erections once the condom is on	“I see you’ve had erection problems. You would be surprised at how many other guys do too. There are some ways you can address this, like using lube.”
9, 10	Not wearing the condom for the entire duration of sex	“Instead of ‘dippin’ to become aroused, you and your partner can do other erotic activities.”
11	Condom breaks during sex	“What happened the times the condom broke?” Suggestions to correct this issue include carefully opening the package, using water-based lubricant, not using oil-based lubricant, finding a condom with the right fit and feel, leaving room at the tip, etc.
12, 13	Uncomfortable fit and feel of the condoms, for example, condoms fitting too tight or condoms that are too loose and slip off.	“I see that you don’t always have the right fitting condom. Condoms come in all different shapes and sizes and once you find the one that fits right, it can make sex so much better. I’ll make sure that you find the right fitting condom by the time you leave here today.”
14	Using oil-based lubricants	“It can be tempting to use whatever is lying around for lubricant---like lotion or baby oil. In a minute I’ll show you why only water-based lubricants should be used.”
15	Not changing the condom between sexual acts, for example, switching from anal sex to vaginal sex, or vaginal sex to oral sex,	“It’s important to have a number of condoms on hand when having sex. This way, if you want to switch from oral to vaginal sex, you’ll be able to protect yourself properly.” “After using a condom for oral sex, it’s important to use a new one if you’re

	without changing the condom.	switching to vaginal or anal. This is because your girl's teeth could have put little tears in the condom, which means it could break."
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- These negative experiences will become "teachable moments" which will be utilized to correct misunderstandings about condom use and problems with condom use.
- Use statements to correct misunderstandings.

6. Firmly establish that condom use is something that takes practice.

- Explain that using condoms is a complex behavior, for example
 - "Just by looking at a condom, it isn't obvious how to use it properly. Condom use is a complex behavior and, like anything else, can be improved with practice."
- Use affirming statements to praise clients for participating in the intervention, for example,
 - "Learning more about the details of condom use is an important use of time. It is clear that you really care about your health and your partners' health by taking time to talk with me and learn more about condoms."

Short Condom Use Survey (SCUS)

Check (✓) “yes” or “no” to the following questions.

Question	Yes	No
1. In the past 3 months, did you ever let a condom you were using touch sharp jewelry, fingernails or teeth?		
2. In the past 3 months, did you ever try to put a condom on when your penis was not fully erect/stiff?		
3. In the past 3 months, did you ever put the condom on your penis with the wrong side up and then have to flip it over before you could use it?		
4. In the past 3 months, did you ever completely unroll the condom <u>before</u> putting it on your penis?		
5. In the past 3 months, did you ever forget to hold the tip of the condom to leave a space before rolling it down to the base of your penis?		
6. In the past 3 months, did you ever use a dry condom? (For example, the condom was non-lubricated and you did not add any lubricant like KY Jelly)		
7. In the past 3 months, have you ever had any problems with losing your erection while putting on a condom?		
8. In the past 3 months, did you ever have any problems with losing your erection once the condom was on and sex had begun?		
9. In the past 3 months, did you ever start having sex without a condom and then pull out and put one on?		
10. In the past 3 months, did you ever start having sex with a condom on and then take it off before sex was over?		
11. In the past 3 months, did the condom you were using ever break during sex?		
12. In the past 3 months, did the condom you were using ever slip off during sex?		
13. In the past 3 months, did you ever have a problem with the way a condom fit or felt on you? (For example, you felt it was too small or too large, the wrong shape, caused skin irritation, or you/your partner couldn't feel anything with it on)		
14. In the past 3 months, did you ever lubricate a condom with lotion, Vaseline, baby oil, massage oil or any other kind of non-water based lubricant?		
15. In the past 3 months, did you ever have one kind of sex with the condom on before switching to another kind of sex, while still using the same condom (e.g., switching between vaginal and anal, or oral and vaginal, etc.)?		

Component 3: Inquire about clients' past condom use experiences, discuss condom negotiation strategies, and increase motivation to use condoms.

Goals

- Rectify issues with condom use;
- Discuss condom negotiation skills and help the client determine ones that will work for him;
- Increase client motivation to improve upon existing condom use skills on behalf of his community by showing disproportionate HIV rates among African American males.

Core Elements

- The PHA shows unconditional respect for men and maintains a non-judgmental environment for the client concerning any risk behaviors disclosed.
- The PHA and client will discuss condom negotiation skills.
- The PHA clearly communicates the importance of the client protecting his future by using condoms correctly and consistently with his partner(s).

Time 10 minutes

Materials

- Color poster (see the end of this component)

Important Considerations for this Component

1. The tone of this part of the intervention should be conversational and positive—this is not an interview by any means.
 - This is a very difficult part in the intervention because clients typically believe they are well versed when it comes to using condoms.
2. Because men who participate in **FOF** have either been diagnosed with an STD or have reason to believe that they may have an STD, they will most likely have problematic experiences using condoms consistently or correctly (or both). It is important to spend as much time as needed discussing challenges and problematic experiences using condoms.
3. One of the problematic experiences men face with using condoms is introducing condoms into relationships. When discussing condom negotiation skills it is important that the PHA presents different options to the client and does not give the client advice.

4. The posters in this section are used to motivate clients to collectively respond to the HIV epidemic.
5. When the poster displaying the disproportionate rates of HIV among African Americans is shown, many clients ask “Why?”
 - Do not attempt to answer this question, but follow it up with a statement such as
 - “No one knows why. The important question isn’t ‘why?’, but ‘what’ can be done about this?”

Procedure



1. Ask about how frequently the client uses condoms and give him an affirmation.

- Ask the client how frequently he uses condoms, for example,
 - “Of the last 10 times you’ve had sex, how many times would you say that you used a condom?”
- This question is asked twice because it has a different purpose each time it is asked.
 - When it is asked in Component 1 it is to introduce the topic of condom use early in the discussion and make clients comfortable with the topic.
 - When it is asked in Component 3 it is to get a more specific idea of how often clients are using condoms so that the PHA can tailor the rest of the intervention to the client’s needs.
- Many clients will say that they use condoms all of the time or almost all of the time. Use affirmations to respond, such as
 - “I respect that you are protecting yourself, your women, and the community from STDs and HIV by using condoms.”
 - “You seem like a responsible person, like you are looking out for your best interests and protecting others at the same time.”
 - “Using condoms is about self-love and a dedication to protect your future.”
 - “I respect your actions to protect yourself and your attempt to prevent STD/HIV among your community.”
- For clients who may imply that having frequent sex with multiple partners is important to them, you can use statement such as
 - “If you are a man with more than one partner, using condoms with all your partners is an important way to protect your wifey.”

- “Given that choice it is clearly important to become proficient at using condoms correctly and consistently.”
- “There are too many diseases around to just not use a condom, especially given that condoms can effectively prevent you from being infected with HIV.”



2. Ask clients to briefly discuss some of their problematic experiences with using condoms.

- For example, ask
 - “What are some things that get in the way of you using condoms every time?”
 - “Tell me about some problematic experiences you’ve had with using condoms?”
- You can refer to errors that the client noted in the SCUS, if necessary.
- This creates an informal opportunity to let clients bring up their main condom-related issues with you.



- Clarify misconceptions and provide accurate information, maintaining a sex-positive, non-judgmental tone. Some of the most common issues raised by clients and strategies to address them include the following.

Common Issue	Strategy to Address the Issue
<p>Why do most of the condoms I use fit so tight?</p> <p>Why are good condoms so hard to find and why do clinics always give us those cheap condoms?</p>	<p>“You’re right, some condoms will fit tight. But when you get a condom with the right fit and feel, it can make sex feel much better.”</p>
<p>My girlfriend and I used a condom and I still got an STD.</p>	<p>“Condoms aren’t as easy to use as they look.”</p>
<p>Condoms can't be trusted; if you're going to get an STD there really is no way to prevent it.</p>	<p>“I can help you learn how to use condoms in a way that will help you decrease your chances of getting an STD or HIV when you use one.”</p>

<p>If the girl looks clean, I don't think I need to wear a condom.</p>	<p>“Even if a girl looks clean, the decision to use condoms is a good decision. Constant use is much easier to achieve than periodic use—it can become a habit much like anything else in life.”</p>
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3. At this point, it is important to discuss how they can introduce condoms into relationships (i.e., condom negotiation).

- Ask the client what he could say to introduce condoms into his relationships.
- Some options that you can present to the client about how to introduce condoms into relationships include him telling his partner that
 - You have an STD so you have to use a condom to protect her from acquiring it (if applicable). Ask the client “How bad could it be if you told your main girl that you have an STD?”
 - You want to start using condoms because you love your partner and you learned it’s a way to protect her from STDs and unwanted pregnancies.
 - You joined a program and that you’ve been asked to use condoms as a part of it.
 - You saw a program, advertisement or commercial about how condoms can make sex feel better.
 - You got a bunch of expensive condoms when you went to the doctor and you want to try them. You heard that they can help enhance the sexual experience for your female partner by adding texture and lubrication. They can also help make you last longer.
 - You saw an advertisement in a magazine that said men and women can have herpes with no symptoms. By using a condom they can protect one another.
 - You went the drug store to buy something and there was a guy handing out free condoms.
 - You have a friend who was selling condoms and you bought some to be nice.

4. Show the client the poster with National HIV rates broken down by race.

- Draw the client’s attention to the poster that displays the national AIDS rates for men and women in the US and highlight that
 - African Americans are disproportionately affected by AIDS in this country;

- African Americans make up 12% of the US population but carry 52% of the HIV burden;
- The risk behaviors that lead to someone getting an STD are similar to the risk behaviors that put someone at risk of getting HIV.
- Use statements to show your dissatisfaction with the information contained in the poster by stating
 - “Look at the difference in HIV rates among African American and all other races of men in this country.”



5. Ask the client what he thinks about the statistics and address his reaction.

- Typically, men react to this information in the following ways
 - Wow—this is shocking and unfair,
 - That pizza is not sliced up evenly,
 - Black men always get a raw deal,
 - This is a conspiracy—the government created HIV to make African Americans sick.



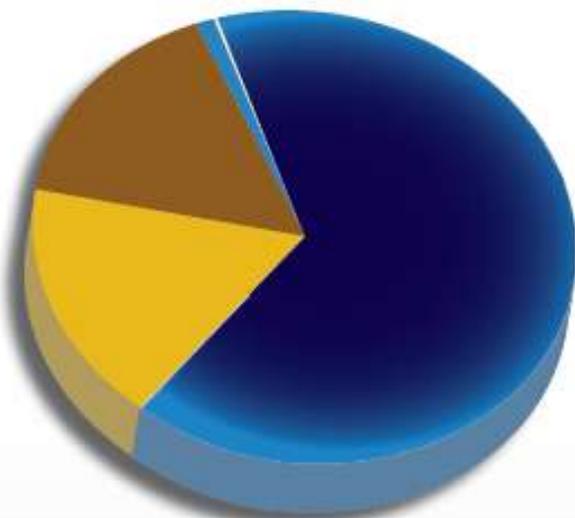
- This negative energy is important because you can now use the energy to motivate clients by using statements such as
 - “This is why I’m here talking to brothers about this stuff. I want to do something about it. You can do something too—by wearing a condom with every person, every time.”
 - “We are all in this (HIV/AIDS) together and the only thing we can do for sure is help protect each other.”
 - “It is time for black men to change the way AIDS has unfairly changed their lives. It starts with each person wearing a condom every time.”
 - “To reduce the rates you see for black men, we have to start with ourselves, wearing condoms correctly every time we have sex.”
 - “One way to change this is to tell other black men about this clinic and talk about using condoms—others may follow your behavior or guidance.”
- If a client focuses on the female rates (as they are higher), you can make the following points.
 - More men are infected with HIV than women (75% of all HIV cases are among men and 25% are among women).
 - There is no documented case of a woman transmitting HIV to another woman while having sex. This means that if a woman gets HIV from having sex, she got HIV from a man.

NATIONAL HIV RATES



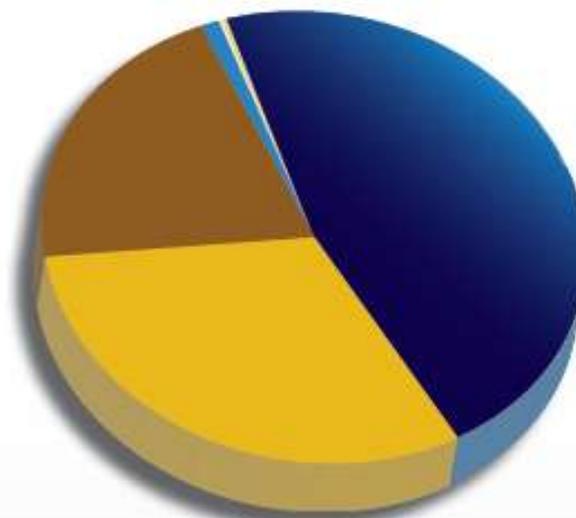
FOCUS
— ON THE —
FUTURE

FEMALES



African-American females made up
66% of all new HIV cases
amongst females in the USA in 2009.

MALES



African-American males made up
46% of all new HIV cases
amongst males in the USA in 2009.

LEGEND



Component 4: Provide guided practice in the correct application and use of condoms and water-based lubricant.

Goals

- Increase clients' self-efficacy for condom and lubricant use;
- Show that oil-based lubricants do not work;
- Develop an understanding of how to introduce condoms into current and future relationships.

Core Elements

- The PHA shows unconditional respect for men and maintains a non-judgmental environment for the client concerning any risk behaviors disclosed;
- The PHA will teach correct condom use skills for clients;
- The PHA clearly communicates the importance of the client protecting his future by using condoms correctly and consistently with his partner(s).

Time 10 minutes

Materials

- Large number and variety of desirable and/or high-end condoms
- Large number and variety of desirable and/or high-end 3 to 8 mL water-based lubricant packets
- Baby Oil
- 1 anatomically correct penile model
- 1 less-lifelike penile model (e.g., wooden model, banana, etc.)
- Wallet-sized contact cards, outlining the 8 steps to correct condom use on one side and contact information of the PHA and clinic on the other. (See the end of this component.)

Important Considerations for this Component

1. The most important goal of the intervention is to build clients' self-efficacy for condom use.
 - This requires a time investment that exceeds the time normally allotted to standard-of-care counseling.

- Because the task of applying a condom to the penile model is not time consuming, this process can be repeated as needed, at least three times, until clients can competently perform the entire sequence without feedback or correction.
2. Clients should be encouraged to use different condoms and water-based lubricant as they practice.
 - If the client is showing excellent skills in applying condoms, the features of the different condoms and lube can be discussed at this point. This is also an opportunity for clients to become comfortable with some of the new condom brands and models that they might not have known about before.
 - However, if the client is struggling with applying the condom correctly, wait to describe the different features of the condoms and lube until after they have finished practicing. This way he will be able to focus all of his efforts on correctly applying the condom.
 3. It is important to have napkins and hand sanitizer or a sink nearby so clients can wash their hands after touching the condoms and lubricant.
 - Clients may be hesitant to touch the condoms and lubricant if they can't see that there is some way for them to clean their hands afterwards.
 - Ensure that there are paper towels and hand sanitizer visible to the client, or he knows he can wash his hands afterwards at the sink.
 4. Effective ways to build a clients' self-efficacy for any given task is to
 - Manually and verbally guide the client through the entire process, one step at a time (a process known as "participant modeling");
 - Provide praise and positive reinforcement to the client;
 - Proceed at a pace and level that is appropriate for each client.
 5. Issues for clients pertaining to condom use may come up during this part of the intervention (e.g., decisions to have sex with a given woman, introducing

condoms to relationships with steady partners, etc.).

- When clients describe these issues in their sexual decision making, it is vitally important that you pursue these conversations with them.
 - Throughout these conversations, be vigilant about showing constant respect for men and keeping your focus on their future.
 - Let clients discuss their fears and concerns and help them see “all sides” of the issue.
6. When performing the oil-based lubricant demonstration, do not let the client know what will happen ahead of time. This experiment is much more impactful for the client when they can be surprised by latex condom shattering unexpectedly.

Procedure

1. Explain that you are going to demonstrate why oil-based lubricants do not work.



- Inflate a condom much like you would inflate a balloon and tie tightly.
- Ask the client to rub some baby oil on the outside of the inflated condom.
- Watch for several seconds—the condom will shatter in at least a dozen pieces as it breaks up.
- Be sure to show clients the shattered pieces of the condom.



2. Use the blown-up condom as an example of why oil-based lubricants should never be added to condoms.

- Tell the client that oils cause latex to lose its elasticity and break down.
- Provide clients with other examples of oil-based lubricants (e.g., chocolate sauce, Vaseline, whipped cream, hand lotion, etc.).

3. Discuss water-based lubricant by describing the following



- Benefit of using water-based lubricant

- “By adding a water-based lubricant the odds of a condom drying out on you are next to impossible. If the female is going dry it can replenish the moistness of her vagina. This will make sex more enjoyable for both you and her.”
- Uses of water-based lubricant
 - “Some people think lube is only for anal sex but that’s not true at all. The vagina is loaded with nerves, making it a very sensitive sexual organ. Unfortunately, the vagina is prone to drying out and most women really do not like the feeling of sex when this happens. Thus, when sex lasts longer than ten minutes you should really consider adding a water-based lubricant.”
- How to use water-based lubricant
 - “Lube is really easy to use. You can apply some on yourself before putting the condom on or drop some into the tip of this condom. This will make sex warmer and more sensitive for you. Then rub it on the outside of the condom right before having sex. The first step is optional, but the second is a must if you have a water-based lubricant on hand and you plan on having sex for more than just a few quick minutes.”

4. Hand the client a wallet-sized contact card that contains the 8 steps to correct condom use.

- Explain that you will do a demonstration and then he will have a chance to practice correctly using a condom with the model.



5. Demonstrate the sequence of steps that comprise correct condom use for the client.

- Put the condom on the penile model, referring to errors noted on the SCUS, describing and using the following 8 steps to condom use, highlighting the key messages below each step.

1. Put the condom on before sex begins.

- The condom doesn't do you or her any good unless it is always on during intercourse. Some couples are tempted to start having sex then put the condom on sometime later—you should avoid this.



2. Check the expiration date.

- If the condom has expired, it is likely to break so throw it out and get a new one.

3. Open the package without damaging the condom (find the perforated edge).
 - It helps to push the condom to one side of the wrapper and rip the wrapper on the opposite side.
 - Don't use your teeth.
4. Use a thumb and forefinger to find the top of the condom.
 - This is to make sure the condom will roll down on the penis correctly.
 - Be careful not to dig your nails in or tear the condom.
 - At this point you can add a few drops of lubricant to the inside of the condom to increase warmth and sensitivity. It will also decrease friction between the tip of the penis and the condom. Be careful—adding more than a drop or two can cause the condom to slip off.
5. Pinching the tip, place the condom on the penis and begin unrolling.
 - If you don't pinch and leave space at the tip, the condom could burst.
 - For those who are uncircumcised, it is best practice to pull the foreskin back before putting on the condom.
6. Unroll the condom to the base of the penis.
 - You want to make sure your entire penis is covered. This can be achieved by finding a condom that will give you the right fit and feel.
7. Add water-based lubricant to the outside of the condom during sex on an "as needed" basis (before dryness is experienced).
 - Lubrication is not a bad thing. In fact it can help improve the sexual experience for you and your partner. Lubrication practices are an essential aspect of enjoying sex while also using condoms. Lubrication is also essential to reducing friction and thereby averting breakage. Even the best condoms can dry out during sex. It is very important to generously add water-based lubricant to the condom during sex for erotic reasons (from the perspective of both partners, but especially the female partner)—especially when sex lasts for more than 5 or 10 minutes.
8. After sex is over, hold the rim of the condom and withdraw the penis while the penis is still erect.
 - Always take precautions to avoid semen spilling onto the genitals, mouth, or rectal opening of the sex partner.
 - If a condom breaks, sex should stop and a new condom should be used.





6. Client practices applying the condom to the model.

- Tell the client that it is his turn to practice.
- Encourage him to use the card with the “8 steps to condom use.”
- Explain that by the end of the session you want him to become a PCU (“professional condom user”). This means the client should be able to put a condom on correctly without thinking—even if he’s in the dark or has had a few drinks.
- If clients are uncomfortable handling the penile model
 - Try to remove any stigma surrounding it. (E.g. “It’s just plastic, and it’s the best way to practice these skills.”)
 - Tell him he can use the less lifelike model. (E.g. a banana or wooden model.)
- Direct the client’s attention to the wide variety of condoms and lubricant on the table. Tell him that he can use any of the condoms he likes to practice correct condom use. Encourage him to try using a different condom each time so he can get a feel for the difference.
- Manually and verbally guide him through the entire process, one step at a time if necessary.
- Provide praise and positive reinforcement to the client.
- Proceed at a pace and level that is developmentally appropriate.
- Address any concerns that are raised.



7. Once the client has achieved a "perfect performance" ask him to repeat the process for at least 2 or 3 repetitions.

- Suggest he try applying the condom at least twice without using the “8 steps to condom use.”
- Praise his work.
- Suggest he try it using different condoms.



- While he is practicing applying the condom, persuade him that women will respect his ability and desire to "smoothly" and carefully apply the condom.
- Highlight that condoms and lubricant can be used as a part of foreplay. Females may enjoy putting the condom on their partners and tasting flavored lubricant.

8. Highlight the importance of using a condom from the beginning to end of sexual intercourse.



- The activity will conclude on a cautionary note message for clients.
 - “Remember the condom doesn't do you or her any good unless it is always on during intercourse. Some couples are tempted to start having sex then put the condom on sometime later. After talking with you today, I know you wouldn't make that mistake.”



8 STEPS for CONDOM SUCCESS

- 1 Put the condom on BEFORE sex
- 2 Open the package without damaging the condom
- 3 Find the top of the condom
- 4 Pinch the tip and roll it down
- 5 Roll all the way to the base of the penis
- 6 Add water-based lubricant to the condom, before and during sex as needed
- 7 After you are finished, hold the rim of the condom and withdraw the penis
- 8 Be careful! Avoid spilling onto the genitals, mouth or rectum



Become a CONDOM PRO

CORRECT & CONSISTENT CONDOM USE SAVES LIVES

QUESTIONS?

Ivy Wilson

HEALTH EDUCATOR

212.###.####

REMEMBER:

- ◆ Respect yourself and your partners
- ◆ Make condom use part of your routine
- ◆ Find 'your brand' and stick with it
- ◆ Use a new condom every time

Component 5: Address erection and access problems.

Goal

- Normalize the loss of an erection thereby helping clients to get beyond this problem without taking off the condom;
- Get clients to "shop ahead" for condoms and lubricant.

Core Elements

- The PHA shows unconditional respect for men and maintains a non-judgmental environment for the client concerning any risk behaviors disclosed.

Time 5 minutes

Materials

- List of stores in the surrounding area that carry a variety of high-end condoms and lubricants with the address and hours listed. (See the end of this component for an example.)

Important Considerations for this Component

1. Bringing up the topic of erection loss;
 - In this part of the session, it is important to bring up the issue of erection loss. This is because clients may not feel comfortable disclosing erection loss as an issue for them. In order to increase correct and consistent condom use, erection loss must be discussed.
 - It is not important for the client to tell you whether or not it is an issue, but it is important to get the message across that erection loss is normal and the best strategy is to ignore it until the erection comes back.
2. Creating a list of stores in the surrounding area that carry a variety of high-end condoms and lubricants with the addresses and hours listed
 - It is important that a list of stores in the surrounding area is created prior to implementing the intervention. At least 4 stores should be included. (See the end of this component for an example.)

Procedure

1. Discuss and normalize erection loss.

- Casually introduce the issue of erection loss, for example
 - “I want to talk about something that is a totally normal thing for guys and if it hasn’t happened to you yet, it may at some point down the road. I’m talking about losing your hard-on.”

- Explain the following 3 points.
 - “Losing a hard-on, partially or completely, just before or during sex is entirely normal at any age.”
 - “Condoms can make the problem better if the condom is viewed as a way to enhance the sexual experience or to get beyond the worries of contracting an STD or causing a pregnancy.”
 - “Erections normally come and go and that the best strategy to use when they ‘go’ is to engage in touching with your partner and completely forget about the loss of the erection. It is normal for this to happen. After ignoring the loss of a hard-on for a while and engaging in touching with partner, the penis will usually get stiff again.”



2. Discuss the importance of planning for sex.

- Explain the following 2 points.
 - “It is very important to plan for sex by having a supply of good fitting condoms on hand before sex occurs. Do not wait until the last minute to buy a condom.”
 - “It’s important to find the right brand and size of condom to suit your needs and some stores or places like gas stations may not have the right kind of condoms when you need them.”

- Restate the following.
 - “If a condom breaks, sex should stop and a new condom should be used.”
 - “I strongly suggest that at least 2 or 3 condoms should be available before having sex.”
 - “You may have sex a few times with your partner in one go, so you want to make sure you have enough condoms if that happens.”
 - “It shows great wisdom when you plan ahead.”
 - “You can stash condoms in your drawers, gym bag, couch, under your bed, in your pockets, socks—the more places they are, the more likely you’ll have one on you when you need one.”



- Note: Condoms should not be kept in cars due to the varying temperatures. In extreme heat or cold, condoms become less strong and are more likely to break during sex.

3. Give the client a list of stores that carry a variety of high-end condoms and lubricants with the address and hours listed.

- Explain that this list contains a number of stores in the area that carry condoms and lubricants.
- Note the stores that are 24 hours, have later hours, or are very convenient, so the client knows where he can go to purchase condoms in emergencies.

Example: Where to Find Supplies in Midtown West Manhattan

<p><u>Kmart</u> Address: 250 West 34th Street 1 Penn Plaza J, NY Phone: (212) 760-1188 Hours: Mon-Sat: 7:00am-11:00pm Sun: 8:00am-10:00pm</p> <p>Condoms Trojan Enz – \$6.99 for 12 or \$17.99 for 36 Trojan Magnum – \$6.99 for 12 or \$17.99 for 36 Trojan Her Pleasure – \$6.99 for 12 Trojan Fire & Ice – \$6.99 for 12 Trojan Twisted Pleasure – \$6.99 for 12 Trojan Ultra Thin – \$6.99 for 12 or \$17.99 for 36 Trojan Ultra Ribbed – \$6.99 for 12 Durex Sensithin – \$6.99 for 12 Durex Pleasure Pack – \$6.99 for 12 Durex Pleasure Max – \$6.99 for 12</p> <p>Lubricant Durex Play – \$6.99 for 10 packets AstroGlide – \$7.99 for 2.5 oz AstroGlide – \$11.99 for 5 oz KY – \$5.49 for 4 oz</p>	<p><u>Walgreens</u> Address: 1471 Broadway, New York Phone: (212) 302-0552 Hours: Mon-Sun: 24 hours</p> <p>Condoms Trojan Enz – \$16.99 for 12 or \$27.99 for 36 Trojan Magnum – \$16.99 for 12 or \$27.99 for 36 Trojan Her Pleasure – \$16.99 for 12 Trojan Fire & Ice – \$16.99 for 12 Trojan Ecstasy – \$16.99 for 12 Trojan Ultra Thin – \$16.99 for 12 Trojan Ultra Ribbed – \$7.99 for 3 Trojan Extended Pleasure – \$16.99 for 12 Durex Extra Sensitive – \$7.29 for 3 Durex Pleasure Pack – \$16.99 for 12 Lifestyles Pleasure Collection – \$14.49 for 13 Lifestyles Ultra Sensitive - \$5.29 for 3</p> <p>Lubricant AstroGlide – \$10.99 for 2.5 oz AstroGlide – \$14.99 for 5 oz KY – \$9.99 for 4 oz</p>
<p><u>Duane Reade</u> Address: 1 Penn East, New York, NY Phone: (212) 268-3999 Hours: Mon-Fri: 24 hours Sat/Sun: 8:00am-11:00pm</p> <p>Condoms Trojan Enz – \$14.99 for 10 or \$24.99 for 36 Trojan Enz Ribbed – \$14.99 for 10 or \$24.99 for 36 Trojan Magnum – \$14.99 for 10 Trojan Fire & Ice – \$14.99 for 10 Trojan Ecstasy – \$14.99 for 10 Trojan Ultra Thin – \$14.99 for 10 Durex Extra Sensitive – \$14.99 for 12 Durex Extra Sensitive Ribbed– \$14.99 for 12 Lifestyles Extra Sensitive – \$21.99 for 40 Lifestyles SKYN - \$5.99 for 3 Kimono Extra Thin - \$17.99 for 12</p> <p>Lubricant AstroGlide – \$8.99 for 2.5 oz AstroGlide – \$12.99 for 5 oz KY – \$6.99 for 4 oz Wet (flavored) - \$8.99 for 5 oz</p>	<p><u>Duane Reade</u> Address: 1430 Broadway, New York Phone: (212) 768-0201 Hours: Mon-Sun: 24 hours</p> <p>Condoms Trojan Enz – \$14.99 for 10 or \$24.99 for 36 Trojan Enz Ribbed – \$14.99 for 10 or \$24.99 for 36 Trojan Magnum – \$14.99 for 10 Trojan Fire & Ice – \$14.99 for 10 Trojan Ecstasy – \$14.99 for 10 Trojan Extended Pleasure – \$14.99 for 10 Durex Avanti Bare – \$14.99 for 12 Durex Extra Sensitive – \$14.99 for 12 Durex Extra Sensitive Ribbed– \$14.99 for 12 Lifestyles Extra Sensitive – \$21.99 for 40 Lifestyles SKYN - \$5.99 for 3 Kimono Extra Thin - \$17.99 for 12</p> <p>Lubricant AstroGlide – \$12.99 for 5 oz KY – \$6.99 for 4 oz Wet (flavored) - \$8.99 for 5 oz</p>

Component 6: Help clients achieve a satisfactory fit and feel.

Goals

- Provide information, motivation, and skills to clients that foster experimentation with different types of condoms until they find a brand and size that best serves their needs;
- Close the session.

Core Elements

- The PHA shows unconditional respect for men and maintains a non-judgmental environment for the client concerning any risk behaviors disclosed;
- Provide clients with 25+ packets of water-based lubricants and 25+ condoms of their choice from a broad selection of high-end and popular brands;
- The PHA clearly communicates the importance of the client protecting his future by using condoms correctly and consistently with his partner(s).

Time 10 minutes

Materials

- Large variety of desirable and/or high-end condoms
- Large variety of desirable and/or high-end 3 to 8 mL water-based lubricants
- A small bag (e.g., ditty bag) for clients to put in 25+ condoms and 25+ water-based lubricants

Procedure

1. Redirect the client's attention to the table with the condoms and water-based lubricants.

- Explain the following
 - “Finding the right condom is really important—like anything else, it has to fit and feel good. By fit and feel, I mean that it should be the right shape, have the right texture, and be as thick or thin as you'd like it to be. It needs to feel comfortable so it can help enhance the sexual experience.”



2. Invite the client to open and touch any condoms he didn't get to feel when he practiced correct condom use skills.

- If he hesitates, open and feel some as a demonstration.



- While he is touching the different condoms, inform him that finding the right "fit and feel" is partly a function of his partner's sexual desires and needs.
- Further, let him know that "fit and feel" is essential to the overall quality of the shared sexual experience and it avoids the common problems of slippage and breakage.

3. Provide instruction regarding selecting the condoms that will give the client the best fit and feel.

- Describe the key features of each type of condom, highlighting the pleasure-related aspects of each (e.g., degree and type of lubrication, shape of the condom, style of the receptacle tip, and thickness of latex).
- Provide information about checking expiration dates, storing condoms, and advice to obtain pre-lubricated condoms that have a satisfactory fit and feel.



- Highlight the benefit of paying more money for "better" condoms and knowing where he can buy his particular brand and size (refer to the list of stores in the area that was given to the client earlier).
- Point out that some men need larger sizes, more room at the head, tapering at the bottom, extra lube, or a thicker condom.
- Do not distribute any polyurethane condoms unless the client tells you that he has been diagnosed by a clinician with an allergy to latex.



4. Invite the client to fill a small bag with any condoms he chooses.

- Give the client a small **FOF** bag.
- Reinforce the idea that the "right condom" makes it much easier to use condoms every time.
- Encourage them to take 25+ condoms.

5. Show the client a variety of lubricants that are water-based

- Remind clients
 - About the dangers of using oil-based lubricants.
 - Lubrication can help make sex more pleasurable and reduce friction, thereby preventing breakage.

- Even the best condoms can dry out during sex.
- Add lubricant generously to the condom before and during sex.
- Show the pieces of broken condom again.



6. Invite the client to fill the small bag with lubricants he chooses.

- Encourage them to take 25+ packages of lubricant.
- Let them know that almost any drug store will have more on hand.
- Refer to the handout you gave the client with the list of stores that carry a variety of high-end condoms and lubricants.
- Reinforce the idea that a good supply of lubrication will prevent breakage.
- Highlight that he can mix packets of the flavored lubricant to create new flavors (e.g., lemon and lime create “Sprite”).

7. Summarize key messages.



- *Condom Use*: “Correct and consistent condom use is key to avoid acquiring STDs and HIV, which will also help protect the African American community as a whole.”
- *Fit and Feel*: “Condoms that fit and feel right and the use of water-based lubricant can enhance your sexual experiences by making sex feel better and giving you the peace of mind that you won’t contract a disease.”
- *Erection Loss*: “Going soft is normal. Forgetting about it and engaging in touching with your partner will usually make it come back.”
- *Plan for Sex*: “It is important to plan for sex by always having condoms with the right fit and feel on you.”



8. Ask the client one thing he will remember and to share information with a friend.

- Close the session by asking the client to name one thing he is most likely to remember long after the session has ended. For example,
 - “What is one thing that you will remember after you leave here?”

- To help reinforce what he has learned and to further protect his community, suggest that he share some of the information obtained today along to a friend. For example,
 - “Today’s session was about how you can protect your future by using a condom every time with every person, but it goes beyond you if you tell your friends about some of the things you learned.”

9. Highlight your contact information on the back of the 8 steps to correct condom use card.

- Show the client your information on the back of the contact card.
- Genuinely encourage him to call if he encounters any problems with condom use or has any questions about condom use.

10. Thank the client for coming to talk with you and helping to reduce HIV rates in his community.

Maintenance

Once the intervention has been implemented, your agency will need to take the necessary steps to ensure that it is maintained so it will achieve the desired outcome, decreases in subsequent STD diagnoses for clients. Ensuring that **FOF** remains successful requires that your agency plans ahead to continuously assess the materials, staff, funding situation, and the value of the program to the community. This includes updating the materials over time, continuing to train current and incoming staff involved with the intervention, making sure that funding remains secure, and monitoring the success of the program through different measures.

Materials

The materials developed for the program were designed during the time when the intervention was originally packaged. Over time, agencies will need to evaluate these materials to ensure that they are relevant and up-to-date.

Condoms and Water-Based Lubricants

One of the core elements of the intervention is that clients are provided with a variety of high-end and desirable condoms and water-based lubricants that they can take home. This, in turn, increases the likelihood of clients using condoms and water-based lubricants in the future. The suggested formulary of condoms and water-based lubrication in this package is based on trends current as of 2011; however, these trends may shift in the months and years after the packaging of this program. There also may be geographic differences in the formulary according to the condoms and water-based lubricants that are desired by clients in different regions of the country. Therefore, the condom and water-based lubricants formulary should be tailored according to what condoms and water-based lubricants are popular for the time period in the region of the country that the intervention is being delivered.

Ditty Bags

In addition to the condoms and lubrication packets that are being provided, clients will be taking home with them a small “ditty” bag branded with the **FOF** logo that they can keep these materials in. The bags allow the clients to leave the clinic and store the materials they receive as discretely or as prominently as they are comfortable. Having a nice bag to put the materials in make the clients feel as if they were part of something special and may increase the effectiveness of the intervention.

During the pilot of this project, Cicatelli Associates Inc. partnered with Idea Stage Promotions (www.ideastage.com) to produce the bags that were given to clients. Agencies are welcome to use their own vendors as they see fit.

Poster with HIV Rates

The poster utilized by the PHAs to demonstrate to clients the disproportionate share of the HIV burden African Americans carry in the US will need to be updated over time as new statistics are available. It will be less persuasive to show a client statistics from five or more years in the past, therefore, it is important to show any shifts in the rates as new information becomes available.

List of Stores in the Area with Condoms/Lube/Addresses/Hours Listed

After the intervention, clients need to know where they can obtain their preferred brand and model of condom and water-based lubrication at a store that is easy to access and at a cost within their price range. Keeping the list of stores in the area with condoms and water-based lubricant accurate and up to date is extremely important as any barriers to acquiring condoms and water-based lubrication may dissuade clients from using protection.

Depending on your agency's location there may be many stores in the area where clients can obtain condoms and water-based lubrication, or there may be very few. Periodically, take the time to investigate what models and brands are available and at what price points, so that clients will always have the most accurate information about where to obtain supplies on their own.

Contact Cards

The contact card that clients receive, reminding them of the steps to correct condom use and providing them with contact information for the PHA, will need to be updated as the PHA staff changes at your agency, or as the PHA's contact information changes. Once there has been a change, these items need to be updated immediately so that clients are not being given incorrect information.

MP3 Player (if applicable)

If the PHA is using an MP3 player to help establish a rapport with clients, the music being played should be updated periodically so that it remains current and appealing to the population. This is something the PHA can update himself, but he may need access to a computer at your agency to facilitate this, or funds in order to purchase new songs. Songs online are inexpensive, rarely costing more than a dollar per song or ten to fifteen dollars per album.

Funding

Securing the necessary funds to continue offering the intervention is a critical aspect of maintaining **FOF** in agency settings. Once the initial funding from the CDC comes to a close, agencies will need to decide how they might best acquire new sources of funding to continue offering the program.

One solution for agencies may be to reapply for additional funding from the CDC. CDC's Prevention Programs Branch has competitive funding for community-based organizations and health departments conducting HIV prevention interventions. Announcements can be found in the Federal Register (usually during April-June) or on CDC's Web site (www.cdc.gov) under "Funding Opportunities." Also, agencies can check their state's Department of Public Health, HIV/AIDS Division. Departments of Public Health receive money from CDC to fund interventions in their respective states. If the package is offered frequently enough that the initial funding has not been completely exhausted by the time the next round of funding is available, agencies may be able to continue offering **FOF** uninterrupted until they receive the package again.

If agencies are unable to secure a new round of funding from the CDC, they may need to acquire funding from other sources. Many private philanthropic organizations award funding to organizations to programs that aim to reduce STD rates in their communities. There are also other sources of public funding, both at the state and federal level, that can be used to fund **FOF**.

It is important that the intervention remains fully funded, as it can be extremely easy to lose fidelity to the original program once budget shortcuts start being implemented. Utilizing free but undesirable condom brands, not supplying water-based lubrication, or reducing the number of hours the PHA is available will impact the core elements, and, therefore, will decrease the effectiveness of the program.

Training

FOF requires that PHAs attend an initial Training of Facilitators (TOF) before they can offer the intervention to the community. It is recommended that other clinic staff who will be involved in the implementation of the Focus on the Future intervention attend the TOF. Staff involvement in the intervention may include individuals responsible for recruiting and screening clients for eligibility, supervising the PHA, and managing the Focus on the Future intervention in your clinic. Other clinic staff involved in the intervention may choose to participate in the full training to gain a thorough understanding of the PHA's role, understand how to appropriately integrate the PHA into the clinic team, and provide support to the PHA as he delivers the intervention to clients on a daily basis. Supervisors and PHAs are required to attend a half-day training or a Webinar to orient them to the intervention. These training programs educate both parties about the pre-implementation, implementation, maintenance and monitoring and evaluation aspects of the intervention. Over time, it may be advantageous to have PHAs and their supervisors review the materials from their training sessions (e.g., handbooks, notes, videos, slides, etc.). This allows them to refresh their skills, bring up questions and concerns about the program, and share information with professionals at other agencies.

Other staff at the agency involved with **FOF**, such as medical or clerical staff, will need training on how implementation of **FOF** will impact their current work flow. This information will also need to be disseminated each time the agency hires a new staff member. Orientation for new hires may need to be adapted to include information about the intervention and how its adoption impacts specific positions at the agency.

While medical and clerical staff do not necessarily need to attend training sessions for **FOF**, giving these staff as much information about the intervention as possible will help them understand what new program the clinic is adopting, why it is important and value additional to the services offered, and how their position impacts the success of the program in the community.

Monitoring and Evaluation

Maintaining the **FOF** intervention core elements and program objectives overtime will require agencies to regularly monitor and evaluate activities. This section is designed to help agencies with monitoring and evaluating the **FOF** intervention. It contains an overview of monitoring and evaluation, as well as information on the two main types. There is also an overview of developing an evaluation, with a sample outline and coverage of how to write SMART objectives. This section will also reference the monitoring and evaluation forms found in the **FOF** appendices.

Monitoring and Evaluation Overview

Program monitoring and evaluation have become routine activities in HIV prevention. In the same way that **FOF** should be made a part of your agency's routine HIV prevention services, monitoring and evaluation should be performed as part of the delivery of this HIV prevention program. Findings from monitoring and evaluation provide the means for you and your agency to strengthen and improve outcomes for your clients.

There are many reasons to conduct program monitoring and evaluation. The two chief reasons are accountability and program improvement. Accountability could be to the community, staff, clients, or your funding source. Feedback on the challenges and successes of the program implementation can be used to make alterations in the next cycle of **FOF**. For example, monitoring and evaluation will allow your agency to

- Determine whether **FOF** is being implemented as intended,
- Determine whether **FOF** is working as intended,
- Determine whether adaptations to **FOF's** content or activities are affecting the integrity of the program,
- Determine accountability for funds and resources,
- Improve program operations to sustain **FOF** within your agency
- Write reports for your agency, Board of Directors, community stakeholders, and funders.

More specifically, program monitoring and evaluation can help your agency learn about

- Recruitment and retention,
- Characteristics of men who participated in the program,
- The extent of men's participation,
- How the program was delivered,
- Outcomes the men experienced.

By taking the time for program monitoring and evaluation, you can demonstrate to your stakeholders, including the participants in **FOF**, that you are doing your best to prevent HIV infection among African American men.

Types of Monitoring and Evaluation

This section focuses on two major monitoring and evaluation activities. These activities are **process monitoring** and **process evaluation**. See below for a more detailed discussion of how to conduct each one.

Two other types of monitoring and evaluation activities are **outcome monitoring** and **outcome evaluation**. Outcome monitoring is the collection of data about participants and their knowledge, attitudes, beliefs and behaviors, and intentions to change behavior before, during, and/or after the intervention. It identifies what components are working as expected and which ones are not in order to improve program effectiveness. Outcome evaluation is the collection of data on changes in participant knowledge, attitudes, beliefs, and behaviors, and compares these results to another group of participants not participating in the intervention. This form of monitoring and evaluation provides evidence that the intervention is causing the intended changes in the community it was designed to deliver. Neither of these types of monitoring and evaluation are recommended as part of **FOF**, however if the resources are available to collect and analyze this type of data it can be a useful tool for your agency to utilize. For the purposes of this section we will only be discussing **process monitoring** and **process evaluation** in depth.

An additional type of monitoring and evaluation activity is formative evaluation. **Formative evaluation** often takes place during the original design and pre-testing of programs. This form of evaluation assesses the feasibility of implementation, the appropriateness of program content and methods, and the match between the prevention needs of the target population and the risk reduction activities in the program. This type of data can assist your agency in making any appropriate adaptations to **FOF** to better fit your community's prevention needs and your agency's resources.

Process Monitoring

Process monitoring is the most fundamental monitoring activity. It involves the collection of basic data throughout the duration of the program. Process monitoring data focus on the characteristics of the men attending the program, the number of sessions delivered to men, resources used to deliver the program, the information and skills-building provided during the sessions, and modifications made to program sessions.

Process monitoring involves routine documentation of

- Number and characteristics of the people served,
- Number of sessions conducted,
- Resources used to conduct the sessions,
- Content covered and activities conducted during the sessions,
- Modifications made to intervention sessions.

Process monitoring answers questions such as

- How many men attended each **FOF** session?

- What are the characteristics of the men attending the **FOF** sessions?
- What resources (funds, staff time) were used to deliver those activities?
- Which **FOF** activities were implemented during the sessions?
- What modifications were made to the intervention sessions?

Ways to answer these questions include use of

- The Sample Client Eligibility Tracking Log (See **Appendix L**),
- The Sample Client Time Log (See **Appendix M**),
- The Router Tool (See **Appendix N**).

You might also use

- A participant sign-in sheet before each session,
- Your agency's financial reports.

Process monitoring is required if your agency receives funding directly from the Centers for Disease Control and Prevention (CDC) for HIV prevention, or if you receive CDC funding indirectly from your health department. Process monitoring and other program monitoring and evaluation activities are requirements for the CDC's National HIV Monitoring and Evaluation program. Information on NHME, including training and support, is available from NHME Service Center is pemsservice@cdc.gov or 1-888-735-7311.

Process Evaluation

Process evaluation is the second type of evaluation that your agency should be conducting. Process evaluation can be defined as the process of collecting more detailed data about how the intervention was delivered, any differences between the implementation plan and actual implementation, and access to the intervention.

Process evaluation takes the data collected during process monitoring activities and compares that information to your agency's program objectives. It compares what actually happened to what was intended to happen. This includes both the characteristics of the participants and the activities conducted.

Process evaluation is comparing process monitoring data to

- The planned number of participants,
- Recruitment and enrollment of the intended people,
- The intended number and length of sessions,
- Other intended components of the program necessary to achieve planned objectives.

Process evaluation can help you answer questions such as

- Did the enrolled participants come from the target population?

- Did the expected number of men complete the session of **FOF**?
- Was the program implemented as planned (e.g., intended number and length of sessions)?
- What barriers or facilitating factors were experienced by participants and facilitators during the course of the program?

Process evaluation data can come from your clinic’s implementation plan, the tracking of the number of men who the intervention session was delivered to, the eligibility screening form that collects information on the clients, and the Peer Health Advisor Quality Assurance Form (see **Appendix W**) completed by the facilitators and the program managers as observations are done.

Process evaluation also looks at whether your agency maintained fidelity to the intervention’s Core Elements and what, if anything, the agency adapted. Process evaluation is a quality assurance piece that ensures agencies are delivering **FOF** and not some unproven variation of the intervention. Some sample questions include

- Was each Core Element presented as outlined in the guide?
- Was the intended target population enrolled?
- Did the expected number of people attend?

For **FOF**, monitoring fidelity to the Core Elements and intervention activities are an important part of process evaluation. Core Elements are required components that represent the theory and internal logic of the program and most likely produce the program’s main effects. In **FOF**, as well as other evidence-based interventions, it is crucial for implementing agencies to maintain fidelity to the program’s Core Elements and required activities.

Adherence to the Core Elements of **FOF** might be evaluated by using a form such as

- FOF Fidelity Checklist (see **Appendix X**).

Ways to monitor fidelity to the activities and the Core Elements in **FOF** include

- During the regular meetings between the PHA and his supervisor,
- During the observation of recorded or live sessions with clients,
- A self-report completed by the PHA regularly (see **Appendix X** for an “FOF Fidelity Checklist” that can be used by the PHA).

If changes were made to any of the Core Elements, then you will need to keep track of which changes were made and why. In addition, you also want to keep track of any and all changes made in the recruitment plan, staffing plan, session schedule, or any other aspect of your original implementation plan. For all changes made, you will want to know what changes were made and why.

Program Monitoring and Evaluation with SMART Objectives

Monitoring and evaluation often begins with the identification of program objectives. It is a good idea to write SMART process objectives for **FOF**. To be **SMART**, these objectives must be **S**pecific, **M**easurable, **A**ppropriate, **R**ealistic, and **T**ime-based.

- **Specific**
 - Identifies concrete events or actions that will take place;
 - Answers the question, “Does the objective clearly specify what will be accomplished?”

- **Measurable**
 - Quantifies resources, activities, or changes;
 - Answers the question, “Does the objective state how much is to be delivered or how much change is expected?”

- **Appropriate**
 - Logically relates the overall problem statement and desired effects of the program;
 - Answers the question, “Does the objective make sense in terms of what the program is attempting to accomplish?”

- **Realistic**
 - Provides an attainable action that can be achieved with available resources and plans for implementation;
 - Answers the question, “Is the objective achievable, given available resources and experience?”

- **Time-based**
 - Specifies the time within which the objective will be achieved;
 - Answers the question, “Does the objective specify when desired results will be achieved?”

SMART Process Objectives

These objectives address what “processes” or activities need to take place before HIV prevention outcome objectives can be met. The activities identified in the **FOF** logic model provided on page 21 can be used to identify variables for SMART process objectives. SMART process objectives identify specific activities you have to complete to prepare for and implement the intervention such as the number of men to recruit for a cycle of the intervention session or the hiring of appropriate PHA to implement the session.

SMART process objectives should cover the specific activities you have to complete to prepare for and implement the intervention. This should include the number of contacts made in the community to recruit participants, number of men screened for eligibility to participate in **FOF**, number of men who participate in the session, or number who complete the full session. Along with the numbers of men, you will also want to collect data on the men themselves such as age, race/ethnicity, and any other variable that is important to your program's recruitment objectives. Process objectives can also cover 1) what you do to get ready for implementation, such as collecting referral information from a certain number of agencies or obtaining the latest local HIV/AIDS statistics by a certain date, and 2) what you do during implementation, such as making referrals to other services.

SMART process objectives also need to address the Core Elements of the intervention so that you can measure fidelity. If the Core Element is an activity, you can write the SMART objective in terms of conducting that activity. A SMART process objective related to an activity from Core Elements #1 and #3 could read

“The PHA will teach correct condom use skills for clients and allow clients to practice condom application by the end of the session.”

“Provide clients with 25+ packets of water-based lubricants and 25+ condoms of their choice from a broad selection of high-end and popular brands by the end of the session.”

If the core element is not an activity, such as Core Element # 8, then the SMART process objective could read

“Between February 1 and June 30, facilitation staff will conduct 70 sessions of **FOF** with 70 African American men who have sex with women.”

Based on these objectives, you are planning to conduct **FOF** with at least 70 African American men who have sex with women in a total of 70 individual sessions of **FOF** to be conducted over five months.

A SMART process objective not related to the Core Elements could read

“Between January 1, 20xx and June 15, 20xx program manager (xx FTEs - full-time equivalent staff) will establish at least three memorandums of agreement (MOA) with agencies that serve African American men who have sex with women to make referrals to the **FOF** program.”

Data Collection, Management, and Analysis

Data Collection

Monitoring and evaluation activities produce data that need to be analyzed and interpreted so they can be put to use to make your agency's implementation of **FOF** even better. You can use monitoring and evaluation findings to write reports for your agency, Board of Directors, or community stakeholders. You can also use the data to make recruitment efforts more productive.

The process monitoring data are best collected through recruitment reports, enrollment records, sign-in sheets, etc. You may want to look at the number of men participating in a cycle of the session throughout the course of the week, for example, for each target population, at each location, by PHAs, or by session.

The process evaluation data come from the process monitoring data from any measures of fidelity you may develop. So it is important to remember to conduct the observations and have the facilitators complete their own "PHA Quality Assurance Form" (see **Appendix W**) at the end of each session.

The sections on the types of evaluation earlier in this section referred you to some specific examples of forms that you can use to collect the data for each type of monitoring and evaluation of **FOF**. The data collection forms and questions contained in this document reflect basic monitoring and evaluation activities. Your agency may have specific reporting requirements, or you may have information needs within your agency that are not reflected in the forms.

Once you have identified the course of the data for your variables you also need to specify who will be responsible for collecting that data and the schedule for collection.

Data Management

As part of your data management and analysis sections of your monitoring and evaluation plan, you will need to determine who will enter the data into its data management system and on what schedule, and how you will maintain the quality of the data. In addition, you need to develop processes for data security, especially if your database will contain personal identifiers.

Since the process monitoring data are almost exclusively numerical data or can be coded as such, the easiest way to manage these data is to enter them into some type of spreadsheet, so that you can easily calculate totals and monitor progress over time.

Data Analysis

The process evaluation analysis is more likely to be a manual process, taking the data from process monitoring and copies of other measures of fidelity and adaptation you create, and comparing them to the original implementation plan and the intervention's core elements. One type of process evaluation documents fidelity to Core Elements and the customizing done to meet the needs of the populations and the resources and capabilities of your agency. These data are primarily descriptive and should be reviewed by the program manager regularly (e.g. monthly or quarterly) to monitor fidelity, to be alert for both inappropriate customizing, and the need for further customizing to make the intervention more relevant to the target population. Another type of process evaluation involves comparing the process monitoring data to the corresponding planned or anticipated numbers of people contacted, recruited, and attending the session, for example. The results of this comparison can expose areas for further review and improvement as well as areas of achievement.

Reporting and Using Evaluation Data to Improve Program

Reporting Monitoring and Evaluation Results

Since one of the main uses of monitoring and evaluation data is to provide accountability, you will want to develop reports to your funding sources, stakeholders, and clients that provide them with the information they need to see that you are meeting your objectives, serving the needs of your clients, and using the funds responsibly.

Developing a plan for reporting includes items for each report such as

- Schedule for completion,
- Contents and format required or needed,
- Dissemination plan,
- Person responsible for compiling, writing, editing, approving, and disseminating the report.

The format of the report is very important to the understanding of its content. You may want to try out different formats for presenting data—tables, pie charts, bar graphs, etc.—to see which works best for the data you are presenting and for the audience who is using the data. Clear narrative discussion of what the data mean in terms of progress, behavior change, and accountability is also necessary.

Using Data for Program Improvement

Once you have analyzed the process evaluation and monitoring data, you can look for ways to use it to plan program improvements. Depending on what you find as you review the data, you may need to make changes to your implementation plan, quality assurance plan, evaluation plan, or some

combination of these. These may, in turn, require you to make other changes, such as replacing or retraining staff, changing the meeting location, or reworking forms.

The data may also reveal the need for changes in the delivery of the sessions. Your facilitators may be in charge of altering **FOF** in these ways, but you will need to work with them to ensure fidelity to the Core Elements.

If you are not meeting your projected numbers of participants for the intervention, you will need to determine whether this is because of problems with recruitment or enrollment of clients. You may consider going back to clinic check-in forms where clients indicate the purpose of their visit and any demographic information provided as a means of overcoming barriers in these areas. For example, incentives also can affect both recruitment and retention as the client is being seen by various clinic staff before the PHA sees him, so you may want to add a question about incentives to stay for the **FOF** intervention to the form.

Developing an Evaluation Plan

The CDC Program Evaluation Branch (PEB) will continue to train and provide technical assistance to directly-funded prevention agencies that are responsible for accurately reporting National HIV Prevention Program Monitoring and Evaluation (NHM&E) data into a common database. Material presented here addresses the fundamental principles for any agency adopting **FOF** to implement basic program process monitoring and evaluation. Other questions need to be directed to stakeholders who are better able to address issues specific to your intervention.

Before implementing any intervention, you are encouraged to develop an evaluation plan. This plan is implemented throughout the delivery of **FOF** and will result in several sets of data to be reviewed and analyzed. Your agency can conduct the following types of evaluation for **FOF**: formative, process monitoring, and process evaluation.

There are two key reasons to evaluate a program or intervention, accountability and program improvement. Accountability could be to the community, staff, clients, or funding source. Implementing agencies must consider their accountability to implement any program or intervention properly. For **FOF** your clinic could look at whether the funds designated for this intervention were spent on its needs, such as PHA and program manager salaries, benefits, and CDC-sponsored training, a wide variety of high-end condoms and lubricants, marketing materials, and private office space. Evaluation can help improve the quality of the content and delivery of the program by looking at what worked and what did not work. Your evaluation plan should identify specific goals of the implementation, such as number of cycles of the intervention session to be held per week or some other time unit, length of session to be between 45-60 minutes, and target number of participants to be recruited. The information gathered can then be used to help your agency fine tune its programs by addressing the areas where the agency plan encounters problems.

Planning for Evaluation

Before your agency begins to implement **FOF**, the staff members need to review the sample evaluation forms in **Appendices W & X**, as well as the tools in **Appendices L through P**, and customize these forms to fit the planned implementation.

While the original intervention does not include follow-up with a client after the session has ended, your agency needs to determine whether or not you are required, or desire, to conduct a follow-up evaluation of your participants 2 to 3 months after the completion of the intervention. This decision impacts the information you need to collect from participants at enrollment, the measures you need to put into place for confidentiality and security of data, the data base for the storage and analysis of data, and the staff time and skills to maintain contact with participants. If you are going to do a Follow-up Assessment Survey, you will have to add sections to your plan on how to obtain follow-up information at enrollment, which will be responsible for maintaining contact with past participants, and how you will conduct the Follow-up Assessment Survey.

Once you have an evaluation plan, you may need to create or update your database to fit the data that will be collected. You also will need to talk with your staff about the need for evaluation and support them as they gather data. Make sure they understand the forms they will be in charge of filling out or collecting, when these forms are to be completed or collected, and how or when they are to be submitted.

Quality Assurance Plan

To maintain a high-level of fidelity to the original research and to maintain the effectiveness of the intervention, a quality assurance plan should be developed prior to implementation. This will help agencies keep track of the different aspects of the program and how they can affect the impact the intervention has on the community. Each of the following elements needs to be accounted for in an agency's Quality Assurance plan.

- Evaluating staff involved with the intervention, including medical and clerical staff
 - Evaluating the PHA will require either recording random sessions of the intervention or having a third party directly observe a session. In the latter case, it is preferred if another male staff member who has been trained on FOF observes in order to reduce the impact of having an third party observe the intervention. Permission from the client is necessary before observation or recordings can occur. The supervising staff can use the “Peer Health Advisor Quality Assurance Form” in **Appendix W**.
 - Evaluating other staff should center on their ability to recruit eligible clients to participate in the intervention, and their ability to facilitate a smooth and timely clinic flow as **FOF** is being implemented.
- Designing a supervision plan for the PHA
 - The PHA's supervisor should be qualified to supervise a member of the community working at the clinic, and needs to be able to take on the additional workload that supervision creates. Regular meetings (at least weekly) between the PHA and his supervisor are necessary components to this plan. These meetings should allow the

- PHA to report on his successes and his concerns, and allow the supervisor to give constructive feedback on the PHA's performance.
- It is important to have a set meeting time each week for the supervisor and PHA to meet.
- Determining how any requirements and standard practices at your agency will apply to **FOF**
 - Agencies may have site-specific policies that pertain to the implementation of **FOF**.
 - For example, if there is any additional training that the PHA needs to participate in, these should be addressed before implementation begins.
 - An agency's confidentiality policies are especially pertinent to **FOF**. A full understanding of how these policies impact implementation is necessary before the program can be made available to the public. All staff involved in the intervention also need to be made aware of these policies if not done already.
 - The PHA may need to undergo your agency's standard performance review in addition to any program-specific evaluations. Both the PHA and his supervisor should be aware of this.
 - Determine what other policies and procedures at your agency apply to **FOF** before implementation.
 - Designing a fidelity checklist to ensure that the core elements of the intervention remain intact
 - The core elements are integral parts of the program and the degree to which they are maintained directly relates to the effect the intervention will have in the community.
 - Both the PHA and his supervisor need to be aware of what the core elements are, and together both need to devise methods to ensure than they are being maintained. This can be accomplished any number of ways, including
 - During the regular meetings between the PHA and his supervisor,
 - During the observation of recorded or live sessions with clients,
 - A self-report completed by the PHA regularly (see **Appendix X** for an "FOF Fidelity Checklist" that can be used by the PHA).
 - Conducting debriefing sessions with select clients to evaluate their experience with the PHA and **FOF**
 - Some of the best feedback will come from the clients. They will be able to report on the value and skills they gained from the intervention, and be able to critique it from a unique perspective.
 - Without this feedback, it will be difficult to determine how effective the intervention is, and where opportunities for improvement are.
 - This feedback is best if it is structured in a standardized way, such as a feedback form completed by random clients after the intervention.
 - Feedback should not take too much of the client's time, as they have already agreed to participate in a fairly lengthy conversation with the PHA.
 - Client record tracking and confidentiality concerns
 - Agencies need to be able to track which clients have already participated in the **FOF** intervention in order to ensure the same clients are not receiving the intervention time and time again.

- In terms of screening clients for eligibility, some agencies may already obtain all of the information necessary to determine this. Others will need to determine how they can best obtain the information they are not currently collecting necessary to determine eligibility.
- When obtaining this information, the PHA should not learn anything about the client that is not necessary for the intervention. They assume that anyone referred to them meets the intervention criteria, but they do not require any specific information about the client.

APPENDICES

A Brief, Clinic-Based, Safer Sex Intervention for Heterosexual African American Men Newly Diagnosed With an STD: A Randomized Controlled Trial

Richard Crosby, PhD, Ralph J. DiClemente, PhD, Richard Charnigo, PhD, Gregory Snow, and Adewale Troutman, MD

In the United States, AIDS case rates are approximately 8 times higher among African American men than among White men.^{1,2} African American men have the highest prevalence and incidence rates of AIDS of all demographic classifications of US residents. Particularly in the South,^{3–5} African American men are also disproportionately affected by sexually transmitted diseases (STDs).⁶ Given these disparities, an important public health imperative is to develop and test interventions designed to reduce the risk of HIV or other STD acquisition among African American men—especially young African American men, who are at the greatest risk of infection.^{7,8} The imperative applies to both African American men who have sex with men and those who have sex with women. In general, however, heterosexual men of all racial/ethnic origins have been largely neglected with respect to the development and evaluation of HIV prevention interventions.^{9–11}

Few studies have specifically investigated clinic-based approaches to reducing HIV or other STDs among young African American men who have sex with women. For example, in a recent review of effective behavioral interventions for HIV infection, Lyles et al. identified 18 programs that met established methodological criteria.¹² Of these 18, 14 were designed for persons who were not knowingly HIV positive, and of these 14, none was designed for heterosexual African American men. The Centers for Disease Control and Prevention currently endorses a brief (60-minute) clinic-based program delivered in a small-group format designed to promote safer sex among African American and Hispanic men of all ages.¹³ To evaluate program efficacy, investigators used a clinic record review (mean of 17 months) to monitor subsequent STDs. Men randomized to the intervention (22.5%) were less likely to acquire a subsequent STD than were men in the routine-care group (26.8%).¹⁴

Objective. We evaluated the efficacy of a brief, clinic-based, safer sex program administered by a lay health adviser for young heterosexual African American men newly diagnosed with a sexually transmitted disease (STD).

Methods. Subsequent to STD diagnosis, eligible men (N=266; aged 18–29 years) were randomized to either a personalized, single-session intervention (delivered by a lay health adviser) or standard of care. We conducted behavioral assessments at baseline and 3 months postintervention (retention was 74.1%). We also conducted a 6-month clinic record review.

Results. Compared to men randomized to the control condition, those receiving the intervention were significantly less likely to acquire subsequent STDs (50.4% vs 31.9%; $P=.002$) and more likely to report using condoms during last sexual intercourse (72.4% vs 53.9%; $P=.008$). They also reported fewer sexual partners (mean 2.06 vs 4.15; $P<.001$) and fewer acts of unprotected sex (mean 12.3 vs 29.4; $P=.045$). Based on a 9-point rating scale, men in the intervention group had higher proficiency scores for condom application skills (mean difference=3.17; $P<.001$).

Conclusion. A brief clinic-based intervention delivered by a lay health adviser may be an efficacious strategy to reduce incident STDs among young heterosexual African American men. (*Am J Public Health*. 2009;99:S96–S103. doi: 10.2105/AJPH.2007.123893)

Although organizing groups of 3 to 8 men demonstrates efficacy, this may be problematic in many STD clinics from an operational perspective. In a multicenter randomized controlled trial, a one-to-one tailored counseling intervention was evaluated among STD clinic patients.¹⁵ Patients randomized to the enhanced counseling and the brief counseling conditions were less likely to acquire subsequent STDs over a 6-month follow-up (estimated odds ratio [OR]=0.69 and 0.71, respectively). The trial had a low participation rate (44%) and high attrition (49%). Although the trial demonstrated a treatment advantage, there was a marginal treatment effect for the primary behavioral outcome, unprotected vaginal sex. Subsequent reanalysis of the data indicated that intervention effects were not uniform across age groups. For example, among adolescents younger than 20 years, the 12-month STD incidence was 17.2% in the enhanced (intervention) group versus 26.6% in the control group. However, among young adults aged 20 to 25 years,

intervention effects were markedly smaller (13.1% vs 14.8%).¹⁶

In another study, a single-session clinic-based intervention produced significant effects in a subset analysis of young men (aged 20–30 years) and African American men over a 6- to 9-month follow-up period,¹⁷ whereas in a 6-session, video-based intervention, reductions were observed in self-reported unprotected vaginal sex among African American men recruited from an urban STD clinic.¹⁸ Unfortunately, the former study was not designed specifically for African American men and was evaluated using a nonrandomized design, whereas the latter study used a small-group intervention format, which limits its utility for clinic-based implementation, and did not assess subsequent STD acquisition. Finally, a clinic-based study using a 1-month (3-session) intervention format failed to observe significant differences in STD acquisition.¹⁹

We sought to test the efficacy of a clinic-based, safer sex program specifically designed

for young heterosexual African American men newly diagnosed with an STD and residing in the southern United States. The trial tested the hypothesis that men randomized to the intervention group would be significantly less likely than would be controls to acquire a subsequent STD and to engage in unprotected sex. Hypotheses pertaining to fewer sexual partners and greater condom application skills for men receiving the intervention were also tested.

METHODS

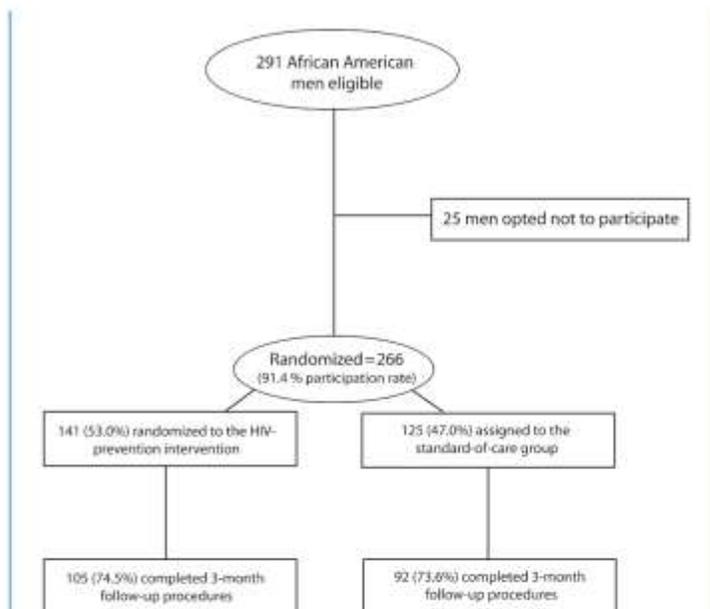
Participants

The study was conducted September 2004 through May 2006. Men were recruited from a public STD clinic located in a southern US city. Recruitment occurred following diagnosis and treatment for STDs. Nurses assessed potential eligibility by determining whether men (1) were newly diagnosed with an STD, (2) self-identified as African American, and (3) were aged 18 to 29 years. Potentially eligible men were asked if they would be interested in volunteering for a study. Those indicating any level of interest (N=306) were escorted to the project's lay health adviser (in an adjacent office), who further screened men for eligibility by determining whether men were English speaking and by asking 2 questions: (1) Are you knowingly HIV positive? and (2) Have you used a male condom at least once in the past 3 months for sexual intercourse (defined as "penis in the vagina") with a woman?

Of the 306 potentially eligible men screened by the lay health adviser, 15 were deemed ineligible based on their responses to the second set of eligibility criteria. These inclusion criteria were important because the brief nature of the intervention was designed specifically to improve the quality and consistency of condom use among men reporting recent experience with condom use. Of the 291 men deemed eligible, 266 (91.4%) were randomized to the 2 trial conditions (Figure 1).

Study Design

In a 2-arm randomized control trial, we used concealment of allocation techniques to minimize allocation bias.²⁰ Before implementing the trial, a random sequence was determined, and envelopes containing allocation cards (coded for intervention or control) were sealed, randomly



Note. STD = sexually transmitted disease.

FIGURE 1—Allocation of study participants in a randomized, controlled trial of a brief, clinic-based intervention to promote STD protective behaviors: Southern United States, September 2004 Through May 2006.

sequenced, and piled; the top envelope on the pile was always used to determine assignment to group. The trial was conducted using a 3-month follow-up assessment and a 6-month medical-records review to assess intervention efficacy.

Intervention Methods

Based on recent evidence suggesting that young African American men experience multiple difficulties with condoms,^{21,22} we designed the intervention to promote men's quality, correctness, and consistency of condom use. A 1-year formative phase was used to develop the intervention. In an initial elicitation study (that used the same inclusion criteria as the trial), we collected qualitative data pertaining to men's barriers in achieving correct and consistent condom use.²³ We used the findings to develop the brief (approximately 45–50 minutes long) intervention, which we then tested and revised based on identified gaps.

The program (named Focus on the Future) was based on a lay health adviser model. Evidence suggests that lay health advisers are instrumental in achieving intervention success among various populations of African Americans across a broad range of health behaviors.²³ The essence of the model is that the most effective change agents are people who come from the community for which the intervention program is intended. This goes beyond the concept of "matching" by race, age, and gender.²⁴

A young African American male who had grown up and resided in the main catchment area served by the clinic was selected, hired, and trained to implement the intervention. His everyday experiences and communication style were indeed no different from those of the men participating in the intervention. The lay health adviser was selected based on his ability to effectively discuss sex and condom use with men in a nonjudgmental manner. Part of this

ability included being adept at quickly establishing rapport with men by finding common ground between them. Once selected, he attended a 3-day training seminar designed to provide him the skills and information needed to deliver the single-session intervention.

The single session was predicated on the information, motivation, and behavioral skills model.²³ Information directly relevant to the quality of condom use was provided. For example, men learned that condoms come in a variety of sizes and shapes, and they learned about the value of periodically adding water-based lubricants to condoms during sexual intercourse. Men learned, by demonstration from the lay health adviser, that oil-based lubricants can quickly erode latex condoms. Enhancing men's motivation to use condoms was an integral component of the session. Throughout the session, the adviser encouraged men to feel good about using condoms, to experience condoms as being compatible with sexual pleasure, and to actively protect themselves from future STD acquisition. The lay health adviser constantly attempted to equate condom use with an investment in the men's future.

The participants were also motivated to personally respond to the AIDS epidemic through our use of large posters illustrating the disproportionate HIV/AIDS burden experienced by African American men. An equally important, but implicit, objective was to have the adviser be responsive to men's questions, problems, and concerns regarding safer sex with their female partners. Men were prompted to think about ways they could initiate condom use with existing partners. Skill acquisition was also emphasized. Correct condom and lubrication use were demonstrated and practiced by men until they expressed a sense of mastery. Men were encouraged to use condoms they felt fit them comfortably and provided them with a sense of security. Based on formative work,²⁴ we decided to provide men with pocket-size vials of water-based lubricants as well as 12 or more condoms of their choice from a broad selection of brands and sizes.

All men enrolled in the study received nurse-delivered messages regarding condom use per Centers for Disease Control and Prevention guidelines.²⁰ These messages were typically delivered in only a few minutes and essentially informed men that condoms are an

effective means of preventing subsequent STD acquisition when used consistently. As patients of the clinic, all men were allowed to take up to 12 condoms—with only 1 size and brand available—from the clinic as they exited. In addition to the disease-specific diagnosis and treatment the men received, these procedures comprised clinical standard of care. Men randomized to the control group received only this standard of care, whereas men randomized to the intervention group received this standard of care and participated in the Focus on the Future program.

Data Collection

Immediately following diagnosis and study enrollment, men completed a self-administered questionnaire that the lay health adviser gave them. To avoid problems associated with low literacy, questions were recorded onto a compact disc that men could play using a portable headset. Next, men completed a directly observed condom-application skills assessment. The same procedures were repeated at the follow-up assessment. Men were compensated \$40 for the first assessment and \$60 for the second.

Primary Outcome Measure

Subsequent diagnosis of an STD constituted the primary outcome. Because this publicly funded clinic was the only low-cost option for men in the entire urban catchment area, a medical-records review was used to assess this outcome.

Other Outcome Measures

Four behavioral outcomes were assessed: (1) number of female sexual partners in the past 3 months, (2) condom use during the last act of penetrative (penile–vaginal or penile–anal) sexual intercourse with a female partner, (3) frequency of unprotected penetrative sexual intercourse with a female partner in the past 3 months, and (4) proficiency in using condoms as determined through direct observation of men's ability to apply condoms to a stationary, life-size, rubber penis model. For the fourth behavioral outcome, a 9-item checklist was refined based on previous research conducted by R.J.D.²⁷ This checklist comprised "yes" versus "no" indicators completed by the lay health adviser as men demonstrated the task of condom application.

Statistical Analyses

Demographic and baseline attributes among intervention and control participants were compared via the 2-sample *t* test with unrestricted variances for quantitative variables and the χ^2 test for dichotomous variables. Demographic and baseline attributes among participants who dropped out of the study and participants who remained in the study were compared similarly.

The outcomes of reinfection at any time within the 6 months and condom use at the last sexual act preceding the 3-month follow-up were analyzed via logistic regression. Remaining outcomes were analyzed via linear regression. Univariate analyses used only intervention or control status as a predictor, and multivariable analyses used intervention or control status and several covariates.

First, a dichotomized version of monthly income was used as a covariate. Monthly income served as a proxy indicator of socioeconomic status. Despite the relatively low average income of the sample, we suspected that socioeconomic status may nonetheless be an important determinant of safer sex practices and reinfection. Second, whether men were diagnosed as having 1 versus multiple STDs at baseline served as a covariate; this provided an objective marker of past sexual risk behavior among this sample of high-risk men. Given the strong predictive power of past behavior to predict future behavior, we determined that this measure was an important covariate. Third, the corresponding baseline measure of the outcome variable (except for reinfection) was always included as a covariate. Fourth, the outcome of reinfection was considered to be confounded by condom use and condom use skills; thus, follow-up values for these 2 variables were included as covariates.

Because outcome variables (except reinfection) had missing values because of attrition, the primary data analyses (described in the previous paragraph) were performed twice: first with only complete cases (participants for whom there were no missing values) and then with multiple imputation²⁸ as implemented in the MI and MIANALYZE procedures of SAS version 9.1 (SAS Institute, Cary, North Carolina).

Finally, because there were some extreme outlying observations with respect to the first

RESEARCH AND PRACTICE

and third behavioral outcomes, sensitivity analyses were performed to complement the primary analyses. One set of sensitivity analyses entailed the removal of records with extreme outlying values, and the other involved logarithmic transformations to mitigate the outliers' influence. All analyses were conducted in SAS version 9.1.

RESULTS

Baseline Comparability of Groups

We assessed differences between men randomized to the intervention and control conditions for demographic and other key variables at baseline (Table 1). The only significant difference observed was demonstrated condom application skills, with men in the control condition scoring lower than men in the intervention condition.

Attrition

Among the 266 participants, 69 (25.9%) did not return to complete the 3-month follow-up assessment (Figure 1). However, we were still able to determine if these men acquired a subsequent STD. Comparing the 197 participants who remained in the study with the 69 who dropped out, there were no significant differences in sociodemographics or baseline attributes (Table 2). Further, the proportions of men dropping out were not significantly different between the 2 groups (intervention or control). Finally, men dropping out were not significantly different from men completing the study with respect to STD reinfection rates.

Effects of the Intervention

With 1 exception, the 5 outcome measures achieved univariate significance in both the complete case and multiple imputation analyses (Table 3). We used the complete case analysis to compare men in the control group and found that those in the intervention group were significantly less likely to acquire a subsequent STD within the 6-month follow-up interval (50.4% vs 31.9%; univariate OR estimate=0.46; 95% confidence interval [CI]=0.28, 0.76). Men in the intervention scored higher on the condom application skills assessment (mean difference estimate=3.17; 95% CI=2.81, 3.53; relative difference=

TABLE 1—Demographic and Other Baseline Attributes of Enrollees in a Risk-Reduction Intervention Evaluation of African American Men Aged 18 to 29 Years Newly Diagnosed With an STD, by Group Assignment: Southern United States, September 2004 Through May 2006

	Intervention (n=141), Mean \pm SD or No. (%)	Control (n=125), Mean \pm SD or No. (%)	P
Age, y	23.1 \pm 3.4	23.4 \pm 3.1	.68
Net monthly income > \$1000	38 (27.0)	42 (33.9) ^a	.22
Current relationship is monogamous	68 (48.6) ^b	60 (48.0)	.92
Current relationship is not monogamous	59 (42.1) ^b	54 (43.2)	.86
Previously taught how to use condoms	127 (90.1)	110 (88.7) ^c	.72
Multiple STDs diagnosed at baseline	41 (29.3) ^b	27 (21.4) ^d	.13
Baseline diagnosis included chlamydia	55 (39.0)	50 (40.3) ^e	.83
Baseline diagnosis included gonorrhea	87 (61.7)	76 (61.3) ^e	.94
Demonstrated condom use skills	3.83 \pm 2.24 ^f	2.60 \pm 1.67 ^f	<.001
Number of female sexual partners, past 3 months ^g	2.91 \pm 2.73	3.08 \pm 2.43	.60
Unprotected acts of sexual intercourse, past 3 months ^h	16.0 \pm 47.3 ^h	14.3 \pm 21.0 ^h	.72
Used condoms last time sexual intercourse occurred	74 (52.5)	53 (42.4)	.10

Note. STD = sexually transmitted disease. All results pertain to men who self-identified as heterosexual.

^aOut of 124 participants with data for variable for which not all participants had data.

^bOut of 140 participants with data for variable for which not all participants had data.

^cOut of 131 participants with data for variable for which not all participants had data.

^dOut of 112 participants with data for variable for which not all participants had data.

^eMedian and interquartile range were 3.0 and 1.0, respectively, for the control group and 2.0 and 1.0, respectively, for the intervention group. Excluding 4 participants in the control group and 3 in the intervention group who claimed more than 100 unprotected acts of sexual intercourse at baseline or follow-up or who claimed more than 25 partners at baseline or follow-up, mean and standard deviation are 3.02 and 2.29 for the control group and 2.70 and 1.71 for the intervention group.

^fMedian and interquartile range were 6.5 and 15.0, respectively, for the control group and 4.0 and 13.0, respectively, for the intervention group. Excluding 4 participants in the control group and 3 in the intervention group who claimed more than 100 unprotected acts of sexual intercourse at baseline or follow-up or who claimed more than 25 partners at baseline or follow-up, mean and standard deviation are 13.51 and 18.08 for the control group and 11.75 and 19.44 for the intervention group.

^gOut of 123 participants with data for variable for which not all participants had data.

^hOut of 114 participants with data for variable for which not all participants had data.

+145%). Also, men in the intervention reported significantly fewer sexual partners (2.06 vs 4.15, mean difference estimate=-2.10; 95% CI=-3.22, -0.98; relative difference=-51%), significantly fewer acts of unprotected sex (12.3 vs 29.4; mean difference estimate=-17.1; 95% CI=-33.6, -0.5; relative difference=-58%) and were significantly more likely to report using condoms during their last episode of sexual intercourse (72.4% vs 53.9%; univariate OR estimate=2.25; 95% CI=1.24, 4.07). Of note, these results remained relatively unchanged with multiple imputation, with the exception of unprotected sex, which narrowly missed significance.

Multivariable analysis yielded more robust intervention effects on subsequent STD

acquisition (Table 3). Men randomized to the intervention had about 68% lower odds of acquiring a subsequent STD (adjusted OR estimate=0.32; 95% CI=0.12, 0.86). Furthermore, findings from the multiple imputation analyses indicated that men in the intervention group had a higher score on the condom application assessment (mean difference estimate=3.19; 95% CI=2.81, 3.56), had fewer female sexual partners (mean difference estimate=-1.87; 95% CI=-2.96, -0.79), and were more likely to report condom use at last sexual episode (adjusted OR estimate=2.06; 95% CI=1.07, 3.96). One outcome did not achieve statistical significance in multivariable analyses, namely, number of episodes of unprotected sex in the past 90 days.

TABLE 2—Differences Between Men Completing Follow-up Assessments and Those Not Completing Follow-up Assessments in a Risk-Reduction Intervention Evaluation of African American Men Aged 18 to 29 Years Newly Diagnosed With an STD: Southern United States, September 2004 Through May 2006

	Stayed in (n=157), Mean ± SD or No. (%)	Dropped out (n=69), Mean ± SD or No. (%)	P
Age, y	23.4 ± 3.3	23.0 ± 3.3	.67
Net monthly income >\$1000	61 (31.1) ^a	19 (27.5)	.58
Current relationship is monogamous	88 (44.9) ^a	40 (58.0)	.06
Current relationship is not monogamous	88 (44.9) ^a	25 (36.2)	.21
Previously taught how to use condoms	179 (91.3) ^a	58 (84.1)	.00
Multiple STDs diagnosed at baseline	52 (26.7) ^b	16 (23.9) ^c	.65
Baseline diagnosis included chlamydia	73 (37.2) ^a	32 (46.4)	.18
Baseline diagnosis included gonorrhea	122 (62.2) ^a	41 (59.4)	.68
Demonstrated condom use skills	3.39 ± 2.16 ^d	2.90 ± 1.84 ^e	.08
Number of female sexual partners, past 3 months	3.13 ± 2.81	2.61 ± 1.78	.08
Unprotected acts of sexual intercourse, past 3 months	16.6 ± 42.0 ^f	11.6 ± 17.9 ^g	.21
Used condoms last time sexual intercourse occurred	90 (45.7)	37 (53.6)	.26
Assigned to intervention group	105 (53.3)	36 (52.2)	.87
Reinfection	78 (39.6)	30 (43.5)	.57

Note. STD = sexually transmitted disease. All results pertain to men who self-identified as heterosexual.

^aOut of 196 participants with data for variable for which not all participants had data.

^bOut of 195 participants with data for variable for which not all participants had data.

^cOut of 67 participants with data for variable for which not all participants had data.

^dOut of 181 participants with data for variable for which not all participants had data.

^eOut of 62 participants with data for variable for which not all participants had data.

^fOut of 171 participants with data for variable for which not all participants had data.

^gOut of 66 participants with data for variable for which not all participants had data.

(mean difference estimate = -11.9; 95% CI = -31.3, 7.5).

Both sets of sensitivity analyses preserved the conclusions from the primary analyses that men in the intervention had significantly fewer female sexual partners than did men in the control group (Table 4). The sensitivity analyses involving logarithmically transformed number of unprotected acts preserved the mixed conclusions from the primary analyses, in particular statistical significance with univariate complete cases but lack thereof with multivariable multiple imputation. The sensitivity analyses entailing removal of records disagreed with the primary analyses only in that statistical significance was not achieved with univariate complete cases.

DISCUSSION

The findings of our study clearly show the efficacy of this brief clinic-based intervention

for young heterosexual African American men at risk of STD or HIV acquisition in terms of lower rates of subsequent STD acquisition, reduction in STD- or HIV-associated sexual behaviors, and improvement in condom application skills. The practical value of the findings is paramount, because they demonstrate marked reductions in STD incidence without the use of lengthy, resource-intensive programs. Moreover, the reduction in incidence over the 6-month postintervention period produced a larger effect size than did those observed in previous trials of brief, clinic-based interventions for African American men.^{14-15,25} The observed protective value relative to subsequent infection was also greater than that derived from a recent meta-analysis of clinic-based STD prevention programs (effect size: .32 vs .85).²⁶ The treatment advantage may be attributable to multiple factors, such as tailoring to a relatively homogeneous population of men, intervening only with men who reported previous

experience in using condoms, and the use of a lay health adviser model. The effect may also be partially explained by the observation that men randomized to the intervention group reported significantly fewer sexual partners at follow-up (an unexpected finding).

In an era when the Centers for Disease Control and Prevention has stated, "In the United States, the HIV/AIDS epidemic is a health crisis for African Americans,"²⁰ the findings offer one approach to addressing this marked racial disparity. The findings also suggest a protective benefit for men's female sexual partners, who are typically African American. Because power imbalances in heterosexual relationships may favor males, intervention with African American men may also protect African American women against HIV or other STD acquisition.³¹ Indirect effects may also occur by lowering the prevalence of STDs within African American women's sexual networks.³² In turn, reductions in STD prevalence and incidence among African American men and women may mitigate the racial disparity in HIV/AIDS prevalence and incidence by removing STDs as a cofactor.³³⁻³⁶

The brief nature of the intervention also warrants comment. Implementation of small-group interventions or multisession interventions may not be optimally efficient in STD clinics. Because clinics are designed to provide patients with a series of one-to-one interactions with clinical staff, triaging young African American men newly diagnosed with an STD into an additional one-to-one session with a lay health adviser is a relatively simple expansion of the existing clinical paradigm. In addition, the use of a lay health adviser to implement the intervention may be a cost-effective strategy. The relative ease of implementation and higher cost-effectiveness may address the problem of effectively translating evidence-based research into practice.³⁷⁻⁴⁰

Limitations

There are a number of limitations to the study. First, as is true for all sexuality research, findings are limited by the validity of retrospective self-report, although this limitation is somewhat mitigated by the medical-records review findings pertaining to STD reinfection. Further, as is typically true for STD or HIV behavioral randomized trials, the use of a nonprobability sample limits the ability to generalize the findings to young heterosexual

TABLE 3—Intervention Versus Control Group Outcomes Assessed 3 Months Postintervention in a Risk-Reduction Intervention Evaluation of African American Men Aged 18 to 29 Years Newly Diagnosed With an STD: Southern United States, September 2004 Through May 2006

	Intervention (n = 141), No. (%) Mean \pm SD (No.)	Control (n = 125), No. (%) Mean \pm SD (No.)	Univariate Measure of Effect		Multivariable Measure of Effect	
			OR Estimate (95% CI)	P	AOR Estimate (95% CI)	P
Reinfection ^a	45 (31.0)	63 (50.4)	0.46 (0.28, 0.76)	.002	0.32 (0.12, 0.86)	.02
Condom use skills ^{b,c}	5.35 \pm 1.21 (104)	2.18 \pm 1.30 (91)	3.17 (2.81, 3.53)	<.001	3.21 (2.80, 3.63)	<.001
Condom use skills ^{b,c}			3.17 (2.79, 3.54)	<.001	3.19 (2.81, 3.56)	<.001
Partners in past 3 months ^{d,e}	2.06 \pm 1.65 (105)	4.35 \pm 5.59 (91)	-2.10 (-3.22, -0.98)	<.001	-2.09 (-3.18, -0.99)	<.001
Partners in past 3 months ^{d,e}			-1.85 (-2.97, -0.74)	.002	-1.87 (-2.96, -0.79)	.001
Unprotected acts of sexual intercourse, past 3 months ^{f,g,h}	13.3 \pm 25.8 (99)	29.4 \pm 79.3 (84)	-17.1 (-33.6, -0.5)	.045	-13.4 (-35.6, 8.8)	.23
Unprotected acts of sexual intercourse, past 3 months ^{f,g,h}			-14.9 (-31.0, 1.3)	.07	-11.9 (-31.3, 7.5)	.21
Condom used at last act of sexual intercourse ^{i,j}	76 (72.4)	49 (53.9)	2.25 (1.24, 4.07)	.008	2.20 (1.08, 4.48)	.03
Condom used at last act of sexual intercourse ^{i,j}			2.27 (1.23, 4.19)	.009	2.06 (1.07, 3.98)	.03

Note. STD = sexually transmitted infection. For quantitative variables, the measure of effect is a mean difference (expected score for intervention participant minus expected score for control participant, adjusted in the multivariable analyses for covariates specified below) and was estimated by linear regression. For dichotomous variables, the measure of effect is an odds ratio (odds in favor for intervention participant divided by odds in favor for control participant, adjusted in the multivariable analyses for covariates specified below) and was estimated by logistic regression. Complete case analysis used only those participants for whom there were no missing values on variables in the regression model. Multiple imputation analyses used all participants. All results pertain to men who self-identified as heterosexual. For variables on which not all participants had data, the numbers in parentheses identify how many participants did have data.

^aMultivariable analysis controls for monthly income level, having 1 vs 2 or more STDs diagnosed at study enrollment (mixed STDs), follow-up values for condom skills, and follow-up values for condom use at last act of sexual intercourse.

^bMultivariable analysis controls for income, mixed STDs, and the baseline value of condom skills.

^cComplete case analysis.

^dMultiple imputation.

^eMedian and interquartile range are 2.0 and 3.0, respectively, for the control group and 2.0 and 2.0, respectively, for the intervention group. Excluding 4 participants in the control group and 3 in the intervention group who claimed more than 100 unprotected acts of sexual intercourse at baseline or follow-up or who claimed more than 25 partners at baseline or follow-up, mean and standard deviation are 3.52 and 4.04 for the control group and 2.00 and 1.47 for the intervention group.

^fMultivariable analysis controls for income, mixed STDs, and the baseline value for number of female sexual partners in the past 3 months.

^gMedian and interquartile range are 4.5 and 21.0, respectively, for the control group and 1.0 and 11.0, respectively, for the intervention group. Excluding 4 participants in the control group and 3 in the intervention group who claimed more than 100 unprotected acts of sexual intercourse at baseline or follow-up or who claimed more than 25 partners at baseline or follow-up, mean and standard deviation are 17.24 and 28.77 for the control group and 11.12 and 21.96 for the intervention group.

^hMultivariable analysis controls for income, mixed STDs, and baseline values for skill, unprotected sex, and condom use at last act of sexual intercourse.

ⁱMultivariable analysis controls for income, mixed STDs, and the baseline values for skills and condom use at last act of sexual intercourse.

African American men newly diagnosed with an STD in other clinics of the United States. Another concern was the attrition rate. That 26% of the enrolled men did not return for the follow-up assessment (despite potential compensation of \$60 and lack of employment) suggests that these men may experience instability in their daily lives, perhaps as a consequence of poverty and discrimination. However, differences between dropouts and men completing the study were not observed, and attrition was not a problem relative to the primary study outcome, because we were able to collect these data by medical record review.

Although urine-based polymerase chain reaction testing for subsequent STD acquisition may have been a more rigorous approach, the use of archival data is not uncommon, even in large-scale trials that employ polymerase chain

reaction testing.⁴¹ Although we could not ascertain whether men were diagnosed with subsequent STD infections elsewhere with this study design, options for alternative sources of clinical care were limited and most likely would be comparably distributed between study groups. The relatively short duration of the follow-up period pertaining to behavioral outcomes is also a limitation, given that maintenance of intervention effects could not be assessed over longer periods. Also noteworthy is that the program was specifically designed to improve the quality, correctness, and frequency of use among men recently using condoms, thereby excluding those entirely rejecting condom use. This planning decision was made based on our awareness that a 40-minute intervention is unlikely to change behaviors of men who never use condoms. However, a complete lack of condom use ("never

use") among young African American men is not the norm; nationally representative data indicate that fewer than 1 of every 6 young African American men reported never using condoms during a 12-month recall period.⁴²

It must also be acknowledged that the use of multiple raters would have allowed us to establish intrarater reliability for the measure of demonstrated condom application skills; this limitation should be considered in the larger context of the study findings (that is, the "skills variable" was only 1 of several supporting outcomes). Finally, the study design cannot determine what portion of the observed effect was attributable to the provision of condoms to men in a variety of sizes and brands. This is less a limitation than a product of the intervention's purpose of increasing men's pleasure in using condoms by providing a range of options.

TABLE 4—Results of Sensitivity Analyses for Selected Outcomes Measures Used to Compare Men Randomized to the Intervention Versus Control Groups in a Risk-Reduction Intervention Evaluation of African American Men Aged 18 to 29 Years Newly Diagnosed With an STD: Southern United States, September 2004 Through May 2006

	Univariate		Multivariable	
	Measure of Effect, Estimate (95% CI)	P	Measure of Effect, Estimate (95% CI)	P
Observations with extreme outlying values excluded^a				
Partners in past 3 months ^{cd}	-1.52 (-2.37, -0.67)	<.001	-1.37 (-2.18, -0.55)	.001
Partners in past 3 months ^{de}	-1.28 (-2.14, -0.43)	.004	-1.19 (-2.01, -0.36)	.006
Unprotected acts of sexual intercourse, past 3 months ^{cd}	-6.1 (-13.7, 1.4)	.11	-1.0 (-9.8, 7.9)	.83
Unprotected acts of sexual intercourse, past 3 months ^{de}	-4.6 (-12.0, 2.8)	.21	-3.3 (-11.9, 5.4)	.43
Response variable transformed logarithmically to reduce the impact of outlying values^b				
Partners in past 3 months ^{cd}	-0.33 (-0.49, -0.17)	<.001	-0.32 (-0.47, -0.17)	<.001
Partners in past 3 months ^{de}	-0.29 (-0.48, -0.10)	.004	-0.29 (-0.48, -0.11)	.004
Unprotected acts of sexual intercourse, past 3 months ^{cd}	-0.53 (-1.00, -0.07)	.05	-0.32 (-0.88, 0.24)	.26
Unprotected acts of sexual intercourse, past 3 months ^{de}	-0.50 (-0.99, 0.00)	.051	-0.42 (-1.00, 0.17)	.15

Note. STD = sexually transmitted disease.

^aFour participants in the control group and 3 participants in the intervention group were excluded who claimed more than 100 unprotected acts at baseline or follow-up or who claimed more than 25 partners at baseline or follow-up.

^bThe transformed value is the natural logarithm of 1 plus the original value. Point and 95% confidence interval estimates for measures of effect are not directly comparable to those obtained in the absence of a logarithmic transformation; the main feature of interest is whether the P value is in qualitative agreement with the corresponding P value in Table 2 (i.e., both <.05 or both >.05).

^cMultivariable analysis controls for income, mixed STDs, and the baseline value for number of female sexual partners in the past 3 months.

^dMultivariable analysis controls for income, mixed STDs, and baseline values for skill, unprotected sexual intercourse, and condom use at last act of sexual intercourse.

Conclusions

The weight of evidence suggests that a brief, clinic-based intervention may be efficacious in reducing subsequent acquisition of STDs among young heterosexual African American men newly diagnosed with an STD. The use of a lay health advisor may help keep intervention costs low, thereby enabling program dissemination in resource-poor environments. As the United States⁴⁰ and other countries⁴¹ implement clinic-based counseling in settings that provide STD screening, the option of postdiagnostic counseling conducted by a lay health advisor may prove useful. Adaptation and application of the program in geographic areas (domestically and globally) experiencing epidemics of STD or HIV may be worth pursuing in future studies. ■

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Contributors

R.A. Crosby originated the study, acquired funding for the study, developed the study protocol, provided oversight for the study, authored the article, and performed revisions of the article. R.J. DiClemente originated the study, developed the study protocol, provided consultation during the data collection phase of the study, and participated in authoring and performing revisions of the article. R. Cherrigo provided oversight of data management and cleaning, analyzed the data, interpreted the findings, and participated in authoring and performing revisions of the article. G. Snow implemented all study protocols for recruitment, data collection, randomization, intervention, retention, and follow-up assessments. A. Trostman provided administrative support for the study, access to the sample, and guidance pertaining to the intervention.

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Human Participant Protection

Study procedures were approved by the Office of Research Integrity at the University of Kentucky. The trial was registered with the clinicaltrials.gov protocol registration system (No. NCT00314028) and monitored by a data safety monitoring board.

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ORIGINAL ARTICLE

If the condom fits, wear it: a qualitative study of young African-American men

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Objective: To extend the current knowledge base pertaining to condom failure among young African-American men by assessing their experiences with male condom use.

Methods: Qualitative assessments were conducted with 19 African-American men (aged 18-29 years) who had just been diagnosed with an STI and reported using condoms in the previous 3 months.

Results: Five categories were identified from the data. These categories pertained to: (1) the "fit and feel" of condoms; (2) condom brand and size; (3) application problems; (4) availability of condoms and lubricants; and (5) commitment to condom use. Common themes included reasons why men believed condoms would break or slip off during sex. Comfort problems, including tightly fitting condoms and condoms drying out during intercourse, were mentioned frequently. Condom associated erection problems were often described. Many men also noted that condom use reduced the level of sexual satisfaction for their female partners. Men noted that finding the right kind of condom was not always easy and it became apparent during the interviews that men typically did not acquire lubrication to add to condoms. Despite their expressed problems with using condoms, men were, none the less, typically emphatic that condom use is an important part of their protective behaviour against STIs.

Conclusion: Men were highly motivated to use condoms; however, they experienced a broad range of problems with condom use. With the exception of losing the sensation of skin to skin contact, the vast majority of these problems may be amenable to behavioural interventions.

Previous studies have investigated errors and problems that may occur when young men use condoms.¹⁻⁴ These studies have focused on two critical events that lead to condom failure: breakage and slippage. Only two studies have sampled men from a high risk population (men were sampled from an STI clinic).^{2,5} One study enrolled men (18-54 years) attending STI clinics in Sydney, Australia. The study found that breakage and slippage were particularly common for a small number of men.⁶ The other enrolled primarily African-American men (15-29 years) from a US STI clinic and found that 78% of those diagnosed with gonorrhoea reported at least one of five events during the previous month (started sex without condom, removed condom before sex was over, flipped the condom over, breakage, or slippage). Among men attending the clinic but not diagnosed with an STI, 74% reported at least one of these events.⁷

Two observations regarding these studies are noteworthy. Firstly, each brought attention to a neglected aspect of STI prevention (that is, the value of correcting user errors). However, the initial findings have not been subsequently investigated to gain a more in-depth understanding. Clearly, identifying common user errors and problems among men is an important task, but one that does not currently lend itself entirely to the use of closed response data collection instruments. Secondly, only one study² sampled men from a priority population for STI prevention in the United States. Evidence clearly suggests that African-American men (especially younger men) are particularly likely to be infected by HIV.¹⁻⁴ Of interest, a nationally representative US study found that African-American men were four to five times more likely to experience condom slippage and breakage than men of other races.⁸

The purpose of this study was to extend the current knowledge base pertaining to condom failure among young African-American men by qualitatively assessing experiences

using the male condom. Because young African-American men are disproportionately infected by STIs, we selected this population for initial study. Further, we sampled men newly diagnosed with an STI; thus, the findings may be useful in the development of clinic based prevention efforts.

METHODS

Study sample

From June through August 2003, 19 men attending an STI clinic were enrolled. Men were recruited during days and times that were arbitrarily selected. Eligibility criteria were: (1) African-American, (2) 18-29 years of age, (3) diagnosis (confirmed or presumptive) of an STI during the clinic visit, (4) reported they were not knowingly HIV positive, and (5) used a condom with a female partner in the past 3 months. Before discharge from the clinic, medical staff determined eligibility based on the first three requirements. Twenty men were referred to a male interviewer who established eligibility based on the latter two requirements. One man stated that he had not used condoms in the past 3 months. All of the remaining 19 eligible men volunteered to participate and provided written informed consent. The institutional review board at Emory University approved the study protocol. A \$30 incentive was provided.

Data collection

Interviews occurred in a private room adjacent to the examination rooms. The interviewer (RC) informed men that he wanted to "find out what kind of problems guys experience when they use condoms." Men were asked to describe any of the problems they may have experienced. The interviewer used prompts (as sparingly as possible) to help men think about problems that may have occurred. Prompts were simple phrases such as, "any problems putting the condom on?" or "do condoms ever slip off during sex?" Prompts were designed to normalise user errors and

problems thereby potentially encouraging men to accurately disclose user related issues. Also, when men provided answers that were unclear or complex, the interviewer asked for clarification and (in many instances) summarised the response for men to verify. Interviews lasted 15–35 minutes, were recorded on audiotape, and were professionally transcribed.

Data analysis

Data were sorted into categories by the first author (RC). The second author (CG) conducted an independent and concurrent review of the data. The identified categories were then verified by the remaining authors (WY and SS).

RESULTS

Five categories were identified: (1) "fit and feel"; (2) brand and size; (3) application problems; (4) availability issues; and (5) commitment to use. Themes (typically focusing on negative events) relating to these categories are presented below.

Category 1: "fit and feel"

One commonly reported problem was that condoms dry out. Men described this problem from their perspective and their sex partners' perspectives. Nearly all of the men describing dryness problems suggested that the issue was primarily a comfort problem for their partners as opposed to themselves (one exception to this was two men who noted that unlubricated condoms typically "pinch" their pubic hairs, causing extreme discomfort). One man astutely observed that a dry condom remains stationary on him while it is constantly moving in and out of the woman's vagina. Men were aware that women disliked the sensation of intercourse when condoms became dry. As one man said, "I'm the type of person where if you're not feeling it, I'm not feeling it." Another man said that his female partners may "grin and bear it" when condoms dry out but even if sex continues "dimaxing can be difficult under those circumstances."

Men related several strategies used to rectify dryness. For example, several men said they would simply take the condom off (often at the woman's request) and continue sex. One man noted that he would "switch out" one condom for another (a fresh one) during any given session of sexual intercourse. He (like a few others) noted that condoms typically don't dry out until sex has lasted 20 minutes or more. He described recently "switching out" condoms three times during a single sexual encounter and then stated his current infection resulted from an occasion where he had taken off a dry condom and continued sex without another condom ("that's why I'm here today—I didn't have the sense to put another one on").

Men were keenly aware that levels of vaginal secretions vary widely among women and they generally stated that dry condoms are more of an issue when secretions "dry up." This awareness that sex could become better or worse as a function of two factors (vaginal secretion and the amount of condom lubrication) was common.

Some men added lubrication to their condoms. Several said they use their saliva (as one said, "I kiss it") and many mentioned their occasional use of KY jelly. One man was very committed to using baby oil: "It (baby oil) suits me better"—"It creates more slip and slide." He noted that the baby oil helps him keep his erection. Others noted they would use any kind of lotion they could find to lubricate condoms. As one man stated, "If it dries out I'll usually put lotion on whatever I can find."

Several suggested that stopping sex to add lubrication was a hassle and could ruin the mood. Yet, men also said that sex

with a dry condom is not as pleasurable and many believed that the dryness was responsible for breakage.

Category 2: condom brand and size

A common theme was that finding the right condom promotes improved use. As one man stated, "Condoms rarely break or slip off once you find the kind that suits you ... everybody has that one (brand) that they like best ... if you're gonna use em' make sure you're comfortable." One man emphatically stated, "If the condom is not comfortable when you start, it will probably break before you climax."

Men reported that some brands/sizes of condoms cause discomfort and erection problems. These problems were typified by one man (diagnosed with syphilis) who described his problem with condoms by saying, "my penis can't breathe" and another man who said, "they be chokin' you." The first man, like many other men in the study, noted that most brands and sizes fit too tightly and this can ruin sex. Men also commonly suggested that tight fitting condoms break ("pop"). With few exceptions, men reporting discomfort said that condoms from the clinic are too tight. They noted that an expensive brand (Magnum) is very comfortable and does not pop.

Loss of erection from tight fitting condoms was common. One man said that 90% of the reason that he sometimes does not use condoms is to avoid erection problems. Several stated that erection problems, caused by condoms, could be so frustrating that they would (despite knowing better) take off the condom and continue sex. Men attributing erection problems to condom use often described pain (from the tight fit), pinching (of the pubic hairs by the rim), and their fears of breakage with tight fitting condoms (as one man said, "small condoms pop almost every time"). Again, men noted that selecting the right brand was the key to avoiding these problems.

Men commonly blamed tight fitting condoms for slippage. One man stated that condoms only slip off when they are too small. Another stated, "the ones that are too tight are the ones most likely to ride up (and slip off)." Most men reporting problems with tightness noted that the unrolled condom did not cover the length of the penis. One stated that he got genital warts because the condom did not cover part of his penis. Some indicated that condoms would slip off as a result of being only partially unrolled. A few also said that they don't always unroll the condom all the way because doing so pinches their pubic hairs. Of interest, one man stated that he was "trapped between sizes" and described how regular condoms are too tight, but the larger condoms slip off. Finally, several men noted at least one past experience when a condom had slipped off during intercourse and remained inside a partner's vagina. Men described this event vividly and talked about the condom getting "lost" inside the vagina, where it was not easy to retrieve. In fact, one man talked about he and his partner going to the emergency room to have a condom retrieved.

Interestingly, one man suggested that it was very important to "find the right condom for the right female." He went on to note that some of his partners liked Magnums and some liked Trojans. He noted he had to keep these preferences straight in order to please "his women."

Category 3: application and use problems

The most common application error that men described in conjunction with breakage was trapped air. As one man said, "I don't pay attention to that (air in the condom)—I didn't even know you was supposed to." Another described his "trick" for expelling air; he would work the air pocket down to the rim and lift the rim just enough to let the air out. Some stated that tight fitting condoms were especially likely to trap

air and one specifically noted a lack of condoms breakage since learning to expel trapped air.

Most men stated they did not have problems putting condoms on. However, further discussion suggested that men had unknowingly been making application errors. One man stated: "I just slap em' on." Nearly all of the men noted they would often place the condom on the penis with the wrong side facing up (this prevents proper unrolling). Although a few knew that the condom should then be discarded (because of pre-ejaculate), most said they turned the condom over and unrolled it.

Some men described the types of lubricants they used on condoms and freely included Vaseline and other oil based substances as valid options—not making a distinction between these and water based lubricants. Men also noted (without apparent concern) that condom packages had been opened with teeth and sharp fingernails.

A majority described at least one example of having the condom break and frequently linked breakage with application errors. Several stated that breakage had been a common occurrence and others believed their current STI resulted from breakage. Men typically said that they had fewer condoms "pop" as they became more experienced using condoms. One was particularly poignant, noting that when you are younger you are thinking about having sex, not how to use the condom. He suggested that experience is typically the teacher: "You're not gonna go out and ask someone, 'hey man how do you put on a condom'—you just take it on yourself to (learn)." Another said, "they used to break all of the time because I was inexperienced ... I had to learn how to put one on—I learned by reading the package." Indeed, a majority noted learning on their own, through friends, or by reading packages. None the less, several had learned how to apply condoms in highschool health classes (many recalled this vividly).

Breakage was common. Many men noted they could "feel it" when the condom broke and said they would immediately stop sex. One man said that he felt it break and he stopped sex then had another condom on within 10 seconds (he believed this caused his current chlamydia infection). Another told about his efforts to stop sex after breakage, but his female partner only began thrusting harder. Conversely, other men stated they often continued having sex after breakage, despite knowing better: "I kept going, but I didn't ejaculate"; another said, "I can feel the difference when it breaks ... if it's with a regular partner I'll usually keep going." Whether men stopped or continued was often described as a function of whether the female partner was known and trusted.

Category 4: availability of condom and lubricants

Although men often expressed clear preferences for certain brands, they also said these brands might not be easily accessible or affordable. The comments of one man were typical: "Dry condoms are bad (implying they break); I've bought them by mistake—you have to use them." This comment is informative in that the man (like others in the study) was implying that once you acquire a condom you should use it. This may be a financial issue (that is, not to waste a condom) or an availability issue. Several men noted that they would obtain condoms from a clinic (despite problems with fit) simply because they were free. Others suggested that cost is less important than availability and described past problems finding well lubricated (and properly fitting) condoms. One man summarised the availability issue nicely by saying, "I may get stuck buying those old dry rubber ones." A quote from one captures sentiments expressed by many, "Late at night you don't have time to look around—you use what you can get."

A few noted that lubricants are not easy to carry around and that while they preferred to use a water based lubricant with a condom, this was not always available.

Category 5: commitment to condom use

Despite problems with "fit," application, and availability, men commonly endorsed condom use as an essential practice in their lives. A comment from one was typical: "I'm not a fan of condoms, but I have to use them to keep from getting STDs." Another remarked: "I try to use them (condoms) because I hate coming here." One noted that he was already at a disadvantage (relative to life expectancy) because he is African-American and that using condoms was necessary to him as a means of avoiding STIs that could make his life even shorter: "Having HIV puts an expiration date on you."

While commitment was strong, men described a number of problems that interfered with intentions. Men noted that they could become too aroused to think clearly enough to use a condom. One man stated, "Grinding before sex is a problem because you forget and slip it in. It is possible to stop and put a condom on but unless she insists, it may not happen—this is why I got my STD." Another noted that being drunk or high was likely to make him "want sex with my lady so bad" and that if she didn't care about using a condom then why should he care. Another (noting erection problems from condoms) said, "I'm not really feeling the person." He repeatedly suggested that he had to "bear down" and mentally discipline himself to use condoms. His comment and experience of condom use is typical of men who suggested that condom use is usually their intent but not always their behaviour.

Despite temptations not to use condoms, many expressed intention to use condoms on every occasion of sexual intercourse, except with a "main" partner (this was seemingly linked to strong fears of getting an STI from an "other" partner). The comments of one man are especially worth noting: "Once I do not use a condom with a girl, then we work into not using them at all." He subsequently suggested that he (or his partners) would feel that there was nothing left to lose by not using condoms.

DISCUSSION

This qualitative study of men newly diagnosed with an STI, produced unique data that provide multiple insights about condom failure. To avoid breakage and slippage—for example, men may have a strong brand and size preference for condoms. Men believed that many negative events they described (including slippage and erection problems) were related to lack of adequate lubrication. Application errors were common. Indeed, men frequently suggested that negative events might be caused by these errors.

Men were generally dedicated to using condoms despite difficulties (for example, erection problems, discomfort, dryness, loss of pleasure). Men were keenly aware of their vulnerability to STIs and they did not mitigate the value of condom use. Yet, men had developed personalised standards for using condoms and some of these practices may be problematic for disease prevention.

A key strength of the qualitative design is the rich narrative. The relative importance for two of the factors (how well the condom fit and how well it felt during sex) was unanticipated given research findings from previous studies.^{1,2} Yet, these factors appear to be critically important with respect to events that precipitate condom failure. Indeed, the men seemed to be saying that condoms are important and should be used, but they expressed a desire to have condoms fit well and have adequate lubrication. The common theme that condoms are important is not surprising given the realities of high STI prevalence among young

Key messages

- Men typically suggested that tight fitting condoms led to erection difficulties, slippage, and breakage. Although most men were aware that larger condoms could be purchased, they typically described problems with accessibility and cost. STI clinics might benefit men by providing a wide selection of various brands and sizes of condoms.
- Problems caused by the inadequate lubrication of condoms were frequently mentioned by men in the study. The problems described (erection difficulties, slippage, and breakage) may easily precipitate user error (for example, taking the condom off) or condom failure that leads to the acquisition (or transmission) of an STI. Providing men with instruction and adequate supplies of lubrication may be beneficial.
- Despite their description of various errors and problems associated with using condoms, men in this study were generally committed to using condoms. This commitment is positive and could form the basis for clinic based counselling protocols designed to help men refine their condom use skills.

African-American men; however, we cannot rule out the possibility of a self presentation bias given these men were newly diagnosed with an STI (and were being interviewed directly afterwards).

Men's responses often suggested that achieving sexual pleasure was at odds with their desire to prevent acquisition of STIs. Although issues pertaining to loss of sensation could be reduced (for example, acquisition of correctly fitting and well lubricated condoms), the overall loss of skin to skin contact was clearly a concern. STI clinic practitioners could address these issues in the process of counselling their young African-American clients. However, further research is needed to determine how couples resolve these issues and whether one partner is more insistent on using condoms.

The findings also suggest that clinic based programmes could help men avoid problems with condom use. For example, breakage, slippage, and erection problems might be avoided by providing men with a wide selection of condoms and encouraging men to find a brand and size that fits and has adequate (and lasting) lubrication. Among low income clients, clinics may benefit men (thereby reducing STI transmission) by allowing them to return and replenish their supply of a favoured condom. STI clinics could also offer men supplies of lubrication (in pocket sized packages). One to one instruction may also be important as a strategy to help men apply condoms more efficiently. Providing this instruction immediately after men are diagnosed with an STI may be particularly effective as this opportunity represents a "teachable moment."

Limitations and further research

Findings based on this purposive sample should not be assumed to fairly represent the larger population of young African-American men newly diagnosed with an STD. Thus,

while intriguing, the current findings should none the less be considered exploratory, especially given the possibility that men have exaggerated their commitment to condom use (that is, self presentation bias) and shifted the blame for condom failure to the product rather than user errors. Further research should build on the study findings to construct structured qualitative interviews that specifically collect event specific data (in a context that avoids self presentation bias).

CONCLUSIONS

Within the limitations of this qualitative study, findings suggest that men in this sample were highly motivated to use condoms, even before their current STI. Despite using condoms, men none the less acquired an STI, possibly due to user error. As opposed to product failure (an irresolvable problem), forms of user failure may be amenable to behavioural interventions. From a policy perspective, STI clinics may benefit men by providing a variety (that is, different brands and sizes) of free condoms and easy to carry packages of lubrication. From a patient education perspective, further research is needed to determine if men can benefit from a brief, interactive, education programme designed to rectify practices that may otherwise lead to user failure or the discontinuation of condom use.

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Appendix C: Agency Fit and Capacity Checklist

Use the checklist below to keep track of what steps still needs to be taken before your agency is ready to implement the intervention. If other parties need to be involved to accomplish these goals you can also use this checklist to keep track of their progress as well.

Statement	Agree	Disagree
FOF meets the purpose, goals, and objectives of my agency.		
FOF meets the needs of the target population that my agency serves.		
My agency can secure adequate funding to successfully provide the intervention to clients.		
My agency has a history of working with the target population and has access to the target population from our existing services. (See Appendix K for a tool to determine the approximate number of eligible clients your clinic sees each day.)		
My agency is ready to implement the intervention. (See “Agency Readiness to Implement the Intervention”.)		
My agency is able to secure “buy-in” for the intervention from key staff in my agency and supporting agencies in the community, as well as from other relevant stakeholders.		
My agency has organizational support to develop and sustain FOF .		
My agency has the policies and procedures in place to support this intervention.		

Appendix D: Stakeholder Checklist

The stakeholder's checklist contains those items the champion can use to convince the stakeholders that **FOF** is an intervention that your agency can and should implement because it meets the needs of the community your agency serves.

1. Identify your stakeholders

- Your agency's Board of Directors/Executive Board
 - Staff members from your agency who will have a role in the operation of the intervention
 - i. Administrators who will obtain support
 - ii. Supervisors who will monitor the intervention
 - iii. Staff who will interact with participants at any level
 - Local agencies from which you could recruit PHAs
 - iv. Agencies offering support groups for African American men ages 18-29 who have sex with women
 - v. Health care providers and mental health professionals serving African American men ages 18-29 who have sex with women
 - vi. Social service agencies reaching African American men ages 18-29 who have sex with women
 - vii. Organizations of African American men ages 18-29 who have sex with women and organizations that may have members who are African American men ages 18-29 who have sex with women
 - Organizations which could provide assistance or other resources
 - viii. Merchants for incentives, refreshments
 - ix. Agencies that can provide a venue for the intervention
 - x. Agencies that can provide transportation
 - xi. Advisory board to help tailor intervention
 - xii. Other collaborating agencies to provide information for resource packets
 - Agencies with which your agency needs to maintain good community or professional relations
 - xiii. State and local health department
 - xiv. Local medical and mental health associations
 - xv. Sexually transmitted disease (STD) clinics and services
 - xvi. Community-based organizations
 - xvii. Your funding source(s)
 - xviii. Others
- ### 2.
- Getting stakeholders informed, supportive, and involved
 - Getting them informed about the intervention
 - i. Decide in advance what specific roles you want each stakeholder to play.
Who will you ask to
 - 1. provide financial support,

2. refer African American men ages 18-29 who have sex with women to the intervention,
 3. assist with implementation of the intervention,
 4. be a resource to which you can refer participants,
 5. help tailor the intervention for your target population,
 6. provide a room in which the sessions can be held,
 7. supply refreshments for participants,
 8. donate small incentives or prizes for participants,
 9. speak supportively about **FOF** in conversations with their associates.
- ii. Send letters that tell stakeholders about **FOF** and its importance; that your agency is/will be making the intervention available, what specific role(s) you think that they might play in the success of the intervention, and to offer an opportunity for them to learn more.
 - iii. Call in 2 weeks and assess their interest. If they are interested, schedule a time to meet (e.g., one-on-one, lunch-and-learn at your agency with a group of other stakeholders, presentation at their agency for several of their staff or association members).
 - iv. Hold the meeting, to describe **FOF** and answer questions.

Getting their support

- v. Describe several specific roles they could play.
- vi. Emphasize the benefits of their involvement to themselves, their agency, the community, and answer questions.
- vii. Invite them to commit to supporting **FOF** by taking on one or more roles. Keep track of commitments.

Getting them involved

- viii. Soon after meeting, send a thank you letter that specifies the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later.
- ix. For persons who committed to a role that is important to pre-implementation, put them to work as soon as possible.
- x. For persons who committed to involvement later in the process, send them brief progress updates and an idea of when you will be calling on their support.
- xi. Hold periodic celebratory meetings for supporters to acknowledge your appreciation for and the value of their contributions; update them on the intervention's progress, and keep them engaged.

Appendix E: Peer Health Advisor Job Description

<CLINIC NAME> POSITION DESCRIPTION

POSITION TITLE **Peer Health Advisor**

REPORTS TO **<SUPERVISOR'S NAME>**

EMPLOYEE STATUS **Full-time/Part-time/Consultant**

GENERAL STATEMENT OF RESPONSIBILITIES

The Peer Health Advisor's primary responsibility is to conduct the **FOF** intervention 4+ times daily with clients from the target population at the clinic. He will attend a 3-day training and receive additional technical assistance throughout the implementation period. He will meet with his supervisor regularly to discuss successes and challenges with implementation and provide feedback about implementation.

MAJOR TASKS AND RESPONSIBILITIES

- Conduct the **FOF** intervention with fidelity to the original intervention materials and in accordance with the training received.
- Maintain supplies for intervention and alert supervisors when new supplies need to be obtained.
- Complete any paperwork designed to record the implementation details.
- Field inquiries and provide support (within reason) by phone to clients after they have participated in **FOF**.
- Provide feedback on experiences implementing the intervention, including any barriers encountered or possible areas for improvement.
- Participate in a 3-day training on **FOF** and how to conduct the intervention.
- Participate in staff meetings and other agency activities as required.

QUALIFICATIONS, CREDENTIALS, EXPERIENCE

- Satisfies the qualities of a peer for this intervention (21 to 35 years old, African American, male, comfortable talking about heterosexual sex, etc.).
- Comes from and currently resides in the surrounding area.
- Relates to men quickly (i.e.,,, easily builds rapport, has a good sense of humor, etc.).
- Outgoing, friendly and caring personality.
- Non-judgmental of others' lifestyles and choices.
- Able to look at sexual behaviors non-judgmentally (sex-positive attitude).
- Comfortable talking about condoms, sex and HIV/STDs.
- Motivated to improve his community.
- Open and receptive to training/learning.

Appendix F: Interview Tool

Use the following tool when interviewing PHA candidates. Individuals involved in conducting the interview include

- The person who will be supervising the PHA,
- Clinic Manager,
- A member of the clinical, nursing or triage staff who will be referring clients to the PHA for the intervention.

Please add additional questions as necessary.

Candidate's Name: _____

Date: _____

Introduction		
Statement/Question	Desired Response	Notes
Welcome and Introductions	N/A	
<p>Introduce FOF</p> <ul style="list-style-type: none"> • 45-60 minute, one-on-one discussion at an STD clinic between a client and a Peer Health Advisor. • Clients: 18-29 year old African American men who have sex with women who reports symptoms of an STD and/or is newly diagnosed with an STD, not knowingly HIV-positive. • Either while the client is waiting to be seen or after the client has been diagnosed with an STD, he is referred to a private room to speak with the Peer Health Advisor. • The Peer Health Advisor has a tailored discussion with the client about <ul style="list-style-type: none"> ○ Past issues with condom use (condoms break, slippage, erection loss, access to condoms, etc.), ○ The importance of protecting his and his community's future, ○ Finding a condom with the right fit and feel, ○ Practicing correct condom use skills. • At the end, men receive 25+ condoms and foils of lubricant. 	Make sure the candidate shows signs of understanding the purpose and design of the program	

Introduction (continued)		
Statement/Question	Desired Response	Notes
Introduce FOF (cont.) <ul style="list-style-type: none"> • Through research it was found that FOF <ul style="list-style-type: none"> ○ Decreases the likelihood of subsequent STD acquisition, ○ Decreases the number of acts of unprotected sex, ○ Decreases the number of sexual partners, ○ Increases correct and consistent condom use. 	Make sure the candidate shows signs of understanding the purpose and design of the program	
Discuss the PHA Role <ul style="list-style-type: none"> • To make clients who are referred to FOF feel comfortable in the training room, • To have a tailored discussion with them about barriers to condom use based on their needs, • Help build men's self-confidence in using condoms and lubricant by modeling correct condom use using a penile model. 	The candidate should understand their role in the intervention	
Discuss the tasks and responsibilities indicated in the job description. <ul style="list-style-type: none"> • Conduct FOF in accordance with the materials and the training received to 4+ clients a day. • Maintain supplies for intervention and alert supervisors when new supplies need to be obtained. • Field inquiries and provide support (within reason) by phone to clients after they have participated in FOF. • Participate in a 3-day training on FOF and how to conduct the intervention. 	Candidates need to understand what will be required of them in terms of the intervention itself as well as upkeep and maintenance of the program.	

General Questions			
Statement/Question	Desired Response	Notes	Response Rating 1=unsatisfactory 2=somewhat satisfactory 3=satisfactory 4=good 5=excellent
“Tell us about yourself.”	<ul style="list-style-type: none"> • Communicates easily and effectively. • Has an outgoing, friendly and caring personality. • Has a good sense of humor. 		
“Why do you want to be a part of this project?”	<ul style="list-style-type: none"> • Has an interest in improving his community. 		
“Why do you think you would be a good Peer Health Advisor?”	<ul style="list-style-type: none"> • Demonstrates a non-judgmental, sex-positive attitude. • Appears comfortable discussing condoms, sex, and HIV/STDs. • Clients will be able to quickly relate to this individual and feel comfortable sharing personal information. 		
Discuss relevant education/experience on his resume.	<ul style="list-style-type: none"> • Has experience working with peers in a “caring brother” role. 		
“What did you like the most about your last supervisor? What did you find challenging about your last supervisor?”	<ul style="list-style-type: none"> • Has a good working relationship with supervisors and any challenges are dealt with appropriately. 		

Situational Questions/Role Plays			
Statement/Question	Desired Response	Notes	Response Rating 1=unsatisfactory 2=somewhat satisfactory 3=satisfactory 4=good 5=excellent
Explain the purpose of the next part of the interview is to give the interviewers a better sense of how he might handle different situations that might come up as a Peer Health Advisor. Highlight that he should treat the interviewer like a 27-year-old African American male who was told today that he has gonorrhea. The candidate should give complete, real-world responses.			
“I am now sitting with you and you will eventually be teaching me about condoms and safe sex. How will you use the first two minutes of our time together? Please show me.”	<i>Ideal Response Resembles:</i> Candidate welcomes client, builds rapport by talking about something he is wearing, music, sports, or news. He could say “I bet this has been a long morning for you. I’m here to help guys not come back here. I promise not to talk “at you” and I want you to know that my primary goal is to help you learn all you can about condom use.”		
“We have been talking about condoms and sex and I say to you ‘But the damn condoms are always breakin’ on me!’ What would say/do at this point?”	<i>Ideal Response Resembles:</i> “A lot of guys have the same experience, it’s pretty common. Here’s the deal though— they don’t have to break. I can teach you ways to keep this from ever happening again. For example, finding condoms that fit you comfortably (not too tight) is an important first step. Using water-based lubricant to keep condoms from drying out during sex is also critical. Have you ever tried lube?”		

Situational Questions/Role Plays (continued)			
Statement/Question	Desired Response	Notes	Response Rating 1=unsatisfactory 2=somewhat satisfactory 3=satisfactory 4=good 5=excellent
<p>“Now, here is a penile model and here is a pile of condoms plus a selection of lubricants. Please use these “props” to teach me (in my same role as the 27-year old) how to keep condoms from ever breaking again.”</p>	<p><i>Ideal Response Resembles:</i> The ideal candidate for this job will comfortably and efficiently use these props to teach the client how to select a condom that fits correctly, how to add lubricant, how to apply condoms correctly, etc. The best possible response would include the candidate asking the 27-year-old to “give it a try with the model” and then guiding him in that effort.</p>		
<p>“We have been talking about condoms and sex and I say to you ‘If I try to start using condoms with my main girl, she’ll wonder what’s up! How can I tell her why I’m using them?’”</p>	<p><i>Ideal Response Resembles:</i> “There are a number of things you could tell her. For example, you have an STD so you have to use a condom to protect her from acquiring it. Or, you could tell her that you want to start using condoms because you love your partner and you learned it’s a way to protect her from unwanted pregnancies. You could also say that you got a bunch of expensive condoms from the doctor and you want to try them. The doctor said that they can help enhance the sexual experience for your female partner by adding texture and lubrication.”</p>		

Closing	
Statement/Question	Notes
Allow the candidate to ask any questions he may have about the PHA position, FOF , or the agency.	
Thank the candidate for their time and inform them of the next steps in the interview process	

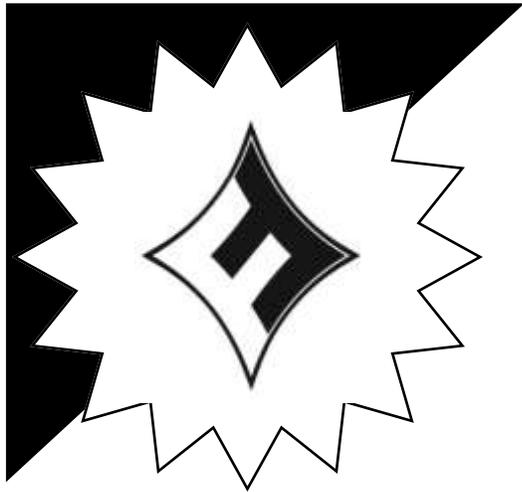
***Note:** It may be necessary to determine the Peer Health Advisor’s literacy level. Because the person hired for the position will be responsible for reading the Facilitator’s Guide on a regular basis, using a survey with clients, and creating a list of stores in the area where clients can purchase condoms and lubricant, the Peer Health Advisor must be literate. In order to address the candidate’s literacy level during the interview, you can

- Ask the candidate to read a pamphlet that you have in the clinic out loud,
- Ask the candidate to write an answer out to one of the questions.

Overall Communication Skills		
Skill Area	Notes	Response Rating 1=unsatisfactory 2=somewhat satisfactory 3=satisfactory 4=good 5=excellent
Does not show judgment.		
Uses a clear voice.		
Makes appropriate eye contact.		
Uses an open body language and relaxed posture.		
Avoids distracting behaviors.		
Smiles.		
Is confident and prepared for the discussion.		

After the interview

- Debrief with staff about the candidates strengths and weaknesses as they relate to the Peer Health Advisor position,
- Write up notes that describe the interview,
- Take notice of the candidate’s communication style, body language, comfort discussing sexual topics, and his motivating factors to take part in **FOF**.



Focus on the Future!

- Earn \$X/hr (40 hours/week)
 - Become part of the clinic team
 - Participate in a 3-day training program
 - Become educated about condom use and STD prevention
 - Help reduce the spread of HIV/AIDS and STDs in your community!
- We're looking for an African American man age 21-35 to be a part of a new STD prevention program called **Focus on the Future**. This program targets other young African American men and focuses on correct condom use.
 - It's not a lecture, it's not a class, it's just a conversation between two guys about how to use condoms correctly in order to have a healthy future!

If interested, please contact [Insert Name of Contact here] at [Insert Name of Agency Here]:

Phone: ###-###-####

E-mail: xxxxx@xxxxxxxxx.xxx

Appendix H: Agency Readiness Checklist

Capacities and Resources Needed for FOF	Yes/No/ Referral
<i>Staffing Requirements</i>	
<ul style="list-style-type: none"> ● Clinic Director <ul style="list-style-type: none"> ○ Do you have a clinic director who is willing to prepare the agency for FOF, secure funds and “buy-in,” hire a PHA, organize training for all necessary staff, provide quality assurance, manage the budget, establish and execute the evaluation plan, and communicate with the clinic manager? 	
<ul style="list-style-type: none"> ● Clinic Manager <ul style="list-style-type: none"> ○ Do you have a clinic manager who is willing to supervise the PHA or the PHA’s supervisor, help to evaluate agency policies and procedures as they apply to FOF, obtain supplies for intervention, determine space to be used for intervention, evaluate agency readiness for implementation, and debrief weekly with the PHA or PHA’s supervisor on intervention successes and challenges? 	
<ul style="list-style-type: none"> ● Clinical, Nursing, Social Work, Disease Investigation Specialist (DIS), and Triage Staff <ul style="list-style-type: none"> ○ Do you have staff who are willing to receive orientation on the screening for eligibility and referral processes, screen clients for eligibility, recruit clients, understand the clinic’s flow for each day, and incorporate the provision of the FOF session by PHA based on client’s eligibility? 	
<ul style="list-style-type: none"> ● PHA’s Supervisor <ul style="list-style-type: none"> ○ Is there someone at the clinic who is willing to receive training on FOF, supervise the PHA, debrief weekly with the PHA, review the PHA’s performance, and support the PHA? 	
<ul style="list-style-type: none"> ● PHA <ul style="list-style-type: none"> ○ Is there someone you know of who meets the criteria to be a successful PHA, is willing to receive training on FOF, conduct FOF, and serve as a consultant on safe sex practices to clients after FOF? 	
<i>Training Requirements</i>	
<ul style="list-style-type: none"> ● Is the PHA able to attend a 3-day training on FOF and the supervisor able to attend a ½-day training? 	
<ul style="list-style-type: none"> ● Is the agency committed to orient the staff about the FOF intervention, integration of FOF into clinic flow, screening eligible client processes, etc.? 	

Capacities and Resources Needed for FOF	Yes/No/ Referral
<i>Resources Required</i>	
Do you have the following resources?	
<ul style="list-style-type: none"> Ability to purchase and securely store 1 realistic penile model, 1-2 less realistic penile models, bottles of baby oil, 600+ condoms (a variety of desirable and/or high-end brands), 600+ 3 to 8 ml water-based lubricants packets (a variety of desirable and/or high-end brands), paper towels, hand sanitizer, pens/pencils, ditty bags (small draw-string bags for clients to put 25+ condoms and 25+ lubricants of their choosing). 	
<ul style="list-style-type: none"> Available wall space in the FOF room to hang the color poster that reveals the dramatic difference in AIDS rates for African Americans versus the rest of the population (nationally). 	
<ul style="list-style-type: none"> Ability to print and prepare wallet-sized cards (outlining the 8 steps for correct condom use on one side and contact information of the PHA and clinic on the other). 	
<ul style="list-style-type: none"> Ability to develop a list of stores in the surrounding area that carry a variety of high-end condoms and lubricants with the address, hours, and prices listed. 	
<ul style="list-style-type: none"> Ability to copy the Short Condom Use Survey (SCUS) and list of stores in the area. 	
<ul style="list-style-type: none"> Access to a laptop computer, iPod/speakers or CD player (optional). 	
<ul style="list-style-type: none"> Availability to purchase/obtain refreshments (water, soda, snacks) (optional). 	
<ul style="list-style-type: none"> A sink for the PHA to wash the penile models daily. 	
<i>Policies and Procedures</i>	
What policies and procedures are currently in place and able to satisfy the needs of FOF ? Which need to be amended, and which need to be created? For example	
<ul style="list-style-type: none"> Patient confidentiality, 	
<ul style="list-style-type: none"> Integrating FOF into clinic flow, 	
<ul style="list-style-type: none"> Screening for eligibility, 	
<ul style="list-style-type: none"> Recruiting clients, 	
<ul style="list-style-type: none"> Referral tracking, 	
<ul style="list-style-type: none"> Managing supplies, 	
<ul style="list-style-type: none"> Ordering supplies, 	
<ul style="list-style-type: none"> Safety and security plan, 	
<ul style="list-style-type: none"> Planning for potential issues, 	
<ul style="list-style-type: none"> PHAs' Clinic Responsibilities. 	

Appendix I: Integration Checklist

This checklist can be used to record the steps that have been achieved and any important notes about particular steps.

Steps	Notes	Step Accomplished (✓)
STEP 1: Determine who from your agency you will involve in the process planning, implementation and feedback process.		
STEP 2: Determine approximately how many eligible clients your clinic can see each day.		
STEP 3: Set FOF targets.		
STEP 4: Determine how to identify clients who are eligible to participate in FOF .		
STEP 5: Once screened for eligibility, determine how eligible clients will be identified by staff who are responsible for recruitment.		
STEP 6: Based on the number of eligible clients your clinic sees each day (from STEP 2), determine when during clinic flow you will recruit eligible clients to participate in FOF .		
STEP 7: Determine what time the PHA will start and end his work day.		
STEP 8: Determine who will recruit eligible clients to participate in FOF .		
STEP 9: Determine recruitment messages that clinic staff will use to recruit eligible clients for the FOF intervention.		

Steps	Notes	Step Accomplished (✓)
STEP 10: Determine who will take clients to the PHA's room and introduce them to the PHA.		
STEP 11: Determine how you will know when the PHA will be available to deliver the intervention to a waiting client.		
STEP 12: Determine how you will manage the timing of client recruitment so that the PHA always has someone to deliver the intervention to, and so that clients don't have to wait too long to receive the intervention.		
STEP 13: Determine what process data you will collect to determine whether you are meeting your targets.		
Step 14: Determine how long you will try out your plan.		
Step 15: Determine how you will ensure that your plan is being implemented as intended.		
Step 16: Set a review process.		
Step 17: Consider your measures of success.		
Step 18: Determine the numbers that indicate that the system needs to change.		
Step 19: Determine the process of revising the system.		

Appendix J: FOF System Integration Planning Tool

Use the following tool when planning how to integrate **FOF** into the flow at your clinic.

Role	Designated Person(s) at Your Clinic	Responsibilities
<p>Members of the Multi-Disciplinary Improvement Team</p>		<ul style="list-style-type: none"> ● Participate in the planning of FOF integration and data collection. ● Review data and recommend changes to the integration plan.
<p>Oversee the integration plan of FOF in the clinic</p>	<p>“Plan Coordinator”</p>	<ul style="list-style-type: none"> ● Provide oversight for all activities related to FOF. ● Orient staff to the plan and review roles and responsibilities. ● Ensure that FOF is being integrated as planned.
<p>Communicate the planned flow of FOF in the clinic</p>		<ul style="list-style-type: none"> ● Review the following with all staff <ul style="list-style-type: none"> ○ How FOF is being integrated into clinic flow, ○ Staff involved in FOF, including their roles and responsibilities.
<p>Screen clients for FOF</p>		<ul style="list-style-type: none"> ● Collect information from clients to determine if they are eligible to participate in FOF. ● Indicate which clients are eligible to participate in FOF so staff responsible for recruitment can easily identify those who are eligible. ● Record the number of clients who screened eligible each day (for data collection purposes).

Role	Designated Person(s) at Your Clinic	Responsibilities
Recruit eligible clients for FOF		<ul style="list-style-type: none"> • Ask eligible clients if they would like to participate in FOF. • Present FOF as a positive and worthwhile experience. • Highlight the incentives associated with participating.
Take eligible clients to the PHA		<ul style="list-style-type: none"> • Introduce clients to the PHA. • Communicate the approximate wait time to the client. • Record the time that the client began waiting to see the PHA.
Collect process data	See sample table.	<ul style="list-style-type: none"> • Collect data to inform the strengths and areas of improvement of the FOF integration process.

Appendix K: Modeling Anticipated Demand for FOF Based on a Calendar Year

When integrating **FOF** into your clinic system, it is important to consider how many eligible clients that your clinic serves on a daily basis. Using data from your clinic, complete the tool on the following page to determine the number of clients from the **FOF** target population that a PHA would be able to see in one day at your agency.

If your clinic does not have this data readily available, a staff member can be designated to collect this information for a set period of time (e.g., 2 weeks). See **Appendix L** for a “SAMPLE Client Eligibility Tracking Log” that can be used to record this data. If this data is unavailable and your clinic is unable to collect it, you may make assumptions or your best guess whenever necessary.

1. How many **African American Males** between the **ages of 18 and 29** (inclusive) did you serve in the last calendar year?

2. Of the group in question 1, how many had a **negative or unknown HIV status**?

3. Of the group in question 2, how many **tested positive for an STD** or were **presumptively treated for an STD**?

4. Of the group in question 3, how many **have sex with women**?
(Note: include those who have sex with men in addition to women. Do not include those who have sex exclusively with men.)

5. Of the group in question 4, how many have **used a condom in the last 3 months**?

This is the eligible population

6. How many weeks is your clinic open per year?
Note: On average, a clinic is open 42 weeks per year when you exclude holidays and other closings.

7. How many days per week is your clinic open?

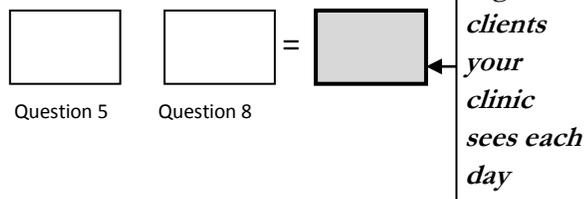
8. Multiply the total in **question 6** by **question 7**. This gives you the number of days your clinic is open per year. x =

Question 6

Question 7

This is the number of days your clinic operates

9. Take the total in **question 5** and divide it by the total in **question 8**. This gives you the number of eligible clients that your Peer Health Advisor could deliver the **FOF** intervention to each day.



Using the information gathered from completing the above tool and the guiding questions below, you will determine how eligible clients who enter your clinic will receive the **FOF** intervention.

Considerations

- Ideally the PHA can conduct one **FOF** intervention per hour.
- Consider the number of hours each day that you are open.
- Based on the number of hours that your clinic is open each day and the number of eligible clients you anticipate to see at your clinic each day, think about whether it is possible to offer **FOF** to all eligible clients or only some.

Appendix L: Sample Client Eligibility Tracking Log

^Sex: M=Male; F=Female; T=Transgender; U=Unknown.
 *Race: AS=Asian; AI/AN=American Indian/Alaska Native; BL=Black/African American; NH/PI=Native Hawaiian/Pacific Islander; WH=White; OTH=Other.

Client No.	Sex^	Race*	Age (Years)	Man who has sex with women (MSW)	Used Condom in last 3 months	Not knowingly HIV+	Reported STD symptoms today or contacted by the clinic to come in	Diagnosed with an STD today	Eligible for FOF?
1.	M	BL	18	Y	Y	Y	N	Y	Y
2.	F	OTH							N
3.	M	BL	29	Y	N				N
4.									
5.									
6.									
7.									
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28.									

Appendix M: Sample Client Time Log

Use the following time log to record the time the client began waiting for the **FOF** intervention, the time the PHA began the intervention with the client, and the time the intervention finished and the client left the PHA's room. There is also a column for notes where additional information can be recorded (e.g., client left while waiting and didn't receive the intervention, client left in the middle of the session, etc.). Use a new form for each day.

Date: _____

Client's Unique Identifier	Client Referred By	Time Client Began Waiting for FOF	FOF Start Time	FOF End Time	Notes
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Appendix N: Router Tool

The Router Tool can be used to collect information about a client’s eligibility, total time in the clinic, time spent waiting to meet with the PHA, and length of the **FOF** session.

The tool can be clipped on or placed within each client’s chart during the registration process. If you plan on using this tool, you should determine when, how and who will place the tool on the client’s chart. You will also need to determine a process to collect the information on the tool and then collect the tools from client charts throughout the day. To protect client confidentiality, please ensure the tool cannot be accessed by the clients.

Once logistics for the tool have been determined, a designated staff member (e.g., the “Plan Coordinator”) should provide an orientation to staff on the purpose of the tool and how to complete it.

-----><-----

CHECK-IN TIME – ARRIVE	____ : ____ am/ pm
APPOINTMENT TIME	____ : ____ am/ pm [note if it is a walk in]
VISIT TYPE [please circle one]	Annual Initial Infection Check Problem Visit Other
ELIGIBLE TO PARTICIPATE IN FOF	____ yes ____ no
START OF WAIT TIME TO MEET WITH PEER HEALTH ADVISOR	____ : ____ am/ pm [note if eligible client declines FOF]
START TIME WITH PEER HEALTH ADVISOR	____ : ____ am/ pm
END TIME WITH PEER HEALTH ADVISOR	____ : ____ am/ pm
COMPLETE AND LEAVE CLINIC	____ : ____ am/ pm

Please be sure to submit this form at the end of the appointment. Thank you!

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Appendix O: Staff Survey

In order to get feedback about the successes and challenges of implementing **FOF** at our clinic, we would like you to complete the following short survey.

Rate each item on a scale from 1 to 5, where 1 is strongly disagree and 5 is strongly agree.

Statement	Strongly Disagree 1	Disagree 2	Undecided 3	Agree 4	Strongly Agree 5
1. Focus on the Future is an important service to offer African American males who have sex with women who come to our clinic.	1	2	3	4	5
2. Focus on the Future does not disrupt patient flow.	1	2	3	4	5
3. Clients who participate in Focus on the Future believe it is a valuable program.	1	2	3	4	5
4. I understand my role and responsibilities in implementing Focus on the Future in our clinic.	1	2	3	4	5
5. The Peer Health Advisor has been adequately trained and knows his responsibilities.	1	2	3	4	5
6. The Focus on the Future program has adequate oversight and support at our clinic.	1	2	3	4	5
7. We provide adequate support for the Peer Health Advisor to be successful.	1	2	3	4	5
8. Focus on the Future is easy to integrate into our clinic setting.	1	2	3	4	5
9. Focus on the Future can change client behavior relating to condom use.	1	2	3	4	5

Additional comments:

Appendix P: Client Survey

In order to get feedback about the successes and challenges of implementing **FOF** at our clinic, we would like you to complete the following short survey.

Rate each item on a scale from 1 to 5, where 1 is strongly disagree and 5 is strongly agree.

Statement	Strongly Disagree 1	Disagree 2	Undecided 3	Agree 4	Strongly Agree 5
1. Focus on the Future is an important program.	1	2	3	4	5
2. I am satisfied with my visit at the clinic today.	1	2	3	4	5
3. Participating in Focus on the Future was a good use of my time.	1	2	3	4	5
4. I found it easy to speak with the Peer Health Advisor.	1	2	3	4	5
5. I felt heard.	1	2	3	4	5
6. I felt my questions were answered.	1	2	3	4	5
7. I learned something new.	1	2	3	4	5
8. I would recommend Focus on the Future to a friend.	1	2	3	4	5
9. I am going to do something different as a result of participating in Focus on the Future.	1	2	3	4	5
10. I felt respected.	1	2	3	4	5

Additional comments:

Appendix Q: Pre-Implementation Timeline

The following timeline outlines when the required tasks should take place in order to successfully prepare to implement the **FOF** intervention. The responsible staff and materials are also listed.

Task	Person(s) Responsible	Materials	Timeline
<p>Determine Agency Fit and Capacity</p> <ul style="list-style-type: none"> • Agency should meet the following criteria <ul style="list-style-type: none"> ○ Ability to diagnose and treat STDs, ○ Serves a large number of the target population, <ul style="list-style-type: none"> ▪ Males, ▪ Ages 18-29, ▪ African American, ▪ Men who have sex with women (MSW), ▪ Newly diagnosed with an STD or report symptoms of an STD, ▪ Uses condoms, ▪ Condom use is incorrect or inconsistent; ○ Has a private space where one-on-one intervention can take place; ○ Has a cupboard, closet or room to securely store supplies for the intervention ○ Able to secure funding to successfully provide the intervention (this timeline may be ongoing); <ul style="list-style-type: none"> ▪ Able to purchase materials such as high-end/popular condoms and lubricants, small bags, and a penile model; ▪ Able to hire, compensate, and supervise a PHA; ○ Able to promote the program within the community; ○ Has a system in place to track referrals to the program; ○ Management and staff “buy-in” to the intervention; ○ Follows CDC Standard of Care guidelines (e.g., screening, treating, post-test/risk reduction counseling); ○ Ability to do case study reviews without difficulty for monitoring and evaluation purposes. 	<p>Clinic Director</p> <p>Clinic Manager</p> <p>Clinic Manager</p> <p>Local and State Health Departments</p> <p>Stakeholders</p> <p>Clinic Director</p> <p>Clinic Manager</p>	<p>See Appendix K for a tool to determine the number of eligible clients your clinic sees per day</p> <p>Clinic Floor Plan</p> <p>Funding Opportunity Announcements</p>	<p>Week 1-2</p>

Task	Person(s) Responsible	Materials	Timeline
Develop Budget <ul style="list-style-type: none"> ● Use budget template to plan expenses. <ul style="list-style-type: none"> ○ Staff ○ Facility ○ Equipment ○ Supplies 	Clinic Director, Clinic Manager, Fiscal managers/officers	See Appendices S & T for an Estimated and Blank Cost Sheet	Week 3-4
Obtain Stakeholder “Buy-in” <ul style="list-style-type: none"> ● Engage stakeholders for support and participation in the planning and execution of the intervention ● See Stakeholder Checklist <ul style="list-style-type: none"> ○ List of internal and external partners to reach out to for support in “buy-in,” recruitment, and funding ● Review Program Review Board requirements 	Clinic Director, Clinic Manager, PHA Supervisor	See Appendix D for the Stakeholder Checklist	Week 5
Identify Appropriate Staff to Implement the Intervention <ul style="list-style-type: none"> ● Identify current staff members who will participate in the day-to-day execution of the intervention. This may include <ul style="list-style-type: none"> ○ Clinic Manager: Oversees the intervention implementation; ○ PHA Supervisor: Oversees the PHA; could be the clinic manager, social worker, nurse, etc.; ○ Clinician, nurses, social workers, DIS, triage staff: Screens and refers clients to the PHA for intervention; ○ New or existing PHA, if applicable. 	Clinic Director, Clinic Manager, PHA’s Supervisor, Clinicians/ Nurses/ Social Workers/ DIS/Triage	Staff Directory	Week 6
Create Data Collection System <ul style="list-style-type: none"> ● If funded by CDC, agencies need to collect data that can be imported into the NHME system. See the Monitoring and Evaluation Section for more details. 	Clinic Director, Clinic Manager	“Monitoring and Evaluation” Section of the IM	Week 7

Task	Person(s) Responsible	Materials	Timeline
Review Policies and Procedures <ul style="list-style-type: none"> • Make sure the current policies and procedures for the following topics are appropriate for FOF, and make adjustments, if necessary, to accommodate the program. 	Clinic Director, Clinic Manager	Clinic Policies and Procedures See “Policies and Procedures”	Week 8
Set-up a “Buy-in” Meeting at the Agency <ul style="list-style-type: none"> • Conduct a meeting with all staff to introduce and gain support for FOF. 	Clinic Manager	See “Staff Buy-in”	Week 9
Hire a PHA to implement the intervention <ul style="list-style-type: none"> • Revise the Job Description included in the IM. • Develop or adapt the marketing materials included in the IM to advertise the position. • Explore existing networks of appropriate individuals. • Interview candidates using the interview tool in the IM. • Hire a PHA. 	Clinic Director, Clinic Manager, PHA’s Supervisor	Refer to “Identifying Appropriate Staff” and Appendices E, F & G	Week 10
Integrate the PHA into Agency Team <ul style="list-style-type: none"> • Introduce the PHA and his role to all staff at the agency. 	Clinic Manager		Week 11
Train the PHA and Supervisor <ul style="list-style-type: none"> • Register the PHA for a CDC FOF Training of Facilitators session – 3-day training. • Attend Training of Facilitators Program. • Debrief with PHA and supervisor about the Training of Facilitators Program. 	Clinic Manager, PHA’s Supervisor, PHA	CDC Website	Week 12
Train the Clinic Staff <ul style="list-style-type: none"> • Register clinic staff for training on the intervention and how to integrate the PHA into the healthcare team. 	All Clinic Staff	CDC Website	Week 12

*See “Implementation Activities at a Glance” for more activities associated with implementing **FOF** at your agency.

Appendix R: Implementation Summary

This chart will help your agency prepare for the implementation of **FOF** by listing what inputs need to be gathered, what activities need to be conducted, and what outputs will be expected. The inputs section is a summary of the elements your agency should have in place before beginning to implement **FOF**. Once you have these resources, you can begin working on the activities section, which, when executed faithfully, should create the tools in the output section that allow you to offer **FOF** to the target population in your community.

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 FOF • A PHA who comes from and resides in the community and relates to men positively and quickly • Clinic Manager who will assist with pre-implementation activities and conduct quality assurance activities • Confidential and safe meeting space to conduct all FOF 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 FOF • Commitment to and completion of three days of intensive training on FOF intervention. • Ability to screen for eligibility • Ability to integrate FOF into clinic flow • Local/state public health officials’ support for FOF implementation • Community and consumer support for FOF implementation 	<ul style="list-style-type: none"> • Closely review FOF curriculum/intervention and understand theory and science behind it • Assess agency capacity to conduct FOF and identify technical assistance needs • Request technical assistance from Project Officer, CBA Coordinator • Introduce and orient staff to FOF • Identify appropriate staff to implement the intervention (Assess need for adaptation of intervention and contact Project Officer for further assistance) • Obtain and utilize consumer, community stakeholder input on FOF intervention • Inform local/state public health officials about FOF to gain their support • Prepare implementation plan with measurable goals and process and outcome objectives • Develop program monitoring plan to improve program and for quality assurance • Identify logistics for FOF (e.g., times, days, space) • Train and build skills of FOF PHA, his supervisor, and staff who will refer clients 	<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 FOF into flow of agency services and programs • Written FOF referral 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 referred for FOF in [timeframe] • % of planned # of FOF sessions held in [timeframe] • % of planned # of FOF participants who satisfy target population characteristics in [timeframe]

<p style="text-align: center;">INPUTS</p> <p style="text-align: center;"><i>Resources needed to implement and conduct intervention activities</i></p> <p style="text-align: center;">(continued)</p>	<p style="text-align: center;">ACTIVITIES</p> <p style="text-align: center;"><i>Actions required to prepare for and conduct the intervention</i></p> <p style="text-align: center;">(continued)</p>	<p style="text-align: center;">OUTPUTS</p> <p style="text-align: center;"><i>Deliverables or products that result from implementation activities</i></p> <p style="text-align: center;">(continued)</p>
<ul style="list-style-type: none"> • Input of agency staff, consumers, and community stakeholders into planning and implementation • External technical assistance 	<ul style="list-style-type: none"> • Plan and implement process/procedures to integrate FOF into flow of agency services and programs • Design participant referral process including who refers and how • Purchase/obtain a variety of high-end male condoms, packets of lubricant, male penis models for demonstration and skill building during the session • Purchase/obtain a small bag (e.g., ditty bag) for the client to put condoms and lubricant in at the end of the session • Conduct FOF intervention 	

Appendix S: Cost Sheet - Estimated

Categories for Provider Costs to Implement Intervention								
<u>Categories</u>	<u>Pre-Implementation (start-up)</u>			<u>Implementation (intervention delivery)</u>			<u>Cost per Participant</u> N=1250	<u>Total cost</u>
Personnel (time spent on intervention)								
	<u># Staff Required</u>	<u>% time or # hrs</u>	<u>weeks</u>	<u># Staff Required</u>	<u>% time or # hrs</u>	<u>weeks</u>		
Salaried								
Clinic Director	1	5%	2	1	2%	50	In Kind	In Kind
Clinic Manager	1	15%	2	1	5%	50	In Kind	In Kind
Other Clinic Staff	TBD	1%	2	TBD	1%	50	In Kind	In Kind
Hourly								
Peer Health Advisor	1	40	2	1	40	50		
Compensation	<u>% allocated</u>	<u>\$/hr</u>	<u>weeks</u>	<u>% allocated</u>	<u>\$/hr</u>	<u>weeks</u>		
Peer Health Advisor		\$10.00	2		\$10.00	50	\$16.64	\$20,800.00
Facilities (time used for intervention)								
	<u># Required</u>	<u># hrs/week</u>	<u>weeks</u>	<u>#</u>	<u># hrs/week</u>	<u>weeks</u>		
Small Private Meeting Space/ Peer Health Advisor Office	1	40	2	1	40	50	In Kind	In Kind
Equipment (time used for intervention)								
	<u># Required</u>	<u>% time</u>	<u>weeks</u>	<u># Required</u>	<u>% time</u>	<u>weeks</u>		
Copier	1	1%	2	1	1%	50	In Kind	In Kind
Computer	1	10%	2	1	1%	50	In Kind	In Kind
	<u># Required</u>	<u>\$ allocated/week</u>	<u>weeks</u>	<u># Required</u>	<u>\$ allocated/month</u>	<u>weeks</u>		
Phone	1	\$6	1	1	\$6.00	50	\$0.24	\$306.00

<u>Categories</u>	<u>Pre-Implementation (start-up)</u>			<u>Implementation (intervention delivery)</u>			<u>Cost per Participant</u> N=1250	<u>Total cost</u>
Supplies								
	<u>Units</u>	<u>x</u>	<u>Price/unit</u>	<u>Units</u>	<u>x</u>	<u>Price/unit</u>		
Condoms	Client(s)*	1	\$7.30	Client(s)*	1250	\$7.30	\$7.31	\$9,132.30
Lubricants	Client(s)*	1	\$6.55	Client(s)*	1250	\$6.55	\$6.56	\$8,194.05
Penile Model - Rubber	Model(s)	1	\$11.00	Model(s)	0	\$11.00	\$0.01	\$11.00
Penile Model - Wooden	Model(s)	1	\$8.00	Model(s)	0	\$8.00	\$0.01	\$8.00
Penile Model - Plastic Banana	Model(s)	1	\$5.28	Model(s)	0	\$5.28	\$0.00	\$5.28
Ditty Bags	Bag(s)	5	\$1.25	Bag(s)	1250	\$1.25	\$1.26	\$1,568.75
Baby Oil	20oz Bottle(s)	1	\$4.50	20oz Bottle(s)	10	\$4.50	\$0.04	\$49.50
External Audio Speakers	Set(s)	1	\$22.00	Set(s)	0	\$22.00	\$0.02	\$22.00
MP3 Player	Player(s)	1	\$30.00	Player(s)	0	\$30.00	\$0.02	\$30.00
Printer Ink - Black	Cartridge(s)	1	\$122.00	Cartridge(s)	3	\$122.00	\$0.39	\$488.00
Printer Ink - Cyan	Cartridge(s)	1	\$122.00	Cartridge(s)	2	\$122.00	\$0.29	\$366.00
Printer Ink - Magenta	Cartridge(s)	1	\$122.00	Cartridge(s)	2	\$122.00	\$0.29	\$366.00
Printer Ink - Yellow	Cartridge(s)	1	\$122.00	Cartridge(s)	2	\$122.00	\$0.29	\$366.00
Printer Paper	Cartridge(s)	1	\$48.99	Cartridge(s)	3	\$48.99	\$0.16	\$195.96
Posters	Poster(s)	7	\$55.00	Poster(s)	0	\$55.00	\$0.31	\$385.00
Contact cards	Contact card(s)	1250	\$0.22	Contact card(s)	0	\$0.22	\$0.22	\$275.00
Total Cost								
Personnel			\$800.00			\$20,000.00	\$16.64	\$20,800.00
Facilities			In Kind			In Kind	In Kind	In Kind
Equipment			\$6.00			\$300.00	\$0.24	\$306.00
Supplies			\$1,298.87			\$20,164.97	\$17.17	\$21,463.84
Phase Total			\$2,104.87			\$40,464.97	\$34.06	\$42,569.84
Final Total:								\$42,569.84

*Assumes 35 high-end condoms and 35 foils of water-based lube per client (25 of each to take home and 10 of each to open and practice with)

Appendix T: Cost Sheet - Blank

Categories for Provider Costs to Implement Intervention - Template								
<u>Categories</u>	<u>Pre-Implementation (start-up)</u>			<u>Implementation (intervention delivery)</u>			<u>Cost per Participant</u> N=1250	<u>Total cost</u>
Personnel (time spent on intervention)								
Salaried Clinic Director Clinic Manager Other Clinic Staff	<u># Staff Required</u>	<u>% time or # hrs</u>	<u>weeks</u>	<u># Staff Required</u>	<u>% time or # hrs</u>	<u>weeks</u>		
Hourly Peer Health Advisor Compensation Peer Health Advisor	<u>% allocated</u>	<u>\$/hr</u>	<u>weeks</u>	<u>% allocated</u>	<u>\$/hr</u>	<u>weeks</u>		
Facilities (time used for intervention)								
Small Private Meeting Space/ Peer Health Advisor Office	<u># Required</u>	<u># hrs/week</u>	<u>weeks</u>	<u>#</u>	<u># hrs/week</u>	<u>weeks</u>		
Equipment (time used for intervention)								
Copier Computer	<u># Required</u>	<u>% time</u>	<u>weeks</u>	<u># Required</u>	<u>% time</u>	<u>weeks</u>		
Phone	<u># Required</u>	<u>\$ allocated/week</u>		<u># Required</u>	<u>\$ allocated/month</u>	<u>weeks</u>		

<u>Categories</u>	<u>Pre-Implementation (start-up)</u>		<u>Implementation (intervention delivery)</u>		<u>Cost per Participant</u> N=1250	<u>Total cost</u>
Supplies						
	<u>Units</u>	<u>x</u>	<u>Price/unit</u>	<u>Units</u>	<u>x</u>	<u>Price/unit</u>
Condoms	Client(s)*			Client(s)*		
Lubricants	Client(s)*			Client(s)*		
Penile Model - Rubber	Model(s)			Model(s)		
Penile Model - Wooden	Model(s)			Model(s)		
Penile Model - Plastic Banana	Model(s)			Model(s)		
Ditty Bags	Bag(s)			Bag(s)		
Baby Oil	20oz Bottle(s)			20oz Bottle(s)		
External Audio Speakers	Set(s)			Set(s)		
MP3 Player	Player(s)			Player(s)		
Printer Ink - Black	Cartridge(s)			Cartridge(s)		
Printer Ink - Cyan	Cartridge(s)			Cartridge(s)		
Printer Ink - Magenta	Cartridge(s)			Cartridge(s)		
Printer Ink - Yellow	Cartridge(s)			Cartridge(s)		
Printer Paper	Cartridge(s)			Cartridge(s)		
Posters	Poster(s)			Poster(s)		
Contact cards	Contact card(s)			Contact card(s)		
Total Cost						
Personnel						
Facilities						
Equipment						
Supplies						
Phase Total						
Final Total:						

*Assumes 35 high-end condoms and 35 foils of water-based lube per client (25 of each to take home and 10 of each to open and practice with)

Appendix U: Implementation Activities at a Glance

The following table outlines the activities that need to be completed in order to successfully implement the **FOF** intervention. The suggested person(s) responsible and required materials are also listed.

Implementation		
Task	Person(s) Responsible	Materials
<p>Collect, organize and set-up supplies for FOF sessions.</p> <ul style="list-style-type: none"> • Pens • 1 color poster with National HIV Rates broken down by race • 1 realistic penile model that accurately represents the anatomy of the target population • 1-2 less realistic penile model (wooden or plastic banana) • Bottles of baby oil • Paper towels • Hand sanitizer • Large number, approximately 35 per participant, and variety of desirable and/or high-end condoms • Large number, approximately 35 per participant, and variety of desirable and/or high-end 3 to 8 ml water-based lubricants packets • Copies of the Short Condom Use Survey (SCUS) • Copies of the list of stores in the surrounding area that carry a variety of high-end condoms and lubricants with the address and hours listed • Wallet-sized contact cards (outlining the 8 steps for correct condom use on one side and contact information of the PHA and clinic on the other) • Small paper or ditty bags (small draw-string bags for clients to put 25+ condoms and 25+ lubricants of their choosing) • Laptop, MP3 player, portable speakers or CD player to play music (optional) • Refreshments, for example, water, coffee, cans of soda (optional) 	<p>Clinic Manager, PHA's Supervisor, Lay Health</p>	<p>See "Facilitator Coordination" for guidance on order supplies and preparing materials</p>

Task	Person(s) Responsible	Materials
<p>Evaluate Agency Readiness to Begin the Intervention.</p> <ul style="list-style-type: none"> ● Readiness Checklist <ul style="list-style-type: none"> ○ List of staff involved in intervention (Clinic Manager, staff who will screen and recruit, PHA, etc.); ○ Resources & Materials <ul style="list-style-type: none"> ▪ Compensation for PHA ▪ Private space for intervention ▪ Condoms and water-based lubricant ▪ Small draw-string bags (e.g., ditty bags) for clients to carry condoms and lubricant home ▪ Lifelike and 1-2 less lifelike penile models ▪ Color contact cards with condom use steps ▪ List of stores in the surrounding area that carry a variety of high-end condoms and lubricants with the address and hours listed ▪ National HIV rates posters broken down by race 	<p>Clinic Manager</p>	<p>See Appendix H</p>
<p>Develop a Process and Schedule for the PHA to practice implementing FOF.</p> <ul style="list-style-type: none"> ● Quality assurance procedures should be developed for practice. 	<p>PHA's Supervisor, PHA</p>	
<p>Set up space for PHA to implement FOF.</p> <ul style="list-style-type: none"> ● Make sure the room is private (with a door) and is available for at least 60 minutes per client. ● Set up chairs and desk/table. ● Hang appropriate posters on the wall. <ul style="list-style-type: none"> ○ Appropriate posters should not detract from the focus of the intervention, which is correct and consistent condom use. ○ For example, the posters that reveal the dramatic difference in AIDS rates for African Americans versus the rest of the population can be hung on the wall. ● Set up laptop, MP3 player, portable speakers or CD player to play music (optional). ● Make sure there is appropriate space and secure space for supplies. 	<p>Clinic Manager, PHA's Supervisor, PHA</p>	<p>Space for Intervention</p>

Task	Person(s) Responsible	Materials
<p>Develop a plan for PHA down time.</p> <ul style="list-style-type: none"> • Determine what tasks the PHA will be responsible for when not facilitating sessions of FOF with clients. For example <ul style="list-style-type: none"> ○ Review the Facilitator’s Guide and video; ○ Review client satisfaction survey results; ○ Assist with recruitment by greeting clients in the clinic or talking with them in the waiting room; ○ Do an inventory of supplies to ensure there are an adequate number of condoms, water-based lubricant, handouts, etc.; ○ If clients who received the intervention are back at the clinic for follow-up treatment, meet with them while they are waiting to get feedback about the intervention; ○ Update materials, for example, the “List of Stores”, if necessary; ○ Adapt the intervention by offering it to clients who are 30-35 years old or 16-17 years old; ○ Call clients who participated in the intervention to see if they have any questions and to get feedback about the intervention. 	<p>Clinic Manager, PHA’s Supervisor, PHA</p>	
<p>Conduct FOF.</p> <ul style="list-style-type: none"> • The PHA implements FOF with clients in the clinic. • Client Surveys can be collected from each client to get feedback about FOF and the PHA’s performance. 	<p>PHA</p>	<p>See “Facilitator’s Guide”</p> <p>See Appendix P</p>
<p>Debrief with the PHA on a weekly basis regarding the implementation of the intervention.</p> <ul style="list-style-type: none"> • Discuss successes, concerns or issues with current implementation, devise solutions. 	<p>PHA’s Supervisor, PHA</p>	<p>See “Supervising the PHA”</p>
<p>Follow-up with M&E indicators for measuring continuous and effective implementation of FOF.</p> <ul style="list-style-type: none"> • M&E indicators should be completed and reviewed (e.g., Quarterly) and used to improve the pre-implementation and implementation process. 	<p>Clinic Director, Clinic Manager</p>	<p>See “Monitoring and Evaluation”</p>

Task	Person(s) Responsible	Materials
<p>Monitor levels of supplies and purchase supplies as required on a weekly basis.</p> <ul style="list-style-type: none"> • Ensure there are a sufficient number of supplies and materials for all clients who participate in FOF at the agency. 	<p>Clinic Manager, PHA's Supervisor, PHA</p>	
<p>Distribute and review Staff Surveys on a monthly basis.</p> <ul style="list-style-type: none"> • Ask staff to complete a survey regarding the value of the intervention at the agency and the successes and challenges with the integration of FOF into clinic flow. 	<p>Clinic Manager</p>	<p>See Appendix O</p>
<p>Address staff “buy-in” drift on a monthly basis.</p> <ul style="list-style-type: none"> • Share FOF successes at staff meetings and via newsletters, ask for feedback about FOF from staff, conduct group problem-solving to address challenges with FOF, provide opportunities for retraining and orientation for new staff, etc. 	<p>Clinic Manager, PHA's Supervisor</p>	<p>See “Staff Buy-in”</p>

Appendix V: Suppliers List

- **Rubber and Wood Penile Models**

Total Access Group, Inc.
1671 E. Saint Andrew Place
Santa Ana, CA 92705
1-800-320-3716
www.totalaccessgroup.com
service@totalaccessgroup.com

- **Plastic Bananas (used as penile model)**

Buy.com
85 Enterprise Suite 100
Aliso Viejo, California 92656
1-800-800-0800
www.buy.com

- **Condoms**

- Durex (Tropical Flavors/Her Sensation/Pleasuremax/XXL/Extra Sensitive/Intense Sensation)

Discount Condom King
Calico Distributors
PO Box 1409
Safety Harbor, FL 34695
1-888-659-5808
<http://www.discountcondomking.com>

- Trojan (Enz/Magnum/Ecstasy)

Trojan Professional
Church & Dwight Co., Inc.
PO Box 975
South Plainfield, NJ 07080
1-800-487-6526
<http://www.trojanprofessional.com/>

- Lifestyles (King Size XL/Rough Rider/SKYN), Kimono (Textured/Microthin/Microthin with Aqualube), Beyond Seven (Lubricated with Aloe)

Total Access Group, Inc.
1671 E. Saint Andrew Place
Santa Ana, CA 92705
1-800-320-3716
<http://www.totalaccessgroup.com>
service@totalaccessgroup.com

- **Water-based Lubrication (Astroglide & ID – Juicy Lube)**

Total Access Group, Inc.
1671 E. Saint Andrew Place
Santa Ana, CA 92705
1-800-320-3716
<http://www.totalaccessgroup.com>
service@totalaccessgroup.com

- **Printing of Contact Cards**

Superfine Printing
247 West 37th Street
14th Floor
New York, NY 10018
212-827-0063
<http://www.superfineprinting.com>
info@superfineprinting.com

- **Ditty Bags***

IdeaStage Promotions LLC
2660 E. Mohawk Lane #16
Phoenix, AZ 85050
480-588-4140
<http://www.ideastage.com>
info@ideastage.com

*The ditty bags have had to be ordered directly through a sales rep as they are not an item traditionally found on the site. The item is called **“8498605 - Deluxe golf caddy bag made of 600 denier polyester with PVC backing. Feature zippered closure and snap hook. Matching color zipper.”** The sales rep contacted was Jeffery Young (jeffrey@ideastage.com).

Appendix W: Peer Health Advisor Quality Assurance Form

Peer Health Advisor’s Name: _____

Date: _____

Time: _____

As the Peer Health Advisor delivers the entire intervention, use the following form to provide feedback to the Peer Health Advisor about his performance.

For each skill area, check the appropriate box

V = Very Well Done

E = Effective

N = Needs Development

Component 1: Rapport Building

Steps of Component 1	V	E	N
Introductions.			
Establish an initial rapport and get the client in a trusting mood by using “small talk.”			
Casually inquire about the client’s frequency of condom use and give affirmations.			
Describe the goal of the session, reinforcing that this is a non-judgmental environment.			

Component 2: SCUS and Common Issues with Condom Use

Steps of Component 2	V	E	N
Introduce the Short Condom Use Survey (SCUS) to the client.			
Ask client to complete the SCUS.			
Review SCUS.			
Based on SCUS, give the client positive feedback about things he is doing well regarding condom use.			
Based on SCUS, discuss client errors and problems with condom use.			
Firmly establish that condom use is something that takes practice.			

Component 3: Problematic Experiences with Condoms & Posters to Motivate

Steps of Component 3	V	E	N
Ask about how frequently the client uses condoms and give him an affirmation.			
Ask clients to briefly discuss some of their problematic experiences with using condoms.			
At this point, it is important to discuss how they can introduce condoms into relationships (i.e., condom negotiation).			
Show the client the poster with National HIV rates broken down by race (show the <i>Color Poster</i> at this point).			
Ask the client what he thinks about these statistics and address his reaction.			

Component 4: Baby Oil Experiment and Condom and Lubricant Use Skill Building

Steps of Component 4	V	E	N
Explain that you are going to demonstrate why oil-based lubricants do not work.			
Use the blown-up condom as an example of why oil-based lubricants should never be added to condoms.			
Discuss water-based lubricant.			
Hand the client a contact card that contains the 8 steps to correct condom use.			
Demonstrate the sequence of steps that comprise correct condom use for the client.			
Client practices applying the condom to the model and discuss condom negotiation strategies.			
Once the client has achieved a "perfect performance" ask him to repeat the process for at least 2 or 3 repetitions.			
Highlight the importance of using condom from the beginning to end of sexual intercourse.			

Component 5: Access and Erection Loss

Steps of Component 5	V	E	N
Discusses and normalizes erection loss.			
Discusses the importance of planning for sex.			
Provides the client with a list of stores in the area that carry high-end and popular condoms with address and hours listed.			

Component 6: Fit and Feel and Features of Different Condom and Lubricant Brands

Skill Area	V	E	N
Redirect the client’s attention to the table with the condoms and water-based lubricants.			
Invite the client to open and touch any condoms he didn’t get to feel when he practiced correct condom use skills.			
Provide instruction regarding selecting the condoms that will give the client the best fit and feel			
Invite the client to fill a small bag with any condoms he chooses.			
Show the client a variety of lubricants that are water-based			
Invite the client to fill the small bag with lubricants he chooses.			
Summarize key messages			
Ask the client one thing he will remember and to share information with a friend.			
Highlight your contact information on the back of the 8 steps to correct condom use			
Thank the client for coming to talk with you and helping to reduce HIV rates in his community.			

Overall Communication Skills

Skill Area	V	E	N
Uses a clear voice.			
Does not show judgment towards the client.			
Makes appropriate eye contact.			
Uses an open body language and relaxed posture.			
Avoids distracting behaviors.			
Smiles.			
Is confident and prepared for the discussion.			

Additional Comments:

Appendix X: FOF Fidelity Checklist

Peer Health Advisor’s Name: _____

Date: _____

Time: _____

After the Peer Health Advisor delivers the entire intervention, the following form should be completed to keep a record of the core elements that were adhered to in each session.

Check the core elements that we covered with each client

Core Element	Check (✓)
1. A trained Peer Health Advisor (PHA) will teach correct condom use skills for clients.	
2. The PHA and client will discuss condom negotiation skills.	
3. The PHA provides clients with 25+ packets of water-based lubricants and 25+ condoms of their choice from a broad selection of high-end and popular brands.	
4. The PHA communicates the importance of the client protecting his future by using condoms correctly and consistently with his partners.	
5. The PHA establishes rapport and a trusting relationship with the client at the beginning of the session.	
6. The PHA shows unconditional respect for men and maintains a non-judgmental environment for the client concerning any risk behaviors disclosed.	
7. The intervention is delivered at a point when the client feeling vulnerable and is highly concerned about his STD infection status. This may be while he is in the clinic waiting, after a presumptive diagnosis, or after a confirmed lab result.	
8. The PHA conducts a customized one-to-one counseling session with the client for 45-60 minutes	

Appendix Y: Marketing Materials

The following documents can be used to market the intervention to potential clients or important staff and stakeholders at your agency. These can be used to engage staff and communicate the benefits of **FOF** to the agency and the target population. The documents are a tool that can be used to introduce parties to the principles, and strategies of the intervention and begin to build the necessary “buy-in” among key staff.

How effective is FOF?

The original research demonstrated that participation in FOF:

- ◆ Reduces subsequent STDs
- ◆ Increases reported condom use
- ◆ Decreases the number of sexual partners
- ◆ Decreases the number of acts of unprotected sex
- ◆ Increases proficiency scores for condom application skills

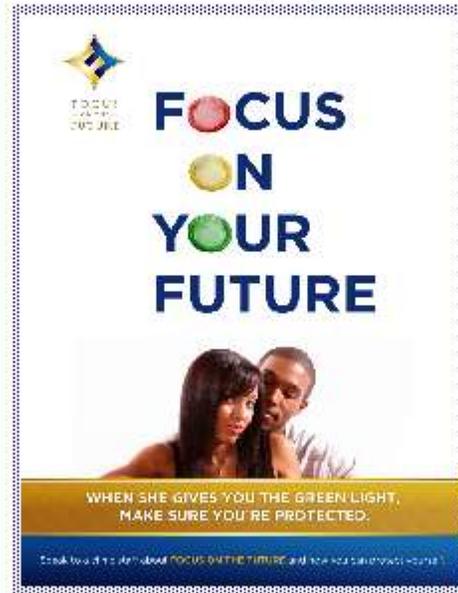
What experiences have agencies had with FOF?

- ◆ "I think this should be mandated (at my agency)" - Social Work Supervisor
- ◆ "(FOF) has been an instrumental tool in stemming the tide of disease" – Disease Investigation Specialist
- ◆ "This is what I've been waiting for!" - Registered Nurse

For more information contact:

Original Developer

Richard A. Crosby, PhD
Chair, Department of Health Behavior
University of Kentucky
Richard.crosby@uky.edu



CDC Contact

Dean Blevins PhD, DBlevins@cdc.gov
Richard Crosby PhD, Rcros2@email.uky.edu

FOF is funded by the CDC under REP Cooperative Agreement #: 1U62PS002084



FOCUS
— ON THE —
FUTURE

A Brief Intervention for Young African American Men on Safer Sex & Condom Use



What is FOF?

FOF is a 45 to 60 minute, individual-level, single session, behavioral intervention that focuses on providing information, motivation and skills to address clients' condom use barriers. This one-on-one conversation between a client and a trained peer, which occurs in an clinical STD setting, allows the intervention to be customized to the clients' individual needs.



Focus on the Future teaches clients:

- ◆ Strategies to address condom use errors and negative condom use experiences
- ◆ Condom negotiation strategies
- ◆ Correct condom and water-based lubricant skills
- ◆ The features of and where to buy a variety of high-end condoms and lubricants so they can find ones with the right fit and feel

Who is FOF for?

Eligible clients for FOF are African American men ages 18-29, who have sex with women (MSW), have used a condom in the last three months, are not knowingly HIV-positive, and either report STD symptoms or have been diagnosed or treated for an STD.

Who facilitates FOF?

FOF is facilitated by a trained Peer Health Advisor (PHA), who is a 21-35 year old African American MSW from the community. Peers are able to build rapport quickly with clients and clients are often more receptive to peers' messages.



What are the goals of FOF?

The overall goal of FOF is to build clients' self-efficacy for using condoms correctly and consistently. This is done by:

- ◆ Discussing condom negotiation skills, the importance of using water-based lubricant, planning for sex, and overcoming negative experiences when using condoms (e.g., condoms breaking, erection loss, etc.)
- ◆ Highlighting that more cases of HIV infection have been reported among African American men compared to other groups of people in the US, in order to motivate clients to take collective action
- ◆ Giving clients the opportunity to practice correctly applying a condom to a model at least 3 times
- ◆ Giving clients 25+ fun and unique condoms and 25+ packets of lubricant to take home

How effective is FOF?

Research shows that participation in FOF will:

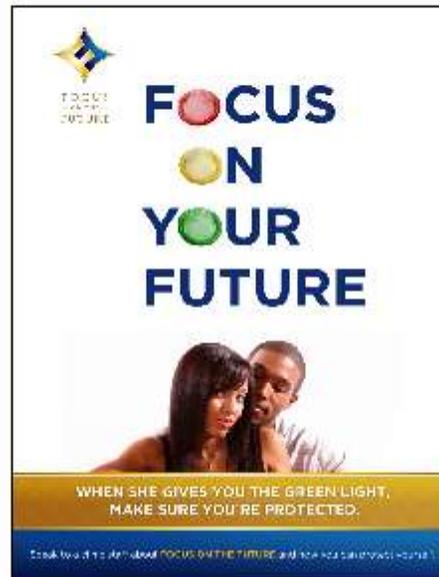
- ◆ Reduce your chances of getting a new STD
- ◆ Increase the chances you'll use a condom
- ◆ Increase your condom use skills

What do participants say about FOF?

- ◆ "No one has ever talked to me about this stuff before."
- Participant
- ◆ "This program makes me want to use condoms." - Participant
- ◆ "We need to have this program everywhere—in schools, barber-shops, outside the clubs."
- Participant

For more information contact:

CLINIC NAME
CLINIC ADDRESS
CLINIC ADDRESS
CLINIC CONTACT INFO
CLINIC CONTACT INFO



PHA NAME
PHA CONTACT INFO
PHA CONTACT INFO
FOF is funded by the CDC under
Cooperative Agreement #: 1U62PS002084



FOCUS
— ON THE —
FUTURE

A Brief Sexual Education Program for Young African American Men on Safer Sex & Condom Use



What is FOF?

FOF is a 45 to 60 minute, one-on-one, one-time conversation that focuses on giving you information, motivation and skills to address issues with using condoms. This is a one-on-one talk between a you and a another young man from the community, which allows the conversation to be customized to your individual needs.

What are the Principles of FOF?

- ◆ Unconditional respect for men
- ◆ There are many options for condoms and lubricants available. It is important to find ones with the right fit and feel for you
- ◆ Practicing condom use is important
- ◆ Condoms can feel good during sex
- ◆ You can protect your future and your community's future



Who is FOF for?

FOF is for African American men ages 18-29, who have sex with women, who have used a condom in the last three months, who are not knowingly HIV-positive, and who either have the symptoms of an STD or have been diagnosed or treated for an STD.

Who facilitates FOF?

During your session you will talk with a Peer Health Advisor (PHA), who is a 21-35 year old African American man from the community. PHAs are not health-care professionals, they are guys like you who want to protect the community.



What are the goals of FOF?

The overall goal of FOF is to make you better at using condoms correctly and consistently. This is done by:

- ◆ Helping you introduce condoms in the bedroom, showing you why you should use water-based lubricant, helping you plan for sex, and teaching you how to overcome negative experiences when using condoms (e.g., condoms breaking, erection loss, etc.)
- ◆ Giving you the opportunity to practice correctly applying a condom to a model
- ◆ Giving you 25+ fun and unique condoms and 25+ packets of lubricant to take home for free!



Appendix Z: Intervention Supply Re-stocking Checklist

FOF Re-Stocking Checklist

- Condoms
 - 15 Trojan Magnum
 - 15 Trojan ENZ
 - 15 Trojan Ecstasy
 - 15 LifeStyles King Size XL
 - 15 LifeStyles RoughRider

 - 15 Durex Tropical Flavors

 - 15 Durex Her Sensation
 - 15 Durex Pleasuremax
 - 15 Kimono Microthin
 - 15 Kimono Aloe
 - 15 Beyond 7
- 1 Lifelike Penile Model
- 1-2 Other Penile Models (e.g. woody)
- 1 Ditty Bag
- 1 Bottle of Baby Oil
- 1-2 Rolls of Paper Towels or Napkins
- 1 Contact card (with 8 Steps to Correct Condom Use and PHA's Contact Info)
- 1 List of Stores Nearby with Condoms and Lubricant
- 1 National HIV Rates Poster
- 1 Short Condom Use Survey
- 1 pen
- Lubricants
 - 30 ID Juicy Lube
 - 30 AstroGlide